



Fraud, Waste and Abuse

Subcontractor Training

Purpose

- Every year billions of dollars are improperly spent because of ***Fraud, Waste, and Abuse***. It affects everyone, including our subcontractors/vendors. This training will help you detect, correct, and prevent Fraud, Waste, and Abuse. We are all part of the solution.
- Combating Fraud, Waste, and Abuse is everyone's responsibility. As an individual or entity who provides health or administrative services for Medicaid enrollees, every action you take potentially affects Medicaid enrollees, or the Medicaid Program.

Training Objectives

- Compliance with the NH Medicaid contract requirement for MCO to provide its subcontractors with training materials regarding the prevention of fraud, waste, and abuse, effective 9/1/2019.
- Recognize instances of Fraud, Waste, & Abuse.
- Identify the major laws and regulations pertaining to Fraud, Waste, & Abuse.
- Recognize potential consequences and penalties associated with violations.
- Identify methods of preventing Fraud, Waste, & Abuse.
- Identify how to report Fraud, Waste, & Abuse.

Meeting the Regulatory Requirement

- **MCO Oversight of Subcontractors**

The MCO shall provide its subcontractors with training materials regarding the prevention of fraud, waste and abuse and shall require the MCOs hotline to be publicized to Subcontractors' staff who provide services to the MCO.

- **Fraud, Waste, and Abuse**

The MCO, or a Subcontractor which has been delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent fraud, waste, and abuse [42 CFR 438.608(a)]

What is Fraud

- ***Fraud*** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody of, any health care benefit program.

What is Fraud (continued)

- Fraud is defined by the Federal Regulation as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (Section 455.2. Definitions).

What is Fraud (continued)

- The Health Care Fraud Statute makes it a criminal offense to ***knowingly*** and ***willfully*** execute a scheme to defraud a health care benefit program.
- Violation of the Health Care Fraud Statute is punishable by imprisonment for up to 10 years.
- It is also subject to criminal fines of up to \$250,000.

What is Waste

- **Waste** includes practices that directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services.
- Waste is generally not considered to be caused by criminally negligent action but rather by misuse of resources.
- Waste is not defined by the Federal Regulation.

What is Abuse

- **Abuse** includes actions that may, directly or indirectly, result in unnecessary costs to the Medicaid Program.
- Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

What is Abuse (continued)

- Abuse is defined by the Federal Regulation as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized care standards for health care.
- It also includes beneficiary practices that result in unnecessary cost to the Medicaid program (Section 455.2. Definitions).

Putting it Together

- Fraud, Waste, and Abuse (FWA) investigations are targeted reviews of a provider or a member in which there is a reason to believe that the provider or member are not properly delivering services or not properly billing for services.

Reasons to be Aware

- Reducing FWA lowers the cost of health care.
- FWA wastes our tax dollars and takes services away from those who need them.
- Fraud can expose patients to unnecessary tests with potentially serious, even fatal outcomes.
- Fraud can harm patients if they don't receive necessary services.

Knowing the Difference

- There are differences among fraud, waste, and abuse.
- One of the primary differences is intent and knowledge. Fraud requires ***intent*** to obtain payment and ***knowledge*** that the actions are wrong.
- Waste and Abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but does not require the same intent and knowledge.

Examples of Fraud

- Knowingly billing for services or supplies not provided, including billing Medicare for appointments the patient failed to keep.
- Knowingly billing for nonexistent prescriptions.
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Examples of Waste

- Conducting excessive office visits or writing excessive prescriptions.
- Prescribing more medications than necessary for the treatment of a specific condition.
- Ordering excessive laboratory tests.

Examples of Abuse

- Unknowingly billing for unnecessary medical services.
- Unknowingly billing for brand name drugs when generics are dispensed.
- Unknowingly excessively charging for services or supplies.
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes.

Knowing the Laws

- Civil False Claims Act (FCA)
 - The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:
 - Conspires to violate the FCA.
 - Carries out other acts to obtain property from the Government by misrepresentation.
 - Conceals or improperly avoids or decreases an obligation to pay the Government.
 - Makes or uses a false record or statement supporting a false claim.
 - Presents a false claim for payment or approval.

Knowing the Laws (continued)

- **New Hampshire False Claims Act (NHFCA)**
 - The NHFCA imposes liability on any person who:
 - Knowingly presents, or causes to be presented, to an officer or employee of the New Hampshire Department of Health and Human Services (the “Department”), a false or fraudulent claim for payment or approval.
 - Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Department.
 - Conspires to defraud the Department by getting a false or fraudulent claim allowed or paid.

Knowing the Laws (continued)

- New Hampshire False Claims Act (NHFCA)
 - The NHFCA imposes liability on any person who:
 - Has possession, custody, or control of property or money used, or to be used, by the Department and, intending to defraud the Department or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt.
 - Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the department.

Knowing the Laws (continued)

- New Hampshire False Claims Act (NHFCA)
 - The NHFCA imposes liability on any person who:
 - Is a beneficiary of an inadvertent submission of a false claim to the Department, who subsequently discovers the falsity of the claim, and fails to disclose the false claim to the Department within a reasonable time after the discovery of the false claim.
 - Penalties of \$5,000 to \$10,000 per claim plus three times the amount of damages to the state government for NHFCA violations may be imposed.

Knowing the Laws (continued)

- Health Care Fraud Statute

- The Health Care Fraud Statute states, “Whoever knowingly and willfully executes or attempts to execute, a scheme or artifice to...defraud any health care benefit program...shall be fined under this title or imprisoned not more than 10 years, or both.”
- Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law.

Knowing the Laws (continued)

- Criminal Health Care Fraud
 - Persons who knowingly make a false claim may be subject to:
 - Criminal Fines up to \$250,000.
 - Imprisonment for up to 20 years.
 - If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

Knowing the Laws (continued)

- **Anti-Kickback Statute**

- The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including the Medicaid Program).
- Violations are punishable by a fine of up to \$25,000 and imprisonment for up to 5 years.

Knowing the Laws (continued)

- Stark Statute

- The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:
 - An ownership/investment interest.
 - A compensation arrangement.
- Damages can include a penalty of around \$24,250 for each service provided.
- There may also be around a \$161,000 fine for entering into an unlawful arrangement or scheme.

Knowing the Laws (continued)

- Civil Monetary Penalties (CMP) Law

- The office of Inspector General (OIG) may impose civil penalties for several reasons, including:
 - Arranging for services or items from an excluded individual or entity.
 - Providing services or items while excluded.
 - Failing to grant OIG timely access to records.
 - Knowing of and failing to report and return an overpayment.
 - Making false claims.
 - Paying to influence referrals.
- The penalties can be around \$15,000 to \$70,000 depending on the specific violation.
- Violators are also subject to three times the amount claimed for each service or item; or of remuneration offered, paid, solicited, or received.

Penalties for Violations

- Penalties for violating these laws may include:
 - Civil monetary penalties.
 - Civil prosecution.
 - Criminal conviction, fines, or both.
 - Exclusion from all Federal health care program participation.
 - Imprisonment.
 - Loss of professional license.

Whistleblowers

- A **Whistleblower** is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.
- Persons who report false claims or bring legal actions to recover money paid on false claims are **protected** from retaliation.
- Persons who bring a successful Whistleblower lawsuit receive at least 15 percent, but not more than 30 percent, of the money collected.

What Causes FWA?

- Uneducated Office Staff
- Staff Turnover
- Keying Errors
- Providers Feel Entitled
- Greed

A Few Common Forms of FWA

- Upcoding
 - Physician provides a low level of service but bills at a higher level
- Unbundling
 - The separate billing of services which are typically billed together for higher payment
- Incorrect use of modifiers
 - The use of a modifier to obtain higher payment. (Modifier 25 and 59)
- Services not rendered
 - The billing for services not performed such as a lab
- Billing for services not within the provider's scope of practice
 - Provider bills for something they are not qualified to perform, such as a doctor billing for physical therapy
- Billing for services not medically necessary
 - The billing of unnecessary procedures or tests, such as a doctor billing for a drug screen daily because they are in a treatment program

How Do You Prevent FWA

- Look for suspicious activity.
- Conduct yourself in an ethical manner.
- Ensure accurate and timely data and billing.
- Ensure coordination with other payers.
- Know FWA policies and procedures, standards of conduct, laws, regulations, and the CMS' guidance.
- Verify all information.
- Know how to report instances of suspected fraud, waste or abuse.

Reporting FWA

- You play a vital part in preventing, detecting, and reporting potential Fraud, Waste, and Abuse.
 - First, you must comply with all applicable statutory and regulatory requirements, including adopting and using an effective compliance program.
 - Second, you have a duty to report any suspected or actual violations of which you may be aware.
 - Third, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

Reporting FWA (continued)

- Everyone is required to report instances of suspected Fraud, Waste, and Abuse.
- Do not be concerned about whether it is Fraud, Waste, or Abuse.

Reporting FWA (continued)

- When reporting suspected Fraud, Waste, and Abuse, include:
 - Contact information for the information source, suspects, and witnesses.
 - Alleged FWA details.
 - Alleged Medicaid or company rules violated.
 - The suspect's history of compliance, education, training, and communication with your organization or other entities.

Reporting FWA (continued)

- FWA Hotline: 1 (866) 685-8664
- Instances of suspected FWA must be immediately reported to NHHF Compliance Mailbox at NHHF_Compliance@CENTENE.COM
- Such instances will then be forwarded to a member of the MCO's Special Investigations Unit (SIU) for further investigation as warranted.

Thank You.