2016 Compliance and Fraud, Waste and Abuse Training
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Compliance Training
Why Do I Need Training?

Compliance is EVERYONE’S responsibility!

Blue Cross of Idaho is required to train providers of government funded programs on fraud, waste, and abuse, and to report the completion of this training annually.

As an individual or business entity providing services for Blue Cross of Idaho enrollees, every action you take potentially affects those enrollees.

This course is designed to provide you the tools and information to help you better serve your clients and to meet the requirements of the program.
To understand Blue Cross of Idaho’s commitment to ethical business behavior

To understand how a compliance program operates

To gain awareness of how compliance violations should be reported
Compliance

An effective compliance program should:

- Articulate and demonstrate our commitment to legal and ethical conduct
- Provide guidance on how to handle compliance questions and concerns
- Provide guidance on how to identify and report compliance violations
Compliance Culture

A culture of compliance within an organization:

- Prevents noncompliance
- Detects noncompliance
- Corrects noncompliance
Compliance Requirement Programs

At a minimum, a compliance program must include:

• Written policies, procedures and standards of conduct
• A compliance officer, compliance committee and high level oversight
• Effective training and education
• Effective lines of communication
• Well publicized disciplinary standards
• An effective system for routine monitoring and identification of compliance risks
• Procedures for prompt response to compliance issues
Compliance Training

As stated in the Blue Cross of Idaho Code of Ethical Business Conduct,* Blue Cross of Idaho applies the CMS training requirements and “effective lines of communication” to the entities with which we partner (such as our providers and vendors).

- Blue Cross expects all of our employees and business partners to act ethically at all times.
- Having “effective lines of communication” means that employees of the organization and the partnering entities have several avenues through which to report compliance concerns.

*A copy is available on our website.
Act Fairly and Honestly

Comply with the letter and spirit of the law

It is important that you conduct yourself in an ethical and legal manner.
It’s about doing the right thing!

Adhere to high ethical standards in all that you do

Report suspected violations
What is Noncompliance?

Noncompliance is conduct that does not conform to the law, and federal healthcare program requirements, or to an organization’s ethical and business policies.
Noncompliance Harms Enrollees

Without programs to prevent, detect, and correct noncompliance there are:

- Delayed services
- Denial of Benefits
- Difficulty in using providers of choice
- Hurdles to care

Noncompliance Harms Enrollees
Noncompliance Costs Money

Noncompliance affects EVERYBODY!
Without programs to prevent, detect, and correct noncompliance you risk:

- Higher Premiums
- Higher Insurance Copayments
- Lower benefits for individuals and employers
- Lower Star ratings

Fines & Penalties
Correcting Noncompliance

- Avoids the recurrence of the same noncompliance
- Promotes effective internal controls
- Protects enrollees
- Ensures ongoing compliance with CMS requirements
How Do I Know the Noncompliance Won’t Happen Again?

• Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.
• Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.
• Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.
Those who engage in noncompliant behavior may be subject to any of the following:

- Mandatory Training or Re-Training
- Disciplinary Action
- Termination
Compliance is Everyone’s Responsibility!

**PREVENT**
- Operate ethically to PREVENT noncompliance!

**DETECT & REPORT**
- Report all detected real or suspected noncompliance!

**CORRECT**
- CORRECT noncompliance to protect beneficiaries and to save money!
Reporting Noncompliance

• There can be NO retaliation against you for reporting suspected noncompliance in good faith.
• Blue Cross of Idaho offers reporting methods that are:
Fraud, Waste and Abuse
Every year billions of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

Including YOU

This training will help you detect, correct, and prevent fraud, waste, and abuse.

YOU are part of the solution.
The Cost of FWA

• 3% of healthcare spending, or $70 billion, is lost to fraud

• Fraud will cost you over $252 this year

• Fraud falsely alters your health history

“Fraud and falsehood only dread examination. Truth invites it.”
Samuel Johnson
Requirements

• The Social Security Act and CMS regulations and guidance govern Medicaid and Medicare programs, including parts C and D.
  • Part C and Part D Medicare sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
  • All sponsors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)
What Are My Responsibilities?

You are a vital part of the effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory and regulatory requirements.
- **SECOND** you have a duty to report any violations of laws that you may be aware of.
- **THIRD** you have a duty to conduct yourself ethically.
How Do I Prevent Fraud and Abuse?

• Understand what is fraud and abuse.
• Make sure you are up to date with laws, regulations, policies.
• Ensure all data submitted is both accurate and timely.
• Be on the lookout for suspicious activity.
What is Fraud and Abuse?

- **Fraud** – Intentionally submitting false information to the government or a government contractor, or any private health plan in order to get money or a benefit.

- **Abuse** – Requesting payment for items and services when there is no legal entitlement to payment. Unlike fraud, there is no intentionally misrepresented facts to obtain payment.
Differences Between Fraud and Abuse

- **Fraud** – Requires the person to have an **intent** to obtain payment and the **knowledge** that their actions are wrong.

- **Abuse** – May involve obtaining improper payment or services, but **does not require the same intent and knowledge**.

In some cases, deliberate ignorance or reckless disregard is no defense.
Waste

• Can be anything from billing inappropriately and “throwing away” the remaining parts
  • For example, you need only 1 unit vial of medication and a 5 unit vial is used. The remaining 4 units are thrown away or discarded.
  • Paying duplicate claims
Understand Fraud and Abuse Laws

18 United States Code §1347 defines criminal fraud as

*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.*
Blue Cross of Idaho’s Compliance with the False Claims Act

H.R. 3590 The Patient Protection & Affordable Care Act – Section 6402(a) Return of Overpayments

Providers and insurers participating in federal health care programs have a legal obligation to report and return overpayments received from Medicare and Medicaid.
Federal Fraud laws

- **Anti-Kickback Statute** - Criminal act to knowingly offer, pay, solicit, or receive any compensation to reward referrals of services reimbursed by a Federal healthcare program. 31 United States Code § 3729-3733

- **Federal False Claims Act** - Imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the government. 42 United States Code §1395nn

- **Physician Self-Referral Law** - Prohibits a physician from making a referral for personal gain or compensation. 42 United States Code §1320a-7b(b)

For more information: Review advisory opinions on the HHS OIG website at https://oig.hhs.gov/compliance/advisory-opinions/index.asp, request an advisory opinion, or seek legal advice.
Exclusion

No federal healthcare program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

- 42 U.S.C. §1395(e)(1)
- 42 C.F.R. §1001.1901

Any individual who is under federal exclusion or debarment cannot be involved with administering our government contract.

Note: If you receive payments from a federal program, you want to make sure that none of your employees are excluded.
Consequences of Committing Fraud and Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil money penalties/criminal conviction/fines
- Civil prosecution
- Imprisonment
- Loss of license
- Exclusion from federal healthcare programs
Common FWA Schemes

Billing for:

- Services not rendered
- Services performed by unsupervised or unqualified employees
- Services performed by employees excluded from federal healthcare programs
- Low-quality or worthless services
- Services included in a global fee
- Medically unnecessary services
Common FWA Schemes – 2

- Waiving out-of-pocket expenses
- Up-coding
- Misrepresenting service
- Falsifying diagnosis
- Unbundling
- Balance billing
- Kickbacks
Common Member FWA Schemes

- Misrepresenting spouse or other dependent status
- Identify theft
- Sharing insurance card
- Misrepresentation of Idaho residence
- Bogus employer group and/or fictitious employee
- Prescription fraud or abuse
The Cost is Personal

Don’t be fooled into thinking that healthcare fraud is a victimless crime. There is no doubt that healthcare fraud can have devastating effects.

• False patient diagnoses, treatment and medical histories
• Medical identity theft
• Physical risk to patients
False Patient Diagnoses, Treatment and Medical Histories

• Perpetrators often record false diagnoses of medical conditions patients do not have, or of more severe conditions than they actually do have.

• Unless this discovery is made, these phony or inflated diagnoses become part of the patient's documented medical history.
Recent Idaho Healthcare Fraud Cases
Specialty Lab Agrees to Pay $256 Million to Resolve Allegations of Unnecessary Drug and Genetic Testing and Illegal Remuneration to Physicians – December 2015

- Idaho will receive $41,019 as part of a multistate settlement with one of the largest urine drug testing laboratories in the United States
- Alleged violations of the False Claims Act for billing Medicare, Medicaid and other federal health care programs:
  - Excessive and unnecessary urine drug testing
  - Standing orders causing physicians to order a large number of tests violated rules that services must be reasonable and medically necessary for the treatment and diagnosis of an individual patient’s illness or injury
  - Free urine drug test cups to physicians, conditioned on the physicians’ agreement to return the urine specimens to the Lab for additional testing, violated the Stark Law and the Anti-Kickback Statute
  - Submitted false claims for genetic testing that was performed routinely and without an individualized assessment of need
- Corporate integrity agreement (CIA) with the Department of Health and Human Services-Office of Inspector General (HHS-OIG)
- Lawsuits filed by whistleblowers under the provisions of the False Claims Act allow private parties to bring suit on behalf of the government and to share in any recovery
Pharmaceutical Corporation Settles with States Over Kickbacks – December 2015

- Idaho will receive $52,342 as part of a $390 million agreement in principle to settle kickback claims against a Pharmaceutical Corporation.
- Resolves allegations that the Pharmaceutical Corporation provided kickbacks to certain specialty pharmacies in exchange for recommending a certain drug to Medicaid and Medicare patients.
- The settlement stems from a whistleblower lawsuit filed in federal court.
- Resolves allegations that between 2007 and 2012, the Pharmaceutical Corporation paid kickbacks to the pharmacies to corrupt the interactions with patients by inducing the pharmacies to exaggerate the dangers of not taking the specialty drug, emphasize the specialty drug’s benefits, and downplay the severity of the specialty drug’s side effects.
Bovill Woman Sentenced for Medicaid Fraud – July 2015

• Pleased guilty on 5/18/15 to 1 count of provider fraud, a felony
• Additional counts were dismissed pursuant to a plea agreement
• Suspended prison sentence of 5 years, must serve 30 days in jail, 3 years’ probation, and reimburse Idaho Department of Health and Welfare, $3,920 and reimburse the Attorney General’s Office $232 for investigative costs
• Defendant’s business was driving Medicaid recipients to and from medical appointments
• Submitted claims for driving 17,020 miles on dates where clients had no corresponding medical services.
• Where corresponding medical services were found, overbilled 22,186 more miles than it would have actually taken to complete a round-trip between the clients’ homes and the appointment
• Medicaid Program Integrity Unit previously terminated the transportation provider from the Medicaid program for billing another $15,308 for undocumented/non-covered services in 2009
Pullman Dentist Sentenced for Medicaid Fraud – May 2015

• Convicted of 4 felony counts of provider fraud
• Suspended prison sentence of 5 years, must serve 90 days in the county jail and pay $100,000 in fines, will spend 5 years on supervised probation, and perform 200 hours of community service
• On 1/28/15, a jury determined that the dentist had intentionally submitted false claims to Medicaid for dental work he had not provided
• 43 former patients were examined by a dentist as part of a Medicaid fraud investigation and 29 did not have the fillings in their teeth that defendant dentist had filed for reimbursement
• The trial focused on alleged misconduct on 2 clients
• False claims were submitted between January 2009 and May 2010
Dental Hygienist Indicted for False Billing at Payette Dental Clinic – February 2016

• A dental hygienist was indicted by a federal grand jury in Boise on 2/9/16 on charges of health care fraud and aggravated identity theft.
• The indictment alleges that between 1/1/10-12/31/13, the Defendant executed a scheme to defraud health care benefit programs, including Medicaid:
  • Performed dental services that may only be performed by a dentist
  • Received payment for from health care benefit programs while fraudulently misrepresenting that the services had been performed by a dentist, and while using the name and provider number of a particular dentist who was not in the office and who was unable to practice at the time
• Maximum sentence for health care fraud is up to 10 years of imprisonment and a $250,000 fine.
• Aggravated identity theft carries a 2 year mandatory minimum prison sentence and up to a $250,000 fine.
• An indictment is a means of charging a person with criminal activity and the defendant is presumed innocent until proven guilty beyond a reasonable doubt in a court of law
Twin Falls Pharmacy Technician Pleads Guilty to Controlled Substance Delivery – January 2015

• Pleased guilty to one count of distributing a controlled substance

• According to the plea agreement:
  • Worked as a pharmacy technician in a pharmacy in Twin Falls, Idaho
  • Controlled substances were prescription medications diverted from the pharmacy where the Defendant worked
  • Stole and sold bottles of controlled substance prescriptions from the pharmacy stock to another individual without a prescription and outside the normal course of standard pharmacy practice
  • Arranged for the sales by text message and then put pill bottles in the car glove box in the pharmacy parking lot, where another individual retrieved the controlled substances and left payments.
What can you do as a Provider to Help Prevent FWA?

• Watch for unusual or questionable practices
• Be cautious not to use the “F” word: FRAUD
• Keep notes answering who, what, where, when, why, and how
• Jot down the time and date of any phone conversations
• Gather together any related records and names of other parties
• Report anything unusual or questionable to the Blue Cross SIU or the Fraud Hotline
What can Consumers do to Avoid or Prevent FWA?

• Protect your health insurance ID card
• Report suspected FWA via compliance/fraud hotlines
• Be informed
• Read your policy and explanation of benefits
• Beware of free offers
Who Do You Call?

Compliance Hotline: 888-258-3543

Fraud Hotline: 800-682-9095
Medicare Parts C and D Fraud, Waste and Abuse Training

Combatting Medicare Parts C and D Fraud, Waste, and Abuse

A new Combatting Medicare Parts C and D Fraud, Waste, and Abuse (FWA) Web-Based Training (WBT) course is available through the Learning Management and Product Ordering System (https://learner.mlnlms.com/Default.aspx). Learn about:

• FWA in the Medicare Program
• The major laws and regulations pertaining to FWA
• Potential consequences and penalties associated with violations
• Methods of preventing FWA
• How to report FWA
• How to correct FWA

To get your certificate you must go through the WBT itself.