

August 2020

Fraud, Waste and Abuse (FWA)

HCP Provider Compliance Training Module



HealthCare Partners, IPA
HealthCare Partners, MSO

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Key Topics

Welcome to HealthCare Partners Fraud, Waste and Abuse (FWA) Training! By completing this course, you will become knowledgeable about the following key topics as a HCP provider:

• Introduction – Deficit Reduction Act	• Stark Law
• Fraud, Waste and Abuse (FWA)	• Beneficiary Inducement Statute
• Member & Broker Fraud	• Red Flag Rule
• False Claims Act (FCA)	• Federal & Criminal Health Care Fraud Statutes
• FCA Amendments	• Exclusion Lists
• FCA Penalties	• Best Practices for Preventing FWA
• New York State FCA	• Reporting Potential FWA
• Anti-kickback Statute	• Whistleblower Provisions

Following this training, you must also complete a separate online Provider & FDR Compliance Attestation found on www.HealthCarePartnerNY.com, under the HCP Compliance Program webpage. **You must complete and submit the online attestation to be in compliance.**

Introduction – Deficit Reduction Act

On February 8, 2006 President Bush signed the Deficit Reduction Act of 2005 (DRA).

The DRA provided needed resources to the Center for Medicare and Medicaid Services (CMS) for the prevention, early detection and reduction of fraud, waste and abuse in the Medicaid program, including establishment of the Medicaid Integrity Program (MIP).

Key components of the MIP include:

- The Federal False Claims Act
- The New York State False Claims Act
- The Whistleblower Provision



Fraud, Waste and Abuse

FRAUD refers to intentionally, knowingly and willfully carrying out, or attempting to carry out a scheme to defraud any healthcare benefit program, or to obtain money or property owned by, or under the custody or control of, any healthcare benefit program.

Examples of the *most common* types of **provider healthcare fraud** include:

• Billing for services not performed	• Unbundling – billing for parts of a single, whole procedure separately
• Providing medically unnecessary services	• Accepting kickbacks or bribes for patient referrals, ordering diagnostic tests, etc.
• Falsifying a member’s diagnosis to justify coverage, tests, surgeries or other procedures that are not medically necessary	• Billing a patient more than the co-pay amount for services that were pre-paid or paid in full by the members’ health plan
• Misrepresenting procedures performed to obtain payment for non-covered services (e.g., cosmetic surgery)	• Waiving patient co-pays & deductibles or overbilling the insurance
• Upcoding – billing for a more costly service than what was actually performed	• Double Billing – billing both the member and Medicare, Medicaid or another insurer
• Theft of a prescriber’s DEA number, prescription pad or e-prescribing log-in credentials	• Billing for “free services” – billing the members’ health plan for tests marketed to and promised to the patient for free (e.g. hearing screening tests)

Fraud, Waste and Abuse (Cont'd.)

WASTE is the overuse of services (not caused by criminally negligent actions) and resources, directly or indirectly, that results in unnecessary costs to the healthcare system, including Medicare and Medicaid programs.

Examples of Waste include:

- A provider ordering excessive diagnostic tests
- A provider prescribing medications without validating if the member still needs them

ABUSE refers to excessive or improper use of services or actions that involves payment for services or items where there was no intent to deceive or misrepresent, but the outcome leads to unnecessary costs.

Examples of Abuse include:

- A provider unknowingly misusing codes on a claim
- Billing for brand name drugs when generics are dispensed
- Charging excessively for services or supplies

Fraud, Waste and Abuse (Cont'd.)

One of the primary differences between healthcare fraud, waste and abuse (FWA) is knowledge and intent.



FRAUD is a person's or entity's intentional deception to obtain payment or benefit they are not entitled to receive from an insurer or government health care program. Fraud also occurs when a person knows or should have known his or her actions were wrong or illegal.



WASTE and ABUSE may involve receiving improper payments, but does not involve the same intent and knowledge.

Member & Broker Fraud

Members and insurance brokers or agents may also commit health care fraud subject to civil and criminal penalties. Examples include:

Member Fraud Examples:	Agent or Broker Fraud Examples:
Filing claims for services or medications not received	Altering documents
Using someone else's insurance card	Bribery and kickbacks
Forging or altering bills or receipts	Falsification or misrepresentation of member or group information to obtain reasonable rates
Using the transportation benefit for non-medical related business	Failure to disclose information that may affect conditions of coverage
	Sale of non-existent policies

False Claims Act

The False Claims Act (FCA) is a federal statute that is intended to prevent healthcare fraud and recover losses involving any federally funded contract or program, including Medicare and Medicaid programs. The act prohibits and establishes liability for any person who knowingly:

- conspires to violate the FCA;
- makes or uses a false record to support a false claim;
- presents a false claim for payment or approval;
- conceals or improperly avoids or decreases an obligation to pay the government;
or
- carries out other acts to obtain property from the government by misrepresentation.

False Claims Act Amendments

The FCA was amended in 2009 and 2010 under The Fraud Enforcement and Recovery Act of 2009 (“FERA”) and the Patient Protection and Affordable Care Act, giving federal prosecutors more power and reversing specific court rulings.

The most significant amendments impacting liability and reporting obligations include:

- (1) Expansion of Claim** – redefined “claim” to include “money or property spent or used on the government’s behalf or to advance a government program or interest, and where the government provides or reimburses any portion of the requested funds.
- (2) Elimination of Presentment Requirement** – imposes liability on *anyone* who knowingly presents, or causes to be presented, a false claim for payment or approval.

False Claims Amendments (Cont'd.)

- (3) Expansion of Liability for Possession of Overpayments** – clarified that Medicaid and Medicare payments overpayments must be reported and returned within 60 days of discovery. Failure for timely reporting and for return of overpayments exposes a provider to liability under the FCA.
- (4) Statutory Anti-Kickback Liability** – automatically made claims submitted in violation of the Anti-Kickback Statute (AKS) a false claim. It also added the provision that "a person need not have actual knowledge or specific intent to commit a violation" of the AKS.
- (5) Reverse False Claims** – expanded liability to “knowingly and improperly” avoiding or decreasing an obligation to pay or transmit money to the government.

False Claims Act Penalties

Health care providers and suppliers who violate the FCA are subject to the following penalties and administrative sanctions:

- a civil penalty range of \$12,000 to \$23,000* per claim;
- payment of three times the amount of damages sustained by the government;
- up to five (5) years in prison;
- a fine calculated under the United States Sentencing Guidelines;
- exclusion from participation in Federal Health Care Programs, such as Medicare and Medicaid;
- denial or revocation of Medicare provider number application;
- suspension of provider payments; and
- license suspension or revocation.

** Penalties increased by the Department of Justice in June 2020*

New York State False Claims Act

The New York State False Claims Act (NYS FCA) applies to false claims of any kind made to the state, municipality, school district, public benefit corporation within the state, or to any contractor whose funding comes in full or in part from the state or local government.

The NYS FCA imposes fines and penalties on individuals that file false or fraudulent claims for payment similar to the federal False Claims Act (\$6,000-\$12,000 per claim + two to three times the value of the amount falsely received).

Additionally, this law allows private individuals to file lawsuits in state court, just as if they were state or local government parties.

Anti-Kickback Statute

The Anti-kickback Statute (AKS) makes it a criminal offense to knowingly and willfully solicit, receive, offer or pay remuneration*, in whole or in part, in return for:

- Referrals for the furnishing or arranging of any items or services reimbursable by a Federal Health Care Program
- Purchasing, leasing, ordering or arranging for any items or service reimbursable by a Federal Health Care Program

Safe Harbor Exceptions, include bona fide employment relationships, personal service arrangements, office space/equipment leases or rentals.



Penalties include fines up to \$25,000, imprisonment for up to 5 years and exclusion from Federal Health Care Programs (e.g., Medicaid & Medicare).

**Remuneration is defined as the transfer of anything of value, directly or indirectly, overtly or covertly in cash or in kind, including kickbacks, bribes or rebates.*

Stark Law

Also known as the “Physician Self-Referral Law”, the Stark Law prohibits a physician from making a referral for certain designated health services to an entity when the physician (or an immediate member of his or her family) has:

- an ownership/investment interest, or
- a compensation arrangement, unless an exception applies.

Damages and Penalties

Penalties for Stark Law violations may include the following fines:

- up to \$15,000 per violation; and
- three times the amount of improper payment(s) the individual/entity received; and
- Exclusion from Federal Health Care Programs (e.g., Medicare/ Medicaid).

Beneficiary Inducement Statute

The Beneficiary Inducement Statute prohibits providing free or discounted items or services, and other certain inducements to Medicare or Medicaid beneficiaries, e.g., waiving the coinsurance and deductible amounts after determining in good faith that the individual is in financial need.

Civil monetary penalties may be imposed of up to \$10,000 for each wrongful act and possible exclusion from Federal Health Care Programs.

Red Flag Rule

The Red Flag Rule requires certain businesses and organizations – including many doctors' offices, hospitals and other health care providers – to develop a written program to detect the warning signs of identity theft.

Health care providers are subject to this rule if they are “creditors”, which in this case is any entity that regularly defers payments for goods or services or arranges for the extension of credit.

If you regularly bill patients after the completion of services, then you must comply with the Red Flag Rule.

Federal & Criminal Health Care Fraud Statutes

Federal Health Care Fraud Statute

Enforces fines and/or imprisonment for up to 10 years for anyone who knowingly and willfully:

- executes, or attempts to execute, a scheme to defraud any health care benefit program; or
- falsely or fraudulently obtains any money or property owned or controlled by any health care benefit program.

Criminal Health Care Fraud Statute

Makes it a criminal offense for any person to knowingly and willfully execute a scheme to defraud a health care benefit program. Healthcare fraud is punishable by:

- Imprisonment of up to 10 years; and
- Criminal fines of up to \$250,000

Exclusion Lists

HCP monitors the following federal and state exclusion lists on a monthly basis:

- OIG – List of Excluded Individuals and Entities;
- General Services Administration - SAM – Exclusion List;
- NYS Office of the Medicaid Inspector General (NYS OMIG) Exclusion List;
- NJ Consolidated Debarment List; and
- CT Quality Assurance Administrative Actions List.

HCP does not contract with providers or vendors on these lists or who are otherwise deemed ineligible, debarred or suspended from participation in Federal Health Care Programs.

Best Practices for Preventing FWA

- Monitor claims for accuracy-ensure encoding reflects services provided.
- Monitor medical records-ensure documentation supports services rendered.
- Perform regular internal audits.
- Establish effective lines of communications with colleagues and staff members.
- Perform regular internal audits.
- Ask about potential compliance issues with staff members.
- Take action if you identify a problem.

Reporting Potential Fraud, Waste, and Abuse

Everyone has the right and responsibility to report possible, fraud, waste, and abuse.



Report issues or concerns to:

- Your organization's compliance office or compliance hotline and/or;
- 1-800-MEDICARE.

You may report anonymously. Retaliation is prohibited when you report a compliance concern in good faith.

Because HCP pays provider claims for services rendered to members enrolled in government programs, we are ethically and legally obligated to be diligent in our efforts to detect and report suspected fraud and abuse.

Whistleblower Provisions

The FCA includes a “qui tam” or whistleblower provision to encourage employees, former employees, or a member of an organization to come forward and report misconduct involving false claims.

This provision essentially allows any person to:

- Report fraud anonymously
- Take legal action against an organization on behalf of the government and to claim a portion of any settlement results

Whistleblowers who report false claims or bring legal action to recover money paid on false claims are protected from retaliation.

In accordance with Federal and NYS Labor Laws, HCP has established a Whistleblower and Non-Retaliation Policy. If it is determined that retaliatory behavior is being taken against an individual for reporting fraudulent activity or for assisting with a related investigation, the individual engaging in that behavior will be subject to termination of employment or provider contract.



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