Fraud, Waste and Abuse Training
Why Do I Need Training?

Every year millions of dollars are improperly spent because of fraud, waste and abuse. It affects everyone,

Including **YOU**.

This training will help you detect, correct, and prevent fraud, waste and abuse.

**YOU** are part of the solution.
Objectives

• Meet the regulatory requirement for training and education.

• Provide information on the scope of fraud, waste and abuse.

• Explain the obligation of everyone to detect, prevent, and correct fraud, waste and abuse.

• Provide information on how to report fraud, waste and abuse.

• Provide information on laws pertaining to fraud, waste and abuse.
Requirements

Statutes, regulations, and policies govern the Medicare Parts A, B, C, and D and Medicaid programs.

The Deficit Reduction Act (DRA) requires companies (like ValueOptions) that receive Medicaid funds to provide training about the federal and state False Claims Acts, including criminal or civil penalties, whistleblower protections, and the company’s policies and procedures for detecting and preventing fraud, waste and abuse.

Contractors must have an effective compliance program which includes measures to prevent, detect and correct Medicare and/or Medicaid non-compliance as well as measures to prevent, detect and correct fraud, waste and abuse.

In addition, contractors must have an effective training for employees, managers and directors, as well as their first tier (like ValueOptions), downstream (for example providers/some vendors), and related entities. (42 C.F.R. § 422.503 and 42 C.F.R. § 423.504)
What are my responsibilities in performing administrative services for Medicare or Medicaid?

You are a vital part of the effort to prevent, detect, and report Medicare/Medicaid non-compliance as well as possible fraud, waste and abuse.

- **FIRST**, you are required to **comply** with all applicable statutory, regulatory, and other Medicare/Medicaid requirements, including adopting and implementing an effective compliance program.
- **SECOND**, you have a duty to the Medicare/Medicaid Program to **report** any violations of laws that you may be aware of.
- **THIRD**, you have a duty to **follow the ValueOptions’ Code of Conduct and Ethics** that explains your and ValueOptions’ commitment to standards of conduct and ethical rules of behavior.

As an employee of ValueOptions, you are required by Federal law to receive compliance training when you are hired and annually thereafter.

**Did You Know:** Most of the referrals for potential fraud, waste and abuse ValueOptions program integrity staff receives are based on member calls from VO employees.
Prevention
How Do I Prevent Fraud, Waste and Abuse?

- Make sure you are up to date with laws, regulations and policies.

**Did You Know:** You can find the most recent false claims act requirements on StaffConnect at [http://staffconnect/corpdept/legal/statecharts/FalseClaimsChart.pdf](http://staffconnect/corpdept/legal/statecharts/FalseClaimsChart.pdf)

- Ensure you coordinate with other payers (for members with other health insurance).

- Put claims edits in place to prevent the payment of inappropriately billed services.

- Ensure data/billing is both accurate and timely.

- Make sure the provider/facility has the appropriate state/federal license and bills with a unique identifier (such as an NPI if required).

- Verify information provided to you.

- Be on the lookout for suspicious activity.
Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste and abuse.

Make sure you are familiar with ValueOptions’ policies and procedures located at [http://staffconnect/app/policy.do](http://staffconnect/app/policy.do).
Detection
What is Fraud, Waste and Abuse?

In order to detect fraud, waste and abuse you need to know the Law.
<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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| **Criminal Fraud** | Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by 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. 18 United States Code § 1347  
For example: Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.  |
| **Waste**        | Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.                                                                                                                                                                                                                                                                                                                                                                             |
| **Abuse**        | Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program. Abuse involves payment 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.                                                                                                                                                                                                                                                                                       |
Differences Among Fraud, Waste and Abuse

There are differences among fraud, waste and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have an intent to obtain payment and the knowledge that his actions are wrong. Waste and abuse may involve obtaining an improper payment but does not require the same intent and knowledge.

- Do not be concerned about whether it is fraud, waste or abuse.
- Just report any concerns to the compliance department or ValueOptions’ Compliance and Ethics Hotline.
- ValueOptions’ compliance department will investigate and make the proper determination.

**Did You Know:** According to the FBI, healthcare fraud costs the country an estimated $80 billion/year.
Indicators of Potential Fraud, Waste and Abuse

Now that you know what fraud, waste and abuse are, you need to be able to recognize the signs of someone committing fraud, waste or abuse.

Did You Know: A majority of health care fraud is committed by providers. 10% of fraud is committed by members.

The following slides present issues that may be potential fraud, waste or abuse. Each slide provides areas to keep an eye on, depending on your role in either of the Medicare or Medicaid programs. We also need to watch these areas in order to protect the money of our commercial and federal clients.
Key Indicators: Potential Provider Issues

- Is a provider billing for members that don’t exist?

- Is the member receiving unnecessary services?

- Is a provider billing for a member who didn’t come to the appointment or for a time when the member is not present?

- Is an individual clinician submitting bills for 24-hours or more services in a single day?

- Is a provider failing to support billed services with proper documentation/progress notes?
Key Indicators: Potential Provider Issues

- Is a provider submitting the same exact note to support multiple billed services?

- Is a provider billing for outpatient individual services but actually providing outpatient group services (upcoding)?

- Does the clinician signing off on/billing for services have an expired, revoked license or forged certification or credentials?

- Is a provider billing for services on days his office is likely closed, such as on holidays or during inclement weather?
Key Indicators: Potential Member Issues

• Is a member complaining that his record shows he received services he didn’t actually receive? (possible identity theft)

• Is a member pretending to be the person who has a medical card in order to receive treatment?

• Is a member failing to tell the assessor/provider about other health insurance?

• Is a member misrepresenting or providing false information in order to receive treatment?

• Is a member signing releases for other members?
Key Indicators: Potential Internal Issues

- Are internal controls inadequate, or are they being overridden?
- Is an employee falsifying records, reports or other documentation, or do you notice that documentation is missing or appears to be altered?
- Is an employee inappropriately using company equipment, such as the telephones, computers and/or copy equipment?
- Is an employee taking work supplies home for personal use?
Key Indicators: Potential Internal Issues

• Do you notice accounting and/or deliverable irregularities?

• Have you noticed unexplained spikes in performance measures?

• Are employees using passwords/logons other than their own?

• Is an employee working unusual hours?

• Have you been instructed to abide by a system or process workaround when you know it does not meet standard policy/procedure?
How Do I Report Fraud, Waste or Abuse?
Reporting Fraud, Waste and Abuse

Everyone is required to report suspected instances of fraud, waste and Abuse. ValueOptions’ Code of Conduct and Ethics clearly states this obligation.

ValueOptions is required to have a mechanism in place in which potential fraud, waste or abuse may be reported by employees, first tier, downstream, and related entities. ValueOptions must be able to accept anonymous reports and cannot retaliate against you for reporting. More information about reporting fraud, waste and abuse can be found in the ValueOptions Code of Conduct and Ethics.

When in doubt, call the ValueOptions Compliance and Ethics Hotline at 1-888-293-3027 or your engagement center Compliance staff. ValueOptions may not retaliate against you for making a good faith effort in reporting.
Correction
Correction

Once fraud, waste or abuse has been detected, it must be promptly corrected.

Correcting the problem saves the government money and ensures we are all in compliance with CMS’ requirements. Prompt reporting allows ValueOptions to take steps to limit or prevent harm to affected members, so the violation may not become as serious.
Once issues have been identified, a plan to correct the issue needs to be developed. Consult compliance staff to find out the process to develop a corrective action plan.

The actual plan will vary, depending on the specific circumstances.
Laws You Need to Know
The following slides provide very high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

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 Office of Inspector General.

42 U.S.C. § 1395(e)(1) and 42 C.F.R. § 1001.1901
# False Claims Act

**31 United States Code § 3729-3733**

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<thead>
<tr>
<th>Prohibits</th>
<th>Criminal Penalties</th>
<th>Civil Penalties</th>
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<tbody>
<tr>
<td>Presenting a false claim for payment or approval;</td>
<td>If convicted, the individual shall be:</td>
<td>The damages may be tripled.</td>
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<tr>
<td>Making or using a false record or statement in support of a false claim;</td>
<td>- fined,</td>
<td>- Plus -</td>
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<tr>
<td>Conspiring to violate the False Claims Act;</td>
<td>- imprisoned,</td>
<td>Civil Money Penalty between $5,000 and $10,000 for each claim.</td>
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<tr>
<td>Falsely certifying the type/amount of property to be used by the Government;</td>
<td>- or both.</td>
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<td>Certifying receipt of property without knowing if it’s true;</td>
<td>If the violations resulted in death, the individual may be imprisoned for:</td>
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<td>Buying property from an unauthorized Government officer; and</td>
<td>- any term of years,</td>
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<td>Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.</td>
<td>- or for life,</td>
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**18 United States Code § 1347**
## Anti-Kickback Statute

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<th>Prohibits</th>
<th>Penalties</th>
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<tr>
<td>• 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 health care program (including Medicare).</td>
<td>• Fine of up to $25,000.</td>
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<td>• Imprisonment up to five (5) years.</td>
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<td>• Or both fine and imprisonment.</td>
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42 United States Code § 1320a-7b(b)
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<tr>
<th>Prohibits</th>
<th>Penalties</th>
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<tbody>
<tr>
<td>• Prohibits a physician from making a referral for certain designated</td>
<td>• Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable.</td>
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<tr>
<td>health services to an entity in which the physician (or a member of</td>
<td>• Up to a $15,000 fine for each service provided.</td>
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<tr>
<td>his or her family) has ownership/investment interest or with which he</td>
<td>• Up to a $100,000 fine for entering into an arrangement or scheme.</td>
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<td>or she has a compensation arrangement (some exceptions apply).</td>
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42 United States Code § 1395nn
HIPAA

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

- Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.
- Mandates safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

In the News: A Pennsylvania man found that an imposter had used his identity at five different hospitals in order to receive more than $100,000 in treatment. At each location, the imposter left behind a medical history in his victim’s name.
Consequences
Consequences of Committing Fraud, Waste or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties.
- Criminal Conviction/Fines.
- Civil Prosecution.
- Imprisonment.
- Loss of Provider License.
- Exclusion from Federal Health Care programs.

In the News: Employees of a managed care company were found guilty of health care fraud, making false statements relating to health care matters, and making false statements to a law enforcement officer. Sentencing ranged from probation to 36 months in prison plus fines and penalties. In a related civil case, the managed care company was ordered to pay $137.5 million in civil fines and penalties.
Ways to Report Potential Fraud, Waste and Abuse

• If you have ServiceConnect, send an inquiry to the Program Integrity queue for your location or to VOFIQFAB.
• Send an e-mail to Program.IntegrityReferrals@valueoptions.com
• Contact your Program Integrity lead.
• Call the Compliance and Ethics Hotline at 1-888-293-3027.

Regardless of how you report, please be sure to provide staff with the following information:

- Provider/Member Name.
- Provider NPI/Number or Member Number.
- Description of your concern.
Scenario #1

A ValueOptions employee reads an article in the newspaper about a provider who is being investigated for fraud. She knows the provider is in the ValueOptions network.

What should she do?


Scenario #1

A. Nothing, that’s the responsibility of the compliance/program integrity staff.

B. Report the incident to the compliance department (via Program.IntegrityReferrals@valueoptions.com or the VOFIQFAB program integrity queue).

C. Contact the provider to let the staff know they need to report the investigation to ValueOptions.

D. Nothing, she doesn’t want to get involved.
Scenario #2

You are responsible for reviewing claims submitted for payment by providers. You notice a certain provider ("Doe Diagnostics") has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other providers and realize that Doe Diagnostics’ claims far exceed any other provider that you reviewed.

What should you do?
Scenario #2

A. Call Doe Diagnostics and request additional information for the claims.

B. Contact the compliance/program integrity department or consult with your immediate supervisor for next steps.

C. Reject the claims.

D. Pay the claims.
Scenario #3

A member contacts you to request an authorization for outpatient therapy. You look in the system and notice that the member already has an authorization for an outpatient provider. You ask the member if there was a reason why she wants to change providers.

The member states she has never been to treatment before. You provide the name of the provider and explain that there are authorizations in the system for the last year. The member insists that she has never seen the provider. What do you do?
Scenario #3

A. Provide a new authorization to the member and advise her that the authorizations are still open for the other provider if she wants to see him too.

B. Provide a new authorization to the member and advise her to contact the previous provider to find out why they requested an authorization.

C. Contact your supervisor and refuse to authorize treatment until the issue is resolved.

D. Provide a new authorization to the member and contact the compliance/program integrity department.
**Scenario #4**

You send your supervisor a client report for approval. She reviews the report and asks you to change some of the numbers. She gives you back the edited report and asks you to send it to the client.

Upon reviewing the report, you see the changes are incorrect. The edited numbers are better than what is actually in the system.

You talk to your supervisor about your concerns and she tells you to keep quiet because she’s trying to avoid performance penalties. She mentions that having to pay performance penalties will look bad for the team and will cause you and your friends to lose their jobs.

What do you do?
Scenario #4

A. Do what your supervisor said and send the report.

B. Save a copy of the original and revised report and report the incident to the compliance department (via the ValueOptions’ Compliance and Ethics Hotline or other mechanism).

C. Send the incorrect report but save a copy of the original report in case someone blames you for changing the report.

D. Tell the client about the programming error and that your supervisor told you to send the incorrect information.