



# **FRAUD, WASTE & ABUSE PREVENTION AWARENESS TRAINING**

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# Why Do I Need Training?

Every year millions of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

**Including YOU.**

This training will help you detect, correct, and prevent fraud, waste, and abuse.

**You are part of the solution.**

# What is Fraud, Waste and Abuse (FWA)

Upon completion of this training you should be able to:

- Recognize and understand the principles underlying state and federal laws related to fraud, waste and abuse (“FWA”).
- Understand the definitions of fraud, waste and abuse as they pertain to state and federal health care programs.
- Understand the significance of our obligations and duties under, the Anti-Kickback Act, False Claims Act(s), and the Civil Monetary Penalties Law.
- Know what to do if you suspect FWA.
- Understand that you and all employees have an affirmative duty to report suspected health care fraud.

# Peace River Center's Commitment

Peace River Center is committed to complying with applicable federal and state laws, rules and regulations by adhering to high standards of business ethics as reflected in our Corporate Compliance Program, Code of Conduct and Code of Ethics.

# Training Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse
- Explain the obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
- Provide information on the types of fraud, waste and abuse that can occur
- Provide information on how to report fraud, waste, and abuse
- Provide information on laws pertaining to fraud, waste, and abuse

# Fraud, Waste and Abuse Requirements

- Statute, regulations, and policy govern both the Medicaid and Medicare (Parts A, B, C, and D) programs.
- Medicaid or Part C and Part D contractors must have an effective compliance program which includes measures to prevent, detect and correct Medicaid or Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
- In addition, contractors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities.
- Federal fraud, waste and abuse training requirements are found at 42 C.F.R. § 422.503(b) (4) (vi) and 42 C.F.R. § 423.504 (b) (4) (vi).

## Where Do I Fit In?

Peace River Center provides services to Medicaid, Medicare and other funded persons. As an employee of PRC, you either provide direct health or administrative services to Medicaid and/or Medicare recipients or support the provision of those services.

Because of your role at PRC, you are required to participate in training for awareness of fraud, waste and abuse.

## What are my responsibilities?

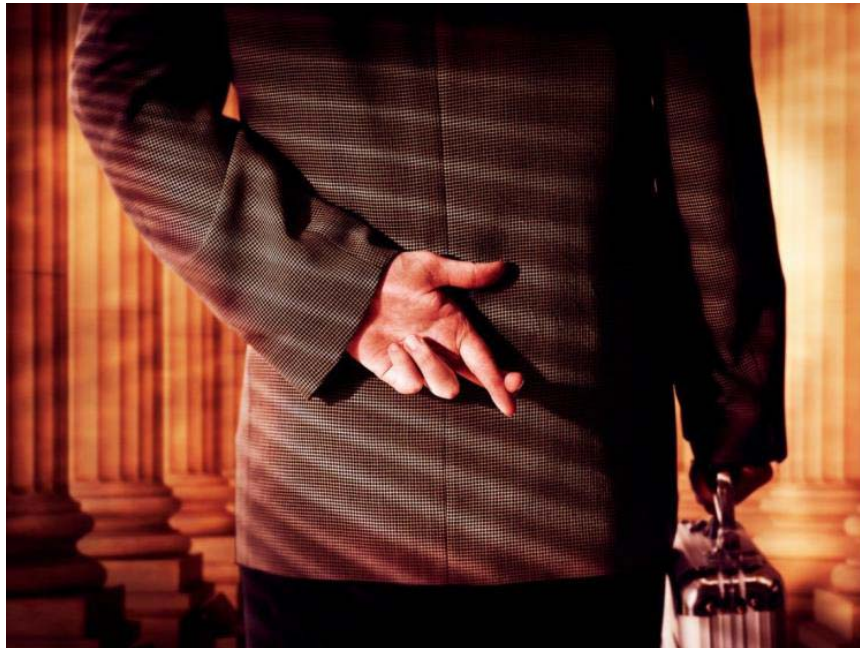
- You are a vital part of the effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.
- You are required to comply with all applicable statutory, regulatory, and other Medicaid and/or Medicare requirements.
- You have a duty to report any violations of laws that you may be aware of.
- You have a duty to follow the Code of Conduct and Code of Ethics that articulate Peace River Center's commitment to standards of conduct and ethical rules of behavior.



# What is Fraud, Waste, and Abuse?

# What is Fraud?

Fraud is an intentional deception or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.



# How Common?

- The United States Department of Health and Human Services-Office of Inspector General (“HHS-OIG”) conservatively estimates that \$100 Billion is lost to healthcare fraud each year.
  - That is \$273 Million a day ... and with healthcare costs escalating, this number is expected to rise.
- Fraud can be committed by any person or entity in the healthcare delivery chain.



# Provider Fraud Examples

- **Billing for services not rendered**
  - Billing for individual therapy, where only group therapy was performed
  - Billing for Durable Medical Equipment (“DME”) supplies never delivered
  - “Phantom” provider obtains Medicaid ID number, and bills for supplies or services never rendered
- **Rendering and billing for non-medically necessary services**
  - Performing Magnetic Resonance Imaging with contrast although the contrast was not indicated or necessary
  - Ordering higher-reimbursed, complete blood lab tests for every patient although specific or targeted tests are indicated
- **Upcoding - Billing a higher level service than provided**
  - Reporting CPT code 99245 (High Level Office Consultation) where services provided only warranted use of CPT code 99243 (Mid level Office Consultation)

# Member and Agent Fraud - Examples

- **Member Pharmacy Fraud**

- Members visiting multiple providers with feigned symptoms in order to obtain prescriptions for narcotics
- Members stealing prescription pads and forging provider's signature

- **Theft of ID/Services**

- An unauthorized individual uses a member's Medicare/Medicaid card to receive medical care, supplies, pharmacy scripts, or equipment; often a family member or acquaintance

- **Falsification of Documentation/Forgery**

- An agent forging a person's signature on an application

- **Misrepresentation of Benefits**

- An agent misrepresenting benefits to persuade an individual to join a health plan

# Health Plan and Provider Fraud - Examples

- **Encounter Data Falsification**
  - Health plans knowingly submitting falsified claims encounter data to gain a higher Healthcare Effectiveness Data and Information Set (“HEDIS”) score
- **Underutilization**
  - Providers or health plans deliberately and systematically deterring members from receiving medically necessary services in order to maximize service funds or capitation revenue
- **Attestations/Conditions of Participation**
  - Falsification of information provided to federal or state regulatory agencies in order to obtain government contracts or other business
- **Quality Access**
  - Falsification of network adequacy reporting in order to obtain government contracts

# FWA Criminal Activity

Examples of associate fraud or fraud “red flags” could include:

- Creating a fictitious provider in the system, and submitting claims that result in checks going back to the associate’s business or designated address, (i.e., to a “dummy” corporation)
- Selling or exchanging member information to sales agents with other plans
- Receiving a kickback or commission from an outside individual or entity in return for approving claims that should have been denied

## **FWA Criminal Activity... continued**

- Falsifying enrollee/client signatures on any type of document
- Providing computer system log-in credentials to other employees or non-employees for purposes of allowing others to access member information
- Falsely inflating production-related statistics in order to meet personal or agency goals
- Intentionally providing or concealing inaccurate data in a report to a government agency



# What is Abuse and Waste?

Requesting payment for items and services when there is no legal entitlement to payment. Unlike fraud, the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

- “Abuse” is sometimes defined as a practice that is inconsistent with accepted business or medical practices or standards and that results in unnecessary cost.
- “Abuse” can be thought of as potential fraud, where the provider’s intent may have been unclear.
- “Waste” includes any practice that results in an unnecessary use or consumption of financial or medical resources.

# Differences Between Fraud, Waste, and Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

# Abuse - Examples

**Abuse can include a range of improper behaviors or billing practices. For example:**

- **Billing for a non-covered service**
  - **Fraud:** The provider knew that service was non-covered, but changed the ICD-9 diagnosis to obtain coverage
  - **Abuse:** Provider suspected that service might not be covered, but figured that she would “test” and submit a claim anyway
- **Misusing codes on the claim**
  - **Fraud:** Provider sat down with billing policies and deliberately identified loop-holes
  - **Abuse:** Provider assumed that must be billing correctly as long as claims paid

# Abuse – Examples - Continued

## Inappropriately allocating costs on a cost report

- **Fraud:** Hospital personnel deliberately misclassified expense items
- **Abuse:** Hospital construes regulatory ambiguities guided solely by financial benefit to hospital



## Waste Example

In a hospital setting, a patient needs 375 ml of medication. The pharmaceutical company does not make a 375 ml bottle but only 500 ml or 1000 ml bottles. Once the bottle is opened, the unused portion must be disposed of, i.e., “wasted.”

Greater waste would occur if the hospital consistently orders and uses the 1000 ml bottle when the 500 ml bottle is available.

**Fraud** may be occurring if the hospital’s choice to purchase 1000 ml bottles is influenced, for example, by favorable manufacturer rebates tied to 1000 ml bottles.



## FWA Red Flags

- Medical claims that duplicate or unbundle procedures to maximize payment
- Dates of service not recorded in medical records or that do not match bill dates
- Different names or addresses of dependents and primary covered person
- Duplicate requests for authorization of a service that has been denied
- Changing documentation during the appeals and grievance process to overturn a denied authorization
- Multiple claims submitted on different dates for the same member, each showing same dates of services or overlapping dates of service
- Significant “spike” in provider’s claims activity or reimbursement in comparison to provider’s historical activity

## How Do I Report Fraud, Waste, or Abuse?

Everyone is required to report suspected instances of fraud, waste, and Abuse. The Peace River Center Code of Conduct and Code of Ethics clearly state this obligation.

- PRC HR 1.0 Code of Conduct
- PRC HR 1.11 Code of Ethics

If you come across situations that do not make sense and you feel might involve fraud, waste or abuse, you can do any and all of the following:

- Discuss the situation with your supervisor;
- Report the situation to the PRC CEO
- Report the situation to the PRC CFO
- Report the situation to the PRC Board Chair

## How Do I Report Fraud, Waste, or Abuse? More Info.

### Direct Reporting – Medicaid

- Consumer Compliant Hotline: 1-888-419-3456
- Florida Attorney General's Office: 1-866-966-7226
- The Florida Medicaid Program Integrity Office: 1-850-412-4600
- Complaint Form:  
[https://apps.ahca.myflorida.com/inspectorgeneral/fraud\\_complaintform.aspx](https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx)

### Direct reporting - Medicare

- Office of Inspector General (OIG): 1-800-447-8477
- TTY: 1-800-377-4950
- Fax: 1-800-223-8164
- [Online: OIG.HHS.gov/fraud/hotline](https://oig.hhs.gov/fraud/hotline) OR
- NBI MEDIC: 1-877-7SafeRX (1-877-772-3379)

**No adverse or retaliatory actions may lawfully be taken against anyone who reports an issue in good faith.**



# Laws You Need to Know About

# Civil Fraud - Civil False Claims Act

## 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's true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

## Civil False Claims Act Damages and Penalties

The damages may be tripled. Civil Money Penalty between \$5,000 and \$10,000 for each claim.

# Criminal Fraud Penalties

If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code §1347

# Anti-Kickback

- **The Anti-Kickback Statute prohibits:**

- The knowing and willful offer, payment, solicitation or receipt of any “remuneration,” in cash or in kind, direct or indirect...
- ...to induce someone to refer a patient or to purchase, order, or recommend any item or service which may be paid for under a Federal health care program.

- **CMS Marketing Guidelines require:**

- All payments that plans make to providers for services must be fair market value, consistent with an arm’s length transaction, for bona fide and necessary services.

42 United States Code §1320a-7b(b)

## Anti-Kickback: Suspect Arrangements

- Paying a physician for each patient who enrolls or remains enrolled in a plan
- Conditioning physician's compensation on minimum percentage of plan enrollees in physician's patient panel
- Offering enhanced fees, or fees clearly exceeding fair market value, to providers without any justification, such as enhanced quality or need for additional resources
- Accepting material gifts or perks from vendors in exchange for selecting vendor's products or services

# Anti-Kickback Safe Harbors

- Limited “safe harbors” that may protect arrangements that might otherwise violate the Anti-Kickback Act
- Most important “safe harbors” for health plans
  - Discounts offered to health plans by providers
  - Price reductions offered to health plans by providers
  - Agreements with contractors with substantial financial risk
- Other relevant “safe harbors”
  - Management contracts
  - Increased coverage, reduced cost-sharing amounts or reduced premium amounts offered by health plans to beneficiaries
- No “safe harbors” for payments made in return for patient enrollment or retention

# Anti-Kickback Statute Penalties

- Fine of up to \$25,000, imprisonment up to five (5) years, or both fine and imprisonment



# False Claims Laws

State and federal false claims laws impose significant penalties for knowingly:

- Submitting (or causing to be submitted) a false or fraudulent claim for payment or approval; or
- Making or using (or causing to be made or used) a false record or statement in support of a false or fraudulent claim; or
- Failing to return overpayments made by a government agency

“Knowingly” includes actions taken in “reckless disregard” or with “deliberate ignorance” of truth or falsity

The *qui tam* provisions of the federal False Claims Act (“FCA”)

- Lawsuit initiated by private individual (defined as “relator”)
- The government may choose to intervene in the private lawsuit
- *Qui tam* “relator” shares in civil monetary recovery, if any, with government

# Potential False Claims Violations

## Misrepresentation of information presented in reports to Medicare or Medicaid

- Pharmaceutical industry paid substantial sums to settle FCA cases based on prices reported to the Red Book and First Data Bank which did not reflect discounts the companies routinely gave customers.

## Misrepresentation of claims or eligibility data reported to Medicare or Medicaid

- Humana paid \$14.5 million to settle allegations that it incorrectly claimed members as dually eligible for both Medicare and Medicaid, and entered into a broad five-year corporate integrity agreement with the OIG.

# Civil Monetary Penalties Law

The Social Security Act authorizes the Secretary of HHS to seek civil monetary penalties (CMPs) and assessments for many types of illegal or unethical conduct. The Secretary of HHS has delegated many of these CMPs to the OIG. Types of prohibited conduct include, but are not limited to, the following:

- Offering inducements that one knows, or should know, are likely to influence Medicare or state health care program beneficiaries to order or receive items or services from a particular provider, practitioner or supplier
- Giving false or misleading information that might affect the decision to discharge a Medicare patient from the hospital
- Misusing Medicare and Medicaid program words, letters, symbols or emblems

## Civil Monetary Penalties Law: Violation Examples

- Physicians who knowingly misrepresent that a Medicare beneficiary requires home health services
- Submitting a claim, or claims, for service not rendered
- Utilizing a CMS logo without approval
- Failing promptly to return a known overpayment
- Offering inducements to influence decisions related to Medicare or Medicaid funds
- Acting to expel or refusing to enroll a Medicaid recipient due to the individual's health status
- Hiring employees who have previously been excluded from participation in federal programs

# Stark Statute (Physician Self-Referral 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

# Stark Statute Damages and Penalties

Medicaid or Medicare claims tainted by an arrangement that does not comply with Stark are not payable. Up to a \$15,000 fine for each service provided. Up to a \$100,000 fine for entering into an arrangement or scheme.

# HIPAA

Health Insurance Portability and Accountability Act of 1996  
(P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

## Coordination with Law Enforcement

Peace River Center investigates suspected fraud, waste or abuse, and, as appropriate, reports and cooperates with both federal and State agencies, including law enforcement, CMS and Medicare Drug Integrity Contractors.



# Auditing and Monitoring

To ensure compliance and to deter and detect fraud, waste and abuse, Peace River Center and many of our payers conducts regular and periodic compliance audits performed by both internal and external auditors and staff who have expertise in federal and state health care laws and regulations.

# Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal /State Health Care programs

## Scenario #1

A person comes to your pharmacy to drop off a prescription for a beneficiary who is a “regular” customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

What is your next step?

## Scenario #1

- A. Fill the prescription for 160
- B. Fill the prescription for 60
- C. Call the prescriber to verify quantity
- D. Call the sponsor's compliance department
- E. Call law enforcement

## Scenario #1 Answer

Answer: C

Call the prescriber to verify

If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the payer's compliance hotline. The payer (sponsor) will provide next steps.

## Scenario #2

Your job is to submit risk diagnosis to CMS for purposes of payment. As part of this job you are to verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the sponsor's process and to adjust/add risk diagnosis codes for certain individuals.

What do you do?

## Scenario #2

- A. Do what is asked of your immediate supervisor
- B. Report the incident to the compliance officer
- C. Discuss concerns with immediate supervisor
- D. Contact law enforcement

## Scenario #2 Answer

Answer: B

Report the incident to the PRC compliance officer.

The compliance officer is responsible for investigating and taking appropriate action. Your sponsor/supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.



## Scenario #3

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider (“Doe Diagnostics”) has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics’ claims far exceed any other provider that you reviewed.

What do you do?

## Scenario #3

- A. Call Doe Diagnostics and request additional information for the claims
- B. Consult with your immediate supervisor for next steps
- C. Contact the compliance officer
- D. Reject the claims
- E. Pay the claims

## Scenario # 3 Answer

Answers B or C

Consult with your immediate supervisor for next steps

or

Contact the compliance officer

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance officer have occurred, including whether additional documentation is necessary.

## Scenario #4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy.

What should you do?

## Scenario #4

- A. Call the local law enforcement
- B. Perform another review
- C. Contact your compliance officer
- D. Discuss your concerns with your supervisor
- E. Follow your pharmacies procedures

## Scenario #4 Answer

Answer E

Follow your pharmacies procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.