

# OptimaHealth

FRAUD, WASTE, & ABUSE (FWA) 2019

# Objectives

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After completing this module you will be able to:

- Define fraud, waste and abuse
- Discuss examples of fraud, waste and abuse
- Recall which laws regulate fraud, waste and abuse
- Describe preventive steps that have been taken
- Recall how to report suspected fraud, waste and abuse
- Distinguish both the provider's and health plan's responsibilities in fraud, waste and abuse prevention

# Did you know?

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- There are over a million health care providers and more than six billion benefit transactions every year
- Health care fraud is now a top priority for the US Department of Justice – second only to terrorism and violent crimes
- In 2017, \$3.5 trillion was spent on health care in America
- The National Health Care Anti-Fraud Association (NHCAA) estimates that 3% of health care expenditures, or \$68 billion dollars, are fraudulent.

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# What is Fraud, Waste and Abuse?

# Fraud

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**FRAUD** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain.

- Rendering and billing for non-medically necessary services
- Up-coding – billing higher level service than provided
- Misrepresentation of benefits
- Encounter data falsification
- Underutilization
- Attestations/conditions of participation

# Waste

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**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.

*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.*

# Abuse

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**ABUSE** is 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.

**Abuse can include a range of improper behaviors or billing practices. For example:**

1. Fraud: **Billing for a non-covered service** - The provider knew that service was non-covered, but changed the ICD-9 diagnosis to obtain coverage
2. Abuse: **Misusing codes on the claim** – The provider assumed they must be billing correctly as long as claims paid

# Distinguishing Between Fraud, Waste, and Abuse

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One of the primary distinguishers 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.

*Example: Optima Health audits a provider and provides education on errors found. Optima Health then completes a 6-12 month follow up audit to ensure the errors have been corrected. The findings of the follow up audit indicate that the provider has not changed his billing practices. This is now considered intent.*

# Most Prevalent PI Allegations: 2017

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- Billing for Services Not Rendered
- Improper Coding (up-coding, unbundling and improper use of modifiers)
- Performing medically unnecessary procedures
- Misrepresenting a non-covered service as covered
- Excessive Billing of Units
- False claims
- Enrollment, Application, Eligibility Fraud

# Optima Health's Responsibility

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- 1) Optima Health is responsible to detect and prevent fraud, waste, and abuse in accordance with the Deficit Reduction Act and the False Claims Act.
- 2) Optima Health will conduct investigations of suspected fraud, waste and abuse of its personnel, participating providers, subcontractors, and enrollees. There is no financial threshold for case notifications. Reportable fraud, waste or abuses may include:
  - Emerging fraud schemes,
  - Suspected internal fraud or abuse by employees,
  - Contractors, or subcontractors
  - Suspected fraud by providers who supply goods or services to Optima Health enrollees,
  - Suspected fraud by Optima Health enrollees.

# Provider's Responsibilities

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- 1) To take a copy of the patients pictured ID and Insurance card to help deter Identity theft.
- 2) Take a photo of the patient
- 3) Do not waive copays or coinsurance

# Accurate Coding and Billing

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**When you submit a claim for services performed for a Medicare patient, you are filing a bill with the Federal Government and certifying you earned the payment requested and complied with the billing requirements.** If you knew or should have known the submitted claim was false, then the attempt to collect payment is illegal. Examples of improper claims include:

- Billing for services that you did not actually render, or were not were not medically necessary;
- Billing for services that were performed by an improperly supervised or unqualified employee;
- Billing for services that were performed by an employee who has been excluded from participation in the Federal health care programs;
- Billing for services of such low quality that they are virtually worthless; and
- Billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery.

# Physician Documentation

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- Maintain accurate and complete medical records and documentation of the services you provide, and ensure it supports submitted claims for payment.
- Good documentation ensures your patients receive appropriate care from you and other providers who may rely on your records for patients' medical histories.

*“If the service was not documented it was not done.” CMS*

# Laws You Should Know

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False Claims Act (FCA)

Physician Self-Referral  
Law  
(Stark Law)

Anti-Kickback Statute  
(AKS)

Deficit Reduction Act

The False Claims  
Whistleblower  
Employee Protection  
Act

The Exclusion Statute

Criminal Health Care  
Fraud Statute

Civil Monetary Penalties  
Law (CMPL)

HIPAA

# False Claims Act (FCA)

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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.

# Physician Self-Referral Law (Stark Law)

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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

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- 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 care programs,
  - criminal penalties,
  - jail, and
  - civil penalties.

# Deficit Reduction Act (DRA)

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- 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 (FCA)

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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.

# Exclusion Statute

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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.

# Criminal Health Care Fraud Statute

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The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to either:

- Defraud any health care benefit program, or
- Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program

Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

# Civil Monetary Penalties Law (CMPL)

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The Civil Monetary Penalties Law authorizes CMPs for a variety of health care fraud violations. The CMPL provides for different amounts of penalties and assessments based on the type of violation. CMPs may assess up to three times the amount claimed for each item or service or up to three times the amount of remuneration offered, paid, solicited, or received. Violations supporting CMPL actions include:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or is false and fraudulent
- Presenting a claim you know, or should know, is for an item or service for which Medicare will not pay
- Violating the Anti-Kickback Statute

# Civil Monetary Penalties Law: Violation Examples

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- Physicians who knowingly misrepresent that a Medicare beneficiary requires home health services
- Submitting a claim, or claims, for service not rendered
- Utilizing a CMS logo without approval
- Failing promptly to return a known overpayment
- Offering inducements to influence decisions related to Medicare or Medicaid funds
- Acting to expel or refusing to enroll a Medicaid recipient due to the individual's health status
- Hiring employees who have previously been excluded from participation in federal programs

# HIPAA

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- Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)
- Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry
- Safeguards to 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

# Investments in Healthcare Business Ventures

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These business relationships can sometimes unduly influence or distort physician decision-making and result in the improper steering of a patient to a particular therapy or source of services in which a physician has a financial interest. **The purpose of the Anti-kickback and Stark law is due to financial gains by providers who hold financial interests in businesses and send ALL of their patients there instead of providing patients with options.** Many of these investment relationships have serious legal risks under the AKS and Stark law.

# Consequences of Committing Fraud, Waste, or Abuse

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Actual consequence depends on the violation. Some potential penalties include:

- - Civil Monetary Penalties
- - Criminal Conviction/Fines
- - Civil Prosecution
- - Imprisonment
- - Loss of Provider License
- - Exclusion from Federal /State Health Care programs

# Program Integrity (PI)

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## Program Integrity:

- 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 PI Combat Fraud, Waste, & Abuse?

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The PI 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



# Case Scenarios

# Fraudulent Billing

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- A psychiatrist was fined \$400,000 and permanently excluded from participating in the Federal health care programs for misrepresenting that he provided therapy sessions requiring 30 or 60 minutes of face-to-face time with the patient, when he had provided only medication checks for 15 minutes or less. The psychiatrist also misrepresented that he provided therapy sessions when in fact a non-licensed individual conducted the sessions.
- An endocrinologist billed routine blood draws as critical care blood draws. He paid \$447,000 to settle allegations of up coding and other billing violations.

# Misuse of Physician Provider and Prescription Number

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A physician was ordered to pay \$50,000 in restitution to the Government for falsely indicating on his provider number application that he was running his own practice when, in fact, a neurophysiologist was operating the practice and paying the physician a salary for the use of his number.

# Kickbacks for Referrals for Self Referral

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

# Do You Think You Have a Problem?

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Problematic relationship or following billing practices you now realize are wrong:

- Immediately cease filing the problematic bills
- Seek knowledgeable legal counsel
- Determine Federal money has been collected in error and report and return any overpayments
- Undo the problematic investment by freeing yourself from your involvement
- Disentangle yourself from the suspicious relationship
- Consider using OIGs or CMS' self-disclosure protocols

# OIG Provider Self-Disclosure Protocol

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A vehicle for physicians' voluntary disclosure of self-discovered evidence of possible fraud. Providers may be able to avoid the costs and disruptions associated with a Federal Government-directed investigation and civil or administrative litigation.

# Reporting to Optima Health

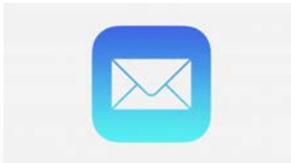
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Reports to the Optima Health Compliance Hotline may be made without fear of intimidation, coercion, threats, retaliation or discrimination.



**Fraud & Abuse Hotline:**

757-687-6326 or 1-866-826-5277



**Email:**

[compliancealert@sentara.com](mailto:compliancealert@sentara.com)



**U.S. Mail:**

Optima Health c/o Program Integrity  
4417 Corporation Lane  
Virginia Beach, VA 23462

# Reporting to Government Programs

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## Direct Reporting – Virginia Medicaid

- Call 1-800-371-0824
- Email [MFCU\\_mail@oag.state.va.us](mailto:MFCU_mail@oag.state.va.us)

## Direct Reporting – Medicare

- Call 1-800-447-8477
- Office of Inspector General  
P.O. Box 23489  
Washington, DC 20026

**No adverse or retaliatory actions may lawfully be taken against anyone who reports an issue in good faith.**

# References & Resources

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- Centers for Medicare & Medicaid Services  
[Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians](#)
- Office of Inspector General  
[A Roadmap for New Physicians: Fraud & Abuse Laws Self-Disclosure Information](#)
- Create a Compliance Program  
[Guidance for Developing a Compliance Program for Individual and Small Group Practices](#)