MODULE II: MEDICARE & MEDICAID FRAUD, WASTE, AND ABUSE TRAINING

2014

Introduction

- The Medicare and Medicaid programs are governed by statutes, regulations, and policies
- PacificSource must have an effective Compliance and FWA Program to prevent, detect and correct FWA
- Our contracts with the Federal and State government also require us to main an effective Compliance and FWA Program
- In addition, we must have effective training for our employees, executive management, committee and Board members, and our contracted vendors

Why Do I Need Training?

- Every year millions of health care dollars are improperly spent because of fraud, waste, and abuse (FWA)
- Inappropriate and unethical behaviors drive up the cost of health care, drain the Medicare Trust Fund, and burden tax payers and the health care system
- This training will help you detect, correct, and prevent FWA

You are part of the solution

Objectives

This training is designed to :

- Meet the regulatory requirement for training and education
- Explain your obligation to detect, prevent, correct and report FWA
- Provide examples of FWA issues
- Test your knowledge of FWA

What is Fraud, Waste, and Abuse?

- Fraud means an intentional deception or misrepresentation that the individual knows to be false, and knows that the deception could result in some unauthorized benefit to himself/herself or to some other person
  - *Example*: A provider intentionally submits a claim for a service that was never provided
- Waste is the inappropriate or inefficient use of resources
- Abuse means an unintentional act to provide information to the government which results in higher payments than the individual or entity is entitled to receive

Differences Between Fraud, Waste, and Abuse

- One of the primary differences between fraud, waste and abuse is intent and knowledge. Fraud requires the person to have an intent to commit the act and the knowledge that their actions are wrong
- Waste and abuse may be inappropriate acts, but are not intentional
- Do not be concerned about whether it is fraud, waste, or abuse. Just report any FWA concerns and the Compliance Department will investigate and make the proper determination

FAQ

Q. What is the difference between a “compliance” issue and a “fraud, waste and abuse” issue?

A. *Fraud, waste and abuse issues are subsets of compliance issues, and usually involve a financial or monetary impact to the government and tax payers*

Q. Is an FWA issue more severe than a compliance issue?

A. *No. The severity of the issue will depend on the facts and circumstances*

Where Do I Fit In?

- As a person who works for a company that does work with PacificSource, you are either:
  - An employee of the company
  - A consultant of the company
  - An office manager of the company
  - An executive of the company
- Whether you touch Medicare and Medicaid infrequently or as part of your daily function, FWA requirements apply to you

What Are My Responsibilities?

- You are a vital part of the effort to prevent, detect, and report non-compliance and FWA
  - FIRST you are required to comply with all applicable statutory, regulatory, and other Part C or Part D requirements, including complying with the Compliance and FWA Program
  - SECOND you have a duty to report any violations that you may be aware of
  - THIRD you have a duty to follow PacificSource's Standards of Conduct that articulate our commitment to proper conduct and ethical rules of behavior

How Do I Prevent Fraud, Waste, and Abuse?

- Make sure you are up to date with laws, regulations, and policies
- Fix processes that are deficient or prone to error
- Fix potential issues before they become problems
- Ensure data is both accurate and timely
- Verify information provided to you
- Be on the lookout for suspicious activity & report it
- Assist in promoting a culture of compliance

How Do I Detect Fraud, Waste, and Abuse?

The following are examples of potential noncompliant and FWA activities that you should watch out for, depending on your role within the organization

Potential Beneficiary Issues

- Does the prescription look altered or possibly forged?
- Has the member filled numerous identical prescriptions, possibly from different doctors?
- Is the person who picks up the prescription the actual member (identity theft)?
- Is the prescription appropriate based on the member's other prescriptions?
- Does the member's medical history support the services being requested?

Potential Provider Issues

- Does the provider primarily write for narcotics or controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?
- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill for services not provided?

Potential Pharmacy Issues

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Do you see prescriptions being altered (changing quantities or DAW)?
- Are generics provided when the prescription requires that brand be dispensed?
- Does the pharmacist provide less than the prescribed quantity and bill for the fully-prescribed amount?
- Are there claims for prescriptions that are never picked up?

Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?

Potential Manufacturer Issues

- Does the manufacturer promote off label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a federal health care program?

Potential Health Plan Issues

- Does the health plan offer cash inducements for beneficiaries to join the plan?
- Does the health plan lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?
- Does the health plan use unlicensed agents?
- Does the claim system make repeated and ongoing errors?

How Do I Correct Fraud, Waste, and Abuse?

- Once FWA has been detected, it must be corrected. Correcting the problem saves the government money and ensures you are in compliance with CMS' requirements
- You can assist by cooperating and providing the necessary information. PacificSource will work with you to correct the issue, usually through a corrective action plan

What are the Consequences?

- In summary, the following are potential penalties and consequences to a FWA violation:
  - Civil Money Penalties
  - Criminal Conviction/Fines
  - Civil Prosecution
  - Imprisonment
  - Loss of Provider License
  - Exclusion from Federal Health Care programs
  - Termination of provider contract

Laws You Need to Know

- **Social Security Act**: This law is the foundation for the Medicare and Medicaid program, and governs how these programs are to be administered
- **False Claims Act**: This law imposes severe penalties when you submit a fraudulent claim to the United States government, even if it's unintentional
  - *Example*: If you intentionally submit a claim for a service that you knew was never rendered, then you have violated the law
  - *Example*: If you know that the claim system is plagued with error, and you submit the erroneous claim anyway, you have violated the law
  - What happens when you violate the law? You can be fined $5,000-$10,000, plus 3 times the amount for damages

- **Physician Self-Referral ("Stark") Statute**: This law prohibits a physician from making a referral for certain services to an entity the physician (or a family member) has an ownership or investment interest in
  - *Example*: If a doctor refers a patient to a physical therapy center that she has an ownership in, this is a violation of the law
  - What happens when the law is violated? The government will deny claims tainted by the violation, and may impose $15,000-$100,000 in fines

- **Anti-Kickback Statute**: This law prohibits you from receiving or paying anything of value to influence the referral of Medicare or Medicaid business
  - *Example*: If you accept money or gift cards from a physician office to encourage members to go there, then you have violated the law
  - *Example*: If you accept money or gift from a nursing home to refer your patients to go there, then you have violated the law
  - What happens when you violate the law? You can be fined $25-50,000, be imprisoned for 5 years, and be excluded from working in Medicare and Medicaid

- **Beneficiaries Inducement Statute**: This law prohibits us from paying beneficiaries as an inducement to enroll with us
  - *Example*: If we give money or gifts to seniors as a condition to joining our plan, then we have violated the law
  - *Example*: If we offer to pay a beneficiary's utility bill as a way to encourage enrollment, then we have violated the law

- **OIG & GSA Exclusion List**: Federal law prohibits you from employing individuals (to work in a Medicare or Medicaid role) who have been excluded from a federal health care program. The law also prohibits providers those from being paid who have been excluded
  - *Example*: If you work in the Billing Department, and you are on the exclusion list, then there is a violation
  - *Example*: If you receive payment and you are on the exclusion list, then there is a violation

How Do I Report Fraud, Waste, or Abuse?

- If you suspect noncompliant behavior, you must report it. Not only is it required by law, but is required by our company policy. Failure to do so may result in disciplinary actions
- You may report anonymously if you choose
- Our non-retaliation policy allows you to report a compliance concern without fear of retaliation
- Once reported, we will treat it confidentially and investigate the issue
- You may also contact the Compliance Officer or any member of the Compliance Department to ask a compliance question, or request a clarification of the rule

- The following methods are available to report compliance issues or inquiries
  - Report to your immediate supervisor
  - Report to your company's Compliance Department
  - Report to the PacificSource Compliance Officer
  - Report to your PacificSource contract administrator
  - Report anonymously to EthicsPoint 24 hours a day/7 days a week: 1-888-265-4068, **https://secure.ethicspoint.com/domain/media/en/gui/16499/index.html**

Resources

- http://medicare.pacificsource.com/Company/Compliance.aspx
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
- http://www.stopmedicarefraud.gov/
- http://exclusions.oig.hhs.gov/
- https://www.sam.gov/portal/public/SAM/
- http://www.ussc.gov/Guidelines
- http://www.justice.gov/jmd/ls/legislative_histories/pl99-562/pl99-562.html
- http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm#f
- https://www.cms.gov/PhysicianSelfReferral/

Test Questions

#1

- What is the primary difference between *fraud* versus *waste* and *abuse*?
  - A. Fraud requires the person to have an intent to commit the act and the knowledge that the action is wrong
  - B. Waste and abuse are more severe than fraud because they involve money
  - Fraud harms members, while waste and abuse harm the financial system
  - D. There is no real difference between fraud and waste and abuse

#2

- Indicate all that are correct:
  - A. I should only report waste or abuse because they involve money
  - B. I should report all known instances of fraud, waste and abuse, regardless of what I think the impact may be
  - C. I should report fraud, waste and abuse only when I know for sure a violation has occurred
  - D. I should not be concerned about whether an issue is fraud, waste, or abuse. I should report it anyway

#3

- Indicate all activities that are potential violations:
  - A. The provider renders unnecessary services
  - B. The plan markets a benefit at one cost-share, but pays the claim at another cost-share
  - C. The pharmacist provides less than the prescribed quantity and bills for the fully-prescribed amount
  - D. All of the above

#4

- What are some things I can do to prevent fraud, waste and abuse (select all correct responses)?
  - A. Verify information provided to you
  - B. Be on the lookout for suspicious activity
  - C. I can't prevent it. Health care is so complex there will always be issues
  - D. Do not take on high-risk responsibilities

#5

- Maintaining an effective Compliance Program to prevent, detect and correct FWA is (select all correct answers):
  - A. Required by Federal and State regulations, your contract with PacificSource, and PacificSource's contracts with the government
  - B. Required as a not-for-profit company
  - C. Voluntary, but a recommended industry best practice
  - D. Required by health care reform

#6

- I have an obligation to report potential issues or violations committed by the following party:
  - A. Providers, including physicians, hospitals, and pharmacies
  - B. Patients
  - C. PacificSource employees
  - D. All of the above

#7

- My duty to report all potential issues or violations is required by (select all correct answers):
  - A. Federal regulations
  - B. PacificSource company policy
  - C. Federal marketing guidelines
  - D. All of the above

#8

- Your office relies on a manual billing process that is prone to human error. Despite repeated attempts to fix the problem, the errors persist. This resulted in submitting incorrect claims to insurers. This is an example of:
  - A. Fraud
  - B. Waste
  - C. Abuse
  - D. All of the above

#9

- A physician's office has been submitting inaccurate claims to PacificSource for 6 months due to a new, inexperienced officer manager. The physician office does not have any process to quality check claim submissions, and the claims are paid. John, who works in the Marketing Department of the physician office, knows the claims are erroneous but does not report it. A potential issue may have occurred with:
  - A. John
  - B. Housekeeping
  - C. Patient scheduling
  - D. The office manager

#10

- Fraud, waste and abuse requirements apply to (select all correct answers):
  - A. Employees and management
  - B. Board and committee members
  - C. Community volunteer organizations
  - D. Delegated vendors and subcontractors

#11

- Sarah, who works in the Billing Department of a physician office, told her immediate supervisor that a number of providers are fraudulently billing for services not rendered. She reported to her supervisor, who decided not to look into the issue. Sarah then documents her attempt at reporting. Has Sarah done everything she can to report the issue?
  - A. Yes. She has reported the issue to her supervisor, and it is up to her leadership to take the next step
  - B. No. She has an obligation to escalate the issue to the next level if the issue remains unresolved

#12

- Tara, who works in payroll for a physician office, discovered that a claim vendor set up the system incorrectly. As a result, the system is processing claims incorrectly. Does Tara have an obligation to report the issue?
  - A. Yes. She must report it even if she doesn't work in the same department
  - B. No. The company's policy gives her discretion to report it, but does not require her to because she doesn't work in the same department, and this is an IT issue

#13

- The law prohibiting a physician from making a referral for certain services to an entity the physician (or a family member) has an ownership or investment interest in is called:
  - A. Federal Referral False Claim Act
  - B. Anti-Kickback Statute
  - C. Physician Self-Referral “Stark” Law
  - D. Kennedy Anti-Referral Statute

#14

- Which activity is a violation of the Federal False Claim Act (select all correct answers)?
  - A. You know the claim system is plagued with error, and you submit the erroneous claim anyway
  - B. You inappropriately release patient information
  - C. You submit a claim for a service that you knew was never rendered
  - D. All of the above

#15

- The law that is the foundation for the Medicare and Medicaid program is called:
  - A. Medicare & Medicaid Security Act
  - B. Social Security Act
  - C. Social Retirements Act
  - D. Federal Securities & False Claim Act

Answer Key

1. **A**
2. **B & D:** I should report any known or suspect FWA concerns and the Compliance Department will investigate and make the proper determination
3. **D**
4. **A** & **B**
5. **A**

6. **D**
7. **A** & **B**
8. **B:** This is an inefficient use of resources that may increase costs to the health care system
9. **A & D:** John has an obligation to report the issue, even if he doesn't work in the same department. The office manager has an obligation to submit accurate claims data. The physician office has an obligation to implement reasonable safeguards to prevent paying erroneous claims
10. **A, B & D**

11. **B:** As long as she knows the issue remains unresolved, Sarah has an obligation to correct the issue. Her obligation does not end when she made the initial report, knowing that the issue still remains
12. **A:** It doesn't matter if Tara works in another area, or that this is a technical issue. She has an obligation to report it
13. **C**
14. **A & C:** You can violate the law even if your action is unintentional. "B" is incorrect because the law only pertains to claims
15. **B**