

# 1 ABOUT THE PLAN

## 1.1 Overview

Neighborhood Health Providers ("NHP" or "the Plan") was established in 1995 by Jamaica Hospital Medical Center and Brookdale University Hospital Medical Center to serve the health care needs and improve access to medical care throughout the five boroughs of New York City. Both of our founding hospitals have long standing commitments to providing quality health care to low-income patients. Our founders' goals were to create a managed care program that provided exceptional medical care that delivered high quality, cost effective and coordinated health services to Medicaid enrollees.

NHP added the New York State funded Child Health Plus program in 1997, followed in 2002, by the addition of the Family Health Plus program. In October 2008, we acquired the Suffolk Health Plan where we operate as *Neighborhood Health Providers doing business as Suffolk Health Plan*. This was followed by the acquisition of the former New York Presbyterian Community Health Plan. The Plan now serves over 215,000 members throughout the five boroughs of New York City and Suffolk County.

The Plan's provider community includes hospital-based health systems, freestanding health centers, federally qualified health centers, independent practitioners, and multi-specialty physician groups. Today our network includes:

- ◆ 52 Hospitals
- ◆ 231 Community Health Centers
- ◆ 2997 Primary Care Practitioners
- ◆ 890 OB/GYN Practitioners
- ◆ 8444 Specialty Care Practitioners

Our commitment to excellence in the delivery of health care services is evidenced through:

- ◆ Dedication to the communities we serve
- ◆ Advocating on behalf of our members
- ◆ Delivery of high quality member and provider service
- ◆ Awareness of the cultural diversity of our members

- ◆ Encouraging teamwork to achieve a common goal
- ◆ Member, provider and employee satisfaction
- ◆ Ability to be fiscally responsible while still achieving positive health outcomes

Our Plan also employs a large group of skilled health care clinicians who provide our care coordination to our members with chronic illness. We strongly encourage you to refer your members who have asthma, diabetes, coronary artery disease, HIV and other chronic or acute conditions to our Case Coordination Program.

If you are an OB/GYN or Primary Care Practitioner who has a member who is pregnant please contact our Care Coordination Program to get the future Mom enrolled in our **Healthy Beginnings** program. This program is designed to address the needs of all our pregnant members and is especially well suited to those who may be at high risk due to a complicating health factor.

## **1.2 How to Contact Us**

### **Via the Internet**

The Plan is available to serve you through the NHP web site ([www.getnhp.com](http://www.getnhp.com)) and SHP website ([www.suffolkhealthplan.com](http://www.suffolkhealthplan.com)) twenty-four (24) hours a day seven (7) days a week. When you go onto the respective web site click the PROVIDERS button and then click on the NHP ONLINE or SHP ONLINE button to enter our secure web portal to have access to member eligibility, claims status, provider lookup, check authorization status and submit requests to prior authorize medical services. You may also request the review of a claim denial or payment; submit a general inquiry; or submit a request to review an authorization denial and attach additional clinical information as appropriate since this is a secure web site.

Since this is a secure web portal you will need to register the first time you access the web portal. Registration is easy and convenient just follow the instructions as prompted.

**You may also submit your claims electronically via our web portal.** The Plan has partnered with MD On-Line to offer our Participating Providers a FREE solution for submitting your CMS1500 claims to us electronically. With electronic claims submission, you will receive your payment faster thus helping to speed up your cash flow. Once you are registered and signed into our web portal, select "Submit Your Claims Electronically". You will be brought to the MD On-Line web site where you will need to create an account in order to begin submitting your claims.

This service works whether or not your office has billing software. For offices that do not have billing software simply enter the claim information into the online claim

form and submit it to us. If you have billing software this solution works with every billing software and allows for fast, easy uploading and submission of your batch claims.

### **Interactive Voice Response (IVR)**

The Plan also has an Interactive Voice Response (IVR) system available 24 hours per day, 7 days week to respond to your eligibility verification and claims status inquiries only. To access the IVR please call Provider Services.

### **To Speak to a Provider Services Advocate**

Provider Services staff is also available to serve you during regular business hours, Monday through Friday from 9:00 AM to 5:00 PM.

## **KEY CONTACT INFORMATION**

### **Online**

Visit the NHP website at [www.getnhp.com](http://www.getnhp.com)

Visit the SHP website at [www.suffolkhealthplan.com](http://www.suffolkhealthplan.com)

### **By Phone:**

Member Eligibility Verification &  
Claims Status Inquiries  
(24 hours per day, 7 days a week)

NHP: 1-800-558-7970  
SHP: 1-877-747-6789

Provider Services

NHP: 1-800-558-7970  
SHP: 1-877-747-6789

Care Coordination  
(Prior Approvals, Care Coordination  
Appeals)

NHP: 1-800-765-3805 (PHONE)  
1-800-338-4195 (FAX)  
SHP: 1-800-250-5007 (PHONE)  
1-877-267-7900 (FAX)

|   |      |  |
|---|------|--|
| Provider Relations  | NHP: | 212-883-0883 (PHONE)<br>212-808-4772 (FAX) |
|   | SHP: | 631-881-6720 (PHONE)                       |
| Member Services<br>(24 hours per day, 7 days a week)                          |      | 1-800-826-6240<br>TTY: 1-800-662-1220      |
| NHP Behavioral Health   |      | 1-866-969-2661                             |
| Davis Vision  |      | 1-800-999-5431                             |
| DentaQuest (Dental)   |      | 1-800-417-7140                             |
| UR Expedited Appeal Requests<br>After Normal Business Hours<br>(Members Only) |      | 1-800-826-6240                             |
| Compliance Hotline  |      | 1-877-655-9900                             |

**To Send Us Correspondence:**

|                                     |  |
|-------------------------------------|--|
| Provider Services/Claims Appeals    | Provider Services Department<br>Neighborhood Health Providers<br>Suffolk Health Plan<br>PO Box 6008<br>Hauppauge, New York 11788                                     |
| Member Services                     | Member Services Department<br>Neighborhood Health Providers<br>Suffolk Health Plan<br>P.O. Box 19769<br>Charlotte, NC 28219-9769                                     |
| Care Coordination (Written Appeals) | Care Coordination Department<br>Neighborhood Health Providers<br>Suffolk Health Plan<br>4944 Parkway Plaza Boulevard<br>Suite 110<br>Charlotte, North Carolina 28217 |

### **To Submit Claims/Encounters**

|                   |   |
|-------------------|---|
| Electronic Claims | Submitter ID: 11325   |
| Paper Claims      | Claims Department<br>Neighborhood Health Providers<br>Suffolk Health Plan<br>PO Box 6008<br>Hauppauge, New York 11788 |

### **1.3 Product Overview**

Our Plan offers three different health plans to the New York City population we are proud to serve.

#### **Medicaid Managed Care**

The Medicaid Managed Care program is a pre-paid health services program available to qualified persons with Medicaid coverage through the Medical Assistance Program. Through its Medicaid Managed Care program, the Plan provides the full range of services covered under the Medical Assistance programs. Most of these services will be provided directly through our Plan. Other services continue to be provided through the fee-for-service Medicaid program.

Plan covered services include:

- Primary Care and Specialist visits
- Inpatient Hospital care in an Acute Care/General Hospital
- Sub-acute inpatient care (also includes Residential Health Care Facility)
- Laboratory Services
- Radiology Services
- Certified Home Health Care Services
- Behavioral Health: Inpatient and Outpatient Mental Health, Alcohol and Drug Treatment Services
- Medical Transportation Services
- Optical Services and Goods
- Hearing Screening and Hearing Aids
- Dental Services

- Outpatient Rehabilitation Therapies: Physical Therapy/Occupational Therapy/Speech Therapy (limited to twenty (20) visits per therapy per calendar year)
- Durable Medical Equipment
- Prosthetic and Orthotic Services
- Preventive health screenings
- Podiatric Services
- Nurse-Midwife Services
- Family Planning Services (including abortion)
- HIV Pre- and Post-Test Counseling Services
- Prescription and Over-the-Counter (OTC) Drugs including enteral formula and selected medical supplies
- Personal Care Services
- Self Management training: Asthma and Diabetes

Dental Services include coverage of up to 4 annual fluoride varnish treatments for children between birth and age 7 when applied by a dentist, physician or nurse practitioner.

### **Child Health Plus**

Child Health Plus members are entitled to receive the full range of covered benefits as established by the Child Health Plus Program.

Plan covered services include:

- Primary care and specialist visits Preventive health screenings (co-pays apply)
- Inpatient Hospital care in an Acute Care/General Hospital
- Laboratory Services
- Radiology Services
- Certified Home Health Care Services (with limitations)
- Hospice Services
- Behavioral Health: Inpatient and Outpatient Mental Health, Alcohol and Drug Treatment Services (with limitations)
- Emergency Transportation
- Optical Services and Goods
- Hearing Screening and Hearing Aids
- Outpatient Rehabilitation Therapies (with limitations)
- Durable Medical Equipment (with limitations)
- Prosthetic and Orthotic Services

- Dental Services (with limitations)
- Podiatric Services
- Nurse-Midwife Services
- Physical Therapy/Occupational Therapy/Speech Therapy (with limitations)
- Family Planning Services (including abortion)
- Prescription (see Appendix for Formulary information) and over the counter drugs (with limitations)
- Medical supplies (with limitations)

Child Health Plus does not cover non-emergent transportation, long term care or personal care services.

### **Family Health Plus**

The Family Health Plus benefit package includes the following Plan covered services:

- All Physician services/Clinic Visits (\$5.00 Co-payment per office visit)
- Preventive health screenings (co-pays apply)
- Inpatient health care (\$25.00 Co-payment per inpatient stay)
- Covered Over the Counter Drugs (\$.50 Co-payment per item)
- Smoking cessation products (\$1.00 Co-payment each)
- Lab tests (\$.50 Co-payment per test)
- X-rays/Radiology services (\$1.00 Co-payment per service)
- Vision care: Replacement frames or lenses or both within the 24 month period are no longer a covered item. Family Health Plus will only cover the following ONCE in a 24-month period:
  - One (1) eye exam
  - Either one (1) pair eyeglass lenses and a frame or prescription contact lenses when medically necessary
  - One (1) pair of medically necessary occupational eyeglasses
- Hearing services (with limitations)
- Durable medical equipment
- Home health services (limited to short term, acute care in lieu of hospitalization, up to forty (40) visits per year)
- Hospice services
- Family planning services and supplies
- EPSDT services
- Emergency room services
- Non-urgent Emergency Room Services (\$3.00 Co-payment per visit)
- Emergency ambulance transportation

- Behavioral health: Inpatient mental health and alcohol and substance abuse treatment thirty (30) days per year)
- Diabetic supplies and equipment
- Other Covered Medical Supplies (\$5.00 Co-payment per office visit)
- Radiation therapy, chemotherapy and hemodialysis; and
- Dental services (\$5.00 Co-payment per visit capped at \$25 per year)
- Prescription Drugs including enteral formula and selected medical supplies (\$6.00 Co-payment for brand and \$3.00 Co-payment for generic drugs)

Family Health Plus **does not cover** long-term care services for the chronically ill. This includes but is not limited to nursing home, home attendant, private duty nursing, non-emergency transportation, medical supplies and non-prescription medications, except for smoking cessation products and diabetic supplies and equipment. Also, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) are not covered.

Family Health Plus members who are in one of the following categories are not subject to the co-payments listed above:

- If the member is under age 21
- If the member is pregnant
- If the member is a permanent resident of a nursing home **or** a resident of an OMH/OMRDD community based residential facility
- If the member indicates to you at the time of service that they can not afford to pay the copayment

## ***1.4 The Member Enrollment Process***

### **Medicaid**

In order to join the Plan's Medicaid Program, a potential member must complete an enrollment form and select a PCP. At the time of enrollment, a Plan Marketing Representative gives the new member an explanation about our program. In the mandatory enrollment process, some members will be auto-assigned to the Plan. In these cases, the member will be assigned to a participating PCP. The member has the option of changing PCPs at any time.

After enrollment, during the first month of membership, the member receives an identification card and a Plan Outreach Representative calls each new member to welcome him/her to the Plan. The purpose of the call is to make sure that each member received his/her welcome materials, to reinforce important managed care

concepts such as scheduling a baseline physical and use of the Primary Care Provider, and to determine if a member has any health needs which the Plan can help to coordinate. The Plan also conducts health assessment screening during the new member call to identify special health care needs among new members.

At the time of enrollment, the member receives a Provider Directory and a Member Handbook that describes the program in more detail.

The Plan also conducts orientation sessions at designated Health Center provider sites in the community. The on-site orientation sessions are conducted in English and other languages (e.g., Spanish, Russian) to meet member needs.

### **Child Health Plus**

To enroll in the Child Health Plus Program, a potential member or his/her parent/guardian must meet New York State defined income eligibility requirements, submit required documentation, pay premium (if applicable) and sign a contract.

After enrollment, the member receives an identification card, a Provider Directory and Member Handbook.

### **Family Health Plus**

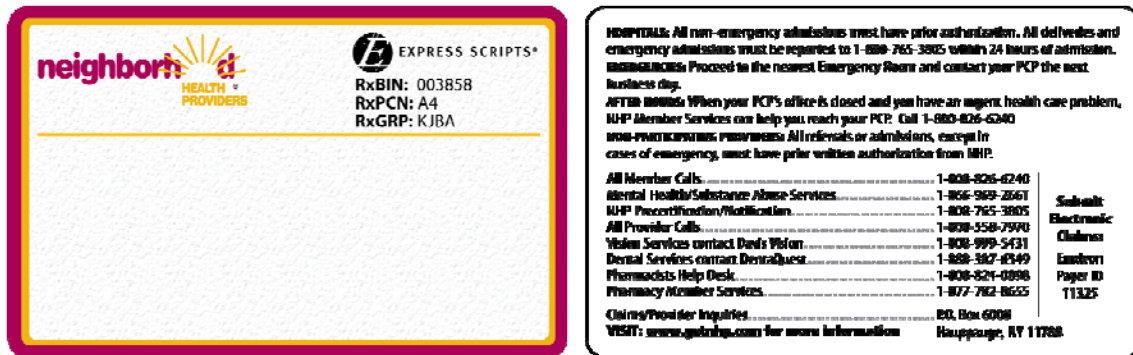
To enroll in the Family Health Plus program, a potential member must meet New York State defined income eligibility requirements, supply required documentation and sign an enrollment form.

After enrollment, the member receives an identification card, a Provider Directory and a Member Handbook. A Plan Outreach Representative calls each new member to welcome him/her to the Plan. The purpose of the call is to make sure that each member received his/her welcome materials, to reinforce important managed care concepts such as scheduling a baseline physical and use of the Primary Care Provider, and to determine if a member has any health needs which the Plan can help to coordinate.

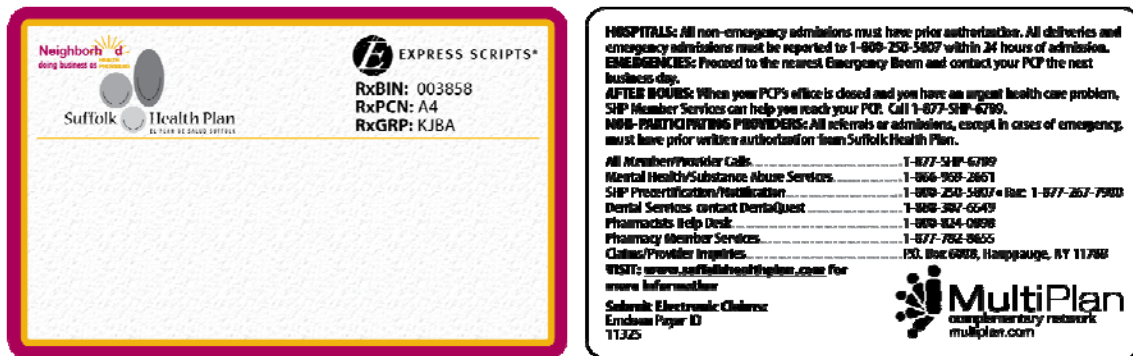
## 1.5 How to Identify a Plan Member

### 1.5.1 NHP Member ID Cards

All newly enrolled NHP members receive a NHP ID card in the mail (examples are below) and must present it at the time they seek to receive medical services.



### 1.5.2 SHP Member ID Cards



**PLEASE REMEMBER TO ALWAYS VERIFY MEMBER ELIGIBILITY THROUGH THE PLAN WEBSITE ([www.getnhp.com](http://www.getnhp.com) OR [www.suffolkhealthplan.com](http://www.suffolkhealthplan.com)) OR THROUGH OUR IVR BEFORE PROVIDING SERVICES.**

## **COMPLIANCE** **INCLUDES FRAUD & ABUSE, HIPAA and BREACH**

The Office of the Medicaid Inspector General (OMIG) was created in November 2006 to protect the integrity of the Medicaid program. Since its inception it has intensified its oversight over hospitals, providers and managed care organizations involved with the Medicaid system. The OMIG website is located at [www.omig.state.ny.us](http://www.omig.state.ny.us).

James Cox has taken over as the state's Medicaid Inspector General. He has extensive experience on the federal level, including oversight of the Albany office of the U.S. Health and Human Services' Inspector General. Prior to July 2011, James Sheehan was the Medicaid Inspector General.

### **The Office of the Medicaid Inspector General**

#### **Mission Statement**

Our mission is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

#### **Vision Statement**

To be **the** national leader in promoting and protecting the integrity of the Medicaid program.

OMIG believes that 1.0% to 3.0% of all Medicaid payments are inappropriate payments or fraud and abuse payments. New York State is committed to make fraud and abuse recoveries of that magnitude and they have implemented their work plan identifying their strategies. The 2011 OMIG Work Plan can be found at [http://www.omig.ny.gov/data/images/stories/work\\_plan/omig\\_work\\_plan\\_2010\\_2011.pdf](http://www.omig.ny.gov/data/images/stories/work_plan/omig_work_plan_2010_2011.pdf)

In 2009 OMIG succeeded in saving the state \$1.61 billion through cost-savings activities (including nearly \$133 million in recipient restrictions). In the fiscal period ending September 30, 2009, OMIG attained \$500 million of federal recoveries.

The intensity of regulatory agencies to uncover fraudulent and abusive practices more than encourages health care organizations and health care providers to ensure they have effective compliance programs in place.

The Plan is committed to identifying, investigating and preventing fraud and abuse. To that end the Plan has implemented a compliance plan. The compliance plan requires all employees, members, providers and other subcontractors to comply with all applicable statutes, regulations and program requirements. This includes program requirements for Medicaid Managed Care, Family Health Plus and Child Health Plus. It also includes state and federal fraud and abuse laws and regulations. The Plan is dedicated to supporting and protecting the integrity of state and federal government sponsored programs and requires **your** cooperation.

## **WHAT IS HEALTHCARE FRAUD AND ABUSE?**

***Fraud*** is any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain. The act does not have to be successful; it is enough that the person attempted the deception.

***Abuse*** relates to practices that are inconsistent with sound business, fiscal or medical practices and result in unnecessary costs to the state, federal government or the Plan. An example is reimbursement of services that are not medically necessary or do not meet professionally recognized standards for health care.

## **COMMON TYPES OF FRAUD**

Fraud and abuse can take many forms and can be committed by dishonest physicians, medical equipment suppliers, dentists, laboratories, hospitals, other health services vendors and health care workers or by Plan members. Some of the common types of fraud committed by providers and members are given below.

### **Providers**

Provider fraud can take many forms. The Plan needs the assistance of its members and providers to identify this type of activity. Examples of provider fraud include:

- Billing for services, procedures and/or supplies that were not provided, e.g. an x-ray that was not taken;
- Double billing, e.g. when a provider bills the Plan and also bills Medicaid fee-for service
- Requiring a Plan member to return for unneeded services;

- Performing unnecessary procedures (over-utilization), tests or even surgeries;
- Up coding, e.g. providing a simple office visit and billing for a comprehensive visit or performing a simple procedure and billing for a complex procedure;
- Unbundling, e.g. billing for portions of a procedure separately rather than for the whole procedure;
- Having an unlicensed person perform services that only the licensed professional should be performing and then billing as if the licensed professional performed the service;
- Billing for more service time than actually provided, e.g. counseling or anesthesia;
- Billing for an office visit when there was none, or adding additional family members' names to bills;
- Accepting payment from another provider as payment for referring a patient to that other provider (kickbacks);
- Altering medical records;
- Routinely waiving member co-pays;
- Billing for "phantom" patients who do not exist and did not receive services;
- Billing for more hours than there are in a day.

### **Members**

Member fraud can take many forms. The Plan needs the assistance of its members and providers to identify this type of activity. Examples of member fraud include:

- Loaning an insurance identification card, such as the Plan identification card to another person or using the identification card of another person;
- Forging or altering a prescription;
- Using more than one insurance identification card;
- Intentionally receiving duplicative, excessive or conflicting health care services or supplies;

- Re-selling items such as prescriptions or medical supplies received through the Plan's programs;
- Providing false information when applying to the Plan in order to try to obtain coverage;
- Using the transportation benefit for non-medical related business

## **YOU CAN HELP!**

***Plan Participating Providers*** can assist with identifying member fraud by notifying the Plan if they suspect a member of being involved in a fraudulent activity. To help prevent fraud, providers can:

- Ask the member for identification, such as a drivers license, to ensure the individual presenting an ID card is the individual named on the card;
- Notify the Plan if you believe an individual has tried to use more than one identification card or a card belonging to another individual;
- Notify the Plan if you are concerned because the individual appears to be trying to obtain unnecessary services or supplies.

As a Plan Participating Provider you should also be aware that the Plan educates its Members to assist with identifying provider fraud by keeping track of the following type of information:

- The date the member had their last healthcare professional service
- Where the service took place
- The name of the healthcare professional who provided the care
- What services were provided during the visit
- What additional services were ordered by the provider

If a Member receives a copy of the explanation of benefits (EOB), they are encouraged to review it to make sure the services, the name of the provider and the dates of service are correct and valid. A member who suspects that a provider is billing for more or different services than were actually received is encouraged to notify the Plan as soon as possible.

Members are also educated with regard to the following:

**DO NOT** Give their ID card or card number to anyone other than their doctor, clinic, hospital or other healthcare provider.

**DO NOT** Ask their doctor or any other healthcare provider for medical services or supplies that they do not need.

**DO NOT** Sign a blank claim form.

**DO NOT** Share their medical records with anyone other than their doctor, clinic, hospital or other healthcare provider.

If you suspect a Member or another Healthcare Professional of potential fraud please contact the Plan immediately so that we can investigate.

### **HOW TO REPORT SUSPECTED FRAUD OR ABUSE:**

If you suspect fraud or abuse by a member, provider, vendor, employee or other person or entity working with or for the Plan, please notify the Plan immediately. You may report your concerns to the Plan by calling the number on the member's identification card, or by calling Provider Services, or by calling the Compliance Hotline or the Plan's Compliance Officer.

Call the Compliance Hotline to report potential violations of the Plan's compliance policies or of state or federal health care program requirements. The toll-free number is below.

**Compliance Hotline**  
**1-877-655-9900 (toll-free)**  
**Hearing Impaired – use NY Relay Service 1-800-877-8973**

The Compliance Hotline is available 24 hours a day, 7 days a week. Calls can be made anonymously if desired and there is NO RETALIATION against an individual reporting a compliance issue or concern regarding improper or unethical activity, such as inaccurate billing or employee conduct.

Or you can contact our Compliance Officer:

**Compliance Officer**  
**Neighborhood Health Providers**  
**Suffolk Health Plan**  
**521 Fifth Avenue, Third Floor**  
**New York, NY 10175**  
**(212) 808-4775**  
**Fax 646-786-4783**

***Remember - if you see something, say something!***  
***We need your help to prevent fraud and abuse!***

## EFFECTIVE COMPLIANCE PROGRAMS

Providers subject to Article 28 or 36 of the Public Health Law or Article 16 or 31 of the Mental Hygiene Law are statutorily mandated to maintain an effective compliance program. Providers, including managed care organizations, covered by 18 NYCRR Part 521 are also required to have such programs in place.

Failure by providers to adopt and implement an effective compliance program will subject them to sanctions or penalties permitted under state or federal laws or regulations including exclusion from the medical assistance program.

There is no “one size fits all” compliance program. However, the Department of Health and Human Services’ Office of the Inspector General (OIG) has outlined the seven basic required elements that every effective compliance program should have.

- Requirement #1: Written Standards of Conduct and Policies & Procedures
- Requirement #2: Designation of Compliance Officer and other related committees
- Requirement #3: Training and Education
- Requirement #4: Communication Lines to Compliance Officer
- Requirement #5: Appropriate Disciplinary Mechanisms
- Requirement #6: Audits and Evaluation of Compliance Risk Areas
- Requirement #7: Responding to Compliance Issues

OMIG’s guidance on compliance programs is similar to the federal guidance. OMIG emphasizes risk (vulnerable) areas of which we should be watchful: quality of care, credentialing, claims processing, claims payment, billing, marketing and enrollment. These are typical risk areas for any health plan or provider.

Functional departments must have policies and procedures in place to detect and prevent improper activities. These departments must perform routine monitoring of processes to ensure compliance standards are met. Monitoring is defined as day-to-day informal reviews (e.g. self-reviews, peer reviews) within a department.

The Plan uses the most current OMIG Work Plan as a guide to their annual monitoring and recommends that providers also use this document. The 2011 OMIG Work Plan can be found at [http://www.omig.ny.gov/data/images/stories/work\\_plan/omig\\_work\\_plan\\_2010\\_2011.pdf](http://www.omig.ny.gov/data/images/stories/work_plan/omig_work_plan_2010_2011.pdf)

## **HIPAA – THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996**

### **PRIVACY AND SECURITY RULES**

The Health Insurance Portability and Accountability Act (HIPAA) *Privacy Rule* provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information" or PHI. At the same time, the Privacy Rule is balanced so that it permits the use and disclosure of personal health information intended for patient care (treatment), payment or other health care operations. If the use or disclosure of the PHI involves any of those three purposes, the PHI can be used or disclosed without getting explicit permission from the individual.

The HIPAA *Security Rule* specifies a series of administrative, physical, and technical safeguards for covered entities to use to assure the confidentiality, integrity, and availability of electronic protected health information.

The Privacy and Security Rules apply only to covered entities, which include health care providers, health plans and health care clearinghouses.

Covered entities must comply with the Rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information.

### **Protected Health Information (PHI)**

Protected Health Information (PHI) is individually identifiable health information, that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual, and which relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

Individually identifiable health information includes many common demographic identifiers (e.g., name, address, birth date, Social Security Number, Medicaid/CIN number), health identifiers (e.g., diagnosis, health services provided, dates of service, medical records, patient history, discharge summary) and other identifiers (e.g., device identifiers & serial numbers, biometric identifiers and any other unique identifying number, characteristic or code).

### **Treatment, Payment, and Health Care Operations**

A covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities. A covered entity also may disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities (if both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship).

### **Protecting PHI**

Covered entities must ensure protected health information is secure and private whether the PHI is in paper or electronic format. Covered entities must have policies and procedures in place to ensure compliance with the HIPAA rules. Training of staff must occur routinely.

Some fundamental safeguards are listed below.

- **DO** confirm you have verified fax numbers and entered the correct number before faxing any PHI; and Do confirm that the information was received by the intended recipient.
- **DO** make sure that when destroying documents containing PHI that they are shredded.
- **DO** password protect or encrypt any files that contains PHI information sent via e-mail and send the password or encryption key in a separate e-mail.
- **DO NOT** share your computer password or PIN with anyone, including co-workers, temporary workers or friends.
- **DO NOT** leave documents containing PHI at the printer, copier or fax machine.

### **HIPAA Breach Notification Rules**

A "breach" is defined as "the acquisition, access, use, or disclosure" of PHI in a manner that violates the Privacy Rule or Security Rule and which "compromises

the security or privacy of the PHI". This means that such breach "poses a significant risk of financial, reputational, or other harm to the individual."

**In the event of a breach of PHI that relates to 500 or less of the Plan's members, you must notify our Compliance Officer.** The phone number is 212-808-4775. The Compliance Officer will guide you through the required process of notifying each individual whose protected health information (PHI) has been, or is reasonably believed to have been, breached. The notice must be in writing and include the following five required elements:

- 1) A brief description of what occurred with respect to the breach, including, to the extent known, the date of the breach and the date on which the breach was discovered;
- 2) A description of the types of PHI that were disclosed during the breach;
- 3) A description of the steps the affected individual should take in order to protect him / her from potential harm caused by the breach;
- 4) A description of what is being done to investigate and mitigate the breach and to prevent future breaches; and
- 5) Instructions for the individual to contact the organization that breached.

Copies of the notice as well as the listing of the individuals notified must be sent to the Plan's Compliance Officer for the required record keeping.

**If the breach of PHI involves more than 500 of the Plan's members, the Plan's Compliance Officer must be notified to assist in the required process of notifying media outlets.** Also the Compliance Officer must also notify the Secretary of the Department of Health and Human Services (DHHS) of any breach involving 500 or more individuals. Notification through the media and to the Secretary of the DHHS must be made within 60 days of the discovery of the breach. Copies of the media notice as well as the listing of the individuals whose information was breached must be sent to the Plan's Compliance Officer for the required record keeping.

Plan providers, vendors and business associates should develop and implement comprehensive Policies and Procedures to detect breaches and provide notice to the Plan's Compliance Officer in the event of a breach. Staff should be trained on these policies and procedures.

**REMEMBER:  
IT ISN'T A CRIME TO MAKE A MISTAKE;  
IT IS A CRIME NOT TO DO ANYTHING ABOUT THE MISTAKE  
ONCE IT IS DETECTED.**

## **Member Authorization to Release PHI**

At the time a member signs the application to join the Plan, the member signs an authorization which allows the Plan to release and receive PHI in order to treat members, pay claims and conduct business related to the care of the patient.

## **Conclusion**

While the Plan has an established compliance program in place, we know that compliance continues to evolve as new laws and regulations are enacted. We acknowledge that an effective compliance program is an ongoing process and we have made it a vital part of the running of our organization.

We are committed to an ethical way of conducting business and we expect our providers, members and other business associates to do the same.

## **Resources:**

**<http://www.hhs.gov/ocr/privacy/index.html>**

**[www.omig.state.ny.us](http://www.omig.state.ny.us)**

**<http://www.hcca-info.org>**

**[http://www.omig.state.ny.us/data/images/stories/provider\\_compliance/adopted\\_regulations\\_521.pdf](http://www.omig.state.ny.us/data/images/stories/provider_compliance/adopted_regulations_521.pdf)**