archcare

The Continuing Care Community of the Archdiocese of New York

FRAUD, WASTE AND ABUSE TRAINING

Provider - 2023

Introduction

Welcome to ArchCare's Fraud, Waste and Abuse Training for providers.

This training will cover definitions of fraud, waste and abuse as well as samples of FWA issues. It will also cover the laws, rules and regulations that apply to ArchCare and methods of reporting overpayment to ArchCare.

Fraud, Waste and Abuse

ArchCare is committed to conducting our business with integrity and in compliance with applicable laws and regulations.

The **ArchCare FWA** prevention program is designed to identify and eliminate FWA.

Fraud

Fraud involves making false statements or misrepresentation of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. The acts may be committed for the person's own benefit or for the benefit of another party. In order to be considered fraud, the act must be performed knowingly, willfully and intentionally.

Examples:

- To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.
- Misrepresenting who provided the services, altering claim forms, electronic claim records or medical documentation.

WASTE

Waste is spending that can be eliminated without reducing quality of care, i.e. deficient management, practices, or controls.

Waste also refers to useless consumption or expenditure without adequate return, or an act or instance of wasting.

Example:

- providing services that are not medically necessary.

Abuse

Abuse describes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in: (1) an unnecessary cost to the Medicaid and Medicare program; (2) reimbursement for services that are not medically necessary; or (3) services that fail to meet professionally recognized standards for health care.

Examples:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or
- Inappropriately allocating costs on a cost report.

Who can be involved in FWA?

LAWS

Federal and State

False Claims Act - 31 U.S.C. § § 3729-3733

The FCA imposes liability on any person or entity that submits a claim to the government that is known to be false.

Honest mistakes are not considered fraud. However, any overpayment from the government can be considered a violation of the FCA, if it is not returned to the government within 60 days of its discovery.

Additionally, the FCA provides protection for whistleblowers, or *qui tam* plaintiffs. *Qui Tam* lawsuits refer to actions taken by private citizens to help recover overpayments from the government or respond to fraudulent practices related to government contracts.

False Claims Act - 31 U.S.C. § § 3729-3733

Criminal Penalties

- imprisonment for up to five years, as well as substantial fines and possible exclusion from the Medicare and Medicaid programs

Civil Penalties

- as much as $10,000 per violation and triple the amount of damages
- possible exclusion from all government programs

Criminal Health Care Fraud Act - 18 U.S.C. § 1347[a][1-2]

In addition to civil liability under FCA, the Criminal Health Care Fraud Act, in relevant part, makes it a federal crime to "knowingly and willfully execute, or attempt to execute, a scheme or artifice to:

- 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 the custody or control of, any health care benefit program in connection with the delivery of or payment for health care benefits, items, or services."

Criminal Health Care Fraud Act - 18 U.S.C. § 1347[a][1-2]

Criminal Penalties

Criminal fines up to $250,000

Imprisonment for up to 20 years

The Anti-Kickback Statute - 42 U.S.C. § 1320a-7b(b)

A criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients).

Some arrangements have been excepted because they were viewed as unlikely to result in a violation of the statute. Compliance Officer or Legal Counsel should be consulted as to whether an arrangement falls within a safe harbor.

Anti-Kickback Concerns include contracts, arrangements with providers and waive of co-insurance and deductible.

The Anti-Kickback Statute - 42 U.S.C. § 1320a-7b(b)

Criminal Penalties

- imprisonment for up to five years, as well as substantial fines and possible exclusion from the Medicare and Medicaid programs

Civil Penalties

- as much as $50,000 per violation and triple the amount of the kickback

The Stark Law – 42 U.S.C. § 1395nn

Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

The Stark Law – 42 U.S.C. § 1395nn

Civil Penalties

- Up to a **$15,000** fine for each service provided. Up to **a $100,000** fine for entering into an arrangement or scheme.

Stark Concerns

- claims tainted by an arrangement that does not comply with Stark are not payable.

Civil Monetary 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

Civil Monetary Penalties (CMP) Law

Civil 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

New York State False Claims Act, N.Y.S. Fin. Law §§ 187-194

- Allows the Attorney General or any other person to file a lawsuit against a person or a company that obtains or withholds funds or property from the state or local government through false or fraudulent conduct.
- A person or company found liable under the act must generally pay treble damages, civil penalties, plus costs and attorneys' fees. Individuals who file suits may be eligible to keep a percentage of the funds they help recover.
- The state False Claims Act also protects employees from being retaliated against for filing qui tam suits against employers who may be engaged in activities or practices that defraud the government of money or property.

New York State, Social Services Law, at § 145-b

- Makes it a violation to knowingly obtain (or attempt to obtain) payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device.
- The state or the Local Social Services District may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation.
- A penalty of up to $30,000 per violation may be imposed if repeat violations occur within five years and involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

New York State, Social Services Law, at § 145-c

- States that if any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement.
- six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least $1,000 but not more than $3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of $3,900), and five years for any subsequent occasion of any such offense.

New York State, Penal Law Article, at § 176

Applies to claims for insurance payments, including Medicaid or other health insurance, and establishes six crimes ranging from Insurance Fraud in the 5th degree (a class A misdemeanor) through Insurance Fraud in the 1st degree (a class B felony). Furthermore, Aggravated Insurance Fraud (committing Insurance Fraud more than once) is a class D felony.

New York State, Penal Law, at § 177

Addresses health care providers, including any publicly or privately funded health insurance or managed care plan or contract, who defraud the system. It also includes crimes ranging from Health Care Fraud in the 5th degree (a class A misdemeanor) through Health Care Fraud in theist degree (a class B felony).

Excluded Providers

42 U.S.C. § 1320a-7 and

18 NYCRR § 515.3 and/or 18 NYCRR § 515.7

OIG/OMIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances

If an individual is on one of these lists, they may not participate in any Federal or State Government programs, including Medicare and Medicaid.

In other words, you might not be able to remain employed at ArchCare if you are on an exclusion list.

Examples of FWA/Compliance Issues

Misrepresentation of eligibility status	Prescription forging or altering	Prescription stockpiling	Prescription diversion	Doctor shopping
Marketing schemes	Illegal Remuneration Schemes	Enrolling members without their knowledge or consent	Illegal Remuneration Schemes	Payment for services excluded under the plan
Kickbacks, inducements or other illegal payments	Billing for services not provided	Misrepresenting the identity of the provider, the date of service or dscription of services provided	Payments for excluded items	Misuse of authority for personal gain
Vendor kickbacks	Overusing medical services and products	Providing services or products that are not medically necessary	Providing services inconsistent with professional standards	Authorizing or receiving payments for goods not received or services not performed

Healthcare Provider Fraud

Coding Issues

- Does the documentation in the Medical Record support the service, and level of the service, billed?
- Was the service actually performed (phantom claims)?

Medical Necessity

- Were the services the most cost effective and clinically beneficial?

Unprofessional Conduct

- Was the provider credentialed to provide the service; was it conducted in accordance with acceptable standards of care?

Provider Schemes

Billing for services not rendered (SNR)	• Bill for tests/procedures that were not provided
Up-Coding (Evaluation & Management, DME or Procedures)	• Bill for a custom-made fitted orthotic brace and provide an off the shelf model
Unbundling – National Correct Code Initiative (NCCI edits)	• Separate procedure codes are billed for a group that are covered by a single comprehensive code. This is done to obtain a higher payment than is allowed. (Ex. – Lab bills each component test rather than the panel).

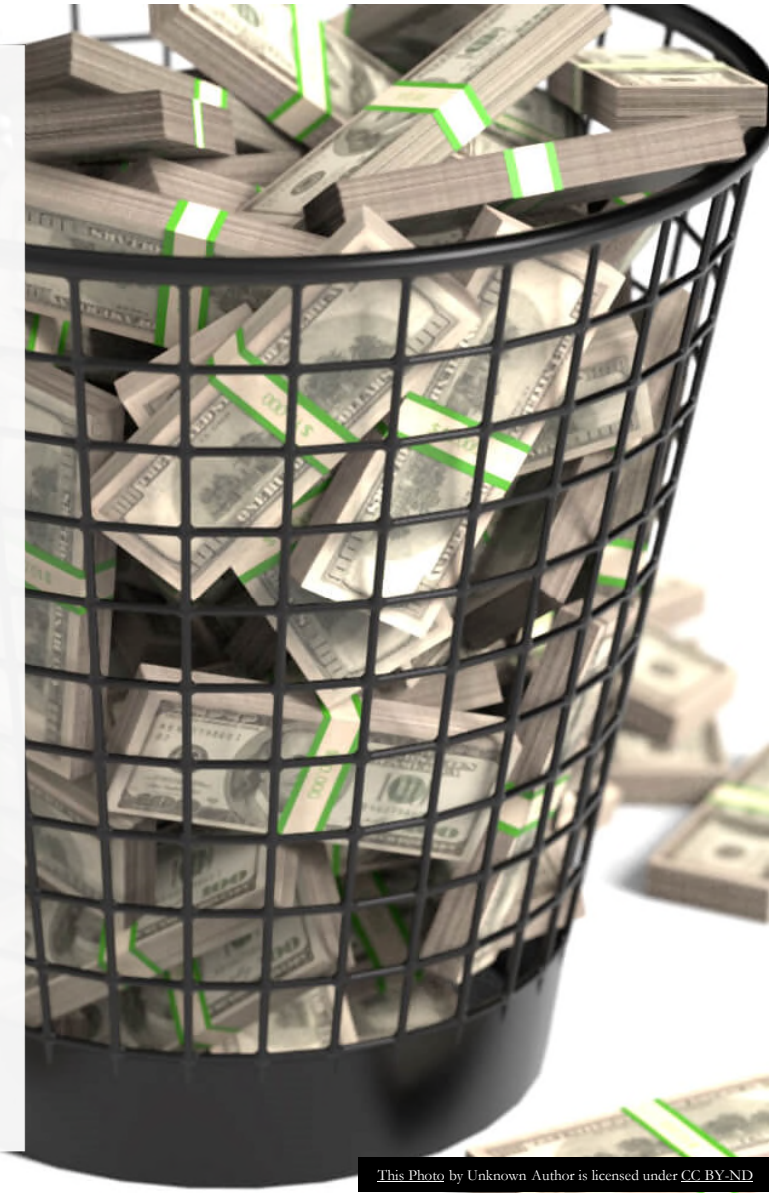
Billing for Services not Rendered

The most common and most basic type of fraud committed by dishonest providers:

- Submitting claims for services, DME/supplies or products that were never provided to the patient
- Patterns are evident in the claims data (ex. - all patients billed for the same services no matter what the diagnoses)
- Patterns of cloning records or authorization requests
- Solo Practitioner with high claims volume having multiple networks and locations
- Time Indicated Codes - Impossible hours serviced
- Indication in the Medical Records

Up-Coding

This is when a provider intentionally bills for a more expensive service than was actually performed.



UNBUNDLING

The itemization and separate billing of services that would ordinarily be covered by a single comprehensive code.

A provider may intentionally manipulate coding and bill separately for each procedure in order to get higher payment than is allowed.

This could also include the failure to use correct Modifiers

Unprofessional Conduct

Rules of the Board of Regents, Part 29, Unprofessional Conduct

Includes, but is not limited to, the following:

- Conduct in the practice of a profession which evidences moral unfitness to practice the profession;
- Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient;
- Ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient.

Unprofessional Conduct

Office of Professional Medical Conduct (OPMC)

- Investigates complaints about physicians, physician assistants and specialist assistants and monitors practitioners subject to State Board for Professional Medical Conduct

Office of Professional Discipline (OPD)

- Investigates and prosecutes professional misconduct in all professions except medicine
  - Nurses (NP, RN LPN etc.)
  - Dentists
  - Others

Consequences of Unprofessional Conduct

- Suspension/Termination from Network
- Office of Professional Medical Conduct (OPMC)/ Office of Professional Discipline (OPD)
- Arrest and/or prosecution

THE CORPORATE & CORPORATE ETHICS HOTLINE

REPORTING FRAUD, WASTE AND ABUSE VIOLATIONS AND OVERPAYMENT

1-800-443-0463

www.archcare.ethicspoint.com

toll free

anonymous

always available

Persons reporting a breach cannot be subjected to retaliation.