Fraud, Waste and Abuse Training

2011

Part I:
Overview

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Objectives

- Convey EmblemHealth's commitment to compliance.
- Explain obligations of EmblemHealth's first tier, downstream and related entities to prevent, detect and report fraud, waste and abuse.
- Provide training regarding the scope of fraud, waste and abuse prohibitions.
- Provide information on how to ask us questions or report potential fraud, waste and abuse to us.

Our Commitment to Fraud, Waste and Abuse Compliance

- Our organization has a strong commitment to compliance and we engage in a variety of activities — such as auditing, monitoring and other oversight — to identify fraud, waste and abuse issues.
- Our activities and the activities of each of our first tier contractors, downstream contractors and related entities must be carried out in accordance with applicable laws that address fraud, waste and abuse and must be consistent with our policies.
- Specific provisions apply to government programs, such as the Medicare Advantage and Part D programs.

Our Expectations of First Tier, Downstream and Related Entities

- Conduct business activities and interactions with our members ethically and with integrity.
- Conduct business activities in full compliance with all applicable statutory and regulatory prohibitions against fraud, waste and abuse.
- Establish policies and procedures to prevent, detect and require reporting of potential fraud, waste or abuse.

What is a First Tier, Downstream or Related Entity?

- *First tier* – The first-tier entity is the person or organization that contracts directly with EmblemHealth to provide administrative or health care services needed to carry out our responsibilities under our Medicare Advantage or Part D contract with CMS.
- *Downstream* – The downstream entity is a person or organization that enters into a contract with a first-tier entity or an entity in a lower contracting tier to provide administrative or health care services in connection with the Medicare Advantage and Part D programs.

What is a First Tier, Downstream or Related Entity? (cont'd)

- *Related entity* – A related entity is an entity that is related to EmblemHealth by common ownership or control that performs some management functions for the Medicare organization or Part D sponsor, furnishes services to the Medicare Advantage organization or Part D sponsor's enrollees or leases real property or sells materials to the Medicare Advantage organization or Part D sponsor at a cost of more than $2,500 during a contract period.

Defining Fraud, Waste and Abuse

- *Fraud* – Using deception or intentional misrepresentation knowing that it could result in some unauthorized benefit to the individual or another party. The term includes any act that constitutes fraud under applicable Federal or State law.
- *Waste* – Deficient practices, systems controls or decisions that result in using, consuming, spending or expending goods, services or funds extravagantly, needlessly, thoughtlessly or carelessly.

Defining Fraud, Waste and Abuse (cont'd)

- *Abuse* – Practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs or payment for services that are not covered or medically necessary.

Part II:
Policies and Procedures to Address Fraud, Waste and Abuse

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Your Policies and Procedures

- First tier, downstream and related entities must adopt policies and procedures that:
  - Address day-to-day fraud, waste and abuse risks;
  - Help reduce the possibility of fraudulent, wasteful and abusive activity by identifying and responding to risk areas;
  - Reflect the entity's commitment to integrity and EmblemHealth's policies with regard to fraud, waste and abuse;
  - Require fraud, waste and abuse training as a condition of employment;

Your Policies and Procedures (cont'd)

- Explain to employees how they may contact EmblemHealth with questions regarding fraud, waste and abuse or to report potential fraud, waste and abuse, including the entity's non-retaliation policy;
- Require reporting of potential fraud, waste and abuse to EmblemHealth; and
- Require cooperation with EmblemHealth in investigating any potential instances of fraud, waste and abuse and putting in place any appropriate corrective action plans.

Part III:
Laws and Regulations Related to Fraud, Waste and Abuse

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Laws and Regulations

You must ensure that your organization and its employees comply with the following laws and related regulations, which are designed to guard against fraud, waste and abuse under Medicare and certain other Federal health care programs:

- ❑ False Claims Act
- ❑ Anti-Kickback Law
- ❑ Physician Self-Referral Law
- ❑ Medicare Advantage and Part D laws
- ❑ Additional Fraud, Waste and Abuse Laws

False Claims Act

- Prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to obtain money or property, any part of which is provided by the government, including claims to a Medicare Advantage organization or a Medicare Part D prescription drug plan sponsor.
- Prohibits knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim presented to the Federal government or its contractors.
- Prohibits concealing an overpayment of government money.
- Prohibits conspiring to get a false claim paid.
- Prohibits a false statement to reduce an obligation to the government.

False Claims Act (cont'd)

- These prohibitions include situations in which an individual or entity makes little or no effort to validate the truth and accuracy of statements, representations or claims or otherwise acts in reckless disregard of the truth.
- Submission of false claims can result in fines and/or imprisonment.

Anti-Kickback Law

- Prohibits knowingly and willfully paying, offering, soliciting or receiving remuneration (anything of value):
  - To induce a referral for services for which payment may be made, in whole or in part, under a Medicare or certain other Federal health care programs; or
  - In return for purchasing, leasing ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item for which payment may be made in whole or in part under a Medicare or certain other Federal health care programs.
- There are certain exceptions identified in so-called safe harbors specified by law.
- Violation of the Federal Anti-Kickback Statute can result in criminal and civil penalties.

Physician Self-Referral Law

- Prohibits physicians from referring Medicare or Medicaid patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applies.
- Also prohibits an entity from presenting or causing to be presented under a Medicare Advantage plan a claim for a designated health service furnished as a result of a prohibited referral.
- Physicians may be subject to civil monetary penalties for violation of the self-referral law. In addition, a claim submitted in violation of the law may be considered a false claim.

Medicare Advantage and Part D Laws

- Prohibits Medicare Advantage organizations and Part D sponsors from paying:
  - Providers who have opted out of the Medicare program, except when they provide certain emergency services.
  - Individuals or entities who have been excluded from participation in a Federal health care program, such as Medicare, for the provision of health care, utilization review, medical social work or administrative services.
- This prohibition also applies to first tier, downstream and related entities.

Medicare Advantage and Part D Laws (cont'd)

- Prohibits first tier, downstream and related entities from contracting with or employing, excluded individuals or entities to furnish health care, utilization review, medical social work or administrative services under the Medicare Advantage and Part D programs.

Additional Fraud, Waste and Abuse Laws

- Federal law imposes *civil monetary penalties* for:
  - Presenting a claim under Medicare or certain other Federal health care programs for a physician's service (or an item incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service was not licensed as a physician or was licensed as a physician, but such license was obtained through a misrepresentation of material fact.

Additional Fraud, Waste and Abuse Laws (cont'd)

- Knowingly billing in violation of the terms of Medicare assignment, a Medicare participation agreement or an agreement with a State agency (or other requirement of a Medicaid State plan) not to charge a person for an item or service in excess of the amount permitted to be charged.
- Offering or providing anything of value to Medicare, Medicaid or Children's Health Insurance Program (CHIP) beneficiaries that is likely to influence the beneficiary to order or to receive from a particular provider any item or service for which payment may be made, in whole or in part, under Medicare, Medicaid or CHIP.

Additional Fraud, Waste and Abuse Laws (cont'd)

- Hospitals knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to Medicare or Medicaid eligible individuals under the direct care of the physician.

Consequences of Committing Fraud, Waste or Abuse

- Administrative recoupment/restitution
- Criminal and/or civil prosecution
- Fines/penalties
- Imprisonment
- Suspension/loss of provider license
- Exclusion from the Medicare program

Part IV:
Examples of Fraud, Waste and Abuse

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Preventing and Detecting Fraud, Waste and Abuse

You are a vital part of the effort to prevent, detect and report possible fraud, waste and abuse. To do that you need to be able to identify various types of misconduct that could rise to the level of fraud, waste or abuse.

Physicians and Other Professionals

- Misreporting/upgrading procedure codes to receive a higher payment.
- Inappropriately altering a patient record.
- Inappropriately prescribing drugs.
- Submitting encounter or diagnostic data to EmblemHealth that the physician knows or should know is incorrect.
- Performing or ordering inappropriate or unnecessary procedures/tests.
- Accepting remuneration in exchange for prescribing particular drugs.

Physicians and Other Professionals (cont'd)

- Providing false information through prior authorization or other utilization management mechanisms in order to justify coverage.
- "Double billing" – charging more than once for the same service; for example by billing for a service as part of an automated or bundled set of services and billing for the same service again in a separate claim.

Hospitals and Other Facilities

- Billing for drugs never received by the patient.
- Reselling drugs not used by patients.
- Drug diversion.
- Billing for labs, procedures or services the patient did not receive.
- Providing false information through prior authorization or other utilization management mechanisms in order to justify coverage.
- Misreporting/upgrading procedure codes to receive a higher payment.
- Inappropriately altering a patient record.

Pharmacies

- Accepting payments to convince beneficiaries or physicians to switch drugs.
- Submitting a false claim for payment.
- Altering prescriptions to receive higher payment.
- Dispensing expired drugs.
- Collecting higher co-pays than allowed or charging more than the negotiated price.
- Routinely waiving copayments.
- Intentionally misreporting the amount of out-of-pocket payments a beneficiary has made.

Pharmacies (cont'd)

- Dispensing less than the prescribed quantity and billing the full amount to the payer without making arrangements to provide the balance of the prescribed drug.
- Billing for brand name drugs when generics are dispensed.
- Providing fewer refills than reflected in submitted claims.
- Billing the payer for drugs that are never picked up by the patient.
- Waiving copayments in exchange for the beneficiary using that pharmacy for all his/her prescriptions.

Pharmacy Benefit Managers (PBMs)

- Accepting a payment to switch a beneficiary from one drug to another or to influence the prescriber to switch the patient to a different drug.
- Accepting remuneration to steer a beneficiary toward a certain plan or drug or to treat a drug favorably in formulary placement. Includes switching fees, as well as other types of unlawful remuneration.
- Allowing the financial benefit to the PBM to take precedence over clinical efficacy and appropriateness of formulary drugs when formulary decisions are made.

PBMs (cont'd)

- Dispensing less than the prescribed quantity through the PBM's mail-order pharmacy and billing the full amount to the payer without making arrangements to provide the balance of the prescribed drug.
- Splitting prescriptions through the PBM's mail order pharmacy to receive additional dispensing fees.
- Failing to offer a beneficiary the negotiated price of a Part D drug.

Beneficiaries

- Permitting another person to use the beneficiary's Medicare ID number/card.
- Falsifying coordination of benefits information to collect duplicate payments from multiple insurance plans.
- Participating in schemes that involve conspiracy between a provider/supplier and beneficiary.
- Going to a number of different doctors for prescriptions for the same controlled substance.

Part V:
Reporting Potential Fraud, Waste and Abuse

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Your Involvement

- Our organization engages in activities such as auditing, monitoring and other oversight to identify fraud, waste and abuse issues. However, we need you to help by taking such actions as these:
  - For entities: Establishing and enforcing policies and procedures to prevent, detect and encourage reporting of fraud, waste and abuse.
  - For entities: Educating staff on the importance of fraud, waste and abuse prevention.
  - For entities and individuals: Reporting any potential incidents of fraud, waste or abuse to EmblemHealth.

Our Policies on Inquiries and Reports

- All inquiries and reports are confidential, subject to limitations imposed by law.
- If an individual is unwilling to identify himself or herself despite this protection, he/she may make an anonymous report.
- If an individual does not identify himself or herself, we ask that he or she provide some method of future contact (for example, an e-mail address). This will allow the internal investigator to ask follow up questions.
- *EmblemHealth policy prohibits retaliation against individuals who raise issues in good faith.*

Our Policies on Inquiries and Reports (cont'd)

To report potential fraud, waste or abuse; if you have questions or concerns or if you have questions regarding fraud, waste and abuse laws or EmblemHealth's policies and procedures you may contact us at:

1-888-4KO-FRAUD
EmblemHealth
Attn: Special Investigation Unit
55 Water Street
New York, NY 10041-8190

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