Independent Health's Special Investigations Unit

FWA Prevention and Referral Process and Training for Providers

Independent Health

FWA Prevention Mission

Independent Health is committed to ensuring its entire provider network meets all regulatory requirements set forth by the various agencies overseeing our industry.

We set out to be an industry leader in adopting an enterprise-wide strategy for combating fraud, waste and abuse in healthcare.

Independent Health will protect subscriber's premiums, engage in "best of class" provider network management and develop business processes to create an environment inherent to growing and defending our organizational value.

Purpose of this Information

Every year billions of dollars are improperly spent because of Fraud, Waste and Abuse (FWA). It affects everyone — including you.

- This information will help you detect, correct, and prevent FWA, and to know where to report it if you encounter FWA.
- Combating FWA is everyone's responsibility!
- You are part of the solution.
- As an individual who provides health or administrative services for our members, we call upon you to be vigilant and protect yourself, protect Independent Health and protect our members from harm that can be caused by FWA.

What is 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, buy 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.

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

- Knowingly submitting false statements or making misrepresentations of fact to obtain health care payments for which no entitlement would otherwise exist.
- Knowingly soliciting, paying, and/or accepting money to induce or reward referrals for items reimbursed by health care programs; or
- Making prohibited referrals for certain designated health services.

Fraud Examples

Examples of actions that may constitute fraud include:

- **Knowingly billing for services not furnished or supplies not provided**
- **Billing more than once for the same service**
- **Misrepresenting a diagnosis to get an authorization or justify payment for services that may otherwise not be covered**
- **Falsifying the identity of a provider of service, so as to obtain payment for services rendered by a non-participating and/or non-licensed provider**
- **Billing for appointments that the patient failed to keep**
- **Billing for non-existent prescriptions**
- **Knowingly altering claim forms, medical records, or receipts to receive a higher payment**

What is Waste and Abuse?

Waste includes practices that, directly or indirectly, result in unnecessary costs, such as overusing services. 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. Abuse involves paying 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.

Waste Examples

Examples of actions that may constitute waste include:

- **Conducting excessive office visits or writing excessive prescriptions**
- **Prescribing more medications than necessary for the treatment of a specific condition**
- **Ordering excessive laboratory and/or diagnostic tests**
- **Not billing in accordance with recognized and approved industry standards**

Abuse Examples

Examples of actions that may constitute abuse include:

- **Billing for unnecessary medical services**
- **Billing for brand name drugs when generics are dispensed**
- **Charging excessively for services or supplies**
- **Misusing codes on claims, up coding or unbundling codes**
- **Improper use of coding modifiers to obtain payment for services that otherwise may be denied**
- **Lack of medical record documentation in support of services submitted for reimbursement**
- **Physicians billing for immediate family members**

Knowledge and Intent

The difference between fraud, waste and abuse is understood by examining knowledge and intent:

Fraud requires that the person have **intent** to obtain payment and the **knowledge** that their actions are wrong.

Waste and **Abuse** may involve obtaining an improper payment but do **not require the same intent and knowledge**.

For the definitions of fraud, waste and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual available on the CMS website.

Penalties for violating the laws that prohibit FWA may include:

- **Civil Monetary Penalties;**
- **Civil prosecution;**
- **Criminal conviction/fines;**
- **Exclusion from participation in all Federal health care programs;**
- **Imprisonment; or**
- **Loss of provider license.**

Your Role in Combatting FWA

You play a vital part in preventing, detecting, and reporting potential FWA, as well as non-compliance.

FIRST, you must comply with all applicable statutory, regulatory, and other requirements, including adopting and using an effective compliance program.

SECOND, you have a duty to report any compliance or FWA concerns, and suspected or actual violations that you may be aware of.

THIRD, you have a duty to follow Independent Health's Code of Conduct that articulates our commitment to standards of conduct and ethical rules of behavior**.**

What We Need From You

How Do You Prevent FWA?

- **Stay informed about FWA policies and procedures, which will detail:**
  - Standards for ethical behavior
  - Mechanisms for reporting non-compliance and FWA
  - Non-Intimidation and Non-Retaliation Policies for Reporting
- **Keep up to date with laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance**
- **Ensure accurate and timely data/billing**
- **Ensure you coordinate with other payers**
- **Verify all information provided to you**

Red Flags Rule – Medical Identity Theft

An estimated **9 Million** Americans have their identities stolen each year.

Medical identity theft is defined as:

- "the appropriation or misuse of a patient's or [provider's] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services.

The Red Flags Rule was created by the Federal Trade Commission (FTC), along with other government agencies such as the National Credit Union Administration (NCUA), to help prevent identity theft.

Red Flags Rule will help you develop, implement, and administer an Identity Theft Prevention Program.

The Red Flags Rule is published at 16 C.F.R. ' 681.1.

See also 72 Fed. Reg. at 63,771 (Nov. 9, 2007).

You can find the full text at http://www.ftc.gov/os/fedreg/2007/november/071109redflags.pdf

Red Flags Rule Compliance - An Overview

1. Identify Red Flags

- Suspicious Documents
  - Identification looks altered or forged
  - The person presenting the identification doesn't look like the photo or match the physical description
  - Information on the identification differs from what the person with identification is telling you or doesn't match a signature card or recent check
- Personal Identifying Information
  - Patient uses an address, phone number, or other personal information that is inconsistent with what you know.
  - Patient provides a fictitious address, a PO Box, or prison address, they supply an invalid phone number or one that's for a pager or answering service
  - Patient omits information on an intake form and doesn't respond to requests to secure those details
  - Patient is unable to provide authenticating information
- Notice from other sources
  - Law Enforcement, Victim of Identity theft notify of fraudulent activity

Red Flags Rule Compliance - An Overview

1. Identify Red Flags
2. **Detect Red Flags**
   - Use identity verification and authentication methods
3. **Prevent and Mitigate Identity Theft**
   - Be Prepared to respond to red flags depending on the degree of risk posed.
   - Ensure any data you collect and maintain about our members/patients are secure.
4. **Update the program:**
   - Periodic review and changes to this program should reflect the changes in technology and the tactics used by identity thieves.

Protecting Yourself and Patients from Identity Theft

Providers are also at risk for medical identity theft.

There are two major approaches where medical identity theft leads to the billing of fraudulent claims made under stolen medical/provider identities:

- Provider medical identifiers are used to make it appear as if providers ordered or referred patients for additional health services, such as durable medical equipment (DME), diagnostic testing, or home health services.
- Fraudsters use provider medical identifiers to make it appear that a physician provided and billed services directly.

Mitigate Risks

- **Keep Information on file with IH current -** By keeping your information current, we can alert you to problems, such as additional billings from old locations or new locations opened without your knowledge**.**
- **Monitor billing and compliance processes** - Be aware of billings in your name - pay close attention to the organization(s) to which you have reassigned billing privileges.
- **Control unique medical identifiers –** Protect your information and that of your patients by training staff on the appropriate use and distribution of your medical identifiers, including when not to distribute them. Carefully consider which staff will have access to your medical identifiers.
- **Control Prescription Pads:** Use tamper-resistant prescription pads and design features that prevent counterfeit prescriptions. Do not inadvertently leave prescription pads unattended in exam rooms or other public areas. Keep prescription pads locked up when not in use, and do not leave them visible in your car. You may want to take a daily count of prescription pads.

Be Cautious with how you use your Medical Identifiers

Common examples of ways providers allow the misuse of their medical identifiers include:

- Signing referrals for patients they do not know;
- Signing Certificates of Medical Necessity (CMNs) for patients they know but who do not need the service or supplies;
- Signing CMNs even though their own documentation disputes medical need;
- Signing CMNs for more than what patients need; and
- Signing blank referral forms.

If you See Something, Say Something

If you suspect fraud, waste or abuse as you conduct yourself on behalf of Independent Health, **you must report it.**

Report any concerns that may arise, even if you can't be sure if the actions are Fraudulent (where the actions have intent and knowledge) or if they are more accurately defined as Waste or Abuse.

Independent Health's SIU will investigate and make the proper determination, as well as help determine the appropriate corrective action.

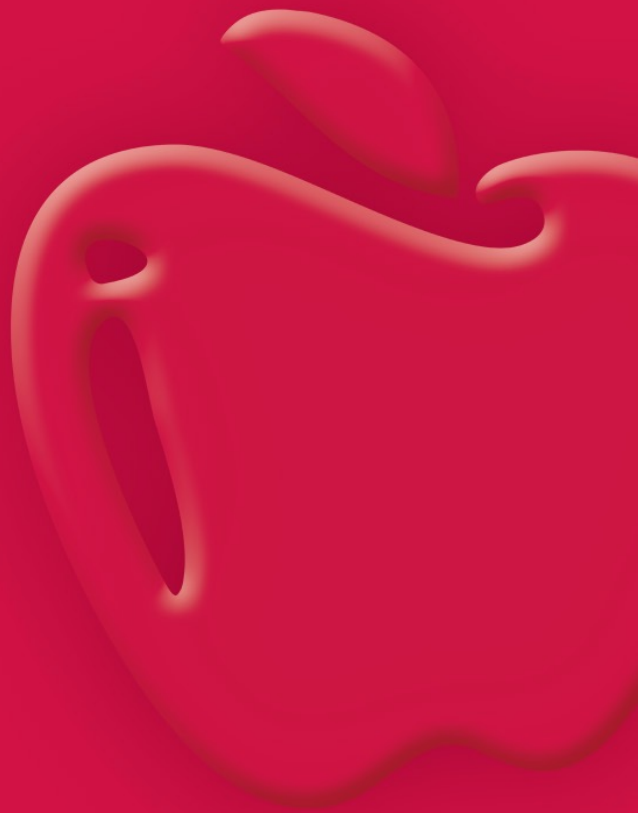
How to Report Fraud, Waste & Abuse

Confidential SIU Hotline: 1-800-665-1182

SIU Email: siu@independenthealth.com

Katherine Jurkas, SIU Manager

Katherine.Jurkas@independenthealth.com



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Fraud and Abuse Laws

False Claims Act (FCA)

Anti-kickback Statute (AKS)

Physician self-referral law (Stark Law)

Social Security Act; and

United States Criminal Code

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Fraud Laws and Deficit Reduction Act Notice Policy

- The Federal Deficit Reduction Act of 2005 (“DRA”) requires Independent Health to provide information to its workforce regarding federal and state laws, dealing with health care fraud, waste, and abuse.
- This policy also explains the legal remedies and protections available to whistleblowers that make reports to the Government about false and fraudulent claims.
- This policy captures important details about the laws we discuss here and additional laws that are relevant to the FWA arena.

You can access this policy through the provider portal offered by Independent Health.

Civil False Claims Act (FCA)

The civil provisions of the FCA makes 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
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

For more information see 31 United States Code (USC) Sections 3729–3733.

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 between $11,181 to $23,331 per claim.

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Civil False Claims Act (FCA) Examples

A Medicare Part C plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes it could submit to increase risk capitation payments from 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

Agreed to pay $22.6 million to settle FCA allegations

The owner-operator of a medical clinic in California:

•Used marketers to recruit individuals for medically unnecessary office visits

•Promised free, medically unnecessary equipment or free food to entice individuals

•Charged Medicare more than $1.7 million for the scheme

Was sentenced to 37 months in prison

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Civil False Claims Act-Whistleblowers

Any person with actual knowledge of fraud or other illegal activity may file a lawsuit on behalf of the government against the person or business that committed the fraud. These people are known as **"Whistleblowers".**

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

Whistleblower actions are Protected

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

Whistleblower actions are Rewarded

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

Health Care Fraud Statute

The Health Care Fraud Statute states,

"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 USC Section 1346

Damages and Penalties:

- Imprisonment up to 10 years
- Criminal Files up to $250,000

Health Care Fraud Statute Examples

A Pennsylvania pharmacist:

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

The owner of multiple DME companies in New York:

- Falsely represented themselves as one of a nonprofit health maintenance organization's authorized vendors
- Provided no DME to any beneficiaries as claimed
- Submitted almost $1 million in false claims, of which $300,000 was paid
- Pleaded guilty to one count of conspiracy to commit health care fraud

Criminal Health Care Fraud

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

- Criminal fines up to $250,000
- Imprisonment for up to 20 years

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 USC Section 1347.

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Anti-Kickback Statute (AKS)

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 Healthcare Program (Including the Medicare Program)

There are specific business arrangements defined by DHHS and DOJ that are not treated as ASK violations, known as “safe harbors”

For more information refer to 42 USC Section 1320a-7b(b)

Damages and Penalties:

Violations are punishable by:

- A fine of up to $25,000
- Imprisonment up to 5 years

For More Information, refer to the Social Security Act (the Act), Section 1128B(b).

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Anti-Kickback Statute Example

From 2012 through 2015, a physician operating a pain management practice in Rhode Island:

- Conspired to solicit and receive kickbacks for prescribing a highly addictive version of the opioid Fentanyl
- Reported patients had breakthrough cancer pain to secure insurance payments
- Received $188,000 in speaker fee kickbacks from the drug manufacturer
- Admitted the kickback scheme cost Medicare and other payers more than $750,000

The physician must pay more than $750,000 restitution and is awaiting sentencing.

Physician Self-Referral Law (Stark Law)

The Stark Law prohibits a physician from making referrals for certain designated health services to an entity in which the physician (or member of his/her immediate family) has

- an ownership/ investment interest or
- a compensation agreement

Exceptions may apply.

For more information, refer to

42 USC Section 1395nn

Or the Physician Self-Referral Webpage on the CMS website.

Damages and Penalties:

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around $24,250 can be imposed for each service provided. There may also be around a $161,000 fine for entering into an unlawful arrangement or scheme.

For more information, refer to the Act, Section 1877.

Physician Self-Referral Law (Stark Law) Example

A California hospital was ordered to pay more than $3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician groups outside the fair market value standards or that were improperly documented as exceptions.

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including but not limited to:

- 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 42 USC 1320a-7a and the Act, Section 1128A(a)

Damages and Penalties:

The Penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three tomes the amount:

- Claimed for each service or item
- Of remuneration offered, paid solicited, or received.

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Civil Monetary Penalties (CMP) Law Example

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

Exclusion

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).**

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 U.S. 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 on the System for Award Management (SAM) website.

When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same.

For more information, refer to 42 USC Section 1320a-7 and 42 Code of Federal Regulations (CFR) Section 1001.1901.

Example:

A Pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the U.S FDA concerning oversized Morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. At the time the unconvinced executive was excluded, there evidence that he was involved in misconduct leading to the company's conviction.

Health Insurance Portability and Accountability Act (HIPPA)

HIPAA created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards help prevent unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.

Example: A former hospital employee pleaded guilty to criminal HIPPA charges after obtaining PHI with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

Damages and Penalties:
Violations may result in Civil Monetary Penalties. In some cases, criminal penalties will apply.

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Summary

You play a vital role in preventing FWA.

- In accordance with your contract with Independent Health, you must comply with all applicable statutory, regulatory, and plan requirements.
- Adhere to our Code of Conduct: Conduct yourself ethically, stay informed of IH policies and procedures, and keep an eye out for key indicators of potential FWA.
- Report potential FWA. Have a process defined in your office/practice outlining the steps to report potential FWA.
- Independent Health can accept anonymous reports and cannot retaliate against you for reporting.
- Promptly correct identified FWA with an effective corrective action plan.

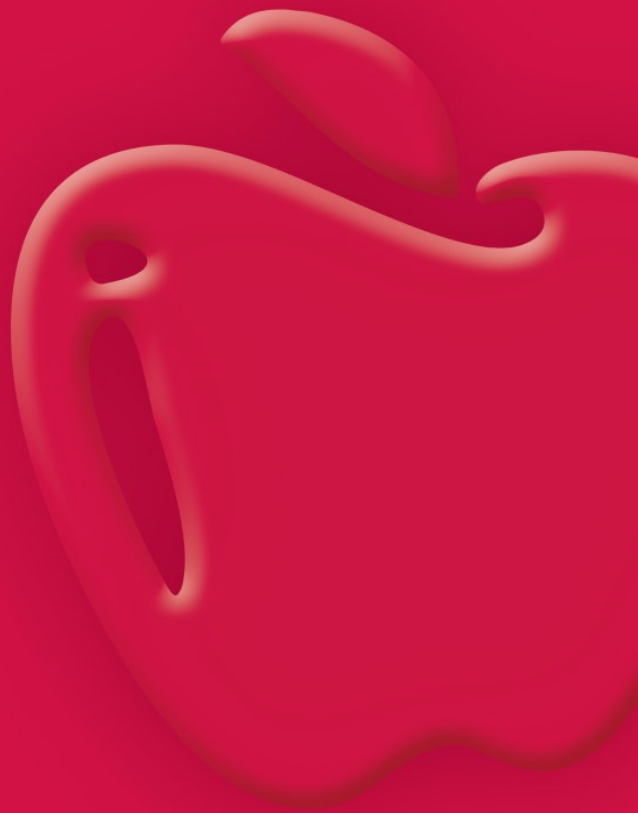
How to Report Fraud, Waste & Abuse

Confidential SIU Hotline: 1-800-665-1182

SIU Email: siu@independenthealth.com

Email Katherine Jurkas, SIU Manager

Katherine.jurkas@independenthealth.com



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Other Places to Report FWA

- HHS Office of Inspector General:
  - Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
  - Fax: 1-800-223-8164
  - Email: HHSTips@oig.hhs.gov
  - Online: Forms.OIG.hhs.gov/hotlineoperations/index.aspx
- For Medicare Parts C and D:
  - Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)
  - CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048
- Office of Medicaid Inspector General (OMIG)