A Message from the Compliance Office…

It's no secret that the new administration has expressed a strong commitment to eliminating fraud, waste and abuse (FWA) within federal programs. This includes healthcare.

The OIG Strategic Plan 2025-2030 establishes three clear goals. Note the #1 goal:

1. **Fight fraud, waste, and abuse**
2. Promote quality, safety and value
3. Advance excellence and innovation.

These goals will guide OIG to "carry out its mission to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs as well as the health and welfare of the people they serve."

In addition, it has been reported that CMS will begin auditing all eligible Medicare Advantage contracts. They will be expediting their efforts to increase auditing numbers through an expanded workforce and enhanced technology.

While the report addresses RADV audits, there is a trickle-down effect that will now pose the potential audit for all of us, regardless of status.

All of this illustrates how **extremely important** it is for UBMD personnel to be able to recognize improper conduct, and how to prevent it and correct it.

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Training Requirements

In order to meet Fraud, Waste & Abuse (FWA) training requirements set by The Centers for Medicare and Medicaid Services (CMS), **all** UBMD providers and staff are **required** to complete FWA training within 90 days of hire, **and** annually thereafter.

This training program is developed from the CMS web-training program to ensure all required information is included.

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Training Objectives

Once training is complete, you should be able to correctly:

- ✓ Recognize & distinguish Fraud, Waste & Abuse;
- ✓ Recognize major laws & regulations pertaining to FWA;
- ✓ Understand potential consequences & penalties for violations;
- ✓ Identify & apply methods of preventing FWA;
- ✓ Report FWA; and
- ✓ Determine how to correct FWA.

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Why do we need FWA training?

- Learn how to detect, correct and prevent FWA.
  - ✓ Prevent improper conduct, whether intentional or not, from occurring.
  - ✓ Detect and prevent patterns of improper conduct, or the appearance of improper conduct, from occurring.
- Billions of dollars are spent every year due to fraud, waste & abuse. Estimates range from $68 billion - $230 billion of annual healthcare expenditure.
  - ✓ In 2024:
    - Improper payments for the Medicare program alone totaled $54.3 billion.
    - Estimated improper payments for Medicaid was $31.1 billion.
    - Improper payments across all CMS programs were estimated at $87.1 billion.
    - Improper payments across 16 federal agencies and 68 programs totaled $162 billion.
- As healthcare workers and UBMD employees, whether provider or administrative, we are ALL responsible for combatting fraud, waste & abuse.
- Any of our actions determined to be fraud, waste or abuse can lead to financial losses not only to government programs, but fines & penalties, including exclusion and imprisonment, to you and your practice plans as well.
- To be part of the solution!

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What is FWA?

- **Fraud**
  - ✓ Knowingly submitting false claims, or causing false claims to be submitted;
  - ✓ Knowingly making misrepresentations of fact to get a federal health care payment;
  - ✓ Knowingly soliciting, getting, offering, or paying remuneration (kickbacks, bribes, rebates) to induce or reward referrals for certain designated services reimbursed by federal health care programs;
  - ✓ 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 custody or control of, any health care benefit program;
  - ✓ Requires willingness, intent, knowledge.
- **Waste**
  - ✓ Practices that directly or indirectly results in unnecessary costs to the Medicare Program, such as overusing services.
  - ✓ Generally not caused by criminally negligent actions, but by misuse of resources.
- **Abuse**
  - ✓ Practices that directly or indirectly result in unnecessary costs to the Medicare Program.
  - ✓ Any practice that doesn't provide medically necessary services or doesn't meet professionally recognized standards of care.

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Examples

- **Fraud**
  - ✓ Knowingly billing for services of higher complexity than services actually provided or documented.
  - ✓ Knowingly billing for services not provided.
  - ✓ Knowingly ordering medically unnecessary patient items or services.
  - ✓ Paying for federal health care program patient referrals.
  - ✓ Billing Medicare for appointments patients don't keep.
  - ✓ Knowingly altering claims forms, medical records, or receipts to receive a higher payment.
- **Waste**
  - ✓ Conducting excessive office visits or writing excessive prescriptions.
  - ✓ Prescribing more medications than necessary to treat a specific condition.
  - ✓ Ordering excessive lab tests.
- **Abuse**
  - ✓ Billing unnecessary medical services.
  - ✓ Charging excessively for services or supplies.
  - ✓ Misusing codes on a claim, like upcoding or unbundling codes.
  - ✓ Not following HIPAA guidelines for protecting a patent's PHI.

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Difference Between Fraud, Waste & Abuse

- Intent, knowledge, and willingness are the primary differences.
- Fraud requires intent to obtain payment, and knowledge that the actions are wrong.
- Waste & Abuse may involve obtaining improper payment or creating unnecessary cost to Medicare Program, but do not require the same intent and knowledge.

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

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Laws & Penalties

To detect FWA, you need to know the key laws involved:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Statute)
- Fraud Statute
- Exclusion Statute
- Civil Monetary Penalties Law (CMPL)
- Health Insurance Portability and Accountability Act (HIPAA)

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Laws & Penalties

- False Claims Act: Protects the Federal government from being over charged, or sold substandard goods or services.
  - ✓ The FCA imposes civil liability on anyone who *knowingly* submits, or causes the submission of, a false or fraudulent claim.
  - ✓ The terms "knowing" and "knowingly" mean a person:
    - Has actual knowledge of the information; or
    - Acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim.
  - ✓ There is also a criminal FCA. Criminal penalties for submitting false claims may include prison, fines, or both.

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- Example:
  - ✓ A physician knowingly submits claims to Medicare for medical services not provided, or for a higher level of medical services than actually provided.

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Laws & Penalties

- The Anti-Kickback Statute (AKS): Makes it a crime to knowingly and willfully offer, pay, solicit or receive any remuneration directly or indirectly to induce or reward patient referrals or business generation involving any item or service payable by a federal health care program.
  - ✓ Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultations.
  - ✓ Safe harbors may apply.
  - ✓ Criminal penalties and administrative sanctions for violating AKS may include fines, imprisonment, and exclusion from participating in Federal health care programs.

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- Example:
  - ✓ A provider gets cash or below-fair-market-value rent for medical office space in exchange for referrals.

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Laws & Penalties

- The Physician Self-Referral Law (Stark Law): Prohibits a physician from referring certain designated health services (DHS) to an entity where the physician, or an immediate family member, has an ownership/investment interest or has a compensation arrangement, unless an exception applies.
  - ✓ Physicians who violate the Stark Law face penalties including fines, repayment of claims, and potential exclusion from participation in Federal health care programs.

- Designated Health Services include:
  - ✓ Clinical lab services
  - ✓ Physical therapy, occupational therapy, and outpatient speech-language pathology services
  - ✓ Radiology and other imaging services
  - ✓ DME and supplies
  - ✓ Parenteral and enteral nutrients, equipment, and supplies
  - ✓ Prosthetics, orthotics, and supplies
  - ✓ Home health services
  - ✓ Outpatient prescription drugs
  - ✓ Inpatient and outpatient hospital services.

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- Example:
  - ✓ A provider refers a patient for a designated health service to a clinic where the physician (or an immediate family member) has and investment interest.

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Laws & Penalties

- The Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme about the delivery of, or payment for, health care benefits, items or services to either:
  - ✓ Defraud any health care benefit program; or
  - ✓ Obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under control of any health care benefit plan;
- Conviction does not require proof that the violator had knowledge of the law or specific intent to violate the law.
  - ✓ Penalties for violating the Fraud Statute may include fines, prison, or both.

- Example:
  - ✓ Several doctors and medical clinics conspire to defraud the Medicare program by submitting claims for medically unnecessary wheelchairs.

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Laws & Penalties

- Exclusion Statute: Requires the OIG to exclude health care providers and suppliers convicted of these criminal offenses from participating in all federal health care programs:
  - ✓ Medicare or Medicaid fraud, and other offenses related to delivering Medicare or Medicaid items or services;
  - ✓ Patient abuse or neglect;
  - ✓ Felony convictions for other health care-related fraud, theft or other financial misconduct; and
  - ✓ Felony convictions relating to unlawful manufacture, distribution, prescription or dispensing of controlled substances.
- The OIG also maintains the List of Excluded Individuals and Entities (LEIE website.
- The U.S. General Services Administration (GSA) administers the Excluded Parties List (EPLS), which enables various federal agencies, including the OIG, to take debarment actions.
- Both the LEIE and EPLS should be checked when looking for excluded individuals and entities as the lists are not the same.

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Laws & Penalties

- Exclusion Statute (Continued)
  - ✓ Excluded providers may not participate in the Federal health care programs for a designated period. If excluded by the OIG, then Federal health care programs, including Medicare and Medicaid, will not pay for items or services that you furnish, order or prescribe.
  - ✓ Excluded providers may not bill directly for treating Medicare and Medicaid patients, and an employer of a group practice may not bill for an excluded provider's services.
  - ✓ At the end of an exclusion period, an excluded provider must seek reinstatement as reinstatement is not automatic.
  - ✓ Mandatory exclusions stay in effect for a minimum of 5 years, but can be longer, or even permanent.

- Permissive Exclusion: OIG may impose exclusions for offenses not under a mandatory exclusion. Permissive exclusions vary in length. Examples include, but are not limited to:
  - ✓ Misdemeanor health care fraud convictions other than Medicare or Medicaid fraud;
  - ✓ Misdemeanor convictions for unlawfully manufacturing, distributing, prescribing or dispensing controlled substances;

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Laws & Penalties

- Permissive Exclusion (Continued)

  - ✓ Revocation, suspension or health care license surrender for reasons of professional competence, professional performance, or financial integrity;
  - ✓ Providing unnecessary or substandard service;
  - ✓ Convictions for obstruction an investigation or audit;
  - ✓ Engaging in unlawful kickback arrangements;
  - ✓ Defaulting on health education loan or scholarship obligations.

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- The UBMD Compliance Plan requires that all practices who bill government programs including, without limitation, Medicare and Medicaid, to check the names of all providers, staff and agents/vendors against exclusionary databases regularly.

  - ✓ Check Monthly:
    - OIG-LEIE, GSA-SAM, and OMIG-List
  - ✓ Check when a provider is credentialed or re-credentialed:
    - SDN List, NPPES, and Death Master

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Laws & Penalties

- Civil Monetary Penalties Law (CMP) authorizes the OIG to seek civil monetary penalties, and sometimes exclusions, for a variety of health care fraud violations, including:

  - ✓ Arranging for an excluded individual's or entity's services or items;
  - ✓ Failing to grant OIG timely access to records;
  - ✓ Filing a claim you know or should know is for an item or service that wasn't provided as claimed, or is false or fraudulent;
  - ✓ Filing a claim you know or should know is for an unpayable item or service;
  - ✓ Violating the AKS;
  - ✓ Violation the Medicare physician agreement;
  - ✓ Providing false or misleading information expected to influence a discharge decision;
  - ✓ Failing to provide an adequate medical screening exam for patients who present to a hospital ED with an emergency medical condition or in labor;
  - ✓ Making false statements or misrepresentations on applications or contracts to participate in federal health care programs.

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Laws & Penalties

Civil Monetary Penalties Law (Continued)

- Damages & Penalties
  - ✓ Vary based on the type & severity of violation.
  - ✓ Approximately $10,000-$50,000 per violation.
  - ✓ Also subject to up to 3 times the amount claimed for each service or item, or up to 3 times the amount of remuneration offered, paid, solicited or received.

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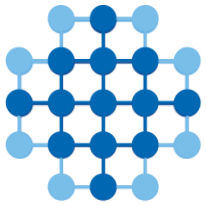
- Example:
  - ✓ A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted unsubstantiated Medicare Part D claims for brand name prescription drugs the pharmacy couldn't have dispensed based on inventory records.



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Laws & Penalties

- Health Insurance Portability & Accountability Act (HIPAA):
  - ✓ Created greater access to health care insurance.
  - ✓ Strengthened protection of privacy of health care data.
  - ✓ Promoted standardization and efficiency in the health care industry.
  - ✓ Deters unauthorized access to protected health information (PHI).
  - ✓ Anyone with access to PHI, must comply with HIPAA.
- Damages & Penalties
  - ✓ Violations may result in Civil Monetary Penalties.
  - ✓ In some cases, criminal penalties may apply.
- Example:
  - ✓ A former hospital employee pleaded guilty to criminal HIPAA charges after getting PHI with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

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Laws & Penalties

In summary, beyond paying restitution to CMS for fraudulently obtained payments, fraud and abuse penalties can include exclusions, civil monetary penalties, and sometimes criminal sanctions, which include fines and prison, against health care providers and suppliers who violate the False Claims Act, Anti-Kickback Statute, Stark Law, or Fraud Statute.

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What are your responsibilities?

- You play a vital role in preventing, detecting and reporting potential FWA, as well as Medicare non-compliance.
- You must comply with all applicable statutory, regulatory and other Medicare requirements, including adopting and using an effective compliance program.
- You have a duty to report any compliance concerns as well as any suspected or actual violations of which you may be aware.
- 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.

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What is a Whistleblower?

- A whistleblower is a person who exposes information or activity deemed illegal, dishonest or violate professional or clinical standards.
- Whistleblowers are protected from retaliation.
- Whistleblowers may receive at least 15% but not more than 30% of money collected in successful lawsuit.

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How can you prevent FWA?

- Conduct yourself in an ethical manner at all times.
- Provide only medically necessary services.
- Accurate and complete documentation that supports claims.
- Accurate and timely coding and billing.
- Comply with other payers' rules.
- Verify all information provided to you.
- Be aware of suspicious activity.

- Keep up to date with FWA & UBMD policies and procedures, standards of conduct, laws, regulations, CMS guidance and UBMD Compliance Office guidance.
  - ✓ Read and understand the UBMD Compliance Plan.
  - ✓ Read newsletters and other communications sent to you from the UBMD Compliance Office as they contain important information and updates.
  - ✓ Complete all compliance training as required.
  - ✓ Know that reported issues will be addressed.

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Reporting FWA

- Everyone is *required* to report *known or suspected* instances of FWA.
  - ✓ 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 and/or the UBMD Compliance Office.
  - ✓ Even if you suspect something is wrong but aren't sure if it is FWA, report it.
  - ✓ Call or email the Compliance Office directly.
  - ✓ Utilize the Compliance Hotline (716.888.4752) or Compliance Issue Reporting Form if you wish to remain anonymous.
  - ✓ All reported concerns will be investigated by the Chief Compliance Officer.

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Reporting FWA

- When reporting suspected FWA, you should include:
  - ✓ Contact information for the source of information, suspects & witnesses;
  - ✓ Details of the alleged FWA;
  - ✓ Identification of specific rules allegedly violated; and
  - ✓ The suspect's history of compliance, education training and communication within UBMD and other entities.

- If warranted, potentially fraudulent conduct must be reported to government authorities such as OIG, DOJ or CMS.
  - ✓ **The UBMD Chief Compliance Officer should ALWAYS be contacted first regarding cases of self-disclosure.**
  - ✓ 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.

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Correcting FWA

- Once FWA is detected, it must promptly be corrected.
- Correcting the problem saves the government (and possibly your practice) money, and ensures that you are in compliance with CMS requirements.
- Always consult the UBMD Chief Compliance Officer to find out the process for corrective action plan development, and develop a plan.
- Actual corrective 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 prevents future non-compliance.
  - ✓ Tailor the corrective action to address the particular FWA, problem, or deficiency identified.
  - ✓ Include timeframe 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.

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Correcting FWA

- Corrective action will depend on the specific circumstances, but may include:
  - ✓ Adopting new prepayment edits or document review requirements;
  - ✓ Conducting additional mandated training;
  - ✓ Providing educational materials;
  - ✓ Revising policies and/or procedures;
  - ✓ Sending warning letters;
  - ✓ Terminating an employee or provider;
  - ✓ Any combination of the above.

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Compliance Hotline

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For more information…

- False Claims Act: 31 United States Code (U.S.C.) Sections 3729-3733
- Fraud Statute: 18 USC Sections 1346-1347
- Anti-Kickback Statute: 42 USC Section 1320a-7b(b)
- Safe Harbors: 42 CFR Section 1001.952
- Stark Statute (Physician Self-Referral Law): 42 USC Section 1395nn
- Civil Monetary Penalties: 42 USC 1320a-7a and the Act, Section 1128A(a)
- Exclusion: LEIE and EPLS and 42 USC Section 1320a-7 and 42 Code of Federal Regulations (CFR) Section 1001.1901
- HIPAA: HIPAA Webpage

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To Complete Your Training…

You are required to successfully complete a brief quiz based on this presentation.

The questions appear on a separate Word document [quiz link]. Use the following link to input your answers.

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

When you submit your answers, if all are correct, you will see a "Success" message on the screen.

If not, the message will tell you which answers you need to go back and re-check.

Training will be complete only when you receive the "Success" message.

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Questions

REMEMBER!!!

Compliance & fraud prevention are **everyone's responsibility** - governing board, management, providers, and staff.

If you have any questions regarding this training, please contact:

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ANONYMOUS COMPLIANCE HOTLINE

716-888-4752

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