AMERICAN THERAPY ADMINISTRATORS OF FLORIDA

Provider Newsletter

2020 Q3

Relaxing telehealth regulations does not mean relaxing fraud enforcement

By Patricia Calhoun | FierceHealthcare

The COVID-19 pandemic rapidly expanded telemedicine use. Telehealth currently addresses everything from routine to pandemic-related care. To facilitate this expansion, federal healthcare programs have loosened, at least temporarily, telehealth restrictions. These eased restrictions, however, create increased opportunities for healthcare fraud and abuse, including Anti-Kickback Statute (AKS) and False Claims Act (FCA) violations.

Recent telehealth regulation changes & telehealth scrutiny

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services adjusted their telehealth requirements to expand telehealth's ability to serve patients during the pandemic:

- Patients no longer need to reside in designated rural areas or have preexisting relationships with their providers.
- Patients can have their telehealth appointments from the convenience and safety of their homes without traveling to medical facilities.

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Demographic Changes or Provider Termination Requirements

As needed, ATA-FL, Health Plans, and Federal agencies perform ad hoc provider practice "mystery shopper" calls or site visits to measure variables including but not limited to provider roster accuracy; urgent, and routine appointment availability; currently accepting new enrollees, and any barriers to scheduling appointments experienced by enrollees.

The accuracy of care provider demographic and practice data plays an important part in the success of a medical practice. Having accurate data helps connect you with members searching for a care provider. It also supports claims processing and compliance with regulatory requirements.

Participating practices are required to notify ATA-FL immediately when:

- A Therapist employee has been terminated or is no longer treating patients at a specific location**

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Demographic Changes or Provider Termination Requirements

- A location is closing or relocating
- Demographic information is changing
- If your practice is or is not accepting new patients
- Changes of ownership
- Changes in hours of operation
- Changes in Languages spoken/written by staff
- Changes in Ages/genders served

**Provider Service Agreement states, you are required to notify ATA-FL of any terminations 90 days prior to the termination.

Participating practices may be subject to penalties for noncompliance. Please refer to your provider service agreement for more details.

Appointment Availability Requirement

Florida Healthy Kids lines of business requirement for a routine visit is (7) Calendar Days and (24) hours for an urgent visit from the Member's request for services.

Medicaid, Medicare and Commercial lines of business requirement for routine visits is (30) Calendar Days and (24) hours for an urgent visit from the Member's request for services.

Fraud, Waste & Abuse

All ATA-FL providers are required to report concerns about actual, potential or perceived misconduct to the HN1/ATA-FL Corporate Compliance Department at:

1 (866) 321-5550

Annual Quality Improvement Documents

Annually the Quality Improvement (QI) Department develops Quality documents, which includes a QI & UM Evaluation, Program Description, and Work Plan. The development of the Quality documents satisfies Health Plan and NCQA Accrediting body requirements. The QI & UM Evaluation analyze the QI department's previous year quality indicators, key accomplishments, identify any areas needing improvement, and develop action plans to improve results. The Program Description and Work Plan establish objectives, goals, QI activities, and the QI Program Structure for the current year. Copies of the annual QI documents are available by contacting the QI department at the address below.

2001 South Andrews Avenue
Fort Lauderdale, FL 33316
Phone: 800-422-3672 Ext. 4701
Fax: 305-614-0364

Clinical Practice Guidelines

ATA-FL uses Apollo, Milliman Care, or our Health Plan partner Clinical Guidelines (depending on the LOB) for Medical necessity determinations. These guidelines are based on appropriateness and medical necessity standards; each guideline is current and has references from the peer-reviewed medical literature, and other authoritative resources such as CMS Medicare. For any medical necessity Recommendation of Denial, the Medical Director shall make an attempt to contact the requesting provider for peer to peer consultation. The Apollo, Milliman Care, or our Health Plan partner Clinical Guidelines are reviewed and approved by HS1 Medical Advisory committee annually, and are available in both electronic and hard copy format. If a provider would like a copy of a guideline that was used to make a clinical determination on a specific case, they may contact their assigned Provider Relations Representative and a copy will be provided.

COVID-19 Relief Help

We salute and admire our provider's commitment to their communities. You've made a conscious choice to run toward calamity, not away from it. Please complete our survey to let us know how you are doing and if you are in need of supplies to open your office or to maintain your offices open.

https://ataflorida.com/covid19survey/

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- More services can now be offered via telehealth, including evaluations to determine continued eligibility for hospice care.
- Telehealth providers can waive patient deductibles and copayments without penalties for offering impermissible kickbacks.
- In some circumstances, Medicare and Medicaid no longer require physicians to be licensed in the state in which their patients are located.
- Providers can use a number of everyday communication technologies to provide telehealth services without being fined by HHS' Office for Civil Rights. Providers are, however, required to make good faith efforts to protect patients' privacy, including, among other things, enabling all available encryption and privacy settings and notifying patients of the increased risk of using such technologies.

Despite these changes, some constants remain, such as the scrutiny telehealth providers face from regulators, particularly for AKS and FCA violations.

In the past year, well before the rise of COVID-19, telehealth providers saw two of the biggest Department of Justice (DOJ) takedowns in history for rampant kickback and fraudulent billing schemes. First, in April 2019, the DOJ charged 24 telemedicine and durable medical equipment company executives and physicians for allegedly paying $1.2 billion in illegal kickbacks and bribes related to prescribing unnecessary back, wrist, shoulder and knee braces.

Second, in September 2019, the DOJ charged 35 individuals in a $2.1 billion fraudulent Medicare billing scheme involving alleged kickbacks to telehealth providers ordering genetic tests. Regulators made clear that COVID-19 will not reduce their focus on prosecuting wrongdoing.

For example, the DOJ recently arrested a Georgia man for his alleged role in a conspiracy involving unnecessary COVID-19 tests. Pandemic or not, the telehealth industry is firmly in the crosshairs of heightened government scrutiny and oversight.

Changed regulations may Increase, rather than decrease, enforcement actions

While easing regulations lead many to assume a decrease in enforcement actions, enforcement actions may increase as regulators respond to new opportunities for fraud. Specifically, telehealth services make it easier for fraudsters to pose as physicians and lure patients into sharing their protected health information or installing malware on their devices.

The relaxed telehealth regulations greatly expand the number of patients for whom fraudulent claims can be submitted. Reduced cybersecurity requirements for telehealth communications increase the risk of hackers intercepting or stealing the protected health information necessary to submit fraudulent claims or commit healthcare identity theft.

Such practices will not go unchecked, and telehealth providers should establish protocols to keep from being unwittingly pulled into the crosshairs.

10 considerations to reduce the risk

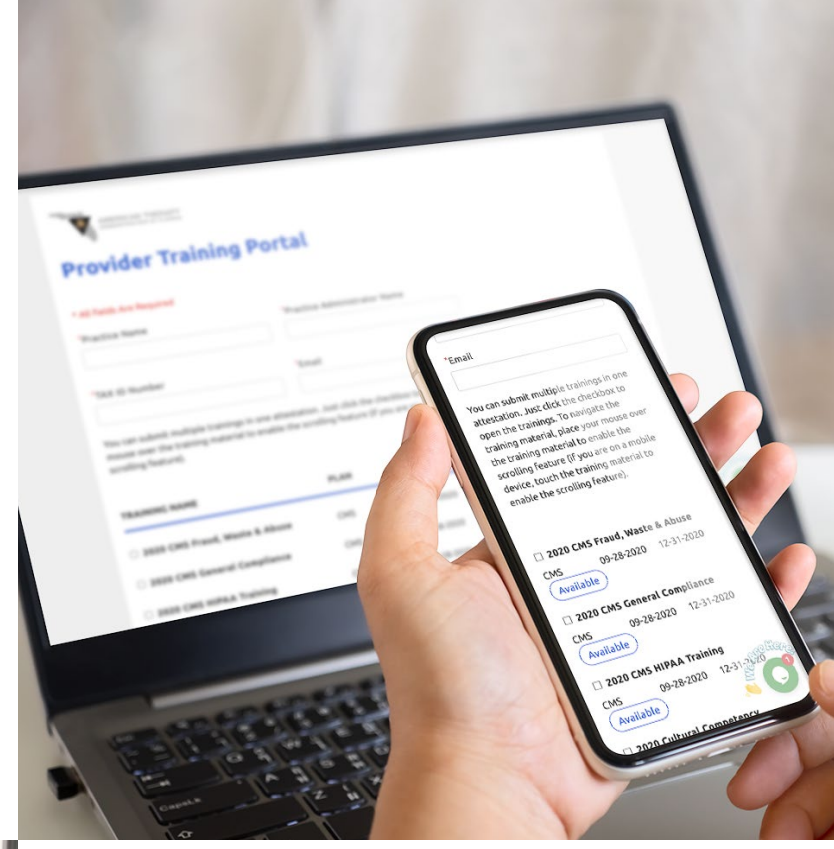
- Establish mechanisms to verify patient identity.
- Establish or maintain protocols for informed consent and beneficiary initiation.
- Identify states that have waived in-state licensure requirements for telehealth, and establish protocols for disengaging telehealth with patients where the provider is not licensed in the patient state after the pandemic emergency is lifted.
- Establish practice standards for patient examinations and remote prescribing.
- Document and maintain patient encounter records, including all regularly mandated documentation (such as patient eligibility for hospice care).
- Properly code telehealth services to ensure coverage.
- Review vendor agreements and patient incentives to ensure compliance with the AKS, FCA and Civil Monetary Penalties Law.
- Ensure compliance with state credentialing and scope of practice requirements.
- Establish privacy and security protocols for telehealth offerings and related systems.
- Notify patients of the increased risk of privacy issues when using telehealth services and strongly consider using telehealth vendors willing to execute a HIPAA-compliant business associate agreement.

Required Annual Provider Training

All providers with ATAFL, are required to complete the Provider Trainings, within thirty days of their contract effective date and annually thereafter. The trainings can be located via the web at

https://ataflorida.com/trainings

You may complete the trainings on any desk top or mobile device for ease of access and completion. Your attestation will confirm that your office has received all mandatory trainings for the year. Should you want a copy of the trainings for your office, they can be downloaded from the attestation page. NOTE: For providers who function under more than one Tax ID; please be sure to complete an attestation for each Tax ID that is contracted with ATAFL.



Affirmative Statement about UM Decision Making

All clinical staff that makes Utilization Management (UM) decisions is required to adhere to the following principles:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
- Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support benefit denials.

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