Simplifying Healthcare Administration

HEALTH CARE FRAUD, WASTE AND ABUSE TRAINING

FWA

July 2023

INTRODUCTION

Health care fraud can cost TAXPAYERS billions of dollars

The Fall 2022 Semiannual Report to Congress (SAR) highlights nearly $1.29 billion in expected recoveries as a result of HHS-OIG audits and investigations conducted during April 1, 2022 to September 30, 2022.

Every year, billions of dollars are improperly spent because of fraud, waste and abuse (FWA). It affects everyone—including you. This training helps you detect, correct and prevent FWA.

OBJECTIVES

- **Identify** fraud and abuse
- **Understand** fraud and abuse laws & penalties
- **Recognize** risk areas or red flags*
- **How** to report fraud and abuse
- **What** happens after detection
- **Recognize** government agencies and partnerships dedicated to fighting fraud and abuse

***Red flags** are warnings or discrepancies that attract attention to potential fraud and abuse. Although not evidence of fraud and abuse, a pattern of red flags can increase suspicion and justify further investigation.

***Red flags** can be general or specific to a line of business and should be reported immediately!

WHAT IS HEALTH CARE FRAUD?

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud a health care benefit program, or to obtain, by means of fraudulent pretenses, representations, or promises, any of the money of property owned by, or under the custody or control of, any health care benefit program.

EXAMPLES OF FRAUD
RED FLAGS

Intentional Act for Gain	FRAUD
	UM – Making prohibited referrals for certain designated health services.
	UM – Documenting a verbal denial falsely attributed to a medical professional.
	Staff – Knowingly receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal or private health care programs.
	Claims – Knowingly submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain payment.

Deception	FRAUD
	UM – Falsifying documents to indicate notifications had taken place for approval, modification, or denying a referral request.
	UM – Redirecting care from a contracted provider because of economic profiling (cost) without regulatory approval.
	Claims – Submitting inaccurate financial reports related to outstanding claims liability.
	Claims – Altering claim audit files to fraudulently show compliance with health plan audits to hide failure to pay claims due to financial insolvency.

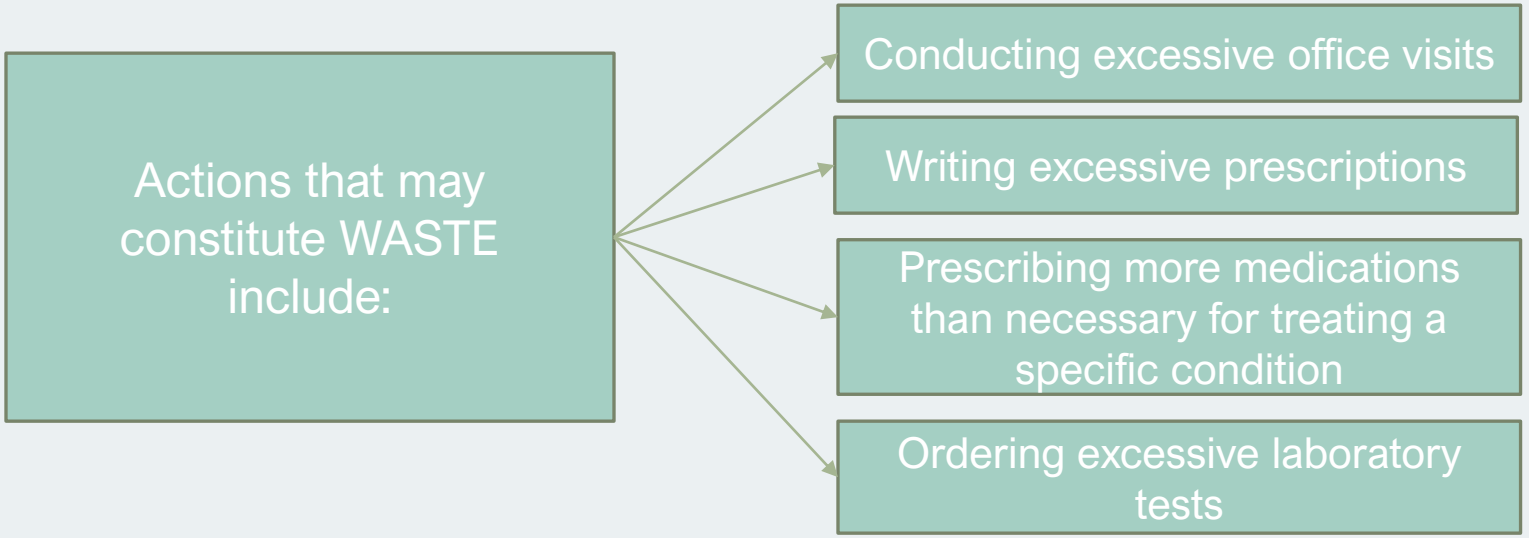
WHAT IS HEALTH CARE WASTE?

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

For the definitions of fraud, waste and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual on the Centers for Medicare & Medicaid Services (CMS) website.

mc86c21.pdf (cms.gov)

EXAMPLES OF WASTE
RED FLAGS



WHAT IS HEALTH CARE ABUSE?

Abuse applies to practices that are inconsistent with sound fiscal, business, medical or recipient practices that result in unnecessary cost to a health care program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Mistakes that are repeated after discovery or represent an on-going pattern could constitute abuse.

Action can directly or indirectly result in unnecessary costs to the Medicare Program.

EXAMPLES OF ABUSE
RED FLAGS

Actions that may constitute Abuse include:

- *Unknowingly billing for unnecessary medical services*
- *Unknowingly billing for brand name drugs when generics are dispensed*
- *Unknowingly excessively changing services or supplies*
- *Unknowingly misusing codes on a claim, such as upcoding or unbundling codes*

DIFFERENCES BETWEEN FRAUD, WASTE AND ABUSE

There are differences among fraud, waste and abuse. One of the primary differences is intent and knowledge.

Fraud requires intent to obtain payment and the knowledge the actions are wrong.

Waste and Abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but does not require the same intent and knowledge.

HOW TO PREVENT FWA

- Make sure you are up to date with laws, regulations, policies
- Conduct yourself in an ethical manner
- Ensure you coordinate with other payers
- Ensure data/billing is both accurate and timely
- Know FWA policies and procedures, standards of conduct, laws, regulation
- Verify information provided to you
- Be on the lookout for non-compliant activity
- Be aware of what could be non-compliant activity

POTENTIAL FWA RED FLAGS FOR POTENTIAL MEMBER ISSUES

- Does the Medicare record or lab test look altered or forged?
- Does the member medical history support the services requested?
- Have you reviewed numerous identical authorization requests for members from this physician that seem suspicious?
- Member questioning services such as not knowing the physician or stating they did not take the test in question.

POTENTIAL FWA RED FLAGS FOR POTENTIAL PROVIDER ISSUES

- Are the provider's authorization requests appropriate for the member's health condition?
- Unusual billing practices or suspicious activity
  - Altering dates of services
  - Unbundling or upcoding services
- Is the provider requesting a higher quantity of a service than medically necessary for the condition?
- Is the provider's diagnosis for the member supported in the medical records?

REPORTING FWA AT <HEALTH PLAN OR DELEGATE NAME>

Everyone *must* report suspected instances of FWA. Your Code of Conduct clearly states this obligation. <<health plan or delegate name>> will not retaliate against you for making a good faith effort in reporting.

<<Left blank for each Health Plan and/or Delegate to fill in the process for reporting FWA. Add additional slides if needed. Provide how to report to Compliance and anonymous reporting>>

REPORTING FWA AT <HEALTH PLAN OR DELEGATE NAME>

If warranted, report fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), or CMS. Reporting to <<health plan or delegate name>> Compliance will facilitate evaluation of every report to identify if external notification is warranted.

Individuals or entities (physicians, companies) who voluntarily disclose a self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.

Do not be concerned about whether it is fraud, waste or abuse.

REPORTING FWA AT <HEALTH PLAN OR DELEGATE NAME>

If warranted:

HHS Office of Inspector General:

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Email: HHSTips@oig.hhs.gov

Online: https://oig.hhs.gov/fraud/report-fraud/

For Medicare Parts C and D:

Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)

CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

WHAT WILL HAPPEN AFTER REPORTING

Once suspected or actual fraud, waste or abuse is detected, work starts promptly to confirm and identify the extent of the issues. Once identified, measures to correct start immediately. Correcting the problem saves the government money and ensures compliance with CMS requirements & other regulatory / governing body.

<Health Plan/Delegate> will develop a plan to correct the issue. If it does not interrupt the investigation, Compliance Department and Leadership may be able to provide the steps in the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances.

1. Design the corrective action to correct the underlying problem that resulted in FWA program violations and to prevent future noncompliance.

2. Tailor the corrective action to address the specific FWA problem or issues identified. Timelines for actions are important to ensure completion.

All corrective actions addressing noncompliance or FWA committed must be documented, including consequences for failure to satisfactorily complete the corrective action.

It is necessary to monitor corrective action continuously until the team can ensure the effectiveness of the correction.

FWA LAWS

The five most important Federal fraud and abuse laws that apply to physicians are the:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark law)
- Exclusion Authorities
- Civil Monetary Penalties Law (CMPL)

http://oig.hhs.gov/fraud/PhysicianEducation/

FWA LAWS
FALSE CLAIMS ACT (FCA)

False Claims Act (FCA) prohibits:

- Presenting a false claim for payment or approval
- Making or using a false record or statement in support of a false claim
- Conspiring to violate the False Claims Act
- Falsely certifying the type/amount of property to be used by the Government
- Certifying receipt of property without knowing if it is true
- Buying property from an unauthorized Government officer
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government

- 31 United States Code § 3729-3733

FWA LAWS
ANTI-KICKBACK STATUTE

Anti-Kickback Statute (AKS)

Prohibits knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

- 42 United States Code §1320a-7b(b)

FWA LAWS
STARK LAW

Physician Self-Referral Law (Stark law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

- 42 United States Code §1395nn

FWA LAWS
CIVIL MONETARY PENALTIES LAW

Civil Monetary Penalties Law

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:

- Arranging for services or items from an excluded individual or entity
- Providing services or items while excluded
- Failing to grant OIG timely access to reports
- Knowing of and failing to report and return an overpayment
- Making false claims
- Paying influenced referrals

FWA LAWS EXCLUSIONS

Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General (OIG). The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the “List of Excluded Individuals and Entities” (LEIE)

The U.S. General Services Administration (GSA) administers the System for Award Management (SAM), which contains debarment actions taken by various Federal agencies, including the OIG. Access to the EPLS is available through the System for Award Management (SAM) website.

<<if Medi-Cal/Medicaid program include: Medi-Cal maintains the Suspended and Ineligible (S&I) Provider List of health care providers and entities that have been barred from participation in the Medi-Cal program.>>

FWA LAWS EXCLUSIONS (CONT.)

Exclusion (continued)

Exclusions are reviewed prior to hiring or contracting a new employee, temp or consultant and monthly thereafter.

Review of monthly exclusions is essential to prevent inappropriate payment to anyone on the exclusion lists.

<<Health Plan and/or Delegate to fill in the name of the policy below and include access link if available>>

<<See policy xxx on Exclusions>>

FWA LAWS
CIVIL MONETARY PENALTIES

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- Paying to influence referrals

HEALTH CARE LAWS

The False Claims Act
- Statute: 31 U.S.C. §§ 3729–3733

The Anti-Kickback Statute
- Statute: 42 U.S.C. § 1320a–7b(b)
- Safe Harbor Regulations: 42 C.F.R. § 1001.952

The Physician Self-Referral Law
- Statute: 42 U.S.C. § 1395nn
- Regulations: 42 C.F.R. §§ 411.350–.389

The Exclusion Authorities
- Statutes: 42 U.S.C. §§ 1320a–7, 1320c–5
- Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)

The Civil Monetary Penalties Law
- Statute: 42 U.S.C. § 1320a–7a
- Regulations: 42 C.F.R. pt. 1003

Criminal Health Care Fraud Statute
- Statute: 18 U.S.C. §§ 1347, 1349

HEALTH CARE LAWS CALIFORNIA

Welfare Institutions Code 14107 [False Claims] - Prohibits claim submission, with intent to defraud, to obtain greater compensation than legally entitled.

Welfare Institutions Code 14107 (a-b) [Anti-Kickback] - Solicits or receives any kickback, bribe or rebate to either refer or promise to refer person(s) for services or merchandise.

CA Penal Code 550(a)(6-7) [False claims] - Imposes liability to knowingly make, or cause to be made, any false or fraudulent claim for health care benefit or which was not used by or on behalf of the claimant.

DISCLAIMER

This course was prepared as a service and is not intended to grant rights or impose obligations. This course may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. Readers are encouraged to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.