

Quality Independent Physicians, LLC

Awareness Training

2015 Fraud, Waste & Abuse Prevention

Fraud, Waste and Abuse (FWA) – Training Objectives

- After completing this training you should be able to:
 - Recognize and understand the principles found in 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 your practice’s obligations and duties under the Anti-Kickback Act, False Claims Act, and Civil Monetary Penalties Law
 - Know what to do if you suspect FWA
 - Understand that all QIP providers and contractors have an affirmative duty to report suspected health care fraud

QIP's FWA Commitment

- QIP is committed to complying with applicable federal and state laws, rules and regulations by adhering to high standards of business ethics as reflected in the Compliance Program.

FWA Training Topics

- During this training, you will learn more about the following:
 - Obligations of first-tier, downstream and related entities, to have appropriate policies and procedures to address fraud, waste and abuse.
 - The process of reporting suspected fraud, waste and abuse of first-tier, downstream and related entities of QIP.
 - Protections for employees of first tier, downstream and related entities, who report suspected fraud, waste and abuse.
 - Various types of fraud, waste and abuse that can occur in the first-tier downstream and related entities.

CMS Training Requirements

- CMS requires that all delegated and contracted providers that render benefits or services to Medicare programs must meet annual fraud, waste and abuse (“FWA”) training requirements.
- This mandate applies to all Accountable Care Organizations (“ACO”)
- Federal fraud, waste and abuse training requirements are found at 42 C.F.R section 422.503(b)(4)(vi) and 42 C.F.R. section 423.504(B)(4)(vi).

What is Fraud?

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

How Common is Fraud in Healthcare?

- The United States Department of Health and Human Services-Office of Inspector General 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.

Examples of Provider Fraud

- **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 99215 (High level of care for an established patient seen in the office) where services provided only warranted use of CPT code 99213 (Mid level care for established patients seen in the office)

Examples of Member and Agent Fraud

- **Member (Patient) Pharmacy Fraud**
 - Members visiting multiple providers with feigned symptoms in order to obtain prescriptions for narcotics
 - Members stealing prescription pads and forging provider signature(s)
- **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

Examples of Health Plan and Provider Fraud

- **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 contractors deliberately and systematically deterring members from receiving medically necessary services in order to maximize revenue

- **Overutilization**

- Providers or contractors deliberately and systematically provide members with unnecessary medical services in order to maximize revenue

- **Attestations/Conditions of Participation**

- Falsification of information provided to federal or state regulators in order to obtain government contracts or other business

- **Quality Access**

- Falsification of network adequacy reporting in order obtain government contracts

Associate / FWA Criminal Activity

- Employees of QIP's providers and contractors have access to systems and information that touches many parts of QIP's business. As a result, we must be alert to the possibility that associates could use such access for their own personal benefit, potentially with assistance from others within or outside the organization. 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.

Associate/FWA Criminal Activity (Continued)

- Falsifying beneficiary 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 corporate goals
- Intentionally providing or concealing inaccurate data in a report to a government agency

What is Abuse? What is Waste?

- “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 resource

Examples of Abuse

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

Examples of Waste

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

Vendor and Contractor Responsibilities

- Learn and comply with QIP FWA policies and procedures
- 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 QIP;
 - Report the situation directly to your company's Compliance or Legal Department.
- QIP can be contacted at (502) 814-3190 or fax (502)426-8272

Deficit Reduction Act of 2005

The Federal Deficit Reduction Act (“DRA”) of 2005, Section 6032, requires entities that make or receive annual Medicaid payments of \$5 million or more to provide, in written policies applicable to all employees, contractors and agents, detailed information about:

- The federal False Claims Act (“FCA”) and any state laws that pertain to civil or criminal penalties for making false claims and statements, as well as the “whistleblower” protection under such laws;
- The rights of the employees to be protected as “whistleblowers” when they report suspected violations of such laws. Employers may not retaliate against employees who report potential misconduct in good faith.
- The organization’s methods for detecting and preventing FWA

Laws and Guidance

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

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

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 SNF
- 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
- Failing promptly to return a known overpayment
- Offering inducements to influence decisions related to Medicare or Medicaid funds
- Hiring employees who have previously been excluded from participation in federal programs

Coordination with Law Enforcement

- Through its Corporate Compliance Program, QIP 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, QIP 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.

Reporting a Suspected Incident

- All QIP providers and contractors are required to report suspected violations or conduct that appears to be fraudulent or in conflict with the principles of QIP's Compliance Program.
- **Reports involving suspected fraud or misconduct by third parties (i.e., providers or members) may be made to QIP's Compliance Office at 502-814-3190**
- **Reports involving suspected fraud or misconduct by employees of QIP, its providers, or its contractors may be made anonymously to QIP Compliance Officer at compliance@qipllc.com.**
- **No adverse or retaliatory actions may lawfully be taken against anyone who reports an issue in good faith.**

Knowledge Check

1. _____ is sometimes defined as a practice that is inconsistent with accepted business or medical practices or standards and that results in unnecessary cost.
2. _____ includes any practice that results in an unnecessary use or consumption of financial or medical resource.
3. _____ is an intentional deception or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.

Attestation

Please complete the fields below including your signature, to attest that you have read and understood the content of this training course, and agree to abide by all laws, policies and guidelines referenced in this program.

- Practice Name: _____
- Name: _____
- Signature: _____
- Date: _____