Compliance Alliance

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UB|MD PHYSICIANS' GROUP

U.B. Associates, Inc. | Fourth Quarter - 2016 | Volume 10, Number 4

In This Issue:

MANDATORY 2016

Fraud, Waste & Abuse Training Module

By reading this issue of *Compliance Alliance* and successfully completing the corresponding quiz, you will meet your mandatory obligation to complete FWA training for 2016.

SPECIAL EDITION
2016 MANDATORY
FRAUD, WASTE, & ABUSE
TRAINING
MODULE

From the Compliance Office

By: Sue Marasi, CHC, CPC-A, Compliance Administrator

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

In an effort to ensure that all practice plan physicians and employees complete the **mandatory** annual training, we have designed this 4th quarter newsletter to focus solely on that topic. Overall, this process seems to have worked well in the past, so we have decided to conduct the 2016 FWA training in this manner once again. Please read the important information contained in this newsletter, then complete the quiz at the end electronically by going to the following website:

https://smbsweb.med.buffalo.edu/ubmd/training.aspx

To ensure that you receive credit for completion, be sure to fill in your full first and last name, and select your **specific practice plan** from the drop down menu. Please do not hesitate to contact me if you have any questions or problems.

Fraud, Waste and Abuse Defined

As health care workers, regardless of specialty or practice setting, you all play an important role in combating medical fraud and abuse. To do so successfully, it is important that you know what to watch for, and to understand what fraud, waste and abuse are.

FRAUD is defined as:

- Knowingly submitting false statements or making misrepresentations of fact to obtain a federal health care payment that you would otherwise not be entitled to;
- Knowingly soliciting, paying and/or accepting remuneration to induce or reward referrals for services or items reimbursed by Federal health care programs; or
- Making prohibited referrals for certain designated health services.

Some examples of fraud include, but are not limited to:

- ✓ Knowingly billing for services and/or supplies not provided;
- ✓ Falsifying records to show delivery of services or supplies not provided;
- ✓ Billing Medicare for appointments patients failed to keep;
- ✓ Knowingly billing for services at a higher level of complexity than was actually provided or documented in patient file.

“Character is much easier kept than recovered."
~ Thomas Paine

WASTE is defined as the **o**verutilization of services or other practices, generally through the misuse of resources as opposed to criminal negligence, that directly or indirectly result in unnecessary costs to the Medicare program.

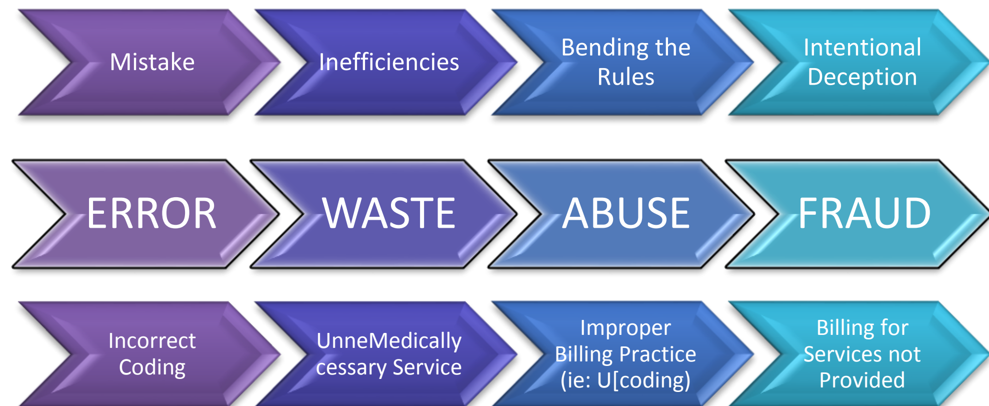
ABUSE is defined as:

- Practices that, either directly or indirectly, result in unnecessary costs to the Medicare program;
- Any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and priced fairly.

Some examples of abuse are:

- ✓ Billing for services that were not medically necessary;
- ✓ Charging excessively for services or supplies; and
- ✓ Misusing codes on a claim, such as upcoding or unbundling codes.

People often confuse fraud, waste and abuse with each other, and with simple mistakes. But there are differences. A primary difference is knowledge. The person must have knowledge that their actions are wrong as well as the intent to obtain payment through those actions for fraud to take place. While obtaining an improper payment may occur in waste and abuse, the same intent and knowledge is not involved. The following illustrates the various causes of improper payments:



“Justice Department Recovers Over $4.7 Billion From False Claims Act Cases in Fiscal Year 2016”

Laws & Penalties

The following laws pertaining to fraud and abuse are enforced by government agencies, including the Department of Justice (DOJ), the Department of Health & Human Services (HHS), the HHS Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS).

FALSE CLAIMS ACT (FCA):

Prohibits knowingly submitting or causing the submission of a false or fraudulent claim to the Federal government. (“Knowingly” includes acting in deliberate ignorance or reckless disregard of the truth.)

Example: A claim is submitted for payment for a higher level of medical services than were actually provided

Civil Penalties: Fines of $5,500-$$11,000 per false claim, and up to three times the amount of damages sustained as a result of the false claims.

Criminal Penalties: Fines, imprisonment or both.

ANTIKICKBACK STATUTE (AKS):

Prohibits knowingly and willfully offering, paying, soliciting or receiving any remuneration for referrals of items or services that are reimbursable in whole or in part by a Federal health care program. Remuneration can be anything of value including but not limited to cash, free rent, free meals, and excessive compensation for medical directorships. However, if an arrangement satisfies certain regulatory

safe harbors, it will not be treated as an offense. (https://oig.hhs.gov/compliance/safe-harbor-regulations).

Example: A Provider receives cash or below market value rent for medical offices in exchange for referrals.

Civil Penalties: Fines up to three times the amount of kickback.

Criminal Penalties: Fines, imprisonment or both.

PHYSICIAN SELF-REFERRAL LAW (STARK LAW):

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician, or an immediate family member, has ownership or investment interest, or a compensation arrangement.

Example: A provider refers a beneficiary for a designated health service to a business in which the provider as an investment interest.

Penalties: Fines, repayment of claims, and possible exclusion from participation in all Federal health care programs.

CRIMINAL HEALTH CARE FRAUD STATUTE:

Prohibits knowingly and willfully executing or attempting to execute a scheme or deception in connection with the delivery of or payment for healthcare benefits, items or services to defraud any health care benefit program, or obtain through false or fraudulant pretenses, any money or property owned by, or under the control of, any health care benefit program.

Example: Several doctors and clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting claims for power wheelchairs that were not medically necessary.

Penalties: Fines, imprisonment, or both.

CIVIL MONETARY PENALTIES LAW (CMPL):

Authorizes penalties of up to $50,000 per violation, and assessments of 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 may include:

- Presenting a claim that you know or should knonw is for an item or service not provided as claimed or that is false and fraudulant;
- Presenting a claim that you know or should know is for an item or service for which Medicare will not pay; and
- Violating the AKS.

THE EXCLUSION STATUTE:

Requires the OIG to impose exclusions from participation in all Federal health care programs on providers and suppliers who have been convicted of:

- Medicare fraud and other offenses related to the delivery of items or services under Medicare;
- Patient abuse or neglect;
- Other health care-related fraud, theft or financial misconduct (felony conviction)
- Unlawful manufacture, distribution, prewcription or dispensing of controlled substances (felony conviction).

Excluded physicians may not bill directly, or bill indirectly through an employer or group practice, for treating Medicare and Medicaid patients.

In summary, being involved in fraud and abuse schemes exposes you and your practice to the possibility of various potential penalties, including: civil monetary penalties, repayment of claims, criminal fines, imprisonment, loss of provider license, exclusion, or a combination of several of these. The actual consequences depend on the violation.

Preventing, Detecting & Reporting Fraud & Abuse

CMS continues to work intensively to prevent, detect and investigate fraud and abuse by partnering with many individuals and entities including Accreditation Organizations, Medicare beneficiaries and caregivers, physicians, suppliers, other health care providers, and an array of investigative contractors, as well as law enforcement agencies such as

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the OIG, FBI, DOJ and Medicaid Fraud Control Units.

Prevention of fraud and abuse within your practice begins with **YOU** – the provider, the administrator, the office manager, the coder, the biller, the receptionist - adhering to the following:

- Accurate coding and billing
- Provide medically necessary, high quality services
- Complete and accurate documentation
- Check for exclusions quarterly
- Comply with all applicable laws and regulations
- Continuous medical AND compliance education

Finally, be pro-active! Use the many available resources available (several listed below), including the UB|MD Compliance Office, to ensure a full understanding of all aspects of fraud and abuse, and healthcare compliance. Never say "I don't have time" or "I can't be bothered with this", because:

PREVENTION is less time consuming, less stressful, and much less costly than it will be if federal investigators come knocking at your office door.

UB|MD COMPLIANCE HOTLINE: 888-4752

If you suspect fraud or abuse in your office, it is your responsibility to report it immediately. You may call Chief Compliance Officer, Larry DiGiulio; or, if you wish to remain anonymous, call the **UB|MD Compliance Hotline at 888-4752**. All hotline calls go to a non-traceable voice mailbox which is monitored by Compliance Office personnel during regular business hours, Monday through Friday. All reports will be thoroughly investigated. Please note that we do have a non-retaliation policy in place.

A Hotline flier was emailed with this newsletter. This flier should be displayed prominently in employee areas at **all** practice sites. If you did not receive the flier attachment, please contact me at smmarasi@buffalo.edu and one will be emailed to you.

Additional Resources/Article References:

The Compliance Office strongly recommends that all practice personnel check the following links to gain further understanding of fraud, waste and abuse, as well as the importance of reporting suspected fraud and abuse, and the potential ramifications of taking part in fraud and abuse schemes.

OIG Fraud Prevention & Detection: https://oig.hhs.gov/fraud

CMS: http://www.cms.gov

HHS: http://www.hhs.gov

Medicare Fraud & Abuse FAQ: https://questions.cms.gov/faq.php?id=5005&rtopic=1887

Comparison of AKS and Stark Law: http://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf

Stark Law: http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral

OIG Exclusion List: https://oig.hhs.gov/exclusions

** Much of the information in this newsletter was obtained through the CMS Medicare Learning Network. This is an excellent online resource for Medicare guidance and learning, and we encourage all of you to reference

Fourth Quarter 2016 Quiz – Mandatory FWA Training

Please go to
https://smbsweb.med.buffalo.edu/ubmd/training.aspx
to submit your quiz answers.

1. Knowingly submitting false statements or making misrepresentations of fact to obtain a federal health care payment that you would otherwise not be entitled to is the definition of:
   a. Waste
   b. Abuse
   c. Fraud
   d. None of the above

2. Billing for services that were not medically necessary is an example of:
   a. Fraud
   b. Waste
   c. Abuse
   d. None of the above

3. Excluded physicians may not bill directly, or bill indirectly through an employer or group practice, for treating Medicare and Medicaid patients.
   a. True
   b. False

4. Penalties for committing Fraud and/or Abuse can include:
   a. Fines
   b. Imprisonment
   c. Exclusion
   d. All of the above

5. There is nothing you, the health care worker, can do to prevent fraud, waste and abuse.
   a. True
   b. False

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Please do not email or fax answers.
Submit your answers to "2016 - 4th Quarter Newsletter - Mandatory FWA" at:

https://smbsweb.med.buffalo.edu/ubmd/training.aspx

Be sure to click on your correct practice group to ensure proper credit!