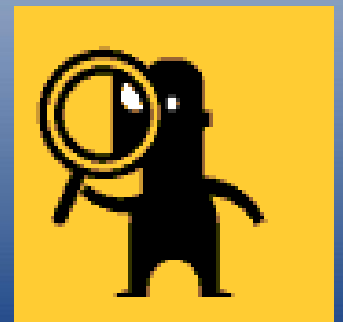




FRAUD & ABUSE

March 2010

VALUEOPTIONS



Fraud & Abuse

It is essential that all Providers and Vendors of ValueOptions understand what Health Care Fraud & Abuse is, how to detect it and how to assist members, providers, vendors or employees who may be reporting suspicious activities.

Training Requirements

ValueOptions is required by Federal Mandate to make available Fraud & Abuse Training to our Providers and Vendors.

This training program provides a general overview of Fraud & Abuse regulations, potential fraud indicators, procedures for reporting fraud & abuse and the ValueOptions Fraud & Abuse Investigative Process.

Purpose

Health Care Fraud is a crime that has a significant effect on the private and public health care payment system. Fraud & Abuse accounts for over 10% of annual health care costs. Taxpayers pay higher taxes because of fraud in public programs such as Medicaid and Medicare. Employers and individuals pay higher private health insurance premiums because of fraud in the private sector health care system.

Recognizing the serious implications of Fraud, ValueOptions' Fraud & Abuse Program is dedicated to detecting, investigating and preventing all forms of suspicious activities related to possible health insurance fraud & abuse, including any reasonable belief that insurance fraud will be, is being, or has been committed.

Training Overview

This training will provide answers to the following questions:

- What is Fraud and Abuse?
- What are the types of Fraud?
- What are potential Fraud indicators?
- What laws regulate Fraud & Abuse?
- What is a Fraud & Abuse violation?
- How is suspicious activity reported?
- What are the Sanctions and Penalties for Fraud & Abuse violations?
- What are the steps in ValueOptions' Fraud & Abuse Investigative Process?
- What are ValueOptions' Providers' and Vendors' responsibilities during an investigation?

Introduction

ValueOptions, in compliance with the Office of Inspector General (Medicare), Insurance Fraud Bureau (Commercial), and Office of Personnel Management (Federal Employee Health Benefits Programs) has put in place a fraud & abuse program designed to meet regulatory requirements and protect health plan members, providers, vendors and employees.

Introduction (cont)

It is the policy of ValueOptions

- To review and investigate all allegations of fraud and/or abuse, whether internal or external;
- To take corrective actions for any supported allegations after a thorough investigation; and
- To report confirmed misconduct to the appropriate parties and/or Agencies.

What is Fraud?

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

What is Abuse?

Abuse is defined as Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Health programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Health program.

Types of Health Care Fraud

Provider Fraud:

- Individual participating or non-participating providers who deliberately submit claims for services not actually rendered, or bill for higher-priced services than those actually provided.
- Providers of medical equipment and home health services who defraud the Medicare program and private payers, often paying kickbacks to dishonest physicians who prescribe unnecessary products and services.
- Charges are submitted for payment for which there is no supporting documentation available, such as x-rays or lab results.

Responsible Parties

Those who might perform such acts may include, but are not be limited to, a provider, a hospital, an agency, an organization, or other institutional provider, an employee of a provider, a billing service, a member, or any person in a position to file a claim for behavioral health benefits.

Claims or Subscriber Fraud (cont)

Claims or Subscriber Fraud:

- Subscriber/Claim fraud can involve alteration of bills or creation of claims, submission of claims for ineligible dependents, and misrepresentation in response to specific questions on the claim forms.
- Subscriber/Claims fraud can be submitted by anyone.

Examples of potential Fraud, Abuse, Inappropriate or Suspicious Activity (cont)

- Falsifying Claims/Encounters
 - Alteration of claim
 - Super imposed material
 - White Outs
 - Erasures
 - Altered Changes
 - Different colored inks
 - Incorrect Coding
 - Inappropriate Balance Billing
 - Failure to collect coinsurance and deductible amounts
 - Lack of Integrity in computer systems (e.g. data entry errors)
 - Duplicate Billing
 - Billing for services not rendered
 - Misrepresentation of services/supplies
 - Substitution of services
 - Misspelled Medical terminology
 - Treatment of conditions which may suggest a pre-existing condition
 - No Provider information on claim
 - Diagnosis does not correspond to treatment rendered

Examples of potential Fraud, Abuse, Inappropriate or Suspicious Activity (cont)

- Unbundling/exploding charges (e.g. the unpacking and billing separately of services that would ordinarily be all inclusive)
- Coding a service at a higher level than what was rendered (e.g. up coding)
- Inappropriate documentation for services rendered
- Violation of provider agreement by provider
- Breaches in provider agreement that result in members being billed for non-allowed amount by ValueOptions
- Billing for a service not furnished as billed; for example; submitted claim for 50 minute session, but provider session duration time did not meet service code minimum requirement
- Billing for non-covered services as covered services (CPT codes)
- False or fraudulent billing of claims
- The acceptance of, or failure to return, monies allowed or paid on claims known to be false or fraudulent or documentation does not support services billed

Examples of potential Fraud, Abuse, Inappropriate or Suspicious Activity (cont)

- **Waiving Member Responsibilities**
- **Co-payment** That portion of a charge for services that must be paid by a member and is not covered by the member's benefit program. Providers are not allowed to bill members for charges not covered by the member's benefit plan aside from any applicable co-payments and deductibles.
- Waiving a co-payment, coinsurance, or a deductible, if the member's benefit's requires one, changes the fee. If you file a claim listing your usual and customary fee of \$100.00, but you plan to waive the \$20.00 co-payment, your fee is really only \$80.00, in the view of the health plan. Accordingly, the provider has misstated the fee to the health plan, and that misrepresentation can constitute either fraud or a false statement within the meaning of the Portability Act.
- **Network providers must collect applicable deductibles, coinsurance and/or co-payments from the member at the time of services.** ValueOptions will reimburse the network provider the balance up to the fee schedule maximum or negotiated rate or the billed charge (whichever is less) for covered services upon receipt of a [clean claim](#) form in compliance with ValueOptions' policies and procedures.

Examples of potential Fraud, Abuse, Inappropriate or Suspicious Activity (cont)

■ Delivery of Services

- Denying access to services/benefits
- Limiting access to services/benefits
- Failure to refer for needed services
- Over-utilization
- Under-utilization

■ Member Eligibility Fraud

- Resource misrepresentation
- Ineligible member using eligible member's services
- Misrepresentation of medical condition
- Failure to report third party billing
- Eligibility determination issues

Potential Fraud Indicators in a Managed Care Setting

- Limited time spent by providers with patients (underprovision of care)
- Frequent referral of patients to specialists (may be indicative of a kickback arrangement)
- Inadequate treatment plan
- Consistently poor outcomes may be a sign of lack of treatment
- Unusual patient encounter ratios
- High number of referrals to emergency rooms
- High rate of services that fall outside those covered by capitated amounts
- High incidence of claims for treatment performed outside HMO service area

What laws regulate Fraud & Abuse?

- False Claims Act (FCA)
- Stark Law
- Anti-Kickback Statute
- HIPAA
- Deficit Reduction Act
- Criminal Penalties for Acts involving Federal Health Care Programs
- The False Claims Whistleblower Employee Protection Act
- Administrative Remedies for False Claims and Statements

False Claims Act

Under the False Claims Act (FCA), [31 U.S.C. §§ 3729-3733](#), those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.

Stark Law

Self-Referral (Stark Law) Statutes, **Social Security Act, 1977**, pertains to physician referrals under Medicare and Medicaid. Referrals for the provisions of health care services, if the referring physician or an immediate family member, has a financial relationship with the entity that receives the referral, is not permitted.

Anti-Kickback Statute

Under the Anti-Kickback Statute, [41 U.S.C.](#), it is a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration for any item or service that is reimbursable by any federal healthcare program. Penalties may include exclusion from federal health care programs, criminal penalties, jail and civil penalties for each violation.

Anti-Kickback Statute (cont)

Examples of Kick-Backs:

- Money
- Discounts
- Gratuities
- Gifts
- Credits
- Commissions

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA), **45 CFR, Title II, 201-250**, provides clear definition for Fraud & Abuse control programs, establishment of criminal and civil penalties and sanctions for noncompliance.

Deficit Reduction Act

The Deficit Reduction Act (DRA), Public Law No. 109-171, 6032, passed in 2005, is designed to restrain Federal spending while maintaining the commitment to the federal program beneficiaries. The Act requires compliance for continued participation in the programs. The development of policies and education relating to false claims, whistleblower protections and procedures for detecting and preventing fraud & abuse must be implemented.

Criminal Penalties for Acts Involving Federal Health Care Programs

This legislation, [42 U.S.C. 1128B, 1320a-7b](#), states that criminal penalties will result in conviction of a felony and a fine of not more than \$25,000 and/or imprisonment for not more than 5 years if false statements are knowingly and willfully made for benefits or payments, or misrepresents services or fees to beneficiaries of federal health care programs.

The False Claims Act Whistleblower Employee Protection Act

Under this legislation, [31 U.S.C. 3730\(h\)](#), 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.

Administrative Remedies for False Claims and Statements

Under this Act, [31 U.S.C. Chapter 8, 3801](#), any person who makes, presents or submits a claim that is false or fraudulent is subject to a civil penalty of not more than \$5,000 for each claim and also an assessment of not more than twice the amount of the claim.

What is a Fraud & Abuse Violation?

Fraud & Abuse Violations occur when a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he/she is not otherwise entitled.

Any employee, member, vendor or provider has the right to make a Fraud & Abuse-related complaint to ValueOptions if he/she feels that there has been suspicious activities.

How is suspicious activity reported?

Complaints from Members, Vendors, Providers, Billing Staff, etc.:

- Report all suspicious or potential fraud and abuse activities to ValueOptions through your Provider Relations Representative; or
- Send a written statement to the Special Investigations Unit. (see Provider Handbook for address)
- Include all information, claim or tip that supports alleged misconduct.

Sanctions and Penalties for Fraud and Abuse violations

ValueOptions must have and apply appropriate sanctions against providers and vendors who fail to comply with the policies and procedures of ValueOptions and/or the requirements of the Federal laws and Statutes. The Federal and State government agencies will prosecute these providers and vendors accordingly.

Sanctions and Penalties for Fraud and Abuse violations (cont)

Conviction of Fraud & Abuse can carry civil and criminal penalties.

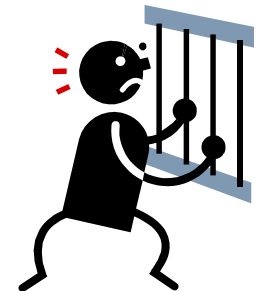


Civil Penalties:

- \$5500 to \$11000 per claim plus up to 3 times the amount of damages

Criminal Penalties:

- Felony conviction: 5-20 years in jail
- Misdemeanor conviction: 1 year in jail



ValueOptions Investigation Stages

Stage 1

Initial Identification of potential fraud through:

- Retrospective Claims reviews
- Requests from the Clinical Department for Review
- Service Calls/Inquiries from Members, Vendors and/ or Providers
- Reports from Members, Providers, Clients or other sources (i.e., billing staff, etc)
- Data Analysis Reports
- Ethics Hotline Calls

ValueOptions Investigation Stages (cont)

Stage 2

SIU Initial review

- Evaluation of complaint
- Evaluation of all supporting documentation
- Review historical data for any previous referrals with similar reasons/patterns
- Review case with all appropriate internal resources
- Decide on action
 - No evidence of fraud or abuse: Findings are documented and results reported back to the referral source
 - Potential fraud and/or abuse: SIU will open a case

ValueOptions Investigation Stages (cont)

Stage 3

SIU investigation:

- Gather pertinent documents
- Run Data query for all claims in designated time period
- Random Sample of member claims requested
- Review documentation. Involve all ValueOptions Departments as necessary.
- Case Findings and Action Plan established

ValueOptions Investigation Stages (cont)

Stage 4

Action Plan (may include any or all)

- Recovery of overpayments
- Provider submitted Corrective Action Plan (CAP)
- NCC review for credentialing issues
- Possible State Insurance Fraud Division notification
- Monitoring Program (6 or 12 months)
- Provider Education

ValueOptions Investigation Stages (cont)

Stage 5

Noncompliance with Claims Audit (may include any or all)

- Reversal of claims
- NCC review for dis-enrollment and suspension of referrals
- Possible State Insurance Fraud Division notification
- Provider and/or Member flags for monitoring claims activities

Correspondence to Providers

- Initial request letter notification
 - List of members' records requested
 - Date records are due
 - Investigator's name and address for mailing
- 2nd request letter for records (if necessary)
 - 1st request letter included
 - Date extension for record receipt
 - Consequences for non-compliance
- Findings letter
 - Date for receipt of overpayment payment to ValueOptions
 - Detailed spreadsheet with overpayment issues outlined
 - Corrective Action Plan and due date
 - Provider Education to be done by Provider Relations
- If applicable – Payment Arrangement letter
 - Arrangements for provider payment
 - Signature required

Provider Responsibilities

ValueOptions' Providers are responsible for understanding:

- Coding Standards
 - Select appropriate CPT code for service rendered
- ValueOptions' Provider Standards
 - Understand roles & responsibilities as participating providers in VO network
 - Know licensure responsibilities and restrictions
- Documentation Standards
 - ValueOptions adheres to national standards for documentation

Our Goal: Eliminating Fraud & Abuse

To eliminate fraud and abuse successfully providers, facilities and vendors must work together with ValueOptions to prevent and identify inappropriate and potentially fraudulent practices. This can be accomplished by:

- Monitoring claims submitted for compliance with billing and coding guidelines;
- Adherence by providers and facilities to Treatment Record Standards;
- Education of all staff members responsible for medical records (billing, coding, maintenance); and
- Referring cases of suspected fraud and abuse.