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UB|MD PHYSICIANS' GROUP

Compliance Quarterly

Special Edition
2020 MANDATORY
FRAUD, WASTE & ABUSE TRAINING

From the Compliance Office…

ALL Medicare contracted providers and their employees are **required** by The Centers for Medicare and Medicaid Services (CMS) to complete Fraud, Waste & Abuse (FWA) training when newly hired, and annually thereafter.

Our training is developed from the CMS web-training course. By reading through this edition of *Compliance Quarterly*, and completing the quiz at the end online, your 2020 FWA training requirement will be fulfilled.

Should a 3rd party payor request proof from you that your practice completed FWA training, we can provide you with a list of employees in your practice who successfully complete the training quiz. You can then attest to completion **IF** the list we provide you includes all of your practice's employees. If you have any questions regarding this, please don't hesitate to contact us.

The Importance of FWA Training

As healthcare workers who provide health or administrative services for Medicare patients, and all medical patients, every action we take potentially affects the Medicare program. Therefore, as we perform our daily tasks, we all have a responsibility to be able to detect and prevent fraud, waste and abuse, and know how to report and correct FWA when we become aware of such activity.

Billions of dollars are improperly spent every year due to fraud, waste and abuse. This affects every one of us. This training, required within 90 days of initial hire and at least annually thereafter, will enable you to be part of the solution.

After training completion, you should be able to correctly:

- Recognize FWA;
- Identify the major laws & regulations pertaining to FWA;
- Recognize potential consequences & penalties associated with violations;
- Identify methods of preventing FWA;
- Identify how to report FWA; and
- Recognize how to correct FWA.

Inside this issue

The CMS Web-Based Fraud, Waste & Abuse training course is the source used to create this FWA training.

For the definitions of fraud, waste & abuse, refer to Chapter 21 Section 20 of the "Medicare Managed Care Manual" and Chapter 9 of the "Prescription Drug Benefit Manual" on the Centers for Medicare & Medicaid Services (CMS) website.

Fraud, Waiste & Abuse Defined

The first step in combating fraud, waste & abuse is understanding what each is, and the difference between them.

Fraud is knowingly and willfully executing, or attempting to execute, a scheme 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 any health care benefit program. Intentionally submitting false information to the government or a government contractor to get money or a benefit is fraud.

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 costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

What is the difference between fraud, waste & abuse?
One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge that the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating unnecessary cost to the Medicare Program, but do not require the same intent and knowledge.

Examples of Fraud, Waste & Abuse

Examples of actions that may constitute Medicare **fraud** include:

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

Examples of actions that may constitute Medicare **waste** include:

- 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 actions that may constitute Medicare **abuse** include:

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

Laws & Penalties

To recognize, detect and deter FWA, it is important to know the laws that pertain to FWA, and the possible penalties faced for FWA.

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; or
- Presents a false claim for payment or approval.

Damages & Penalties

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

Example:
The owner-operator of a medical clinic in California used marketers to recruit individuals for medically unnecessary office visits, promised free, medically unnecessary equipment or free food to entice individuals, and charged Medicare more than $1.7 million for the scheme.
The owner-operator was sentenced to 37 months in prison.

For more information on the FCA: 31 United States Code (U.S.C.) Sections 3729-3733

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% but not more than 30% of money collected.

The UBMD Compliance Plan includes a non-retaliation policy which states that retaliation for reporting actual or potential violation in good faith will not be tolerated.

FRAUD STATUTE

The Fraud Statute makes it a criminal offense to knowingly and willfully execute, or attempt to execute, a scheme to defraud a health care benefit program. Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law.

Damages & Penalties

Punishable by up to $250,000 fine or up to 10 years imprisonment, or both.

Criminal Health Care Fraud Damages & Penalties

Persons who knowingly make a false claim may be subject to criminal fines of up to $250,000, imprisonment for up to 20 years, or both. If the violations result in death, the individual may be imprisoned for any term of years or for life.

Examples:
A Pennsylvania pharmacist submitted claims to a Medicare Part D plan for non-existent prescriptions and drugs not dispensed.
The pharmacist pleaded guilty to health care fraud, received a 15 month prison sentence, and was ordered to pay more than $166,000 in restitution to the plan.

◇

The owner of multiple Durable Medical Equipment (DME) companies in New York falsely represented themselves as one of a nonprofit HMO's (that administered a Medicare Advantage plan) authorized vendors , provided no DME to any beneficiaries as claimed, and submitted almost $1 million in false claims to the nonprofit ($300,000 was paid).
The owner pleaded guilty to one count of conspiracy to commit health care fraud.

For more information: 18 USC Sections 1346-1347

"Bad things will eventually be discovered."
- Unknown

ANTI-KICKBACK STATUTE (AKS)

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 Medicare). Safe harbors may apply.

Damages & Penalties

Violations are punishable by a fine of up to $25,000; imprisonment for up to 5 years; or both.

Example:

From 2012 through 2015, a physician operating a pain management practice in Rhode Island conspired to solicit and receive kick-backs for prescribing a highly addictive version of the opioid Fentanyl, reported patients had breakthrough cancer pain to secure insurance payments, received $188,000 in speaker fee kickbacks from the drug manufacturer, and admitted the kickback scheme cost Medicare and other payers more than $750,000.

The physician must pay more than $750,000 restitution and is awaiting sentencing.

For more information on AKS and safe harbors: 42 USC Section 1320a-7b(b)
For more information on damages and penalties: Social Security Act (the Act), Section 1128B(b)

CIVIL MONETARY PENALTIES (CMP) LAW

The Office of Inspector General (OIG) may impose civil monetary penalties for a number of reasons, including:

- Arranging for services or items from an excluded individual or entity;
- Providing services or items while provider is excluded;
- Failing to grant OIG timely access to records;
- Knowing of and failing to report and return an overpayment within 60 days of identification;
- Making false claims; or
- Paying to influence referrals.

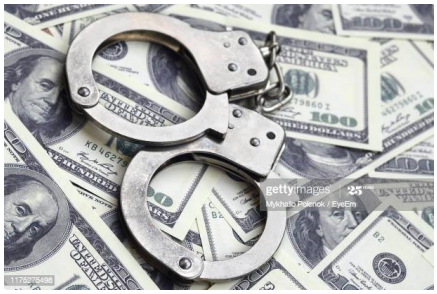
Damages and Penalties

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.

Example:

According to the DOJ, a Florida medical practice allowed credit balances from various federal health care programs to accrue despite multiple internal warnings that the balances should be paid back. DOJ alleged that failure to return those credit balances within 60 days violated the False Claim Act. DOJ and the practice resolved the alleged $175,000 in unreturned payments for $448,821.58.

For more information: 42 USC 1320a-7a and the Act, Section1128A(a)



STARK STATUTE (PHYSICIAN SELF-REFERRAL LAW)

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 on the Stark Statute and exceptions: 42 USC Section 1395nn

Damages & Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around $24,250 can be imposed for each service provided. There may also be around a $161,000 fine for entering into an unlawful arrangement or scheme.

For more information on damages and penalties: Physician Self-Referral webpage and refer to the ACT, Section 1877

Example:
A California hospital was ordered to **pay more than $3.2 million** to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician group outside the fair market value standards or that were improperly documented as exceptions.

EXCLUSION

No Federal health care program payment may be made for any item or service furnished, ordered or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs, and maintains the List of Excluded Individuals and Entities (LEIE). Click LEIE to access the list.

The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. Click EPLS to access the list.

If looking for excluded individuals or entities make sure to check both the LEIE and the EPLS monthly since the lists are not the same.
For more information: 42 USC Section 1320a-7 and 42 Code of Federal Regulations Section 1001.1901

Example:
A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the Food and Drug Administration concerning oversized morphine sulfate tablets.
The executive of the pharmaceutical firm was excluded based on the company's guilty plea.
At the time the executive was excluded, he had not been convicted himself, but there was evidence he was involved in misconduct leading to the company's conviction.

Health Insurance Portability & Accountability Act (HIPAA)

HIPAA created greater access to health care insurance, strengthened protection of privacy of health care data and promoted standardization and efficiency in the health care industry. HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.

Example:
A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain.
He was sentenced to 12 months and 1 day in prison.

Damages and Penalties

Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply. It is also an improper practice of medicine under New York law to violate patient confidentiality, and can lead to action against a provider's license to practice medicine.

For more information: HIPAA Webpage

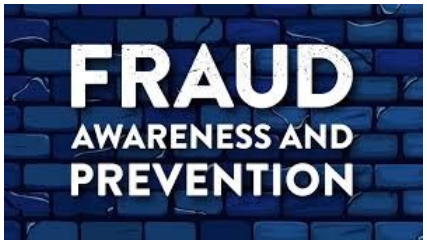
Compliance is everyone's responsibility.

Your Responsibilities

We all play a vital part in preventing, detecting and reporting potential FWA, as well as Medicare non-compliance.

- First, you must comply with all applicable statutory, regulatory and other Medicare requirements, including adopting and using an effective compliance program.
- Second, you have a duty to report any compliance concerns and suspected or actual violations of which you may be aware.
- Third, you have a duty to follow the UBMD Compliance Plan (including the Code of Conduct), which articulates UBMD's commitment to standards of conduct and ethical rules of behavior.

Preventing FWA



To prevent FWA, you need to stay informed about policies and procedures and standards of conduct.

- Look for suspicious activity;
- Conduct yourself in an ethical manner at all times;
- Ensure accurate and timely data/billing;
- Ensure you comply with other payers' rules;
- Verify all information provided to you; and
- Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance.
  - ⇒ Know that reported issues will be addressed and corrected.
  - ⇒ Read the *Compliance Quarterly* newsletters and other communications sent to you by the UBMD Compliance Office. They contain important information and updates that everyone needs to know.
  - ⇒ Complete all compliance and HIPAA training as required.

Compliance & prevention are everyone's responsibility, from the top of the organization to the bottom.

Reporting FWA

Everyone must report known or suspected instances of FWA. It is important to note that retaliation for reporting compliance concerns in good faith will not be tolerated regardless of whether or not a violation is found as a result of the initial report. This, and the process for reporting, is clearly stated in the UBMD Compliance Plan.

Any concerns should be reported to your supervisor or the UBMD Compliance Office. Even if you see something you suspect is wrong, but you're not sure it is FWA, report it. You may call or email the Compliance Office directly, or utilize the Compliance Hotline if you wish to remain anonymous. All reported concerns will be investigated by the Chief Compliance Officer.

If warranted, potentially fraudulent conduct must be reported to government authorities, such as the Office of Inspector General (OIG), the Department of Justice (DOJ), or CMS. Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a government directed investigation and civil or administrative litigation. The UBMD Chief Compliance Officer should be contacted regarding cases of self-disclosure.

When reporting suspected FWA, you should include:

- Contact information for the source of the information, suspects and witnesses;
- Details of the alleged FWA;
- Identification of the specific Medicare rules allegedly violated; and
- The suspect's history of compliance, education, training and communication within UBMD and other entities.

Correcting FWA

Once fraud, waste or abuse has been detected, it must be promptly corrected. Correcting the problem saves the Government money and ensures that you are in compliance with CMS requirements.

Develop a plan to correct the issue. Consult the UBMD Chief Compliance Officer to find out the process for the corrective action plan development. The actual plan will vary, depending on the specific circumstances. But in general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance;
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions;
- Document corrective actions addressing non-compliance or FWA committed by the employee and include consequences for failure to satisfactorily complete the corrective action;
- Once started, continually monitor corrective actions to ensure they are effective.

Corrective action may include:

- Adopting new prepayment edits or document review requirements;
- Conducting additional mandated training;
- Providing educational materials;
- Revising policies or procedures;
- Sending warning letters;
- Terminating an employee or provider.

OIG 2019 Fraud Actions & Recoveries Report

In June 2020, the OIG and the DOJ issued an Annual Report for Fiscal Year 2019 regarding the Health Care Fraud and Abuse Control Program. The DOJ reported that 1,060 new criminal health care fraud investigations were opened. The following numbers from this report illustrate why understanding, preventing, reporting and correcting fraud, waste and abuse is so important.

- $3.6 billion recovered and returned to the Federal Government or paid to private persons.
- 485 criminal charges filed, involving 814 defendants, with 528 defendants being convicted of health care fraud-related crimes.
- 1,112 new civil health care fraud investigations opened, and 1,343 civil health care fraud matters pending at the end of the Fiscal Year.
- 747 criminal actions against individuals or entities, and 684 civil actions, including civil monetary penalties settlements and administrative recoveries, resulted from OIG investigations conducted.
- 2,640 individuals and entities added to the OIG List of Excluded Individuals and Entities (LEIE), among which were exclusions based on:
    - ⇒ Criminal convictions for crimes related to Medicare and Medicaid (1,194) or other health care programs (335);
    - ⇒ Patient abuse or neglect (238); and
    - ⇒ As a result of state health care licensure revocations (576).

Compliance Training Update

New Provider E/M & Documentation Training

This is also a good refresher for the not-so-new providers! To be set up for this online training session, please contact Bev Welshans at welshans@buffalo.edu or 888-4702.

Lunch-n-Learn

Sessions are usually held once a month. Bring your lunch, and join us as we cover a variety of important topics related to coding and compliance!

AAPC & AHIMA CEUs are often available for the sessions. All are welcome to attend.

If you would like to be added to the session contact list, please contact Bev Welshans.

Please Note: Due to the COVID epidemic, Lunch-n-Learn sessions are currently on hold, but will be rescheduled once a new methodology for the training can be developed. At that time, an email will be sent to those on the contact list.

If you have questions on any of the above training, please contact Bev Welshans via telephone (888-4702) or e-mail: welshans@buffalo.edu

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Report suspect fraud/abuse, potential problems,

or HIPAA concerns.

Ask questions or request guidance | Provide relevant information.

Remain anonymous if you wish | Non-retaliation policy will be adhered to.

(This is a voice mail box monitored during working hours. If there is an immediate threat to person or property, do not leave message; contact direct supervisor immediately!

Note: According to the UBMD Compliance Plan, it is the responsibility & duty of all UBMD employees to immediately report any known or suspected misconduct, violations of law, or other wrongdoing.

Compliance Quarterly Quiz

To submit your quiz answers, please click on the link below:

2020 FWA Training Quiz

1. Which of the following statements is false?

   A. Combatting fraud, waste and abuse is everyone's responsibility.
   B. There is no difference between fraud, waste and abuse.
   C. In the case of abuse, the provider doesn't knowingly and/or intentionally misrepresent facts to obtain payment.
   D. Waste is generally not considered to be caused by criminally negligent actions, but rather by the misuse of resources.

2. Which of the following action(s) may constitute Medicare fraud??

   A. Knowingly billing for services not furnished, including billing Medicare for appointments the patient failed to keep.
   B. Knowingly altering claim forms, medical records, or receipts to receive a higher payment.
   C. Billing for non-existent prescriptions.
   D. All of the Above

3. No Federal health care program payment may be made for any item or service furnished, ordered or prescribed by an individual or entity excluded by the OIG.

   A. True
   B. False

4. When fraud, waste or abuse has been detected, corrective action may include, but is not limited to, which of the following?

   A. Conducting additional mandated training and/providing educational materials.
   B. Revising policies and procedures.
   C. Termination of employee or provider.
   D. All of the above

5. Which of the following regarding the reporting of known or suspected fraud, waste or abuse is false?

   A. Retaliation for reporting compliance concerns in good faith will not be tolerated regardless of whether or not a violation is found as a result of the initial report.
   B. Any concerns should be reported to your supervisor or the UBMD Compliance Office.
   C. You should only report something if you are sure it is FWA.
   D. You may use the UBMD Compliance Hotline to report known or suspected fraud if you wish to remain anonymous.

To ensure you receive proper credit for training, make sure you provide your full name, and select your correct practice plan from the drop down menu.