

Sharp HealthCare's 2020 Compliance Education

Fraud, Waste and Abuse: Prevention, Detection and Reporting Module 2

Learning Objectives:

In this module you will learn about the following:

- Recognize Fraud, Waste, and Abuse (FWA) in the workplace
- How fraud and abuse affects Sharp HealthCare and you
- Your responsibility to prevent fraud and abuse
- Reporting potential acts of FWA

Workplace Fraud and Abuse

Workplace **fraud and abuse** is:

- **Fraud** is defined as any deliberate and dishonest act committed with the knowledge that it could result in an unauthorized benefit to the person committing the act or someone else who is similarly not entitled to the benefit.
- **Abuse** is defined as practices that are inconsistent with accepted sound fiscal, business, or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary.

Workplace Fraud and Abuse

Workplace fraud is an expensive and growing problem that negatively impacts organizations and their employees. Organizations lose an estimated 5% of annual revenues to fraudulent activities.

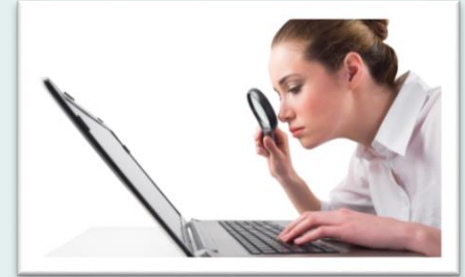
- Fraud is an organizational wide issue.
- Sharp has a zero tolerance policy towards fraud.
- Fraud is punishable up to and including termination.



(Source: The 2018 ACFE Report to the Nations on Occupational Fraud and Abuse.)

Workplace Fraud and Abuse

- Sharp HealthCare (SHC) wants to find and stop healthcare fraud and abuse.
- Proactive detection measures, such as, hotlines, audits, and monitoring mechanisms are vital in catching fraudulent behavior early and limiting its losses.



Workplace Fraud

Most workplace fraud perpetrators exhibit certain behavior traits that can be warning signs of their fraud, such as:

- Living beyond their means and/or having unusually close associations with vendors or customers.

All Sharp employees, affiliated physicians, volunteers and contractors need to recognize these warning signs that, when combined with other factors, might indicate fraud.



Examples of Workplace Fraud:

- Falsifying work related documents or time cards
- Giving false information about credentials, such as, a college degree
- Misusing Sharp's time, equipment or information
- "Soliciting or accepting gifts from outside sources"
- Stealing or embezzling Sharp's property or money
- "Violating conflict of interest standards"



Source: OIG Hotline Operations <https://forms.oig.hhs.gov/hotlineoperations/posters/OIG%20Hotline%20Ops%20Poster%20-%20Employee%20Fraud.pdf>

Workplace Fraud and Abuse

Fraud and abuse also hurts organizations by causing:

- Decreased productivity
- Investment of time and money spent on investigations
- Lost resources
- Lower morale
- Possible punishment
- Negative impact on organization's reputation



Workplace Fraud and Abuse



Fraud and abuse can negatively affect Sharp employees, affiliated physicians, volunteers and contractors by:

- Decreased trust throughout the organization
- Increased scrutiny from regulatory agencies
- Loss of time and resources to address fraudulent acts
- Fewer resources available to provide needed care and facilities to our community

Summary



The foundation of SHC's Compliance Program is preventing, detecting and correcting workplace fraud, while incorporating CMS FWA.

Now that you understand workplace fraud and abuse, the following lessons present CMS FWA guidelines:

- ✓ **Lesson 1:** [What is Fraud, Waste, and Abuse?](#)
- ✓ **Lesson 2:** [Your Role in the Fight Against Fraud, Waste, and Abuse.](#)

LESSON 1: WHAT IS FWA?

Lesson 1: Introduction and Learning Objectives

This lesson describes FWA and the laws that prohibit it. Upon completing the lesson, you should be able to correctly:

- Recognize FWA in the CMS Program;
- Identify the major laws and regulations pertaining to FWA; and
- Recognize potential consequences and penalties associated with violations.



Fraud



Fraud is 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 the custody or control of, any health care benefit program.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to \$250,000.

In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

Waste and Abuse

Waste includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. 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 payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of FWA



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; and
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Examples of FWA

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; and
- Ordering excessive laboratory tests.



Examples of FWA

Examples of actions that may constitute Medicare abuse include:

- Billing for unnecessary medical services;
- Billing for brand name drugs when generics are dispensed;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.



Differences Among Fraud, Waste, and Abuse

There are differences among fraud, waste, and 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 an unnecessary cost to the Medicare Program, but does not require the same intent and knowledge.

**Intent and
knowledge**

Understanding FWA

To detect FWA, you need to know the law.

The following screens provide high-level information about the following laws:

- Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud;
- Anti-Kickback Statute;
- Stark Statute (Physician Self-Referral Law) and
- Exclusion

For details about the specific laws, such as, safe harbor provisions, please consult the applicable statute and regulations.



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;
- Knowingly conceals or knowingly and 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 and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty. The Civil Monetary Penalty (CMP) may range from \$5,500 to \$11,000 for each false claim.

For more information, refer to [31 United States Code \(U.S.C.\) Sections 3729-3733](#) on the Internet.

Example:

A Medicare Part C plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from the Centers for Medicare & Medicaid Services (CMS);
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported;
- Failed to report the unsupported diagnosis codes to Medicare; and agreed to pay \$22.6 million to settle FCA allegations.

Civil FCA (continued)

Whistleblowers:

A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected:

Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded:

Persons who bring a successful whistleblower lawsuit receive at least 15 percent but not more than 30 percent of the money collected.



Health Care Fraud Statute

Health Care Fraud Statute

The Health Care Fraud Statute states that “Whoever knowingly and willfully executes, or attempts to execute, a scheme to ... defraud any health care benefit program ... shall be fined ... or imprisoned not more than 10 years, or both.”

Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law. For more information, refer to 18 U.S.C. Section 1346 on the Internet.

Example:

A Pennsylvania pharmacist:

- Submitted claims to a Medicare Part D plan for non-existent prescriptions and for drugs not dispensed;
- Pleaded guilty to health care fraud; and
- Received a 15-month prison sentence and was ordered to pay more than \$166,000 in restitution to the plan.

The owners of two Florida Durable Medical Equipment (DME) companies:

- Submitted false claims of approximately \$4 million to Medicare for products that were not authorized and not provided;
- Were convicted of making false claims, conspiracy, health care fraud, and wire fraud;
- Were sentenced to 54 months in prison; and
- Were ordered to pay more than \$1.9 million in restitution.

Criminal Fraud



Persons who knowingly make a false claim may be subject to:

- Criminal fines up to \$250,000;
- Imprisonment for up to 20 years; or
- Both.

If the violations resulted in death, the individual may be imprisoned for any term of years or for life. For more information, refer to [18 U.S.C. Section 1347](#) on the Internet.



Anti-Kickback Statute

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 the Medicare Program).

For more information, refer [to 42 U.S.C. Section 1320A-7b\(b\)](#) on the Internet.

Damages and Penalties

Violations are punishable by:

A fine of up to \$25,000;

Imprisonment for up to 5 years; or both.

For more information, refer to the [Social Security Act \(the Act\), Section 1128B\(b\)](#) on the Internet.

EXAMPLE:

A radiologist who owned and served as medical director of a diagnostic testing center in New Jersey:

Obtained nearly \$2 million in payments from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests;

- Paid doctors for referring patients;
- Pleaded guilty to violating the Anti-Kickback Statute; and was sentenced to 46 months in prison.

The radiologist was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

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 apply).

For more information, refer to [42 U.S.C. Section 1395nn](#) on the Internet.

Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of up to \$15,000 may be imposed for each service provided. There may also be up to a \$100,000 fine for entering into an unlawful arrangement or scheme.

EXAMPLE:

A physician paid the Government \$203,000 to settle allegations that he violated the physician self-referral prohibition in the Stark Statute for routinely referring Medicare patients to an oxygen supply company he owned.

Civil Monetary Penalties Law

The Office of Inspector General (OIG) may impose Civil penalties for a number of 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 an overpayment and failing to report and return it;
- Making false claims; or
- Paying to influence referrals.

For more information, refer to [the Act, Section 1128A\(a\)](#) on the Internet.

Damages and Penalties

The penalties range from \$10,000 to \$50,000 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:

A California pharmacy and its owner agreed to pay over \$1.3 million to settle allegations they submitted claims to Medicare Part D for brand name prescription drugs that the pharmacy could not have dispensed based on inventory records.

Federal Health Care Excluded Providers

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). You can access the LEIE at <https://exclusions.oig.hhs.gov> on the Internet. The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS at <https://www.sam.gov> on the Internet. If looking for excluded individuals or entities, make sure to check both the LEIE and the EPLS since the lists are not the same.

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.

STATE SUSPENDED AND INELIGIBLE PROVIDER LIST

Medi-Cal law, Welfare and Institutions Code (W&I Code), sections 14043.6 and 14123, mandate that the Department of Health Care Services (DHCS) suspend a Medi-Cal provider of health care services (provider) from participation in the Medi-Cal program when the individual or entity has:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reason;
- Lost or surrendered a license, certificate, or approval to provide health care; or
- Breached a contractual agreement with the Department that explicitly specifies inclusion on this list as a consequence of the breach.

You can access the Medi-Cal Suspended and Ineligible Provider List by clicking on this link:

<http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Introduction and Learning Objectives:

This lesson explains the role you can play in fighting against Fraud, Waste, and Abuse (FWA), including your responsibilities for preventing, reporting, and correcting FWA. Upon completing the lesson, you should be able to correctly:

- Identify methods of preventing FWA;
- Identify how to report FWA; and
- Recognize how to correct FWA.

Where Do I Fit In?

As a person who provides health or administrative services to a Medicare Program enrollee, you are either an employee of a:

- Sponsor (Medicare Advantage Organizations [MADs] and Prescription Drug Plans [PDPs]).
- **F**irst-tier entity (Examples: Pharmacy Benefit Management (PBM), hospital or health care facility, provider group, doctor office, clinical laboratory, customer service provider, claims processing and adjudication company, a company that handles enrollment, disenrollment, and membership functions, and contracted sales agent);
- **D**ownstream entity (Examples: pharmacies, doctor office, firms providing agent/broker services, marketing firms, and call centers); or
- **R**elated entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®).

What Are Your Responsibilities?

You 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 Program requirements.
- **SECOND**, you have a duty to the Medicare Program to report any compliance concerns, and suspected or actual violations that you may be aware of.
- **THIRD**, you have a duty to follow Sharp HealthCare's Code of Conduct that articulates your commitment to standards of conduct and ethical rules of behavior.

How Do You Prevent FWA?

- ✓ Look for suspicious activity;
- ✓ Conduct yourself in an ethical manner;
- ✓ Ensure accurate and timely data/billing;
- ✓ Ensure you coordinate with other payers;
- ✓ Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the CMS guidance; and
- ✓ Verify all information provided to you.



Stay Informed About Policies and Procedures

The SharpNET is the best place to access information regarding SHC's Compliance Policies.

1. From the SharpNET intranet site, click on the Departments banner. Then click the Compliance tab.

The screenshot shows the SharpNET intranet homepage. The top navigation bar includes 'Benefits & Pay', 'Departments', 'Locations', and 'About Sharp'. The 'Departments' banner is highlighted with a blue arrow. Below it, a sub-menu is open, and a blue arrow points to the 'Compliance' tab.

2. Then click the Compliance Policies tab.

The screenshot shows the 'Compliance' page on SharpNET. The page title is 'Compliance'. The main content area contains a 'Compliance' section with a list of links: 'Code of Conduct', 'Documents', 'Education', 'Ethics in Action', 'MS-DRG', 'Online Resources', 'Organization Chart', and 'Reporting Violations'. Below this is a 'Mission Statement' section. In the 'Helpful Links' section, a blue arrow points to the 'Compliance Policies' link.

3. Click the Search Policies and Procedures Button.

The screenshot shows the 'Search Policies and Procedures' page on SharpNET. The page title is 'Search Policies and Procedures'. The main content area contains a 'Search Policies and Procedures' section with a blue arrow pointing to the 'Search Policies and Procedures' button. Below this is a 'Need help knowing where to begin?' section and a 'NOTE' section.

Reporting FWA

To report a confirmed or suspected violation, you may do any of the following:

- Contact your manager to discuss questionable issues
- Contact senior management or the compliance liaison from your facility (see the Compliance Department Organization Chart tab on SharpNET for Liaisons)
<http://sharpnet.sharp.com/compliance/organizational-chart.cfm>
- Contact the Sharp HealthCare Compliance Department or Legal Affairs Department
- To report anonymously, call the Sharp HealthCare Confidential Hotline at (800) 350-5022 or file a report online at www.mycompliancereport.com

Correction

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

Develop a plan to correct the issue. Consult SHC's compliance officer to find out the process for the corrective action plan development. The actual plan is going to vary, depending on the specific circumstances. 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 a Sponsor's employee or FDR's employee and include consequences for failure to satisfactorily complete the corrective action; and
- Once started, continuously monitor corrective actions to ensure they are effective.

Corrective Action Examples

Corrective actions may include:

- Adopting new prepayment edits or document review requirements;
- Conducting mandated training;
- Providing educational materials;
- Revising policies or procedures;
- Sending warning letters;
- Taking disciplinary action, such as loss of employment, the inability to continue doing business with Sharp, or the loss of staff membership privileges.

Indicators of Potential FWA

Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.

The following pages present issues that may be potential FWA. Each page provides questions to ask yourself about different areas, depending on your role as an employee or other entity involved in the delivery of Medicare Program benefits.



Key Indicators: Potential Beneficiary Issues:



- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the medical service the actual beneficiary (identity theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

Key Indicators: Potential Provider Issues:

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Does the provider bill the Sponsor for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Is the provider's diagnosis for the member supported in the medical record?

Key Indicators: Potential Pharmacy Issues:

- Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires that brand drugs be dispensed?
- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?



Key Indicators: Potential Wholesaler Issues:

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics and then marking up the prices and sending to other smaller wholesalers or pharmacies?



Key Indicators: Potential Manufacturer Issues:

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a Federal health care program?

Key Indicators: Potential Sponsor Issues:

- Does the Sponsor encourage/support inappropriate risk adjustment submissions?
- Does the Sponsor lead the beneficiary to believe that the cost of benefits is one price, only for the beneficiary to find out that the actual cost is higher?
- Does the Sponsor offer cash inducements for beneficiaries to join the plan?
- Does the Sponsor use unlicensed agents?

Exit Instructions:

We hope this course has been informative and helpful.



Next Steps:

Click on the “X” (close button) in the upper right hand corner of the screen when you are ready to complete the requirements for this course.