# Fraud, Waste & Abuse

# Provider Training


*Revised 10.16.2019*

# Learning Objectives

After taking this training, you will:

- Have a working knowledge of Fraud, Waste, and Abuse (FWA) and your role in preventing, detecting, reporting, and correcting FWA concerns
- Have an understanding of related Federal and State Laws/Regulations
- Be familiar with the CountyCare Code of Ethics and your responsibilities

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# FWA Training is a Requirement

- Combating FWA is **everyone's** responsibility!
- As an individual who provides health or administrative services for Medicaid enrollees, every action you take potentially affects Medicaid enrollees and the Illinois Medicaid Program.
- CountyCare providers and their employees and agents must complete this FWA training within **60 days of initial hire/contract start** and **annually** thereafter.

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# Definitions

## FRAUD

**Fraud:** 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.

- Health care fraud is punishable by imprisonment for up to **10 years** and criminal fines up to **$250,000**.

## WASTE

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

## ABUSE

**Abuse:** includes actions that may, directly or indirectly, result in unnecessary costs to the Medicaid program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented the facts to obtain payment.

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# FWA Definition Differences

There is a significant difference between activities that are defined as fraud or waste/abuse:

- Fraud requires *intent* to obtain payment and the *knowledge* that the actions are wrong.
- Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Illinois Medicaid Program, but does not require the same intent and knowledge.
- All instances of FWA, regardless of intent or knowledge, are improper and should be immediately addressed and reported when discovered.

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# Examples of Fraud, Waste, and Abuse

## FRAUD

- Knowingly billing for services not furnished or supplies not provided, including billing Medicaid for appointments that the patient failed to keep
- Billing for non-existent prescriptions
- Paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment
- Knowingly altering claim forms, medical records, or receipts to receive a high payment

## WASTE

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for the treatment of a specific condition
- Ordering excessive laboratory tests

## ABUSE

- Billing for unnecessary medical services
- Billing for brand name drugs when generics are dispensed
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes
- Violating the participating provider agreement with Medicaid

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# Who Can Initiate FWA?

## Member

- **Identity theft:** uses another person's insurance card to obtain prescriptions
- **Doctor shopping:** consults several physicians to obtain multiple prescriptions for drugs
- **Prescription stockpiling:** obtains and stores large quantities of drugs to avoid out-of-pocket costs
- **Prescription forging or altering**

## Provider

- **Altering claim forms**, medical documentation, etc., to obtain a higher payment
- **Upcoding**: billing for a more expensive service than actually performed
- **Falsifying or misrepresenting information on prescriptions**
- **Dispensing expired or altered prescription drugs**
- **Billing for dead and jailed beneficiaries**

## Manufacturer

- **Illegal usage of free samples:** free samples are provided to physicians knowing they will bill the drugs
- **Kickbacks or inducements:** inappropriate marketing of products
- **Inappropriate relationships with physicians**
- **Illegal off-label promotion**

## Pharmacy

- **Prescription drug shorting:** pharmacist dispenses less than what's prescribed but bills the full amount
- **Prescription forging or altering:** existing prescriptions are altered to increase the quantity or number of refills
- **Prescription refill errors:** pharmacist provides the incorrect number of refills prescribed by the provider
- **Bait-and-switch pricing:** member is led to believe that a drug will cost one price, but is charged a higher amount

# Understanding FWA

- To detect FWA, you need to **know the law.**
- Every CountyCare provider and delegated vendor must comply with the following federal and state regulations:
  1. Civil False Claims Act and (Qui Tam) Whistleblower Protections
  2. Health Care Fraud Statute and Criminal Fraud
  3. Anti-Kickback Statute
  4. Stark Statute (Physician Self-Referral Law)
  5. Civil Monetary Penalties Law
  6. Exclusion Authority
  7. Health Insurance Portability and Accountability Act (HIPAA)
  8. Deficit Reduction Act (DRA)

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# The Civil False Claims Act (FCA) and what you need to know

- It is illegal to submit claims for payment to Medicare or Medicaid that **you know or should know are false or fraudulent.**
- May result in fines of up to three times the programs' loss plus $11,000 ***per claim filed***.
- The civil FCA defines "knowing" to include not only actual knowledge but **also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information**.
- There is a **whistleblower provision** that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers who, in good faith, report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

**Source**: 31 U.S.C. § 3729 – 3733 and OIG Physician Education

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# Health Care Fraud Statute and Criminal Fraud

- Criminal penalties for submitting false claims include **imprisonment and criminal fines**. Physicians have gone to prison for submitting false health care claims.
- Heath care fraud is defined as whoever knowingly and willfully executes, or attempts 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…
- With respect to violations of this section, a **person need not have actual knowledge of this section or specific intent to commit a violation of this section.**

**Source**: 18 U.S.C. § 1346-7; criminal FCA (18 U.S.C. § 287) and OIG Physician Education

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# The Anti-Kickback Statute (AKS)

- 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. **In some industries, it is acceptable to reward those who refer business to you – in the Federal health care programs, paying for referrals is a crime.**
- "Remuneration" includes transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. This includes: free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.
- Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in the Federal health care programs.

**Source**: 42 U.S.C. § 1320a - 7b(b) ) and OIG Physician Education

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# The Stark Law (Physician Self-Referral Law)

- The Stark law prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with **which the physician or an immediate family member has a financial relationship, unless an exception applies.**
- Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.
- The Stark law is a strict liability statute, which means **proof of specific intent to violate the law is not required.**

**Source**: 42 U.S.C. § 1395nn and OIG Physician Education

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# Civil Monetary Penalties Law

- The Office of Inspector General (OIG) may impose penalties ranging from $15,000 - $70,000, plus damages, for:
  - Arranging for services or items from an excluded individual or entity;
  - Providing services or items while excluded;
  - Failing to grant OIG timely access to records;
  - Knowing of an overpayment and failing to report and return it;
  - Making false claims; OR
  - Paying to influence referrals.

**Source**: refer to 42 USC 1320a-7a and the Social Security Act, Section 1128A(a).

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# Exclusion Authority

- 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 OIG.
- Sanction screening is performed by checking, at a minimum, each of the following four (4) websites to identify listings of individuals and companies which are subject to government sanction.
  - System for Award Management (SAM) under the United States General Services Administration (GSA) List of Parties Excluded from Federal Programs: https://sam.gov/portal/SAM/#1
  - Health and Human Services (HHS) – Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE): https://exclusions.oig.hhs.gov/
  - Illinois Department of Healthcare and Family Services (HFS) Office of Inspector General (OIG) List of Terminated/Suspended Providers and Barred Individuals: https://www.illinois.gov/hfs/oig/Pages/NewSanctions.aspx
  - Office of Foreign Assets Control (OFAC) List of Specially Designated Nationals (SDN) and Blocked Persons: https://sanctionssearch.ofac.treas.gov/

**Source**: 42 U.S.C. § 1320a-7; 42 CFR § 1001.1901

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# Health Insurance Portability & Accountability Act (HIPAA)

- In addition to privacy and security, HIPAA established a comprehensive program to combat fraud committed against all health plans, both public and private. The legislation required the establishment of a national Health Care Fraud and Abuse Control Program (HCFAC).
- Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

**Source**: P.L. 104 – 191

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# Deficit Reduction Act

- The Deficit Reduction Act:
  - Requires Medicaid programs to look for FWA
  - Provides incentives for states to adopt whistleblower programs similar to the federal False Claims Act
  - Requires employers who receive more than $5 million in Medicaid payments to train their staff on the False Claims Act, qui tam lawsuits, and FWA plan

Source: Deficit Reduction Act

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# CountyCare's FWA Plan

- CountyCare's FWA Plan was established by CountyCare Compliance to identify, investigate, and report any fraudulent, wasteful, or abusive activities committed by CountyCare affiliates (employees, members, providers, subcontractors, etc.).
- Compliance with the FWA Plan and related policies is the obligation of all CountyCare affiliates.
- CountyCare maintains an active Special Investigations Unit (SIU) which is tasked with identifying and investigating instances of FWA.

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# Your Responsibilities as a Provider of Care

- You play a vital role in preventing, detecting, and reporting potential FWA:
- FIRST, you must comply with all applicable statutory, regulatory, and other Medicaid requirements;
- SECOND, you have a duty to the Illinois Medicaid Program to report any compliance concerns or suspected or actual violations of which you become aware;
- THIRD, you have a duty to follow the CountyCare Code of Ethics, which articulates our organization's commitment to standards of conduct and ethical rules of behavior;
- FOURTH, you have a duty to comply with records requests, audits, and inquiries.

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# Code of Ethics

- The CountyCare Code of Ethics outlines procedures on how to recognize and report FWA, other misconduct, and compliance violations.
- If situations arise where you are unsure of how to proceed, discuss your options with your immediate supervisor and if necessary the CountyCare Compliance Officer at (countycarecompliance@cookcountyhhs.org)

# How Suspected FWA is Identified

- CountyCare utilizes both internal and external resources to identify any potential FWA in healthcare claims.
  - CountyCare's claims editing system checks every CountyCare claim for errors, omissions, and questionable coding relationships and tests the data against government and industry rules, regulations, and policies governing healthcare claims.
  - An external company conducts investigations to identify suspected financial misconduct, potential collusion among members/providers, abusive and wasteful charges, billing errors, and coding issues that fall outside standard (automated) code edits.
  - CountyCare provides an anonymous hotline for reporting of suspected FWA.
  - CountyCare provides training, such as this, to ensure all employees are aware of the rules and have the knowledge to report suspected FWA and to prevent FWA from occurring.

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# Corrective Action

- Where FWA is identified, CountyCare will take corrective action. Corrective action may include:
  - Applying prepayment edits or document review requirements;
  - Ongoing auditing or monitoring;
  - Training and education;
  - Revising policies or procedures;
  - Disciplinary action, such as suspension of marketing, enrollment, or payment;
  - Terminating an employee or provider; and
  - Recouping of improper payments.

# How Do You Prevent FWA?

- Look for suspicious activity;
- Conduct yourself in an ethical manner;
- Ensure accurate and timely records, data, and billing;
- Ensure you coordinate with other payers;
- Keep up to date with FWA policies and procedures, standards of conduct, laws, and regulations; and
- Verify all information provided to you.
- **YOU ARE RESPONSIBLE!!**

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# Your Obligation to Prevent, Detect, and Identify FWA

- CountyCare encourages members, providers and employees to report all cases of fraud, waste, and abuse. If you know of any Medicaid members or providers, including doctors, hospitals and pharmacies, who have committed actions of fraud, waste, or abuse, you must report them using the process described below. You may report them anonymously if you choose.

## Confidentiality

- Reports are considered confidential regardless of how the issue under review was identified.
- The Compliance Officer/ Special Investigation Unit staff will only discuss a report with those who have direct knowledge of the potential FWA activity.

## Anonymity

- The identity of the individual reporting is generally protected.
- **NOTE:** the identity of the individual is disclosed if the government is involved in the investigation.

## Non-retaliation

- In accordance with the Whistleblower Protections under the False Claims Act, retaliation in response to any contracted provider who, in good faith, asks a question or makes a report of suspected FWA is **ALWAYS PROHIBITED**

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# 3 Ways to Report Suspected FWA Activities

| **Anonymously report to CountyCare Compliance** | **Write to the CountyCare Compliance Officer** |
|---|---|
| Call<br>**1-844-509-4669** | E-Mail<br>countycarecompliance@cookcountyhhs.org |
| **Contact the HHS Office of the Inspector General** | |
| • Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950<br>• Email: HHSTips@oig.hhs.gov<br>• Online [unclassified complaints]: https://oig.hhs.gov/fraud/report-fraud/index.asp | |

Please remember:

- Everyone has the right and responsibility to report potential FWA.
- You may report anonymously.
- You may self-report.
- You may report to CountyCare or to HHS. Retaliation is prohibited when you report an incident in good faith.

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# Remember….

Everyone has the right and responsibility to report potential FWA.

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# Government References

| Regulation | Link |
|---|---|
| Criminal Penalties for Acts Involving Federal Health Care Program and the Anti-Kickback Statute 1128B(b)) | http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm#f |
| Exclusions from the Office of Inspector General (OIG) | https://oig.hhs.gov/exclusions/background.asp |
| False Claims Act: | https://www.govinfo.gov/app/details/USCODE-2010-title31/USCODE-2010-title31-subtitleIII-chap37-subchapIII-sec3729/summary |
| Federal Sentencing Guidelines | http://www.ussc.gov/guidelines-manual/guidelines-manual |
| Fraud Alerts, Bulletins and Other Guidance from the Office of Inspector General (OIG): | http://oig.hhs.gov/compliance/alerts/index.asp |
| Health Insurance Portability and Accountability Act (HIPAA) | https://www.hhs.gov/hipaa/for-professionals/index.html |
| Stark Law (Physician Self-Referral) | http://www.cms.gov/PhysicianSelfReferral/ |
| System for Awards Management | https://www.sam.gov |

# Other References

- Association of Certified Fraud Examiners (ACFE): http://www.acfe.com
- National Health Care Anti-Fraud Association (NHCAA): http://www.nhcaa.org

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# Contact Us

Provider Services: 312-864-8200

Website: www.countycare.com

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# Key Concept Review

# Fraud, Waste & Abuse

# Provider Training

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# Identify the potential violation – 1

A Florida health plan hired a consultant to review medical records and find additional diagnosis codes that could be submitted to increase its risk capitation payments from CMS. The consultant told the health plan that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported. The health plan failed to report the unsupported diagnosis codes to Medicare and ended up paying $22.6 million to settle FCA allegations.

A. Civil False Claims Act
B. Fraud Statute and Criminal Fraud
C. Anti-kickback Statute
D. The Stark Law

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# Identify the potential violation – 2

A Pennsylvania pharmacist submitted claims to a health plan for non-existent prescriptions and for drugs not dispensed. He plead guilty and received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the health plan.

A. Civil False Claims Act
B. Fraud Statute and Criminal Fraud
C. Anti-kickback Statute
D. The Stark Law

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# Identify the potential violation – 2

A Pennsylvania pharmacist submitted claims to a health plan for non-existent prescriptions and for drugs not dispensed. He plead guilty and received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the health plan.

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C. Anti-kickback Statute
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# Identify the potential violation – 3

A radiologist who owned and served as medical director of a diagnostic testing center in New Jersey obtained nearly $2 million in payments from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests, by paying doctors to refer patients. The radiologist plead guilty and was sentenced to 46 months in prison. He was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

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A. Civil False Claims Act
B. Fraud Statute and Criminal Fraud
C. Anti-kickback Statute
D. The Stark Law

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# Identify the potential violation – 3

A radiologist who owned and served as medical director of a diagnostic testing center in New Jersey obtained nearly $2 million in payments from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests, by paying doctors to refer patients. The radiologist plead guilty and was sentenced to 46 months in prison. He was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

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D. The Stark Law

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# Identify the potential violation – 4

A physician routinely referred Medicare patients to an oxygen supply company he owned. He paid the Government $203,000 to settle allegations that he violated the physician self-referral prohibition.

A. Exclusion Authority
B. The Stark Law
C. HIPAA
D. Civil Monetary Penalties Law

# Identify the potential violation – 4

A physician routinely referred Medicare patients to an oxygen supply company he owned. He paid the Government $203,000 to settle allegations that he violated the physician self-referral prohibition.

A. Exclusion Authority
B. The Stark Law
C. HIPAA
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# Identify the potential violation – 5

A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted claims to health plans for brand name prescription drugs that the pharmacy could not have dispensed based on inventory records.

A. Exclusion Authority
B. The Stark Law
C. HIPAA
D. Civil Monetary Penalties Law

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# Identify the potential violation – 5

A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted claims to health plans for brand name prescription drugs that the pharmacy could not have dispensed based on inventory records.

A. Exclusion Authority
B. The Stark Law
C. HIPAA
D. Civil Monetary Penalties Law

# Identify the potential violation – 6

A pharmaceutical company plead guilty to two felony counts of criminal fraud related to failure to file required reports with the Food and Drug Administration concerning oversized morphine sulfate tablets. The executive of the pharmaceutical firm was excluded based on the company's guilty plea. At the time the executive was excluded, he had not been convicted himself, but there was evidence he was involved in misconduct leading to the company's conviction.

A. Exclusion Authority
B. The Stark Law
C. HIPAA
D. Civil Monetary Penalties Law

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# Identify the potential violation – 6

A pharmaceutical company plead guilty to two felony counts of criminal fraud related to failure to file required reports with the Food and Drug Administration concerning oversized morphine sulfate tablets. The executive of the pharmaceutical firm was excluded based on the company's guilty plea. At the time the executive was excluded, he had not been convicted himself, but there was evidence he was involved in misconduct leading to the company's conviction.

A. Exclusion Authority
B. The Stark Law
C. HIPAA
D. Civil Monetary Penalties Law

# Identify the potential violation – 7

A former hospital employee plead guilty to criminal charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

A. Exclusion Authority
B. The Stark Law
C. HIPAA
D. False Claims Act

# Identify the potential violation – 7

A former hospital employee plead guilty to criminal charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

A. Exclusion Authority
B. The Stark Law
C. HIPAA
D. False Claims Act

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# Thank You

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