Fraud, Waste and Abuse

Basic Training

I. The government spends a lot of money on healthcare programs. They want to make sure their money is being used to properly care for residents and patients. They have therefore enacted laws to protect their money. These laws are designed to prevent Fraud, Waste and Abuse.

II. What is fraud, waste, and abuse?
   1. Fraud – an intentional act of deception, misrepresentation, or concealment in order to gain something of value. Example: Billing for patients who don't exist or for services you never provided to the resident.
   2. Waste – over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
   3. Abuse – excessive or improper use of service or actions that are inconsistent with acceptable business or medical practices. Includes incidents that do not extend to the level of fraud but may directly or indirectly cause financial loss.
      a) *Note to trainer:* stress the difference between 'abuse' as it pertains to the safety of the resident and 'abuse' as it pertains to mishandling government funds.

III. Relevant laws
   1. False Claims Act
      a) Originally enacted in 1863 to fight procurement fraud in the Civil War.
      b) Prohibits knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval.
      c) Amended in 2009 (American Recovery and Reinvestment Act – ARRA) to expand the scope of liability and allow the government enhanced investigative powers. Liability know extends to subcontractors of government funded projects,

which may include liability for claims submitted to MAO and Medicaid HMOs.

2. Anti-Kickback Statute
    a) It is a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
3. Beneficiary Inducement Statute
    a) Prohibits certain inducements to Medicare beneficiaries. i.e. waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or fails to collect coinsurance or deductible amounts after making reasonable collection efforts.
4. Self-Referral Prohibition (Stark Law)
    a) Prohibits physicians from referring Medicare patients to an entity with which the physician or physician's immediate family member has a financial relationship—unless an exception applies.
5. Red Flag Rule (Identity Theft Protection)
    a) Requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft
6. HIPAA
    a) Expanded the exclusion authority and definition of fraud so that fraud of any health care benefit program (including private programs) is considered "health care fraud" and may result in exclusion from participation in government healthcare programs.
7. Excluded Entities and Individuals
    a) First tier, downstream and related entities may not employ or contract with entities or individuals who are excluded from doing business with the federal government.

IV. Sanctions and Penalties
    1. Administrative

a) Denial or revocation of Medicare provider number application.
b) Suspension of provider payments
c) Addition to the OIG List of Excluded Individuals/Entities (LEIE)
d) License suspension or revocation

2. Civil or Criminal Penalties
    a) Social Security Act
        - Penalties generally involve assessment of significant damages of up to $25,000 for each enrollee adversely affected.
    b) United State Attorney's Office
        - May file a civil suit, establish a Corporate Integrity Agreement (a plan which requires the entity to implement some sort of corrective action) and may subject the entity to periodic audits by the federal government.
    c) False Claims Act
        - $5500-$11000 base per claim
        - May be liable for three times the loss claimed by the government.
    d) Anti-kickback
        - Up to five years in prison and fines of up to $25000 per violation
        - If a patient suffers bodily injury, prison sentence may be 20+ years.

V. Reporting Suspected Fraud, Waste and Abuse
1. Every employee has the right and responsibility to report possible fraud, waste or abuse
2. Reports can be anonymous
3. Reports or concerns can be made to
    a) You supervisor
    b) The compliance officer (directly or through the hotline)
    c) Relevant authorities

VI. Whistleblower Protections

1. A whistleblower is an individual who reports misconduct to people or entities that have the power to take corrective actions.
2. Retaliation of whistleblowers is prohibited and expressly protected by federal law and company policy.

VII. Examples of FWA
1. Pharmaceutical: prescription drug switching, "shorting" the medication provided, billing for brand name when generics were dispensed, billing for prescriptions that were never filled.
2. Providing services that are medically unnecessary.

Compliance Basics

I. Compliance program is designed to prevent fraud, waste and abuse of government money.
1. Abuse = misuse of government healthcare funds, not abuse of a resident

II. Required elements of a compliance program
1. Designate a Compliance Officer
2. Establish Policies and Procedures
3. Provide Education/Training
4. Establish Required Reporting/Communication Methods
    a) Hotline can be anonymous and confidential
    b) Non-intimidation and non-retaliation
        - Whistleblower protections
5. Establish and Enforce Discipline and Disciplinary Standards
6. Conduct Internal Audits and Monitoring
7. Respond to Detected Offenses
8. Reassess, as needed
    a) Evaluate the program's effectiveness and adjust the program, as indicated