Health Plan of San Joaquin

Fraud, Waste and Abuse Prevention Training

Objectives

The objective of this lesson is to meet the regulatory and effective Compliance Program requirements for training and education.

- Provide information on the scope of fraud, waste and abuse (FWA)
- Explain the obligation of everyone to detect, prevent and correct FWA
- Provide information on how to report non compliance and FWA
- Provide information on laws pertaining to compliance and FWA

Why Focus on FWA

Based on government and private studies, and on the hundreds of millions of dollars of fraud the Bureau of Medi-Cal Fraud and Elder Abuse frequently recovers in a single year, the amount stolen from Californians by Medi-Cal fraud reaches billions of dollars annually.

The financial burden for health care fraud lands firmly on the shoulders of the people of California in the form of higher premiums for health insurance and increased taxes for social programs. For those needing health care services, Medi-Cal fraud means the loss of already scarce funds to pay for vital services. Additionally, there are direct public health risks created by those who engage in FWA by re-using syringes, performing needless medical procedures, or assigning unqualified staff to provide treatment.

Fraud

- Fraud is when an individual intentionally deceives or misrepresents the truth, knowing that it could result in some unauthorized benefit to himself or herself or some other individual.
- Fraud schemes range from individuals acting alone to broad-based activities by institutions or groups of individuals in collusion.
- Sometimes these activities employ sophisticated techniques to defraud both Medicare and Medi-Cal.

Who Commits FWA

- Physicians or other practitioners
- Hospitals or other institutional providers
- Clinical Laboratories or other suppliers
- Durable Medical Equipment providers
- Employees of any provider
- Billing Services
- Members
- Medi-Cal Contractor Employees
- Any individual in a position to file a claim for a Medi-Cal benefit

Provider Fraud Examples

- Altering claims forms (either paper or electronic claims forms) or other medical documentation to obtain higher payment amount.
- Allowing another individual's Medi-Cal Identification Card to be used to obtain medical care.
- Completing EMR's for patients unknown by the provider and supplier.
- Misrepresentations of dates, descriptions of services furnished, the identity of the beneficiary or the individual who furnished the services
- Paying for a referral or patients in exchange for the ordering of diagnostic tests and other services or medical equipment.
- Soliciting, offering or receiving a kickback, bribe or rebate.

Provider Fraud Examples – continued

- Unbundling – the separate pricing of goods and services to increase revenue.
    - Billing separately for a post-operative visit when it is included in a global billing code.
    - Billing a series of tests individually instead of billing a global or “panel” code. Provider Prescription Drug Fraud.
- Overprescribing opioids and high cost drugs which are in turn sold on the street with the provider getting a cut (also known as “pill mills”) or result in harm to a patient.
    - Dilution or illegal importation of drugs from other countries; example high cost cancer treatment drugs.
    - Falsifying information in order to justify coverage such as ruling out lower cost generics.

More Provider Fraud Examples

Rendering and billing for non-medically necessary services

- Performing Magnetic Resonance Imaging with contrast was not indicated or necessary.
- Ordering higher-reimbursed, complete blood lab tests for every patient although specific or targeted test are indicated.
- Up coding – billing a higher level service than provided.
- Reporting CPT code 99245 (High Level Office Consultation) where services provided only warranted use of CPT code 9943 (Mid-level Office Consultation).
- Reporting CPT code 99233 (High Level Subsequent Hospital Care) where services provided only warranted use of CPT code 99231 (Lower Level Subsequent Hospital Care).

Examples of Member Fraud

- Card Sharing, loaning or using another persons Medi-Cal Identification Card.
- Obtaining prescription medication that is not prescribed to you.
- Forging or selling your prescribed medications.
- Providing false information to obtain Medi-Cal benefits.
- Misrepresenting a medical condition.
- Failing to report a change in family status, such as a divorce or change in dependent status.

Examples of Pharmacy Fraud

- Pharmacy increases the number of refills on a prescription without the prescriber's permission.
- Pharmacy shorting – providing less medication than ordered and billed.
- Pharmacy dispenses expired drugs or adulterated drugs.
- Processing for services that are not covered under HPSJ over-the-counter (OTC) benefit.
- Splitting prescriptions, such as splitting a 30-day prescription into four 7-day prescriptions to get additional copays and dispensing fees.
- Billing for prescriptions that are never picked up.
- Re-dispensing unused medications that have been returned or not picked up.

Abuse

ABUSE describes a practice that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to HPSJ or Medi-Cal.

Fraud differs from abuse because fraud is committed knowingly, willfully and intentionally.

Abusive billing practices may not result from “intent” or it may be impossible to determine the intent to defraud exists. However, abusive practices may develop into fraud if there is evidence the subject was knowingly and willfully conducting an abusive practice.

Examples of Abuse

- Charging in excess of services or supplies
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards
- Billing Medi-Cal based on a higher fee schedule
- Submitting bills to Medi-Cal when another carrier is primary
- Violating the participating provider agreement with HSPJ
- Breaches in the assignment agreement
- Violating the maximum actual charge limit or the limitation amount when applicable.

Examples of Waste

In a hospital setting, a patient needs 375 ml of medication. The pharmaceutical company does not make a 375 ml bottle but only 500 ml or 1000 ml bottles. Once the bottle is opened, the unused portion must be disposed of, i.e., “wasted.”

Even greater waste would occur if the hospital consistently orders and uses the 1000 ml bottle when the 500 ml bottle is available.

(Fraud may be occurring if the hospital’s choice to purchase 1000 ml bottles is influenced, for example, by favorable manufacturer rebates tied to 1000 ml bottles.)

Medi-Cal FWA

Medi-Cal fraud is generally defined as the billing of the Medi-Cal program for services, drugs, or supplies that are:

- Unnecessary
- Not performed
- More costly than those actually performed

Medi-Cal fraud also refers to paying and/or receiving kickbacks for Medi-Cal billing referrals.

Who Governs Medi-Cal FWA

Combating fraud and abuse of the state's Medi-Cal program is a primary focus for the State of California Attorney General's Bureau of Medi-Cal Fraud and Elder Abuse.

The Bureau of Medi-Cal Fraud and Elder Abuse aggressively pursues criminals who are directly or indirectly involved in filing false claims for medical services, drugs or supplies. These perpetrators can be registered Medi-Cal providers who allow others to use their billing privileges, or crooks who manage to tap into the billing privileges of registered providers. They can be identity thieves who steal information from providers and patients, or beneficiaries who accept payment for using a particular provider or for selling their Medi-Cal identities. Suspects can encompass anyone who is involved in the administration of the Medi-Cal program, including government workers and employees of contracting agencies.

Responsibility

HPSJ investigates suspected fraud, waste or abuse, and, as appropriate, reports and cooperates with both federal and state agencies, including law enforcement, CMS, DHCS, DMHC, California OAG and the Medicaid Program Integrity Unit.

To ensure compliance and to deter and detect fraud, waste and abuse, HPSJ conducts regular and periodic compliance audits performed by both internal and external auditors and staff who have expertise in federal and state health care laws and regulations.

If you suspect that a provider or member may be committing fraud against HPSJ, or any compliance issues, you must report it to the HPSJ Fraud Anonymous Hotline (1-855-400-6002) or refer to the Compliance reporting website at www.lighthouse-services.com/hpsj. You may also report in person to your direct supervisor or to any member of the Compliance Department.

HPSJ supports a strong Non-Retaliation Policy and does not tolerate retaliation against anyone who, in good faith, reports possible or actual misconduct.

False Claims Act (FCA)

The False Claims Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system.

"Knowingly" means:

- Actual knowledge of the information
- Deliberate ignorance of the truth or falsity of the information
- Reckless disregard of the truth or falsity of the information
- Require not proof of specific intent to defraud

Federal and State False Claims Act

California False Claims Act (FCA) is more stringent than the Federal False Claims Act.

The California FCA permits the Attorney General to bring a civil law enforcement action to recover treble damages and civil penalties against any person who knowingly makes or uses a false statement or document to either obtain money or property from the State, or avoid paying or transmitting money or property to the State.

The California FCA also allows the “whistleblower” to receive a higher percentage of the recoveries and to participate even when prosecuted by the Department of Justice (DOJ) or Office of Attorney General (OAG).

The California FCA allow actions to be filed no more than six years after the violation or no more than three years after the date when material facts became or should have become known. The amended California FCA continues to prohibit actions brought ten or more years after the violation, as does the federal FCA.

False Claims Act

- Under the civil FCA, each instance of an item or a service billed to Medicare or Medi-Cal counts as a claim. California penalties start at $10,000 a claim.

- The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the Anti-Kickback Statute or Stark law.

- There also is a criminal FCA. Criminal penalties for submitting false claims include imprisonment and criminal fines.

Whistleblower Protections

The federal False Claims Act protects employees who report a violation under the False Claims Act from discrimination, harassment, suspension or termination of employment as a result of reporting possible fraud. Employees who report fraud and consequently suffer discrimination may be awarded:

- two times their back pay plus interest
- reinstatement of their position without loss of seniority
- compensation for any costs or damages they incurred.

Prohibition on Bribes, Kickbacks, and Illegal Inducements

The Federal Anti-Kickback statute (AKS) is designed to protect patients and Federal health care programs (such as Medicare and Medi-Cal) from fraud and abuse.

It is a felony to knowingly and willfully solicit, receive, offer or pay anything of value (also called "remuneration") in return for:

- Patient referrals; or
- Recommendations or orders for any item or service reimbursed by a Federal health care program.

Compliance with this law is of the utmost importance because you no longer need intent or knowledge to commit a violation of the statute.

Prohibition on Bribes, Kickbacks, and Illegal Inducements

Actions that may violate this law include the receipt or offering of gifts or entertainment, forgiveness of debts, sales of items at less than fair market value, and payment for services that exceed fair market value.

> **REMINDER –** providing gifts or cash incentives to HPSJ members or physicians in exchange for enrollment or accepting payments from drug or device manufacturers for coverage of their products is prohibited.

There are some exceptions to the federal AKS, but given that several states have enacted anti-kickback laws that may be more restrictive than the federal AKS, please contact HPSJ Compliance if you are asked to give or receive certain items referred to above.

Physician Self – Referral – "Stark Law"

The Stark Law is related to, but not the same as, the Federal Anti-Kickback Statute.

The Stark Law:

- Prohibits a physician from making referrals for certain designated health services payable by Medicare and Medi-Cal to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.

- Prohibits the entity from presenting or causing to be presented claims to Medicare and/or Medi-Cal (or billing another individual, entity, or third party payer) for those referred services.

- Establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

Physician Self – Referral – "Stark Law" - continued

Penalties:

- Civil monetary penalties of potentially $15,000 for each service.
- Civil assessment up to treble the amount claimed.
- Overpayment refund obligation.
- False claims liability.
- Program exclusion for knowing violations.

Excluded Entities and Individuals

HPSJ is prohibited from employing or contracting with an individual or entity that has been excluded or debarred.

HPSJ reviews the List of Excluded Individuals/Entities for excluded or debarred individuals monthly.

Excluded Entities and Individuals

The Code of Federal Regulations (CFR) provides the OIG the authority to exclude individuals or entities from participating in federal or state healthcare programs.

- First tier, downstream and related entities may not employ or contract with entities or individuals who are excluded from doing business with the federal government.

- The OIG maintains a database of excluded individuals and entities and all providers have an obligation to screen individuals and entities prior to hiring and on a periodic basis.

Summary

- Follow the Code of Conduct and Business Ethics.
- Align with all HPSJ Policies and Procedures.
- Adhere to State and Federal Regulations.
- Report Any Suspected Compliance Violations.
- Complete Compliance training annually.