Prevention of Fraud, Waste and Abuse Training
For Group Health Contracted Providers
FWA Department | Office of Compliance and Ethics
Outline

• Purpose

• “Deemed” Compliant

• Group Health Compliance Program

• Fraud, Waste, and Abuse (FWA) Defined

• Fraud and Abuse Laws

• What does FWA look like?

• Expectations

• Reporting FWA Concerns

• Whistleblower Protection
The Centers for Medicare & Medicaid Services (CMS) requires Group Health, as a sponsor of government health care programs, to provide prevention of fraud, waste, and abuse training to all its employees and contracted providers upon hire and on an annual basis thereafter as a pre-requisite to providing services to the beneficiaries of those programs.

Eliminating fraud, waste, and abuse in the delivery of healthcare is an obligation, a responsibility, and a legal requirement of all Group Health employees, including our contracted providers.

Attendance/participation in training programs is a condition of employment or contracting.
Effective June 2010, if you hold a valid Medicare provider agreement or supplier approval and can bill Medicare directly and receive payment, you are “deemed” compliant with having received prevention of fraud, waste, and abuse training.* You are, of course, still free to participate in any prevention of health care FWA training you may want to.

* If you or your organization do not qualify for the deemed status, training is required by December 31, and annually thereafter. There is no deemed compliant status pertaining to the Code of Conduct and Conflict of Interest policy distribution, nor to the reviews for exclusion and debarment from federal health care programs.
Group Health has a comprehensive compliance plan to detect and prevent FWA:

• Written policies and procedures.

• Designated compliance officer and committee.

• Effective training and education for governing body members, employees, and contractors.

• Effective lines of communication between Group Health’s Compliance Officer and its employees, contractors, agents, directors, and members of the compliance committee.

• Internal monitoring and auditing procedures.

• Enforcement of standards through disciplinary guidelines.

• Prompt response to detected problems and implementation of corrective action plans.
Best Practice - Code of Conduct

• Highest professional standards at all times.

• Basic guiding principles for acceptable behavior with respect to employees, pharmacies, members, competitors, and the community.

• Commitment to compliance with all statutory, regulatory, and government-sponsored health care program requirements.
Exclusion and Debarment Review

• First-tier, downstream, and related entities must review federal exclusion lists at the time of hire/contracting and periodically thereafter with their current employees/contractors, health care professionals, or vendors that work on Medicare Advantage, Part D or Medicaid programs to ensure that none are excluded from participating in federal health care programs.

• For more information or access to the publicly-accessible, excluded-party online databases, please see the following links:
  
  • List of excluded individuals/entities: http://exclusions.oig.hhs.gov
  
  • General Services Administration (GSA) list of parties excluded from federal procurement and non-procurement programs: https://www.epls.gov
Conflict of Interest (Col)

• A Col refers to a situation in which financial or other personal interests directly and significantly influence, or appear to influence, professional judgment and responsibilities.

• Group Health’s Col policy and procedures, including its yearly financial disclosure/attestation system, are designed to address and manage conflicts of interest.
Group Health Compliance Program

Potential Conflicts of Interest:

• An employee, contractor, officer, director, or family member holds an undisclosed, substantial financial interest in a:
  
  o Supplier
  
  o Drug manufacturer
  
  o Competitor
  
  o Customer

• Having an undisclosed interest in a transaction in which your company is known to be involved or interested.

• Receiving undisclosed fees, commissions, or other compensation or benefits from a supplier, competitor, or customer.
Best Practice – Workplace Conduct

• Confidentiality rules enforced.

• Accounting and financial responsibility.

• Antitrust provisions followed.

• Conflict of interest attestations mandatory.

• Bribes, gratuities, and gifts for government employees prohibited.

• Appropriate use of company property.

• Marketing practices follow all guidelines and regulations.

• Vendor/subcontractor relations managed.
Group Health Compliance Program

Best Practice – Employment Practice

• Reporting actual or potential wrong-doing.

• Licensure, certification, and registration requirements.
Best Practice – Disciplinary Guidelines

- Mandatory retraining.
- Oral and written warnings or reprimands.
- Suspensions.
- Other disciplinary action, including possible termination of employment, business contracts, or agreements when such behavior is serious or repeated or when knowledge of a possible violation is not reported.
Best Practice – Mandatory Training

• Condition of continued employment.

• Maintain records of all training, including dates, method of training, materials used for training, identification of trained employees via sign-in sheets or other methods, as well as records for Code of Conduct distribution and all exclusion and debarment review activity.
Best Practice – Record Retention

• Comply with 10-year record retention requirements.*

* Records Retention: Group Health complies with the CMS requirement for records retention for the current contract period and 10 prior contract periods to ensure the availability to the CMS, the Department of Health and Human Services (DHHS), the Comptroller General or their designee, access to Medicare Advantage Organization facilities and records to evaluate through inspection or other means.
Fraud, Waste, and Abuse Defined

• Fraud

Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

• Health Care Fraud

Health care fraud is defined in Title 18, United States Code (U.S.C.)§1347 as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.
• **Waste**
  Practices that result in unnecessary costs.

• **Abuse**
  Excessive or improper use of a resource. Intentional destruction, diversion, manipulation, misapplication, or misuse of resources. Extravagant or excessive use as to abuse one’s position or authority. Circumventions and violations of departmental policies and procedures which impair the effective and efficient execution of operations.
Fraud and Abuse Laws

- False Claims Act (FCA), 31 U.S.C., s. 3729
- Anti-Kickback Statute 42 U.S.C. s. 1320a-7b(b)
- Physician Self-Referral ("Stark") Statute, 42 U.S.C. s.1395nn
- Deficit Reduction Act of 2005
- HIPAA of 1996, Title 18, Section 1347
- Fraud Enforcement and Recovery Act of 2009 (FERA)
Fraud and Abuse Laws

Federal False Claims Act

Known as the “Lincoln Law,” covers fraud involving any federally funded contract/program. Imposes civil liability on any person who:

- **Knowingly** presents, or causes to be presented, to an officer or 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; or

- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid.
Federal False Claims Act

Key word is “knowingly.”

• “Knowingly” does not require proof of specific intent to defraud the government.

• “Actual knowledge of the information” or acting “in deliberate ignorance of the truth or falsity of the information” or “in reckless disregard of the truth or falsity of the information” is enough.
Federal False Claims Act

Amended in 1986 to increase the penalties and qui tam awards:

• Civil monetary penalty: $5,500 to $11,000 per false claim.

• Treble damages.

• OIG sanction/exclusion from participation in federal health care programs.
Anti-Kickback Statute

It is a felony to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services paid in whole or in part by a federal health care program. “Remuneration” includes transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
Physician Self-Referral Prohibition Statute

The “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/her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.
Fraud and Abuse Laws

Deficit Reduction Act

- Requires Medicaid programs to look for FWA.

- Mandates procedures on FWA.

- Requires employers who receive more than $5 million per year in Medicaid payments to train their staff on the False Claims Act, qui tam lawsuits, and FWA program.

- Creates incentive for states to have their own whistleblower laws.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI) as well as provisions related to the prevention of health care fraud and abuse.

• **HIPAA Privacy**
  The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.

• **HIPAA Security**
  The Security Rule outlines specific protections and safeguards for electronic PHI.

• If you become aware of a potential breach of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.
Sample HIPAA Fraud, Waste and Abuse Provisions:

• The creation of the Healthcare Fraud Abuse and Control Program for coordination of state and federal health care fraud investigation and enforcement activities.

• The expansion of the exclusion authority so that any health care fraud conviction, even if the fraud is not related to Medicare or Medicaid, results in mandatory exclusion from participation in the Medicare or Medicaid programs.

• The creation of a new series of federal crimes, together referred to as “health care fraud,” which make it a federal crime to defraud health care benefit programs—any benefit program, not just Medicare or Medicaid.
HIPAA

HIPAA established health care fraud as a federal criminal offense and increased the penalties:

- Forfeiture of property derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

- Imprisonment for up to 10 years/up to 20 years if the violation results in “bodily injury”/life if patient dies.
Fraud and Abuse Laws

HIPAA

- Created funding for states to fight fraud and abuse.

- HIPAA s.203(b)(1) created the Medicare Incentive Reward Program (IRP) to encourage reporting of sanctionable activities. IRP will pay a reward for information that leads to a minimum recovery of $100 from a party determined by CMS to have committed sanctionable offenses.
Fraud Enforcement and Recovery Act of 2009 (FERA)

- In May 2009, President Barack Obama signed into law the Fraud Enforcement and Recovery Act (FERA) of 2009.

- Boosts federal government’s power to investigate and prosecute any financial fraud against the government and expands liability under the False Claims Act.
Fraud and Abuse Laws

Enforcement Agencies

- Office of Inspector-General (OIG)
- Federal Bureau of Investigation (FBI)
- Federal Department of Justice (DOJ)
- Postal Inspectors (mail fraud)
- United States Attorneys
- Medicaid Fraud Control Unit (MFCU)
- AHCA Bureau of Medicaid Program Integrity
- Medicare Integrity Contractors (MEDICs)
- Quality Improvement Organizations (QIO)
Potential Sanctions

- Civil or criminal prosecution
- Fines/Civil Monetary Penalty ($10K/violation)
- Restitution
- Imprisonment
- Administrative sanctions (exclusion, Corporate Integrity Agreement)
- Treble damages
Fraud and Abuse Laws

Where to find additional information:

• National Healthcare Anti-Fraud Association [www.nhcaa.org](http://www.nhcaa.org)

• CMS website [www.cms.hhs.gov](http://www.cms.hhs.gov)

• OIG website [www.oig.hhs.gov](http://www.oig.hhs.gov)


• MLN website [www.cms.hhs.gov/MLNGenInfo](http://www.cms.hhs.gov/MLNGenInfo)

• Health Care Fraud Prevention and Enforcement Action Team (HEAT) website [www.stopmedicarefraud.gov](http://www.stopmedicarefraud.gov)
What does FWA look like?

Potential FWA actors:

• Pharmacy
• Provider
• Member/Patient
• Pharmacy Benefit Manager (PBM)
• Manufacturer
Inappropriate billing practices include:

• Incorrectly billing for secondary payers to receive increased reimbursement.
• Billing for nonexistent prescriptions.
• Billing for brand drugs when generics are dispensed.
• Billing for non-covered prescriptions as covered items.
• Billing for prescriptions that were never picked up.
• Inappropriate use of dispense-as-written codes.
• Drug diversion.
• Prescription splitting to receive additional dispensing fees.
• **Prescription drug shorting**
  A pharmacist dispenses less than what was prescribed but bills for the full prescribed amount.

• **Bait-and-switch pricing**
  A member is led to believe that a drug will cost one price, but at the point of sale, he or she is charged a higher amount.

• **Prescription forging or altering**
  Existing prescriptions are altered to increase the quantity or number of refills.

• **Prescription refill errors**
  A pharmacist provides the incorrect number of refills prescribed by the provider.
Potential Pharmacy FWA

- Illegal remuneration schemes
  A pharmacy is offered, solicits, or receives unlawful remuneration to induce or reward it to:
  - Switch patients to different drugs.
  - Influence prescribers to prescribe different drugs.
  - Steer patients to prescription drug plans.
• Billing for services that were not provided.

• Performing medically unnecessary services solely to obtain insurance payments.

• Altering claim forms, medical documentation, etc., to obtain a higher payment.

• Duplicate billing (deliberate).

• Unbundling or “exploding” charges.

• Upcoding (billing for a service that costs more).

• Soliciting, offering, or receiving a kickback for referral of patients in exchange for other services.
• Prescribing drugs that are not medically necessary (script mills).

• Falsifying or misrepresenting information on a prescription.

• Theft of a Drug Enforcement Administration (DEA) number or prescription pad: A DEA number or prescription pad can be stolen and used to illegally write prescriptions for controlled substances.

• Falsifying information submitted through prior authorization.

• Dispensing expired or altered prescription drugs.
• Billing for dead and jailed beneficiaries.

• Billing by dead doctors (on July 9, 2008, the U.S. Senate Permanent Subcommittee on Investigations estimated that Medicare paid $60.3 to $92.8 million to companies that used the UPINs of dead doctors).

• Waiving patient co-pays or deductibles.

• Misrepresenting non-covered services as medically necessary, for example, billing “nose jobs” as deviated-septum repairs, routine foot care as diabetic foot care.
• **Prescription forging or altering**
  Prescriptions are altered, by someone other than the prescriber or pharmacist without prescriber approval, to increase quantity or number of refills (prescription is written in different inks, looks like it is photocopied, or quantity is more than the usual dispensed amounts).

• **Doctor shopping**
  A member or other individual consults several doctors to inappropriately obtain multiple prescriptions for narcotic painkillers or other drugs.

• **Identity theft**
  An individual uses another person's insurance card to obtain prescriptions.
• **Prescription diversion**
  A member obtains prescription drugs and gives or sells them to someone else.

• **Prescription stockpiling**
  A member obtains and stores large quantities of drugs to avoid out-of-pocket costs.

• **Resale of drugs on the black market**
  A beneficiary falsely reports loss of drugs to obtain drugs for resale on the black market.
Potential PBM FWA

- **Inappropriate formulary decisions**
  Costs take priority over criteria, such as clinical efficacy.

- **Prescription drug switching**
  A PBM receives a payment to switch a patient from one drug to another.

- **Unlawful remuneration**
  A PBM receives unlawful remuneration to steer a patient toward a certain plan or drug.
Potential Manufacturer FWA

• **Kickbacks or inducements**
  Inappropriate marketing of products.

• **Inappropriate relationships with physicians**
  ▪ Offering the prescriber money to switch prescriptions.
  ▪ Offering incentives to physicians to prescribe medically unnecessary drugs.
  ▪ Improper entertainment or incentives offered by sales agents.

• **Illegal usage of free samples**
  Free samples are provided to physicians knowing that they will bill the drugs

• **Illegal off-label promotion**
Expectations

- **Know and abide** by all applicable laws and regulations.

- **Have appropriate policies and procedures** to address FWA and record retention.

- **Provide general compliance training**
  - Upon initial hiring of an employee.
  - When requirements change.
  - When an employee works in an area previously found to be non-compliant with program requirements or implicated in past misconduct, and at least annually thereafter as a condition of employment.
Expectations

• **Provide specialized compliance training**, at least annually, to employees.

• **Retain adequate records* of employee training** (including attendance logs and material distributed at training sessions) for 10 years.

  * **Records Retention:** Group Health complies with the CMS requirement for records retention for the current contract period and 10 prior contract periods to ensure the availability to CMS, DHHS, the Comptroller General, or their designee, access to Medicare Advantage Organization facilities and records to evaluate through inspection or other means.

• **Strive for accuracy and excellence** in service, coding, and billing.

• **Timely report and investigate concerns** of suspected FWA to Group Health.

• **Attend scheduled FWA/Compliance training opportunities**.
NPI Enforcement

• National Provider Identifier (NPI) - The 10-digit NPI replaces NCPDP numbers, legacy IDs, and other identifying numbers used to identify pharmacies, prescribers, et al.

• The NPI number must be used in all claims adjudication submissions.
Everyone has the right and responsibility to report possible fraud, waste, and abuse.
Group Health policies and procedures include the following protections for reporters of FWA:

• **Confidentiality**
  Reports or questions are required to be kept confidential to the extent permitted by law, and the ability to address concerns by Group Health.

• **Anonymity**
  The identity of those reporting is generally protected. However, identity, if known, may be disclosed if the government becomes involved in the investigation.

• **Non-retaliation**
  Retaliation in response to any employee who, in good faith, asks a question or makes a report of known or suspected non-compliance is always prohibited.
Reporting FWA Concerns

Reporting Process

• When in doubt, ask for help.

• Report concerns of suspected FWA right away.

• Email FWA@ghc.org or call 206-988-2967 (confidential).

• Call the Group Health Compliance Hotline 800-741-7817 (confidential and anonymous).
Whistleblower Protection

Non-retaliation

• Retaliation in response to any contracted provider who, in good faith, asks a question or makes a report of known or suspected non-compliance is always prohibited.

• If you believe you have been retaliated against for asking or reporting a FWA or compliance-related question or concern, call either the:
  - Compliance Hotline 800-741-7817, or
  - The Chief Compliance Officer
    (206-448-2541 or 800-320-2541)
Please answer the following questions and then check your answers.

If you cannot answer these questions correctly without referring to the answers, please review the training materials again.

1. Which of the following is **NOT** part of an effective compliance program?

   a) Written standards of conduct
   b) High level oversight
   c) Effective lines of communication
   d) Conference calls

   Answer: d)
2. True or false? CMS is the part of the federal government that oversees the Medicare program.

Answer: True

3. True or false? If I identify or am made aware of potential misconduct or a suspended fraud, waste, or abuse situation, I should keep this information to myself and not tell anyone else.

Answer: False
4. The effort to prevent and detect fraud is_____________________.

a) Primarily the responsibility of state and federal law enforcement agencies (OIG, FBI, DOJ, and MFCU).

b) A cooperative effort involving CMS, Medicare beneficiaries, providers, health plans, QIOs, and MEDICs in addition to state and federal law enforcement agencies (OIG, FBI, DOJ, and MFCU).

Answer: b)
5. True or false? Those making false statements and receiving kickbacks, bribes, and rebates in relation to the Medicare program may be determined to be guilty of a felony and may be fined or imprisoned, or both.

Answer: False
6. The following are potential elements of civil prosecutions and penalties:

   a) Civil monetary penalty (CMP).

   b) Penalty for up to three times the amount claimed for each item or service.

   c) Exclusion from federally funded programs for a specified number of years.

   d) Signing a Corporate Integrity Agreement which subjects the entity to federal monitoring.

   e) All of the above.

Answer: e)
Review Questions

7. True or false? Medicare will not pay a provider who has been excluded by the OIG from participation in federal health care programs.

Answer: True
8. Fraud is:

a) An unintentional act that results in unnecessary cost.

b) Intentionally, or knowingly and willfully attempting to execute a scheme to falsely obtain money.

c) An intentional act that results in unnecessary cost.

d) Unintentionally or unknowingly attempting to falsely obtain money.

e) Both b) and c).

f) Both a) and d).

Answer: b)
9. The _________________ prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his/her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

   a) The Anti-Kickback Statute.

   b) The “Stark” Statute.

Answer: b)
10. The _____________ has the authority to exclude (sanction) providers or suppliers who have been convicted of health care-related offenses.

a) Social Security Act.

b) Medicare Program.

c) Medicare Integrity Program.

d) Office of Inspector-General (OIG).

e) Federal Bureau of Investigation (FBI).

Answer: d)
11. The ____________ pays an incentive award to individuals who provide information on Medicare fraud and abuse or other sanctionable activities.

a) Medicare Incentive Reward Program.

b) Medicare Trust Fund.

c) Social Security Act.

d) HIPAA Public Law.

Answer: d)
Questions?

Fraud, Waste, and Abuse Dept.
FWA@ghc.org
or
206-988-2967

GroupHealth