American Behavioral 2018

Fraud, Waste, and Abuse Training and General Compliance Training

This training module consists of two parts:

(1) **Fraud, Waste, and Abuse (FWA) Training and**

(2) **General Compliance Training**

Part 1: Fraud, Waste, and Abuse 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.

When you finish this training, you should be able to:

- Recognize FWA;
- Identify the majority of laws and regulations pertaining to FWA;
- Recognize potential consequences or penalties associated with violations;
- Identify methods of preventing FWA;
- Identify how to report FWA;
- Recognize how to correct FWA;

Fraud is **Knowingly** and **Willfully** executing, or attempting to execute, a scheme or artifice (trickery) 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.

18 United States Code §1347

- The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program.
- Health care fraud is punishable by up to:
  - 10 years imprisonment and
  - criminal fines of $250,000

Fraud: Intentionally submitting false information in order to get money or a benefit. Deliberate deception to secure financial or personal gain.

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

Abuse: includes actions that may, directly or indirectly, result in unnecessary costs. 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 facts to obtain payment.

- Fraud Examples:
  - Knowingly billing for services not furnished or supplies not provided, including billing for appointments that the patient failed to keep;
  - Billing for non-existent prescriptions; and
  - Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

- Waste Examples:
  - Conducting excessive office visits or writing excessive prescriptions;
  - Prescribing more medications than necessary for the treatment of a specific condition; and
  - Ordering excessive laboratory tests.

- Abuse Examples:
  - Billing for unnecessary medical services;
  - Billing for brand name drugs when generics are dispensed;
  - Charging excessively for services or supplies; and
  - Misusing codes on a claim, such as upcoding or unbundling codes.

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.

In order to detect fraud, waste, and abuse you need to know the **Law.**

The following slides provide high-level information about the following laws:

- Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud;
- Anti-Kickback Statute;
- Stark Statute (Physician Self-Referral Law);
- Exclusion; and
- Health Insurance Portability and Accountability Act (HIPAA).

For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

False Claims Act makes a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA;
- Carries out other acts to obtain property from the Government by misrepresentation;
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement in support of a false claim;
- Presents a false claim for payment or approval;

31 United States Code § 3729-3733

A Medicare Plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from the Centers for Medicare & Medicaid Services (CMS);
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported;
- Failed to report the unsupported diagnosis codes to Medicare; and
- Agreed to pay $22.6 million to settle FCA allegations.

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty.

Whistleblowers:

A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

- **Protected:** Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- **Rewarded:** Persons who bring a successful whistleblower lawsuit receive at least 15 percent but not more than 30 percent of the money collected.

The **Health Care Fraud Statute** states that "Whoever knowingly and willfully executes, or attempts to execute, a scheme to … defraud any health care benefit program … shall be fined … or imprisoned not more than 10 years, or both."

Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law. For more information, refer to 18 U.S.C. Section 1346

Health Care Fraud Statute Example:

- A Pennsylvania pharmacist:
  - Submitted claims to a Medicare Part D plan for non-existent prescriptions and for drugs not dispensed;
  - Pleaded guilty to health care fraud; and received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan.

Health Care Fraud Statute Example:

- Owners of two Florida Durable Medical Equipment (DME) companies:
  - Submitted false claims of approximately $4 million to Medicare for products that were not authorized and not provided;
  - Were convicted of making false claims, conspiracy, health care fraud, and wire fraud;
  - Were sentenced to 54 months in prison; and
  - Were ordered to pay more than $1.9 million in restitution.

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000;
- Imprisonment for up to 20 years; or
- Both.

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

18 U.S.C. Section 1347

Anti-Kickback Statute Prohibits:

Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

42 United States Code §1320a-7b(b)

Anti-Kickback Example:

- 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;
  - Paid doctors for referring patients;
  - Pleaded guilty to violating the Anti-Kickback Statute; and
  - Was sentenced to 46 months in prison.

The radiologist was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

Anti-Kickback Statute violations are punishable by:

- A fine of up to $25,000;
- Imprisonment for up to 5 years; or
- Both.

Social Security Act (the Act), Section 1128B(b)

Stark Statute 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
- a compensation arrangement (exceptions apply).

42 United States Code §1395nn

Stark Statue Example:

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

Damages and Penalties:

Medicare Claims tainted by an arrangement that does not comply with Stark Statute 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

Civil Monetary Penalty Law (CMP)

The Office of Inspector General (OIG) may impose Civil penalties for a number of reasons, including:

- 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.

CMP Example:

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

Damages and Penalties:

- The penalties range from $10,000 to $50,000 depending on the specific violation. Violators are also subject to three times the amount:
- Claimed for each service or item; or
- Of remuneration offered, paid, solicited, or received.

Exclusion

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 Office of Inspector General. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).

The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

Exclusion Example:

- A pharmaceutical company pleaded 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.

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

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

HIPAA safeguards help 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.

HIPAA Example:

- A former hospital employee pleaded guilty to criminal HIPAA 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

Damages and Penalties:

- Violations may result in Civil Monetary Penalties.
- In some cases, criminal penalties may apply.

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

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

- Civil Monetary Penalties;
- Civil prosecution;
- Criminal conviction/fines;
- Exclusion from participation in all Federal health care programs;
- Imprisonment; or
- Loss of provider license

Which of the following requires intent to obtain payment and the knowledge that the actions are wrong?

Select the correct answer

A. Fraud

B. Abuse

C. Waste

Answer: **A**

Fraud is intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse also cause unnecessary costs but are not the result of intentional actions

Which of the following is NOT potentially a penalty for violation of a law or regulation prohibiting Fraud,

Select the correct answer

A. Civil Monetary Penalties

B. Deportation

C. Exclusion from participation in all Federal health care programs

Answer: **B**

Civil Monetary Penalties and Exclusion from participation in Federal health care programs are both penalties for FWA, but deportation is not used as a FWA penalty.

You are a vital part of the effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Medicare or Medicaid requirements.
- **SECOND** you have a duty to the Medicare and/or Medicaid Programs to report any violations of laws that you may be aware of.
- **THIRD** you have a duty to follow American Behavioral's Compliance Program that articulates your and American Behavioral's commitment to standards of conduct and ethical rules of behavior.

- Look for suspicious activity;
- Conduct yourself in an ethical manner;
- Ensure accurate and timely date/billing;
- Ensure you coordinate with other payers;
- Make sure you are up to date with FWA policies and procedures, laws, regulations, policies;
- Verify all information provided to you;

Familiarize yourself with your entity's policies and procedures.

Every Sponsor and First-Tier, Downstream, or Related Entity (FDR) must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.

Standards of Conduct should describe the Sponsor's expectations that:

- All employees conduct themselves in an ethical manner;
- Appropriate mechanisms are in place for anyone to report non-compliance and potential FWA; and
- Reported issues will be addressed and corrected

Everyone must report suspected instances of FWA. Sponsors may not retaliate against you for making a good faith effort in reporting.

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your supervisor and Debbie Garvin.

The American Behavioral Compliance Department area will investigate and make the proper determination.

If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General, the Department of Justice, or CMS. Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.

Details to Include When Reporting FWA

- When reporting suspected FWA, you should include:
  - Contact information for the source of the information, suspects, and witnesses;
  - Details of the alleged FWA;
  - Identification of the specific Medicare rules allegedly violated; and
  - The suspect's history of compliance, education, training, and communication with your organization or other entities.

You may report potential fraud as listed in the previous slide or to the following:

HHS Office of Inspector General
Office of Inspector General
Phone: 800-447-8477 or TTY 800-377-4950
Fax: 800-223-8164
Email: HHSTips@oig.hhs.gov
Online: https://forms.oig.hhs.gov/hotlineoperations

Medicare Parts C and D
National Benefit Integrity Contractor (NBI MEDIC)
Phone: 877-772-3379

For all other Federal health care programs:
CMS Hotline: 800-MEDICARE (800-633-4227 or TTY 877-486-2048)

HHS and US Department of Justice (DOJ)
https://www.stopmedicarefraud.gov

Medicaid

- **Medicaid Program Integrity Division**
- Phone: (866)452-8930
- Address:

AL Medicaid Program Integrity Division
PO Box 5624
Montgomery, AL 36103-5624

Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves money and ensures you are in compliance with Laws and Regulations.

Develop a plan. Consult the American Behavioral Compliance Department to find out the process for the corrective action plan development.

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance;
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions;
- Document corrective actions addressing non-compliance or FWA committed by a Sponsor's employee or FDR's employee and include consequences for failure to satisfactorily complete the corrective action; and
- Once started, continuously monitor corrective actions to ensure they are effective.

Corrective actions may include:

- Adopting new prepayment edits or document review requirements;
- Conducting mandated training;
- Providing educational materials;
- Revising policies or procedures;
- Sending warning letters;
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment; or
- Terminating an employee or provider.

- As a person who provides health or administrative services to consumers, you play a vital role in preventing FWA. Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.
- Report potential FWA. Every Sponsor must have a mechanism for reporting potential FWA. Each Sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting.
- Promptly correct identified FWA with an effective corrective action plan.

Part 2: Compliance Training

Compliance is EVERYONE'S responsibility!

As an individual who provides health or administrative services for consumers, every action you take potentially affects consumers.


To understand our commitment to ethical business behavior
To understand how a compliance program operates
To gain awareness of how compliance violations should be reported

An effective compliance program should:

A culture of compliance within an organization:

- **Prevents noncompliance**
- **Detects noncompliance**
- **Corrects noncompliance**

At a minimum, a compliance program must include the 7 core requirements:

1. **Written Policies, Procedures and Standards of Conduct**
2. **Compliance Officer, Compliance Committee and High Level Oversight**
3. **Effective Training and Education**
4. **Effective Lines of Communication**
5. **Well Publicized Disciplinary Standards**
6. **Effective System for Routine Monitoring and Identification of Compliance Risks**
7. **Procedures and System for Prompt Response to Compliance Issues**


Act Fairly and Honestly
Comply with the letter and spirit of the law
It is important you conduct yourself in an ethical and legal manner.
It's about doing the right thing!
Adhere to high ethical standards in all that you do
Report suspected violations

American Behavioral Standards of Conduct:

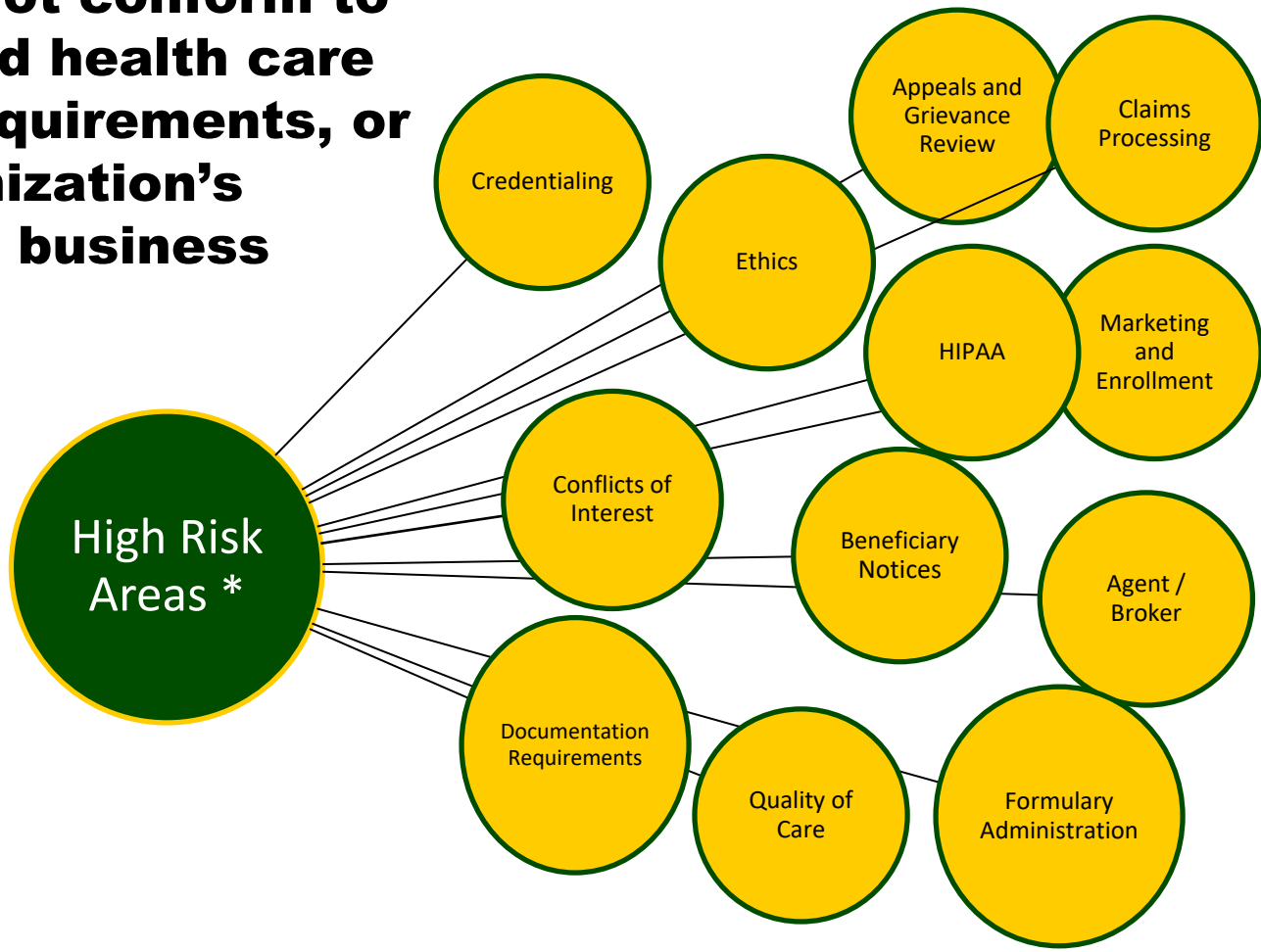
- Be Honest
- Know the Rules
- Ask Questions
- Do Not Be Afraid to Ask for Help
- Admit Mistakes
- Report Concerns

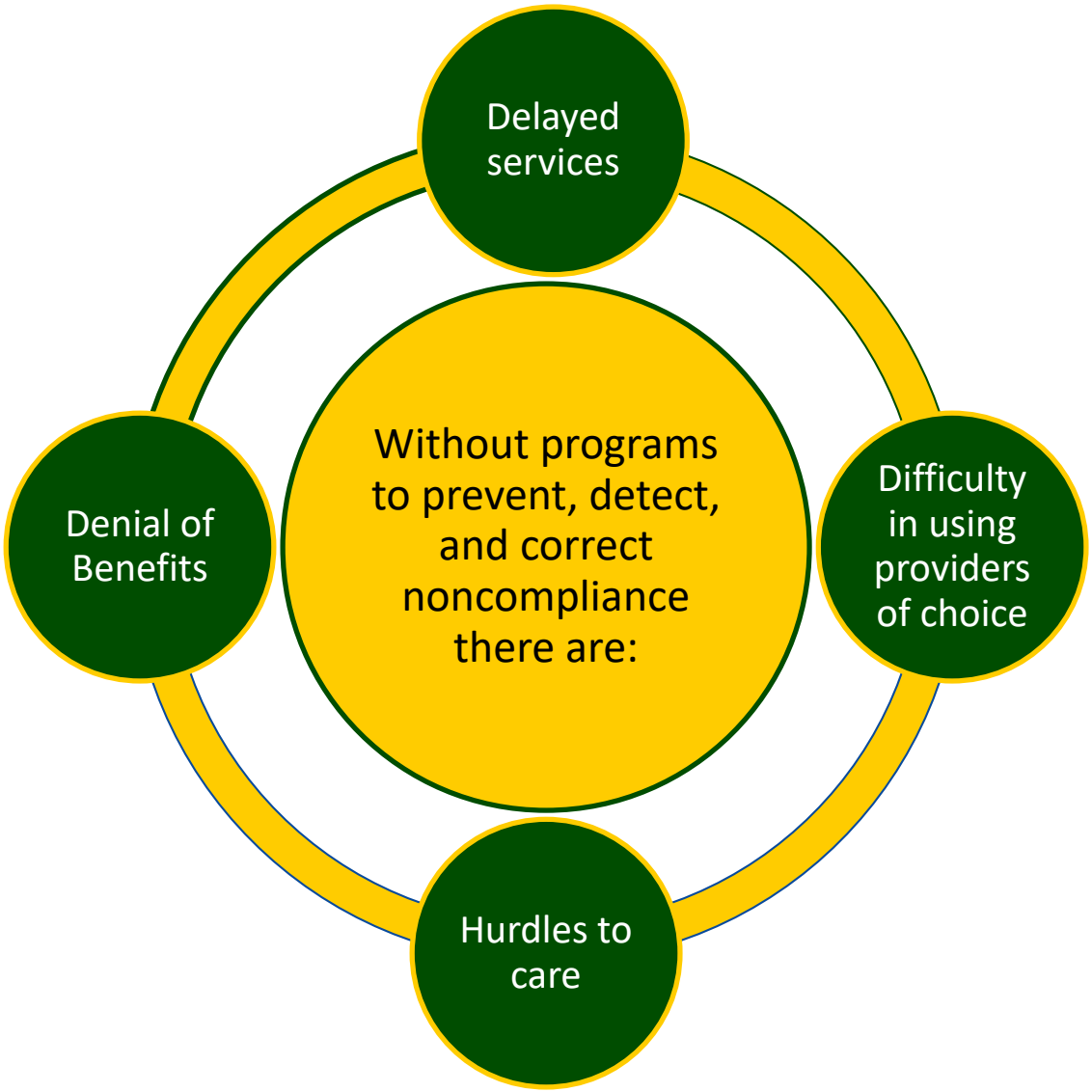
Everyone is required to report violations of Standards of Conduct and suspected noncompliance.

- To get assistance or make a report:
  - Communicate with an American Behavioral supervisor/manager; or
  - Contact Debbie Garvin

* Use the method that makes you the most comfortable.

Noncompliance is conduct that does not conform to the law, and health care program requirements, or to an organization's ethical and business policies.




Delayed services
Denial of Benefits
Without programs to prevent, detect, and correct noncompliance there are:
Difficulty in using providers of choice
Hurdles to care

There can be NO retaliation against you for reporting suspected noncompliance in good faith.

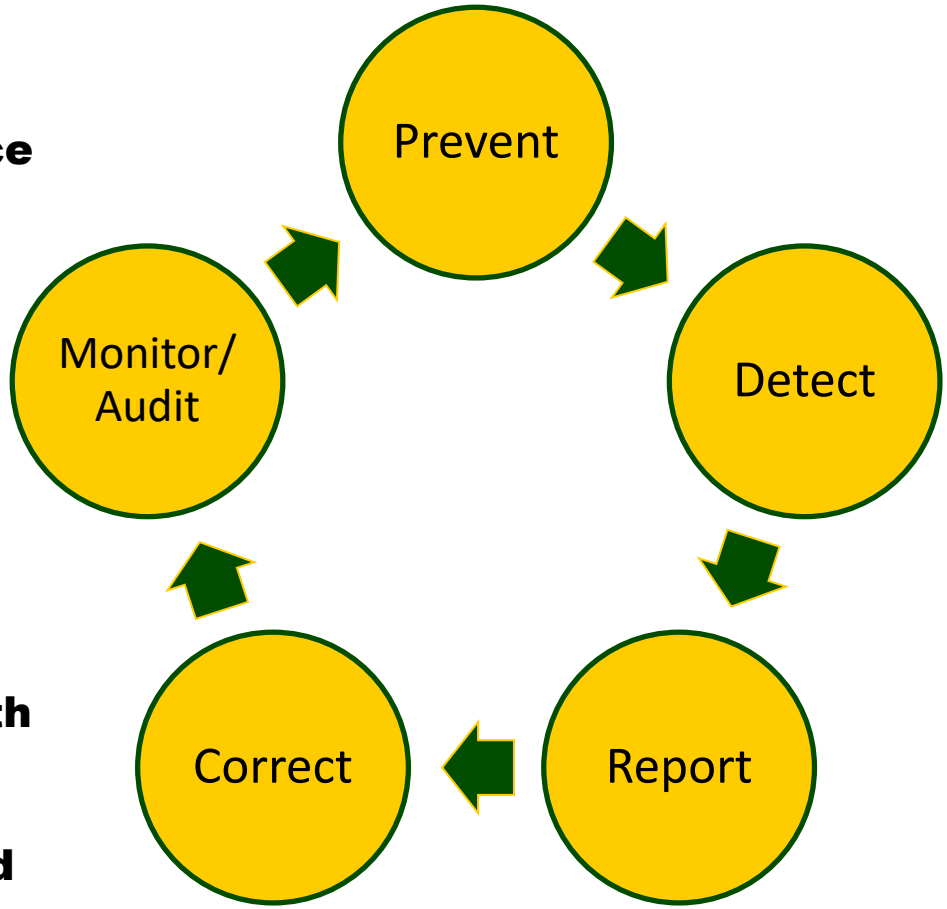
American Behavioral offers reporting methods that are:

- HIPAA Privacy Officer and Director of Compliance and Quality Improvement, Debbie Garvin (205) 868-9633
- HIPAA Security Officer, Debbie Childress (205) 868-9619
- Report to your direct supervisor

Correcting Noncompliance

- **Avoids the reoccurrence of the same noncompliance**
  - **Promotes efficiency and effective internal controls**
    - **Protects enrollees**

- **Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.**
- **Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.**
- **Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures**



American Behavioral is required to have disciplinary standards in place for timely enforcement of non-compliant behavior. Those who engage in noncompliant behavior may be subject to any of the following:

- **Social Security Act:**
  - **Title 18**
- **Code of Federal Regulations*:**
  - **42 CFR Parts 422 (Part C) and 423 (Part D)**
- **CMS Guidance:**
  - **Manuals**
  - **HPMS Memos**
- **CMS Contracts:**
  - **Private entities apply and contracts are renewed/non-renewed each year**
- **Other Sources:**
  - **OIG/DOJ (fraud, waste and abuse (FWA))**
  - **HHS (HIPAA privacy and security)**
- **State Laws:**
  - **Licensure**
  - **Financial Solvency**
  - **Sales Agents**

**** 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)***

- **For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:**
  - **Title XVIII of the Social Security Act**
  - **Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)**
  - **Civil False Claims Act (31 U.S.C. §§ 3729-3733)**
  - **Criminal False Claims Statute (18 U.S.C. §§ 287,1001)**
  - **Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))**
  - **Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)**
  - **Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))**
  - **The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)**
  - **OIG Compliance Program Guidance for the Healthcare Industry: http://oig.hhs.gov/compliance/compliance-guidance/index.asp**