Provider
Navigator
YOUR CONNECTION TO LIFESYNCH

LifeSynch
Changing behaviors, improving lives
a HUMANA company

First Quarter 2010

Health Literacy: Why it's so Important

Some people have good health literacy skills and use the health care system quite comfortably. For others with limited health literacy skills, the situation is more complex. The number in the latter group is staggering: a report from the Institute of Medicine indicates that about half of all American adults (90 million people) have limited health literacy. According to the National Adult Literacy Survey, 42 million adult Americans can't read – about one out of every six.

The problem doesn't just affect one or two categories of people. It doesn't matter how much money they earn, how much schooling they have, the language they speak, or the race they belong to – the health literacy problem can still exist.

Given the scope of the problem, the saying "choose your words carefully," has added meaning for behavioral health and Employee Assistance Program (EAP) providers and companies. It means we must strive to speak, write and communicate in ways that our members and your patients can understand and use to take care of their health.

Helpful Tips to Promote Health Literacy

Here are some ideas to consider:

- Be clear about how and when your patient should take medications. Check for understanding of what you have said or written before your patient leaves the office.
- Make sure your patient is aware of how to apply what he or she learns in therapy.
- Help your patient be clear about appointment schedules. This can benefit your patient and your practice by preventing missed appointments.
- Check to be sure your patient was able to understand any materials you provided previously.

For more information about health literacy, visit one or more of the following websites:

www.pfizerhealthliteracy.com
www.chcs.org (search for "Fact Sheets")
www.healthy-america.org
www.wellzone.org

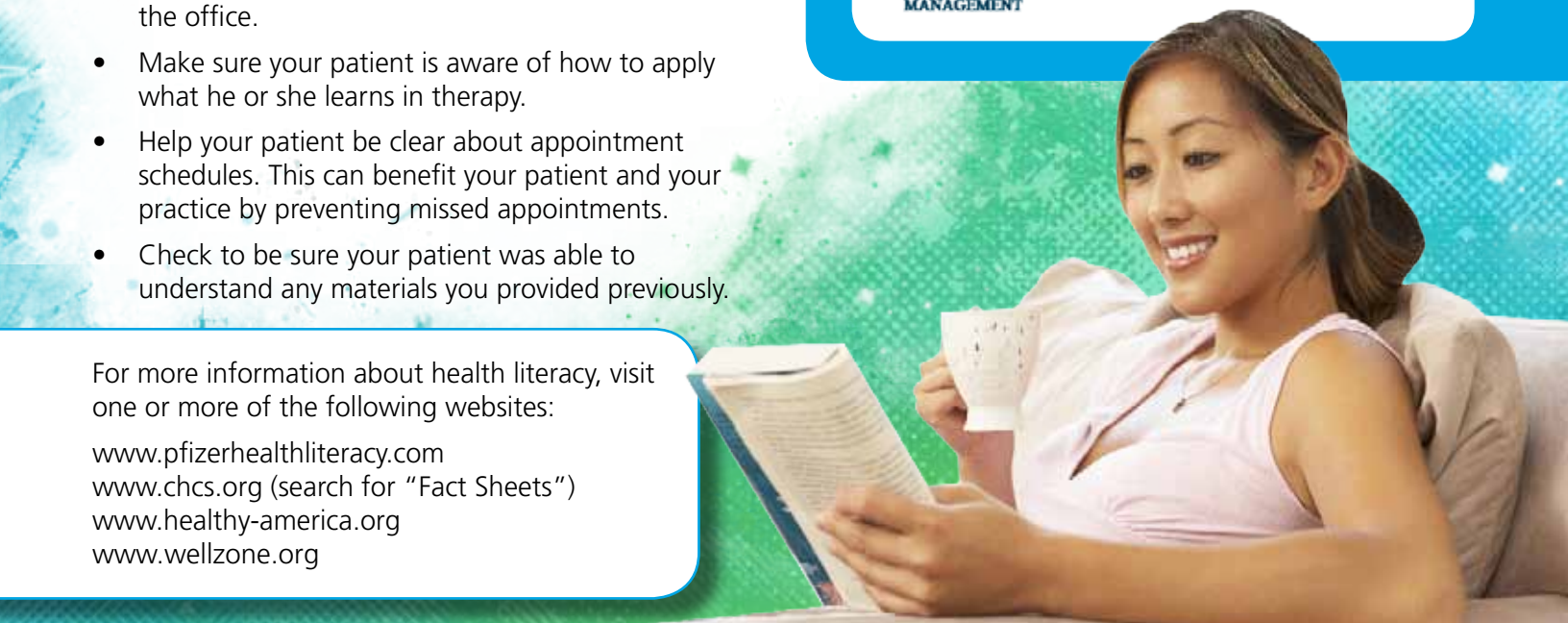
What We're Doing

LifeSynch is committed to making it as easy as we can for our members to interact with us. This means we are focused on making our forms easier to use, our letters and materials easier to read and our conversations with our members clearer and easier to understand. The work has already begun.

IN THIS EDITION

ACCREDITATIONS

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT
URAC ACCREDITED CASE MANAGEMENT
NCQA ACCREDITATION FULL



Fraud & Abuse Prevention: What You Need to Know

Every year the Medicare program loses millions of dollars to fraud, waste and abuse. Reducing the negative flow of dollars can help the Medicare program and help address rising health care costs. It's important to recognize problems when you see them and know how to report them. This article can help.

Fraud is a big problem in Medicare. The following list shows types of fraud and the extent of its reach:

- Health plan fraud
- Fraud by agents/brokers
- Fraud due to misrepresentation of enrollment information
- Claims fraud
- Provider fraud
- Dental fraud
- Pharmacy fraud
- Member fraud

Important Definitions

The detection and prevention of insurance fraud, waste and abuse is essential to maintain a health care system that is affordable for everyone. Both state and federal law enforcement agencies are increasingly focused on investigating health care fraud, waste and abuse. These terms are defined as follows:

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself, or some other person. It includes any act that constitutes fraud under applicable federal or state law. Some examples of fraud include, but are not limited to:

- Double billing
- Billing for more expensive services or procedures than were actually provided
- Doctor shopping for prescription drugs
- Eligibility fraud
- Short-filling prescriptions
- Prescription forging or altering

Waste means to use up health care benefits or spend health care dollars without a real need such as:

> Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed for 60 days.

Abuse is provider practices that are inconsistent with sound fiscal, business or medical practices that result in unnecessary costs to the health care system, such as:

> Reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the health care system.

Important Laws

Federal laws and regulations designed to prevent or improve the situation with fraud, waste and abuse include, but are not limited to the following: the False Claims Act, the Anti-Kickback Statute and the "Stark Law."

False Claims Act

The Federal False Claims Act (FCA), 31 U.S.C. Title 1347, is the primary federal law used to fight fraud in Medicaid and Medicare and has become one of the most widely enforced statutes to fight health care fraud. The False Claims Act addresses any person or entity that does any of the following:

- Knowingly presents, or causes to be presented, to an employee of the United States government a false or fraudulent claim for payment or approval
- Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid
- Knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money to the government
- Has actual knowledge of the information
- Acts in deliberate ignorance of the truth or falsity of the information
- Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required

The False Claims Act imposes two sorts of liability: (1) the submitter of the false claim or statement is liable for a civil penalty, regardless of whether the submission of a claim actually causes the government any damages and even if the claim is rejected, and (2) the submitter of the claim is liable for damages that the government sustains because of the submission of the false claim. Under the False Claims Act, the Centers for Medicare and Medicaid Services (CMS) Manual states that those who knowingly submit or cause another person to submit false claims for payment by the government are liable for three times the government's damages plus civil penalties of $5,000 to $10,000 per false claim.

Continued on page 3

Continued from page 2

The Anti-Kickback Statute and the physician self-referral law are two important fraud and abuse authorities. Violations of these laws can result in nonpayment of claims, civil monetary penalties, exclusion from the Medicare program and liability for the submission of false claims to the government. Violation of the Anti-Kickback Statute may additionally result in imprisonment and criminal fines.

Anti-Kickback Statute

The Anti-Kickback Statute, 42 U.S.C. 1320a-7b, makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program. For more information, see http://oig.hhs.gov/index.asp.

The Stark Law

The Physician Self-Referral Prohibition Statute, 42 U.S.C. 1395nn, commonly referred to as the "Stark Law," prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship — unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a designated health service furnished as a result of a prohibited referral. For more information, see http://www.cms.hhs.gov/PhysicianSelfReferral on the CMS website.

Reporting and Referral of Fraud

If you become aware of a possible violation of any federal or state rule, law, regulation or policy, or of any violation of Humana's Principles of Business Ethics: Compliance and Fraud Prevention Guide, immediately report it by calling the Ethics Help Line at 1-877-5THE KEY (1-877-584-3539). Your call to the Ethics Help Line may be made anonymously

Humana strictly prohibits retaliation against any health care professional, entity or vendor who, in good faith, reports an actual or possible violation of any federal or state law or regulation, policy or ethical standard. You are expected to cooperate fully in any investigation of an alleged violation.

You may also contact the following:

Humana Special Investigations Unit
1100 Employers Blvd.
Green Bay, WI 54344

Phone number: 1-800-558-4444, ext. 8187 or
920-337-8187

Fax number: 920-337-5487

Reports of fraud can be made to the state's Department of Insurance (DOI) through the Smithsonian Institution Research Information System (SIRIS), the National Association of Insurance Commissioners (NAIC), or through the state's DOI Website. Suspected fraud, waste and abuse for Medicare (Parts A, B and C) is reported to CMS through the Department of Health and Human Services (HHS) Office of Inspector General (OIG). Suspected Medicaid fraud, waste and abuse is reported to the Medicaid Program Integrity (MPI) Administrator, Agency for Health Care Administration (AHCA), Analyst with the Bureau of Managed Health Care, Medicaid Fraud Control Unit (MFCU) or appropriate Medicaid agency.

Referrals may be made to state fraud bureaus, the U.S. Postal Inspectors, FBI, U.S. Department of Health and Human Services, Medicare Drug Integrity Contractor (MEDIC), state medical licensing and disciplinary boards, state insurance commissioners, federal, state and county attorneys, local police departments, Immigration and Naturalization Service, Internal Revenue Service or any other appropriate authority.

Additional Resources

Below are some additional resources regarding Medicare fraud and abuse, including information about what to do if you become aware of incidents and suspect possible fraud or abuse:

- The Fraud, Waste and Abuse Prevention Training Guide provides information to help providers find out more about Medicare and fraud abuse. You will find a link to the guide on the home page of the LifeSynch provider portal at lifesynch.com (registration required).
- Department of Health & Human Services (HHS) Office of Inspector General (OIG) website offers a wealth of information regarding fraud and abuse prevention, detection and reporting: http://www.oig.hhs.gov
- CMS' website offers a vast amount of information pertaining to Medicare program rules and requirements: http://www.cms.gov
- The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid and all other federal health care programs: http://www.oig.hhs.gov/fraud/exclusions.asp
- If you have identified billing practices that cause you to suspect potential fraud or abuse, you may call the OIG's National Hotline at 1-800-HHS-TIPS (1-800-447-8477) to report the activity.

The information for this article was obtained, in part, from the Medicare Fraud and Abuse brochure, January 2009. Retrieved from http://www.cms.hhs.gov/MLNProducts/downloads/110107_Medicare_Fraud_and_Abuse_brochure.pdf.

Some Common Claims Questions That Providers Ask

Check below and see if there is a question you have wanted to ask, but haven't had a chance. It may save you the time of having to make a call or send an inquiry.

Can I file my claims electronically?

While LifeSynch does not accept claims electronically, in-network providers can submit and view claims via our secure provider portal at lifesynch.com. Please contact our customer service department at 1-800-777-6330 to enroll in the portal if you have not done so already.

My patient's plan managed by LifeSynch is secondary. Do I still need to obtain precertification?

No, precertification is not required for secondary plans. However, the services received will still need to meet all the requirements of the benefit plan. Please remember to include the Explanation of Benefits from the primary insurance plan when you submit your claim to us.

Office Relocation

LifeSynch completed the relocation of its corporate office from Fort Worth to Irving, Texas, during the fourth quarter of 2009. The new office is located at 2101 N. John Carpenter Freeway, Irving, TX 75063.

New Addresses for Non-Humana and EAP Claims

Effective immediately, please send your claims to the addresses below.

For Non-Humana Claims

LifeSynch
2101 N. John Carpenter Freeway, Suite 100
Irving, Texas 75063

For All EAP Claims (Including Humana EAP Claims)

LifeSynch
2101 N. John Carpenter Freeway, Suite 150
Irving, Texas 75063

Note: LifeSynch's toll-free numbers will remain the same. You may continue to reach us through the toll-free number on the back of the member ID card or call our provider relations line at 1-800-890-8288.

Thank you for your cooperation!

Provider Portal Offers Quick, Convenient Access

Looking for a simple, easy way to manage your practice? Try LifeSynch's provider portal. Access is available any time, any day. Once you sign up, you just log in and begin. The provider portal enables you to do the following:

- Submit claims electronically
- Make demographic changes
- View certifications
- Check the status of a claim
- Look up member information and benefits
- E-mail inquiries directly to our customer service or provider relations staff
- Obtain an initial outpatient certification

You are a valuable partner to LifeSynch and we want to be sure you have the latest tools and simplest access to take care of your patients and our members.

You can sign up for the provider portal by calling provider relations at 1-800-890-8288 or sending an e-mail to providerservices@lifesynch.com.

Thank you for being a LifeSynch provider!

Visit us on the Web for provider information

Visit lifesynch.com for the following:

- The toll-free number to contact LifeSynch staff who can answer questions about utilization management
- Medical necessity clinical criteria for mental health and chemical dependency
- Availability of peer reviewers to discuss utilization management decisions
- Clinical practice guidelines and process to measure adherence
- Information exchange expectations for continuity and coordination of care
- Availability of independent external appeals process for adverse determinations
- Policy prohibiting financial incentives for utilization management decision-makers
- Statement of member rights and responsibilities
- Confidentiality policies
- Information about the quality improvement program
- Results of the annual survey to gauge enrollee and provider satisfaction
- Information about how to obtain a copy of the quality improvement program description
- Preventive behavioral health programs designed to help members stay healthy
- Treatment record policies regarding confidentiality of records, documentation standards, systems for organization of treatment records at the practice site, and performance goals

Paper copies of each topic are available by calling 1-866-279-7214.

Welcome New Facilities

- Able To Change Recovery, Westlake Village, CA
- Allegiance Health, Jackson, MI
- Allied Health Services Medford, Medford, OR
- Alternative Options, Cerritos, CA
- Arapahoe Douglas Mental Health Network, Englewood, CO
- Broadlawns Medical Center, Des Moines, IA
- Cedar Hills Hospital, Portland, OR
- Coastal Recovery Center, Wilmington, CA
- Community Recovery Resources, Grass Valley, CA
- Defiance Regional Medical Center, Defiance, OH
- Doctors Hospital at Renaissance, LTD, Edinburg, TX
- Eliza Coffee Memorial Hospital, Florence, AL
- Emerald Coast Behavioral Hospital, Panama City, FL
- Exempla Behavioral Heath at West Pines, Wheat Ridge, CO
- Flower Hospital, Sylvania, OH
- Gateways Recovery, Cincinnati, OH
- Genesis Medical Center, Davenport, IA
- Greenbrier Behavioral Health, LLC, Covington, LA
- Haven Senior Horizons, Phoenix, AZ
- Herrick Medical Center, Tecumseh, MI
- Horizon Human Services, Inc., Casa Grande, AZ
- Human Service Center, Hamilton, Peoria, IL
- Human Service Center, Jefferson, Peoria, IL
- Human Service Center, Newleaf Ln, Peoria, IL
- Human Service Center, Richard Pryor, Peoria, IL
- Human Service Center, Rochelle Ln, Peoria, IL
- Human Service Center, Willow Knoll, Peoria, IL
- LaCheim School, Inc., San Pablo, CA
- Lancaster General Hospital, Lancaster, PA
- Lenape Valley Foundation, Doylestown, PA
- Medical University Hospital Authority, Charleston, SC
- Memorial Hermann Prevention and Recovery Center Pearland, Houston, TX
- Memorial Hermann Prevention and Recovery Center, Adolescent Center, Houston, TX
- Memorial Hermann Prevention and Recovery Center, Clear Lake, TX
- Memorial Hermann Prevention and Recovery Center, Northwest IOP, Houston, TX
- Memorial Hermann Prevention and Recovery Center, Sugarland, TX
- Memorial Hermann Southwest Hospital (Psych Unit), Houston, TX
- MMO of Covington, LLC, Covington, LA
- Newport Integrated Behavioral Healthcare, Inc., Decatur, GA
- Northeast Alabama Regional Medical Center, Anniston, AL
- Pegasus Schools, Inc., Lockhart, TX
- Penrose – St. Frances Health Services, Colorado Springs, CO
- Philhaven Incorporated, Mount Gretna, PA
- Promise Hospital of Louisiana, Shreveport, LA
- Roanoke Treatment Center, Roanoke, VA
- Saints Mary & Elizabeth Medical Center, Chicago, IL
- Shoals Hospital, Muscle Shoals, AL
- Temecula Valley Treatment Center, Cupertino, CA
- 10th Street Clinic, Milwaukee, WI
- Texas Health Presbyterian Winnsboro, Winnsboro, TX
- The Toledo Hospital, Toledo, OH
- The Walker Center, Gooding, ID
- Toledo Childrens Hospital, Toledo, OH
- Valley Forge Medical Center & Hospital Inc., Philadelphia, PA
- Western Montana Addiction Services, Missoula, MT