Sentara®
Health Plans

Fraud, Waste, and Abuse Provider Guide

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Purpose of the Guide

Learn more about fraud, waste, and abuse, including its definition, examples, and prevention, as well as your responsibilities as a provider.

This guide will outline the following:

1. Define fraud, waste, and abuse.
2. Discuss examples of fraud, waste, and abuse.
3. Recall which laws regulate fraud, waste, and abuse.
4. Describe preventive steps that have been taken.
5. Recall how to report suspected fraud, waste, and abuse.
6. Distinguish both the provider's and health plan's responsibilities in fraud, waste, and abuse prevention.

Did You Know?

- There are over one million healthcare providers and more than six billion benefit transactions every year.
- Healthcare fraud is now a top priority for the U.S. Department of Justice—second only to terrorism and violent crimes.
- The False Claims Act (FCA) allows any person who knowingly submitted false claims to the government to be liable for triple the government's damages plus an inflation-linked penalty.
- In 2021, there was $5.6 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending September 30th, 2021.

What Is Fraud, Waste, and Abuse?

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain.

- rendering and billing for non-medically necessary services
- upcoding–billing higher level service than provided
- misrepresentation of benefits
- encounter data falsification
- underutilization
- attestations/conditions of participation

Waste is the overutilization of services or other practices that result in unnecessary costs. Generally, it is not considered to be caused by criminally negligent actions but rather a misuse of resources.

Example: *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." Greater waste would occur if the hospital consistently ordered and uses the 1000 ml bottle when the 500 ml bottle is available.*

Abuse is an individual's activities that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost, reimbursement for services that are not medically necessary, or failure to meet professionally recognized standards for healthcare.

Abuse can include a range of improper behaviors or billing practices. For example:

1. Fraud: Billing for a noncovered service–The provider knew that the service was noncovered but changed the ICD-9 diagnosis to obtain coverage.
2. Abuse: Misusing codes on the claim–The provider assumed they must be billing correctly as long as claims paid.

Distinguishing Between Fraud, Waste, and Abuse

One of the primary distinguishers is **intent and knowledge**. Fraud requires the person to have an 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.

Example: *Sentara Health Plans conducts an audit and educates the provider on the errors found. Sentara Health Plans then completes a 6–12-month follow-up audit to ensure the errors have been corrected. The findings of the follow-up audit indicate that the provider has not changed his billing practices. This is now considered intent.*

Common Types of Healthcare Fraud

According to **FBI.gov**

Fraud Committed by Medical Providers

- **Double Billing:** submitting multiple claims for the same service
- **Phantom Billing:** billing for a service visit or supplies the patient never received
- **Unbundling:** submitting multiple bills for the same service
- **Upcoding:** billing for a more expensive service than the patient received

Fraud Committed by Patients and Other Individuals

- **Bogus Marketing:** convincing people to provide their health insurance identification number and other personal information to bill for nonrendered services, steal their identity, or enroll them in a fake benefit plan
- **Identity Theft/Identity Swapping:** using another person's health insurance or allowing another person to use your insurance
- **Impersonating a Healthcare Professional:** providing or billing for health services or equipment without a license

Fraud Involving Prescriptions

- **Forgery:** creating or using forged prescriptions
- **Diversion:** diverting legal prescriptions for illegal uses, such as selling your prescription medication
- **Doctor Shopping:** visiting multiple providers to get prescriptions for controlled substances or getting prescriptions from medical offices that engage in unethical practices

Sentara Health Plans' Responsibility

Sentara Health Plans is responsible for detecting and preventing fraud, waste, and abuse in accordance with the Deficit Reduction Act and the False Claims Act.

Sentara Health Plans will conduct investigations of suspected fraud, waste, and abuse of its personnel, participating providers, subcontractors, and enrollees. There is no financial threshold for case notifications. Reportable fraud, waste, or abuses may include:

- emerging fraud schemes
- suspected internal fraud or abuse by employees, contractors, or subcontractors
- suspected fraud by providers who supply goods or services to Sentara Health Plans enrollees
- suspected fraud by Sentara Health Plans enrollees

Provider's Responsibilities

- to take a copy of the patient's pictured ID and insurance card to help deter identity theft
- to take a photo of the patient
- not to waive copays or coinsurance

Accurate Coding and Billing

When you submit a claim for services performed for a Medicare patient, you are filing a bill with the federal government and certifying you earned the payment requested and complied with the billing requirements. If you knew or should have known the submitted claim was false, then the attempt to collect payment is illegal.

Examples of improper claims include:

- billing for services that you did not actually render or were not medically necessary
- billing for services that were performed by an improperly supervised or unqualified employee
- billing for services that were performed by an employee who has been excluded from participation in the federal healthcare programs
- billing for services of such low quality that they are virtually worthless
- billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery

Physician Documentation

Maintain accurate and complete medical records and documentation of the services you provide, and ensure it supports submitted claims for payment.

Good documentation ensures your patients receive appropriate care from you and other providers who may rely on your records for patients' medical histories.

> "If the service was not documented, it was not done."
>
> Centers for Medicare & Medicaid Services (CMS)

Laws You Should Know

False Claims Act (FCA)

The False Claims Act (FCA), 31 U.S.C. 3729-3733, states that a person who knowingly submits a false or fraudulent claim to Medicare, Medicaid, or other federal healthcare program is liable to the federal government for three times the amount of the federal government's damages plus penalties of $5,000 to $11,000 per false or fraudulent claim.

Physician Self-referral Law (Stark Law)

Social Security Act, 1877, deals with referrals for the provisions of healthcare services. If a physician or an immediate family member has a financial relationship with an entity, the physician may not refer to the entity for health services where compensation may be made. This is to prevent physicians from making a financial gain and/or overutilization of services.

Anti-kickback Statute

Anti-kickback Statute, 41 U.S.C, states that it is a criminal offense to knowingly and willfully offer, pay, solicit, or receive any compensation for any item or service that is reimbursable by any federal healthcare program.

Penalties include:

- exclusion from federal healthcare programs
- criminal penalties
- jail
- civil penalties

Deficit Reduction Act (DRA)

DRA, Public Law No. 109-171, requires compliance for continued participation in the Medicare and Medicaid programs.

The law requires:

- the development of policies and education relating to false claims
- whistleblower protections
- procedures for detecting and preventing fraud, waste, and abuse

False Claims Whistleblower Protection Act (FCA)

Whistleblower Protection Act, 31 U.S.C. 3730 (h) states that a company is prohibited from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee because of lawful acts done by the employee on behalf of the employer or because the employee testifies or assists in an investigation of the employer.

The FCA also includes the "qui tam" provision, which allows persons to sue those who defraud the government. Persons would be eligible to receive a percentage of recoveries from the defendant. The Whistleblower Act protects a person when they file a qui tam claim.

Exclusion Statute

The Office of Inspector General (OIG) is required by **Law 42 U.S.C. §1320a-7,** to exclude from participation in all federal healthcare programs individuals and entities convicted of the following types of criminal offenses:

- Medicare or Medicaid fraud
- patient abuse or neglect
- felony convictions
- Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for healthcare benefits, items, or services to either:

- defraud any healthcare benefit program

  or

- obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any healthcare benefit program

Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Civil Monetary Penalties Law (CMPL)

The **Civil Monetary Penalties Law** authorizes CMPs for a variety of healthcare fraud violations. The CMPL provides for different amounts of penalties and assessments based on the type of violation. CMPs may assess up to three times the amount claimed for each item or service or up to three times the amount of remuneration offered, paid, solicited, or received. Violations supporting CMPL actions include:

- presenting a claim you know, or should know, is for an item or service not provided as claimed or is false and fraudulent
- presenting a claim you know, or should know, is for an item or service for which Medicare will not pay
- violating the Anti-kickback Statute

Civil Monetary Penalties Law: Violation Examples

- physicians who knowingly misrepresent that a Medicare beneficiary requires home health services
- submitting a claim, or claims, for service not rendered
- utilizing a CMS logo without approval
- failing promptly to return a known overpayment
- offering inducements to influence decisions related to Medicare or Medicaid funds
- acting to expel or refusing to enroll a Medicaid recipient due to the individual's health status
- hiring employees who have previously been excluded from participation in federal programs

HIPAA

The **Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA):**

- created greater access to healthcare insurance, protection of privacy of healthcare data, and safeguards to prevent unauthorized access to protected healthcare information
- promoted standardization and efficiency in the healthcare industry

As an individual who has access to protected healthcare information, you are responsible for adhering to HIPAA.

Investments in Healthcare Business Ventures

These business relationships can sometimes unduly influence or distort physician decision-making and result in the improper steering of a patient to a particular therapy or source of services in which a physician has a financial interest. The purpose of the Anti-kickback and Stark laws is to stop providers from pursuing financial gains by sending all of their patients to businesses in which they hold financial interests rather than providing patients with options. Many of these investment relationships have serious legal risks under the AKS and Stark laws.

Consequences of Committing Fraud, Waste, or Abuse

Actual consequence depends on the violation. Some potential penalties include:

- civil monetary penalties
- criminal conviction/fines
- civil prosecution
- imprisonment
- loss of provider license
- exclusion from federal/state healthcare programs

Program Integrity (PI)

- reviews and investigates allegations of fraud and abuse
- takes corrective actions for any supported allegations
- reports misconduct to all appropriate agencies
- provides staff training per the Deficit Reduction Act

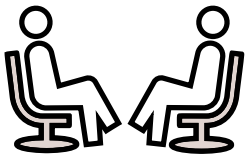
How Does the PI Combat Fraud, Waste, and Abuse?

The PI identifies potential fraud through:

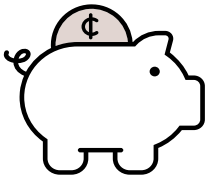
- prepayment claims reviews
- retrospective claims reviews
- service calls/inquiries from members, vendors and/or providers
- data analysis
- hotline calls
- compliance emails
- case scenarios (blank page)
- fraudulent billing

Examples:

- *A psychiatrist was fined $400,000 and permanently excluded from participating in the federal healthcare programs for misrepresenting that he provided therapy sessions requiring 30 or 60 minutes of face-to-face time with the patient when he had provided only medication checks for 15 minutes or less. The psychiatrist also misrepresented that he provided therapy sessions when, in fact, a nonlicensed individual conducted the sessions.*



- *An endocrinologist billed routine blood draws as critical care blood draws. He paid $447,000 to settle allegations of upcoding and other billing violations.*



Misuse of Physician Provider and Prescription Number

- *A physician was ordered to pay $50,000 in restitution to the government for falsely indicating on his provider number application that he was running his own practice when, in fact, a neurophysiologist was operating the practice and paying the physician a salary for the use of his number.*

Kickbacks for Referrals for Self-referral

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

Do You Think You Have a Problem?

Do you have a problematic relationship or are you following billing practices you now realize are wrong?

- Immediately cease filing the problematic bills.
- Seek knowledgeable legal counsel.
- Determine federal money has been collected in error and report and return any overpayments.
- Undo the problematic investment by freeing yourself from your involvement.
- Disentangle yourself from the suspicious relationship.
- Consider using OIG's or CMS' self-disclosure protocols.

OIG Provider Self-disclosure Protocol

This is a vehicle for physicians' voluntary disclosure of self-discovered evidence of possible fraud. Providers may be able to avoid the costs and disruptions associated with a federal government-directed investigation and civil or administrative litigation.

Reporting to Sentara Health Plans

Reports to the Sentara Health Plans Compliance Hotline may be made without fear of intimidation, coercion, threats, retaliation, or discrimination.

Fraud & Abuse Hotline: **757-687-6326** or **1-866-826-5277**

Email: **compliancealert@sentara.com**

Sentara Health Plans c/o Program Integrity
PO Box 66189
Virginia Beach, VA 23466

Reporting to Government Programs

Direct Reporting–Virginia Medicaid

- DMAS Fraud & Abuse Referral Hotline: **1-866-486-1971**
- Email address: **recipientfraud@dmas.virginia.gov**

Direct Reporting–Medicare

- Call: **1-800-447-8477**
- Fax: **1-800-223-8164**
- Online: **oig.hhs.gov/fraud/report-fraud/**
- Office of Inspector General: PO Box 23489 Washington, DC 20026

References and Resources

justice.gov/civil/false-claims-act

No adverse or retaliatory actions may lawfully be taken against anyone who reports an issue in good faith.