Medicare and Corporate Compliance Fraud, Waste, & Abuse Training

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UNIVERSITY OF MICHIGAN
HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

Important Notice

This training module will assist Medicare and Corporate Compliance fraud, waste, and abuse (FWA) training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
- 42 CFR Section 423.504(b)(4)(vi)(C)
- CMS-4182-F, Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs
- Section 50.3.2 of the Compliance Program Guidelines (Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual)

Agenda

1. Introduction
2. What is FWA?
3. Your Role in the Preventing FWA
4. Detecting FWA
5. Corrective Actions
6. Summary
7. Resources

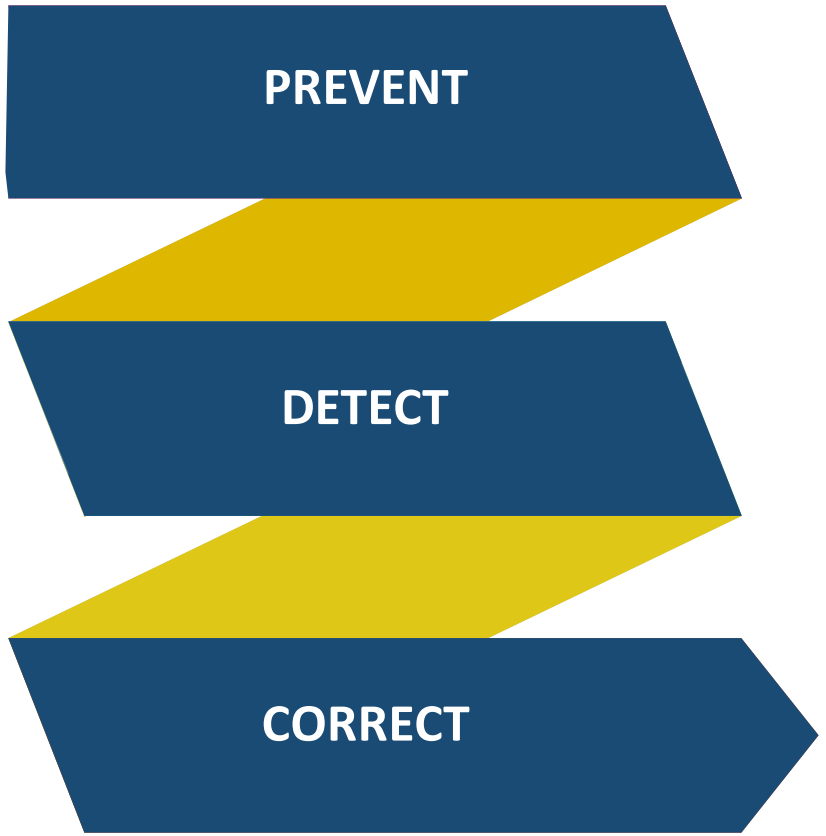
Introduction

Why Do I Need Training?

FWA Compliance is **everyone's** responsibility!

Every year billions of dollars are improperly spent because of FWA, impacting all healthcare areas.

As a healthcare associate, this training will show you how to detect, correct, and prevent FWA and be part of the solution.



Training Objectives

- Recognize the different areas of FWA.
- Understand the significant laws and regulations regarding FWA.
- Understand the potential consequences and penalties associated with violations.
- Understand how to report suspected FWA.
- Learn methods for preventing FWA.
- Understand how the Health Plan addresses and corrects FWA findings

What is FWA?

Fraud, Waste, & Abuse

Fraud

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 money or property owned by, or under the custody or control of any health care benefit program.

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 actions but rather by the misuse of resources

Abuse

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

Difference Among Fraud, Waste, & Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve receiving improper payments or creating unnecessary costs to the Medicare program but do not require the same intent and knowledge.

Examples of Fraud

1. Knowingly billing for services not furnished
2. Billing for nonexistent prescriptions
3. Knowingly altering claims forms, medical records, etc. for higher payment

Examples of Abuse

1. Unknowingly billing for unnecessary medical services
2. Unknowingly excessively charging for services or supplies
3. Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Your Role in the Fight Against FWA

How Do You Prevent FWA?

1. Understand fraud, waste, and abuse, look for and report any suspicious activity
2. Conduct yourself in an ethical manner
3. Ensure accurate and timely data and billing
4. Ensure coordination with other payer types
5. Verify all received information

What Are Your Responsibilities?

- Comply with all applicable laws
- Report any noncompliance
- Follow UMHP's Code of Conduct

Stay Informed About Policies & Procedures

We must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.

The Code of Conduct communicates to employees, and FDRs compliance is everyone's responsibility, from the organization's top to the bottom.

Code of Conduct expectations:

- Conduct yourself in an ethical manner
- Stay up to date on procedures that help you detect, prevent, report, and correct FWA.
- Report noncompliance and FWA concerns using the appropriate mechanisms
- UMHP policies and procedures are reviewed regularly and adhered to

Do not be afraid to Report FWA or Noncompliance

- There can be NO retaliation against you for reporting suspected FWA and noncompliance in good faith
- All employees are required to report issues of FWA and noncompliance
- UMHP prohibits any retaliatory action for good faith reporting of suspected violations of law, regulation, or UMHP policy
- Managers are to promote/support employees reporting FWA and noncompliance issues

To Detect FWA, You Need to Know the Law

1. Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud
2. Anti-Kickback Statute
3. Stark Statute (Physician Self-Referral Law)
4. Exclusion from all Federal health care programs

Civil False Claims Act (FCA)

The civil provisions of the FCA makes 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
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty

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.
- For more information, refer to 18 USC Sections 1346–1347.

Criminal Health Care Fraud

- Persons who knowingly make a false claim may be subject to:
  - Criminal fines
  - Imprisonment for up to 10 years

- If the violations resulted in death, the individual might be imprisoned for any term of years or for life.

- For more information, refer to 18 USC Section 1347.

Anti-Kickback Statue

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 Medicare Program).

For more information, refer to 42 USC Section 1320a-7b(b).

Damages and Penalties

- Violations are punishable by:
- A fine up to $25,000
- Imprisonment up to 5 years

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 or
- A compensation arrangement

Exceptions may apply. For more information, refer to 42 USC Section 1395nn

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. Potential for penalties upward of $100,000 for arrangements considered to be a circumvention scheme.

Civil Money 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

If no exemption exists, each civil monetary penalty is $15,000 to per service. Violators may also be subject to three times the amount. Violators are also subject to three times the amount:
Claimed for each service or item or
Of remuneration offered, paid, solicited, or received

Detecting FWA

Indicators of Potential FWA

Now that you know your role in preventing and reporting. What are some key indicators to help you detect FWA.

FWA can be committed by beneficiaries, providers, agents, associates, vendors, and other downstream entities.

Red Flag for detection of FWA

- Report of lost or stolen card
- Complaints about being billed or EOB received for services not rendered
- Complaints about medical record documentation or quality of service received
- Requested for information without willingness to complete appropriate paperwork
- Late Amendments to medical records to maximize payments
- Outlier in utilization and billing
- Reports of unauthorized enrollment
- Misrepresenting diagnosis to
- justify payment
- Attempt to add an ineligible individual as a dependent
- Providing false employer or group eligibility information to secure health care coverage
- Actions that directly or indirectly result in unnecessary costs to UMHP plans
- Services that fail to meet professionally recognized standards of care
- Sloppy business practices
- Lack of complete documentation supportive of charges rendered

Key Indicator: Potential Beneficiary Issues

- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- Have numerous identical prescriptions for this beneficiary been filled, possibly from different doctors?
- Is the person receiving the medical service the beneficiary (identify theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

Key Indicator: Potential Provider Issues

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Does the provider bill UMHP for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Does the provider's prescription have an active and valid NPI on it?

Key Indicator: Potential Pharmacy Issues

- Are drugs being diverted, being sent elsewhere?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires dispensing brand drugs?
- Are PBMs billed for unfilled or never picked up prescriptions?
- Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or dispense as written)?

Key Indicator: Potential Health Plan Issues

- Does UMHP encourage or support inappropriate risk adjustment submissions?
- Does UMHP lead the beneficiary to believe the cost of benefits is one price when the actual cost is higher?
- Does UMHP offer beneficiaries cash inducements to join the plan?
- Does UMHP use unlicensed agents?

Recent OIG Reviews and Findings

- Between October 2023 to March 2024, the OIG office, with partners DOJ; Medicaid Fraud Control Units (MFCUs); and other Federal, State, and local law enforcement agencies, led to $2.76 BILLION in expected investigation recoveries and resulted.
- 60 Audits were issued and 18 evaluations
    - From the Audits OIG had 195 new audit and evaluation changes to policies and procedures within the HHS programs.
- There was 712 Criminal and Civil Actions taken
- identified and excluded 1,795 bad actors from participation in federally funded programs

Recent OIG Reviews and Findings

- A resident of Fort Lauderdale, Florida, was sentenced in federal court to 120 months of imprisonment, to be followed by three years of supervised release, and was ordered to pay more than $97 million in restitution and to forfeit more than $30 million and the proceeds from the sale of a yacht for conspiring to commit health care fraud and conspiring to pay and receive unlawful kickbacks.
- Hospice owner sentenced to 240 months of imprisonment, three years of supervised release and $2,300 in mandatory special assessment fees, in relation to an extensive health care fraud scheme and ordered to repay the $42 million of fraudulent proceeds back to Medicare.
- A medical device company plead guilty to violations of the federal Food, Drug and Cosmetics Act and pay a $21.8 million fine, $10.9 million in forfeiture and a minimum of $9.3 million to compensate patient victims.
- Rehabilitation Center owner was sentenced to 84 months in federal prison for orchestrating a $15 million health care fraud and kickback scheme. The owner was also ordered to pay $8,680,380 in restitution to government health care programs and will be subject to three years of supervised release following her prison term.

How to Report FWA Concerns

Verbal: Contact your Supervisor, Medicare Compliance Officer (MCO) (Michelle Coberly), the Corporate Compliance Officer (CCO) (Michael Krupnik), or designee in person, by telephone, or via e-mail

Written correspondence to University of Michigan Health Plan Compliance Department at:

- PO Box 30377 Lansing MI 48909-7877
- E-mail phpcompliance@phpmm.org

Call the Compliance Hotline to report concerns and violations confidentially and anonymously, 24 hours a day, 7 days a week, 866.747.2667

Corrective Action

Once fraud, waste, or abuse is detected, we will promptly correct it. Correcting the problem saves the government money and ensures our compliance with CMS requirements.

In collaboration with the business department, the Medicare compliance department will develop a plan to correct the issue. The actual plan is going to vary, depending on the specific circumstances. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future noncompliance.
- Tailor the corrective action to address the identified FWA, problem, or deficiency. Include timeframes for specific actions.
- Document corrective actions addressing noncompliance or FWA committed by our employee or FDR's employee, and include consequences for failure to complete the corrective action satisfactorily.
- Monitor corrective actions continuously to ensure effectiveness.

Corrective actions may include:

- Adopting new prepayment edits or document review requirements
- Conducting mandated training
- Providing educational materials
- Revising policies or procedures
- Sending warning letters
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment
- Terminating an employee or provider

Summary

As a person providing health or administrative services to a Medicare Part C or D enrollee, you play a vital role in preventing FWA. Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.

Report potential FWA. Every Medicare Advantage plan must have a mechanism for reporting potential FWA. We must accept anonymous reports and cannot retaliate against you for reporting.

We will promptly correct identified FWA with an effective corrective action plan.

Everyone plays a role in preventing , detecting, and correcting FWA

Resources

Additional Compliance Resources

Job Aids: Applicable Laws for Reference

- Anti-Kickback Statute 42 USC Section 1320a-7b(b)
- Civil False Claims Act 31 USC Sections 3729–3733
- Civil Monetary Penalties Law 42 USC Section 1320a-7a
- Criminal False Claims Act 18 USC Section 287
- Exclusion 42 USC Section 1320a-7
- Criminal Health Care Fraud Statute 18 USC Section 1347
- Physician Self-Referral Law 42 USC Section 1395nn
- Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training
- OIG's Provider Self-Disclosure Protocol
- Physician Self-Referral
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians
- Safe Harbor Regulations