Combating Fraud, Waste, and Abuse

On-Line Training

The information contained in this presentation is intended to prevent and/or combat Fraud, Waste, and Abuse with respect to Medicare and other benefit programs.

The information is available both on HEG's website (www.heginc.com) and in paper form (which may be obtained by contacting HEG by telephone (585-241-9500) or by mail:

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Combating Fraud, Waste, and Abuse

Training For Employees, Providers, Clients, and Plan Participants (Members)

Purpose

The Centers for Medicare & Medicaid Services (CMS) require(s) all organizations that provide services and/or facilitate payment for Medicare Advantage enrollees to assure that they have in place training programs to help combat Fraud, Waste, and Abuse (FWA) with respect to Medicare Advantage programs.

Topics covered in this training

- Information about various laws and regulations related to FWA
- How to detect, prevent, and combat FWA
- How and where to report possible FWA violations

Position Statement

Health Economics Group (HEG) strives to retain our reputation for lawful and ethical behavior. It is HEG's intent to ensure the business integrity and ethical behavior of our employees and of the firms with which we do business.

HEG operates with the understanding that each employee, subcontractor, and/or agent of the company has an obligation to uphold contractual responsibilities, comply with regulatory standards, and report suspect practices and potential violations of State and Federal laws and regulations – without any fear of retribution or adverse consequences for doing so.

Key Definitions

- **Fraud** is when someone intentionally submits, or causes someone else to submit, false or misleading information for use in determining the amount of health care benefits that are payable.
- **Waste** refers to specific provider or beneficiary practices that result in unnecessary costs to health benefit programs. Waste also applies to the practices of claims administrators.
- **Abuse** is reckless disregard or conduct that goes against and is inconsistent with acceptable business and/or medical (including dental) practices resulting in improper benefit payments.

Potential FWA Risks

Provider

Falsifying Claims

- Altering information on a claim
- Incorrect coding (up coding)
- Double billing – billing for services not provided
- Providing unnecessary services
- Unbundling – charging separately for services that should be part of a single procedure code

Eligibility Fraud

- Misrepresenting dates of service to meet coverage dates in order to indicate that a person was covered when he/she was not, or in order to avoid quantity- or dollar limits

Potential FWA Risks

Medicare (or other program) Beneficiaries

Using someone else's program identification card

Adding or maintaining ineligible dependents (if applicable)

Not paying appropriate co-payments or deductibles

Falsifying information, including medical/dental conditions, on an application or claim

Altering a claim

Potential FWA Risks

Claims Administrator (such as HEG)

Employees not catching possible instances of FWA

Employees fabricating claims

Employees changing provider addresses to intercept payments

Employees not identifying conflicts of interest

FWA
Relevant Laws and Regulations

- **Federal False Claims Act** – those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

- **Anti-Kickback Statute** – this statute prohibits a physician or dentist or immediate family member who has a financial relationship with an entity to refer a patient to the entity for services for which payment is made under Medicare or Medicaid.

CMS Data Use Agreements

Encounter (claims) data are submitted to the Centers for Medicare and Medicaid Services (CMS), which in turn are used to determine future payments to the Medicare Advantage Plan.

The Medicare Advantage Plan certifies that the submitted data are accurate, complete, and true to the best of its knowledge. HEG, as an agent of the Medicare Advantage Plan, has an obligation to process claims correctly, and to audit and evaluate claims for authenticity and accuracy. **Identifying fraudulent claims is essential to assuring data accuracy.**

Exclusions List

The company checks the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists for all new employees, and monthly thereafter to ensure that employees and other entities that assist in the delivery of services (including administrative services) to Medicare beneficiaries are not included on such lists.

- The OIG list of Excluded Individuals/Entities
  https://oig.hhs.gov/exclusions/exclusions_list.asp
- SAM Database of Excluded Individuals/Entities
  https://www.sam.gov/portal/SAM

Whistleblower Protections

A whistleblower is an employee, former employee, or member of an organization who reports misconduct by individuals or that organization to people or entities that have the power to take corrective action.

A provision of the False Claims Act allows individuals to:

- Report fraud anonymously
- File suit against an organization on behalf of the government and collect a portion of any settlement that results

The company will take no action and, within its capabilities, will not permit any other person or entity to take any action of retaliation or intimidation against any person who, in good faith, presents evidence of possible or actual fraud, waste, and/or abuse.

Consequences of Fraud, Waste, and/or Abuse

Possible Administrative Sanctions

- Denial or revocation of Medicare provider number application
- Suspension of provider payments
- Addition to the OIG and GSA List of Excluded Individuals/Entities
- License suspension or revocation
- Civil monetary penalties (CMPs)

  The Social Security Act authorizes the imposing of CMPs when Medicare determines that an individual or entity has violated Medicare rules and regulations

  Typically, penalties involve assessments of significant damages such as CMPs up to $25,000 for each Medicare Advantage enrollee directly adversely affected

Consequences of Fraud, Waste, and/or Abuse

Possible Civil and Criminal Penalties

- False Claims Act
  - For each false claim: $5,500 - $11,000
  - If the government proves it suffered a loss, the provider is liable for three times the loss
- Anti-Kickback Statute
  - Up to five years in prison and fines up to $25,000
- If a person suffers bodily injury as a result of a scheme, the prison sentence may be 20+ years

Confidential Methods for Reporting FWA

- Health Economics Group's phone number for confidential reporting: 1-585-241-9500 x323
- Health Economics Group has posted information for employees to report suspected FWA
- Health Economics Group puts instructions on EOBs for beneficiaries to report suspected FWA
- Health Economics Group puts instructions on communications with providers to report suspected FWA
- Office of the Inspector General

  By phone: 1-800-447-8477
  By TTY: 1-800-377-4950
  By email: HHSTips@oig.hhs.gov
- Centers for Medicare & Medicaid Services (CMS)

  By phone: 1-800-633-4227
  By TTY: 1-877-486-2048

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If you have questions about this material contact Health Economics Group.

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