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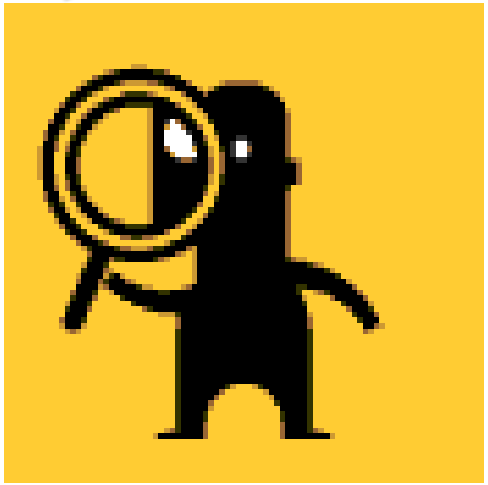
# FRAUD, WASTE, & ABUSE (FWA) for Brokers



revised 10/17

# OBJECTIVES

After reviewing this information, you will be able to:

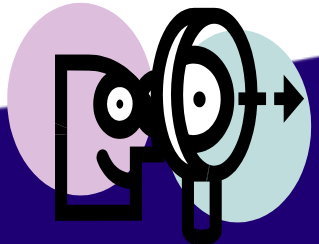
- Understand Fraud, Waste, and Abuse (FWA) training requirements;
- Be familiar with the laws that regulate Fraud, Waste, and Abuse;
- Describe steps that are taken to prevent and combat FWA;
- Refer suspected FWA to the appropriate individuals.

# INTRODUCTION

- With over a million health care providers and over six billion benefit transactions going on every year, health care fraud is on the rise. Health care fraud is now a top priority for the US Department of Justice – second only to terrorism and violent crimes.
- In 2009, $2.5 trillion was spent on health care in America. The National Health Care Anti-Fraud Association (NHCAA) estimates that 3% of health care expenditures, or $75 billion dollars, are fraudulent.

# EMPLOYEE RESPONSIBILITIES

- It is essential that all health care employees understand what fraud and abuse is, how to detect it and how to assist Members, Providers, Brokers, Clients and other customers who may need to report suspicious activities.
- Your company must have measures in place to prevent, detect and investigate all forms of insurance fraud, including fraud involving employees or agents; fraud resulting from misrepresentations in the application, renewal or rating of insurance policies and claims fraud.
- Everyone is responsible for the detection and prevention of fraud, waste, and abuse. Each employee should become familiar with these types of improprieties and alert for any irregularities.



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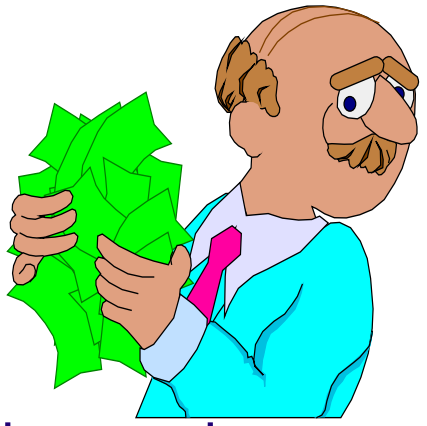
# FWA DEFINITIONS

- **FRAUD –** An intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- **WASTE –** Is overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather misuse of resources.
- **ABUSE –** An individual's activities that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost, reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.

# FWA EXAMPLES

- Unnecessary treatments
- Billing for services not rendered and/or supplies not provided
- Double billing
- Eligibility fraud
- Misrepresentation of services
- Coding schemes
- Altering claim forms
- Altering medical record documentation
- Limiting access to needed services
- Soliciting, offering or receiving a kickback, bribe or rebate
- Misrepresentation of medical conditions
- Failure to report third party billing
- Billing for enrollments not done



# FRAUD, WASTE & ABUSE LAWS

- False Claims Act (FCA)
- Stark Law
- Anti-Kickback Statute
- Deficit Reduction Act
- The False Claims Whistleblower Employee Protection Act
- The Exclusion Statute

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# FALSE CLAIMS ACT (FCA)

- The False Claims Act (FCA), **31 U.S.C.** 3729-3733 states that a person who knowingly submits a false or fraudulent claim to Medicare, Medicaid or other federal healthcare program is liable to the federal government for three times the amount of the federal government's damages plus penalties of $5,000 to $11,000 per false or fraudulent claim.

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# STARK LAW


- Stark Law, **Social Security Act, 1877** deals with referrals for the provisions of health care services. If a physician or an immediate family member has a financial relationship with an entity, the physician may not refer to the entity for health services where compensation may be made. This is to prevent physicians from making a financial gain and/or overutilization of services.

# ANTI-KICKBACK STATUTE

- Anti-Kickback Statute, **41 U.S.C**, states that it is a criminal offense to knowingly and willfully offer, pay, solicit or receive any compensation for any item or service that is reimbursable by any federal health care program.
- Penalties include
  - exclusion from federal health programs,
  - criminal penalties,
  - jail, and
  - civil penalties.

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# DEFICIT REDUCTION ACT (DRA)

- DRA, **Public Law No. 109-171 ,** requires compliance for continued participation in the Medicare and Medicaid programs.
- The law requires:
  - the development of policies and education relating to false claims,
  - whistleblower protections and
  - procedures for detecting and preventing fraud, waste, and abuse.

# FALSE CLAIMS WHISTLEBLOWER PROTECTION ACT

- Whistleblower Protection Act, **31 U.S.C. 3730 (h)** states that a company is prohibited from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee because of lawful acts done by the employee on behalf of the employer or because the employee testifies or assists in an investigation of the employer.
- The FCA also includes the "qui tam" provision, which allows persons to sue those who defraud the government. Persons would be eligible to receive a percentage of recoveries from the defendant. The Whistleblower Act protects a person when they file a qui tam claim.

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# EXCLUSION STATUTE

The Office of Inspector General (OIG) is required by law **42 U.S.C. §1320a-7**, to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses:

- Medicare or Medicaid fraud
- Patient Abuse or Neglect
- Felony convictions

Excluded providers may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.

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# SPECIAL INVESTIGATIONS UNIT (SIU)

The Special Investigations Unit at Optima Health is dedicated to detecting, investigating and preventing all forms of suspicious activities related to possible health insurance fraud and abuse, including any reasonable belief that insurance fraud will be, is being, or has been committed.

The SIU:

- Reviews and investigates allegations of Fraud and Abuse
- Takes Corrective Actions for any supported allegations
- Reports misconduct to all appropriate agencies
- Provides Staff Training per the Deficit Reduction Act

# HOW DOES THE SIU COMBAT FRAUD, WASTE, & ABUSE?

- The Optima Health SIU identifies potential fraud through:
  - Prepayment claims reviews
  - Retrospective claims reviews
  - Service Calls/Inquiries from Members, Vendors and/or Providers
  - Data Analysis
  - Hotline Calls
  - Compliance E-mails


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# OPTIMA HEALTH FWA REPORTING

- You may make reports to the Optima Health (OH) Compliance Hotline without fear of intimidation, coercion, threats, retaliation or discrimination.
- OH Employees may contact their immediate supervisor, or call the Compliance Hotline to file a complaint. The Hotline is available 24 hours a day for anyone's use. The Sentara Integrity Hotline number is 1-866-826-5277. The OH FWA Hotline is 757-687-6326. All hotline calls may remain anonymous.


- OH Employees may report suspicious claims activity to the Special Investigations Unit (SIU) via an Internal Service Form, or direct contact with the unit.
- OH Employees may also report via the SIU Compliance e-mail at any time. The Compliance e-mail is Compliancealert@sentara.com.

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