This presentation is for anyone who may come in contact with a Medicare Advantage patient through their work. This includes anyone who handles information such as billing.
What You’ll Learn

• Definitions of fraud, waste and abuse
• Examples of each
• Relevant statutes
• Your responsibilities

In this presentation, we’ll define fraud, waste and abuse and provide examples of each. We’ll inform you of the relevant statutes and explain your responsibilities relating to fraud, waste and abuse.
Fraud, waste and abuse account for billions of dollars being lost each year, money that could be spent providing quality health care. Almost everyone pays for fraud, waste and abuse. Patients may face benefit cuts and working people may see their taxes increased. Reimbursement rates for honest physicians, hospitals, and other health care providers may be reduced to help control costs. Everyone has a financial stake in curtailing health care fraud.
Why FWA Training?

Centers for Medicare and Medicaid Services (CMS) mandates it!

- Initial training by December 31, 2009
- Attestation due January 1, 2010
- Annual training
- Providers must maintain records

This new requirement of the Centers for Medicare and Medicaid Services maintains that you take this training or equivalent training. It’s something you MUST do this year and every year thereafter. For your office’s contract to remain in force with our health plan, the person in your office who signed a contract with us must attest in writing that everyone who has contact with Medicare Advantage patients and/or information regarding these patients has completed the training. This must be done by January 1, 2010. CMS requires that providers maintain records of these trainings for 10 years. Our health plan is responsible for ensuring that its vendors meet this CMS training requirement. We do not maintain your records, but we may audit them.
What Is Health Care Fraud?

What is health care fraud? It comes under Title 18 of the United States Code, Section 1347. In laymen’s terms, health care fraud is committed when someone knowingly or willfully schemes or uses trickery to defraud any health benefit program. They may use false or deceitful practices, representations or promises to obtain money or property that is owned by or under the control or custody of any health care benefit program, including Medicare. It specifically involves the delivery of payment for health care benefits, items or services to benefit the perpetrator or some other person. This isn’t about the occasional mistake made from time to time. This definition clearly implies dishonesty and an intent to do the wrong thing.
Examples of Health Care Fraud

- Follow-up visit billed as initial
- Toenail trim billed as surgery
- Charges for blood tests not done
- Billing for expensive wheelchair; delivering a standard one
- Billing for different item or service or one not provided

Let’s look at common examples of health care fraud: A doctor bills for a follow up visit as an initial visit. A podiatrist trims toenails and bills for foot surgery. A lab charges for blood tests that were not done. A durable medical equipment company bills for an expensive wheelchair but delivers a standard model. A rehab facility bills for an item or service which was not provided or is different from the service provided.
Health care waste occurs when specific practices result in unnecessary cost. These include:

- Overuse, underuse and misuse of care
- Non-value-added services
- Medical mistakes; medication errors
- Overuse of emergency departments
- Unnecessary lab tests and imaging
What Is Health Care Abuse?

- Unnecessary, inappropriate care
- Care doesn’t meet professionally recognized standards
- Provider conduct inconsistent with acceptable business and/or medical practices resulting in greater reimbursement

Health care abuse is: Care that is not medically necessary or appropriate care Care that fails to meet professionally recognized standards for health care Provider conduct that is inconsistent with acceptable business and/or medical practices resulting in greater reimbursement. Fraudulent intent is implied in this last statement.
Examples of Health Care Abuse

- Billing for medically unnecessary items or services
- Services exceed what is needed
- Billing for a non-covered service
- Misusing codes on a claim

Waste/abuse may become fraud

Some examples of abuse are Billing for medically unnecessary items or services such as home medical equipment that’s not needed Ordering services, such as diagnostic X-rays or clinical laboratory services, that are unnecessary Billing for a service that is not covered. Misusing codes on a claim. This can occur, for example, when the service coded on the claim does not comply with national or local coding guidelines or is not billed as rendered. What sometimes starts out as abuse or waste quickly becomes fraud when the provider realizes that substantial money can be made. With CMS decreasing provider reimbursement rates, the temptation to defraud increases.
Who Commits Health Care Fraud?

Almost anyone can commit health care fraud, including doctors, hospitals, ambulance companies, pharmacy benefit managers and their employees. Others are beneficiaries, health insurance companies and their employees, pharmacists and pharmacy personnel. Still others are vendors, who may provide durable medical equipment, pharmaceutical supplies or billing services, for example. People with access to personal health information such as Social Security or Medicare numbers also have greater opportunity to commit health care and other kinds of scams such as identity theft.
Examples of Provider Fraud

- Upcoding
- Duplicate billing
- Ghost beneficiaries
- Misrepresenting services
- Unbundling services
- Phantom billing
- Billing for “free” services

Here are some examples of how providers can defraud the health care system. Upcoding – billing for a more expensive service or for more time than actually used. Duplicate billing – A provider submits two claims with different dates of service for the same service. Or two or more providers, say a physician and radiologist, provide the same service, such as reading an X-ray, but bill separately. Billing for ghost beneficiaries – patients never seen

Misrepresenting services that are not covered, such as cosmetic surgery, as a covered service by using a different name and CPT code

Unbundling – billing separately for services and/or supplies that are considered to be part of a single procedure or global fee

Phantom billing – billing for services or supplies that were never received by the beneficiary

Offering a “free” hearing test, but billing Medicare for the service
How can health care fraud happen?

- People trust their doctors
- Only doctors decide what is medically necessary
- Elderly patients or those with disabilities are especially vulnerable
- Elderly and disabled patients are intimidated by the health care system
- Patients are reluctant to question their doctor

While most providers are honest, there are some situations that make it easy for the dishonest to commit health care fraud. These reasons include People trust their doctors and expect them to be the experts. Only doctors can decide what services, supplies and equipment are “medically necessary” or fill out a Certificate of Medical Necessity. Elderly patients or patients with disabilities can be particularly vulnerable because they may not completely understand the health care system and often fail to voice concerns or ask questions. Patients can be afraid of a negative impact on their care or that the doctor will no longer treat them.
Examples of Beneficiary Fraud

- Identity swapping
- Identity theft
- Doctor shopping
- Resale, inappropriate use or diversion of prescription drugs
- Forging or altering bills, receipts or prescriptions

What kinds of beneficiary fraud should you be aware of? Identity swapping – a beneficiary lends their insurance card to someone else. Identity theft – a beneficiary steals someone else’s identity. Doctor shopping – bouncing from one doctor to another to obtain prescriptions for controlled substances either to satisfy an addiction or to sell drugs on the black market. Forging or altering bills or receipts and then submitting them directly to the insurance carrier.
Some of the primary laws and regulations that address health care fraud, waste and abuse are: The False Claims Act, The Anti-Kickback Statute, Physician Self-Referral Statute, Health Insurance Portability and Accountability Act of 1996, also known as HIPAA.
Federal False Claims Act

The Federal False Claims Act provides a legal tool to combat fraudulent billings turned into the federal government. The act allows private citizens to sue --on behalf of the government--those who defraud the government. Persons filing under this act may receive anywhere from 15 to 25 percent of any recovered damages. Informally, this is known as "whistle blowing." Claims under the law have been filed by persons with insider knowledge of false claims. Recent revisions to the law create liability for "reverse false claims" which includes the knowing retention of overpayments, even if they were innocently received.
False Claims Act Penalties

• *Three* times the amount of damages

• Civil penalties of $5,500 to $11,000 per false claim

• One false claim of $100 may result in a penalty that’s 114 times original claim

Penalties under the Federal False Claims Act are calculated by the government uses a formula consisting of: Three times the amount of damages sustained by the government, plus Civil penalties of $5,500 to $11,000 per false claim One false claim of just $100 can result in a penalty 114 times the cost of the original service.
Here's how that happens: Take one false claim for 100 dollars—what the government was billed. Now add triple the damages ... that's 300 dollars. Add the penalty for this one claim or 11,000 dollars. 100 dollars + 300 dollars + 11,000 dollars equals 11,400 dollars.
The Anti-Kickback statute prohibits knowingly or willfully soliciting, receiving, offering, requesting or paying any remuneration, directly or indirectly, to induce or reward referrals of business payable under a federal health program. It's also knowingly and willfully making false statements or representations in applying for benefits or payments under federal and state health care programs. If false statements are used, it's also a violation of the False Claims Act. A violation the anti-kickback statute can occur if knowledge of an event relating to an initial or continued right to benefits or payments is fraudulently concealed or has not been disclosed. Recent changes in the pharmaceutical industry should help physicians avoid some potential anti-kickback problems.
Conviction of an Anti-Kickback violation is a felony. This comes with jail time of up to five years plus a 25,000 dollar fine and possible exclusion from federal health care programs.
There are two Stark statutes. Under Stark I, physicians or their immediate family members who own or are paid by an entity cannot make referrals to that entity. Stark II extends the relationship to any entity providing “designated health services” under Medicare. There are some safe harbors and exceptions identified in these laws. Seek legal counsel before entering into a relationship with or referring to an entity where one of these statutes might apply.
Penalties for Stark violations are Payments for the designated health service can be denied. Amounts collected up to 15,000 dollars for each service must be refunded. Physicians and entities that enter into an arrangement to get around the referral restriction law are subject to civil monetary penalties up to 100,000 dollars per occurrence.
The Health Insurance Portability and Accountability Act, commonly known as HIPAA, prohibits anyone from obtaining or disclosing individually identifiable health information in an inappropriate manner or for a reason other than allowed by law. Under HIPAA, even if you don’t know the specific violation, you can still be found guilty and penalized if you obtain or disclose personal health information for a reason other than allowed by law.
HIPAA Violation Penalties

HIPAA Civil Penalties
• $100/violation up to $50,000 per violation not to exceed $1,500,000/year

HIPAA Criminal Penalties
• $50,000/up to 1 year in prison

• $100,000 fine/up to 5 years for false pretenses

• $250,000/up to 10 years with intent to sell

Civil penalties for violating HIPAA range from 100 dollars per violation up to 50,000 dollars per violation not to exceed 1,500,000 a year. For a simple violation, criminal penalties can be 50,000 dollars and up to one year in prison. If the information was obtained under false pretenses, the fine is 100,000 dollars and prison time can be up to five years. If the information was obtained with intent to sell, the penalties are much stiffer: 250,000 dollars and up to 10 years in jail.
Civil Monetary Penalties

- Where the person did not know and by exercising due diligence would not have known, $100 per violation up to $50,000 per violation, not to exceed $1,500,000 per year;
- Where the violation was due to reasonable cause and not to willful neglect, $1,000 per violation up to $50,000 per violation, not to exceed $1,500,000;
- Where the violation was due to willful neglect but was corrected within 30 days $10,000 per violation up to $50,000 per violation, not to exceed $1,500,000; and
- Where the violation was due to willful neglect and was not corrected within 30 days $50,000 per violation not to exceed $1,500,000.

Civil monetary penalties are where the dollars can really add up. If the violation was not due to willful neglect the fine will be 1,000 dollars up to 50,000 dollars per violation but not to exceed 1,500,000 dollars. If the violation was due to willful neglect but was corrected within 30 days you can be fined 10,000 dollars up to 50,000 dollars per violation but not to exceed 1,500,000 dollars. If the violation was due to willful neglect and not corrected within 30 days the fines are 50,000 per violation not to exceed 1,500,000. This can get into some pretty serious money, especially if civil monetary penalties are going to apply whenever there’s a false claim. Civil monetary penalties are on top of any penalties applied under the False Claims Act.
Beneficiary Inducements

A beneficiary inducement occurs when a Medicare or Medicaid beneficiary is offered or transferred any remuneration he or she knows or should know is likely to influence his/her selection.

- Remuneration that the Medicare or Medicaid beneficiary "knows or should know" is likely to influence his/her selection.
- “Remuneration” includes:
  - Cash
  - Waivers of copayments/deductibles
  - Transfer of items or services for free or other than fair market value
  - Non-cash items, gifts or services

A beneficiary inducement occurs when a Medicare or Medicaid beneficiary is offered or transferred any remuneration he or she knows or should know is likely to influence their selection of a provider, practitioner, or supplier of Medicare or Medicaid payable items or services. "Remuneration" includes more than cash. It also means without limitation, waivers of copayments and deductibles or any part thereof and transfers of items or services for free or for other than fair market value. Non-cash gifts or services can be no more that 10 dollars in value for individuals and no more than 50 dollars in the aggregate annually per patient.
Beneficiary Inducement Penalties

- Fines up to $10,000 per violation, plus
- Three times damages incurred by the government
- Potential exclusion from participation in government programs
- Civil monetary penalties may apply

The penalties for beneficiary inducements are tough: 10,000 dollars per violation PLUS three times the damages incurred by the government. The provider also may be excluded from participating in government programs, including Medicare, Medicaid, SCHIP and FEP. Civil monetary penalties may also apply.
The purpose of Exclusion or Debarment is to protect the government from doing business with anyone who poses a business risk to the government. Exclusion and/or debarment prevents companies and individuals from participating in government contracts, subcontracts, loans, grants and other assistance programs. In other words, exclusion and/or disbarment means a provider would not be able to treat anyone who participates in a government program.
Although there are many reasons a provider or other entity could be excluded from Medicare, Medicaid and other government programs, violating the fraud and abuse laws is a primary one. Exclusion from federal health care programs means that no payment may be made for any items or services furnished by an excluded person. Nor is payment to be made for services ordered for a program beneficiary by an excluded person, even if the excluded person does not actually furnish the services. This payment ban applies to all methods of federal program reimbursement. Payment is also precluded for items and services furnished to a hospital inpatient or outpatient based on orders by an physician who is a member of the hospital’s medical staff but who has been excluded from federal program participation.
OIG Exclusions continued

- Items/services furnished or ordered by an excluded person
- Items/services furnished to a hospital inpatient or outpatient based on an excluded person’s orders
- Administrative and management services not directly related to patient care but necessary to the provision of care and items

Other exclusions include: Items/services furnished or ordered by an excluded person
Items/services furnished to a hospital inpatient or outpatient based on an excluded person’s orders
Administrative and management services not directly related to patient care but necessary to the provision of care and items
Some of the items and services that could violate OIG exclusions, if provided by an excluded person: Services related to preparation of surgical trays or review of treatment plans, for example, if such services are reimbursed directly or indirectly, e.g., through a prospective payment to the hospital or a bundled payment of the physician group, even if the excluded person does not furnish direct care to federal program beneficiaries. Administrative services, including the processing of claims for payment submitted to a Medicare fiscal intermediary or carrier or Medicaid/Medi-Cal fiscal agent; Services performed by an excluded administrator, billing agent, accountant, claims processor, or utilization reviewer that are related to and reimbursed, directly or indirectly, by a federal health care program; Items or equipment sold by an excluded manufacturer or supplier and used in the care or treatment of beneficiaries and reimbursed, directly or indirectly, by a federal health care program.
OIG/GSA Exclusion/Debarment

OIG exclusion precludes the employment of an excluded individual in any capacity by a health care provider that receives reimbursement from any federal health care program. Hospitals, nursing homes, hospices, group medical practices, and other health care providers who employ or enter into contracts with excluded persons to furnish items or services to federal program beneficiaries face exposure to the civil monetary penalties and assessments. The OIG may impose a penalty of up to 10,000 dollars for each claim for payment submitted to a federal health care program for items or services furnished by a person or entity during a period of exclusion. For civil monetary penalty liability to be imposed, the statute requires that the person/company “knows or should know” that the employee who furnished the items or services was excluded from participation in the program. Contracting entities have an affirmative duty to check the program exclusion status of individuals and entities prior to entering into a contractual relationships or risk civil monetary penalty liability. The OIG maintains a List of Excluded Individuals/Entities on its Web site, hhs.gov/oig.
Your responsibilities are to know and follow all applicable laws, regulations, policies and procedures that apply specifically and generally to your job. Report any known or suspected violations of any laws, regulations, policies or procedures. Participate in annual compliance AND specialized Medicare Compliance training. Adhere to your Code of Conduct. Medicare Advantage requires that you have a Code of Conduct and Compliance Program. Do not retaliate against anyone who, in good faith, reports a known or suspected violation of your code, policies, procedures, laws or regulations.
Reporting Potential FWA

- CommunityCare Compliance Officer
  - Remsen Beitel
  - Phone: (918) 594-4123
  - E-Mail: rbeitel@ccok.com
- CommunityCare Compliance Hotline
  - Phone: (877) 382-9317

We want to help you do the right thing. You can contact us by telephone, online at our website or by US mail. The important thing is not how you contact us, but that you do contact us.
Medicare Fraud & Abuse Resources

- Medicare Fraud and Abuse brochure (attachment)
- http://www.ccok.com
- http://www.medicare.gov/

Along with this presentation is a 4-page brochure from CMS that lists a variety of resources to help you and your organization prevent or report fraud and abuse. Please print and post a copy where employees can easily read it. You may also visit our Web site at www.ccok.com or the Medicare Web site, medicare.gov.
As a reminder to the contracting physician, anyone in your office who may come into contact with a Medicare Advantage beneficiary is required to complete fraud, waste and abuse training. Once everyone you have identified has been trained, please click on the link located next to this presentation on the provider website to access the certification for your entire organization. The attestation must be submitted on or before January 1, 2010.

Remember: Only the contracting physician has the authority to sign the attestation.
Thank you for participating in our fraud, waste and abuse training program. To close this presentation, click on the X in the upper right corner.