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# 2018 Fraud, Waste, and Abuse Prevention Training

**You have been identified as a direct care team member or a team member who is involved with processes linked to submitting health care claims for reimbursement.**

**Due to your role at NMH, you are required to complete the following Fraud, Waste and Abuse Prevention training to comply with Centers for Medicare and Medicaid (CMS) requirements.**

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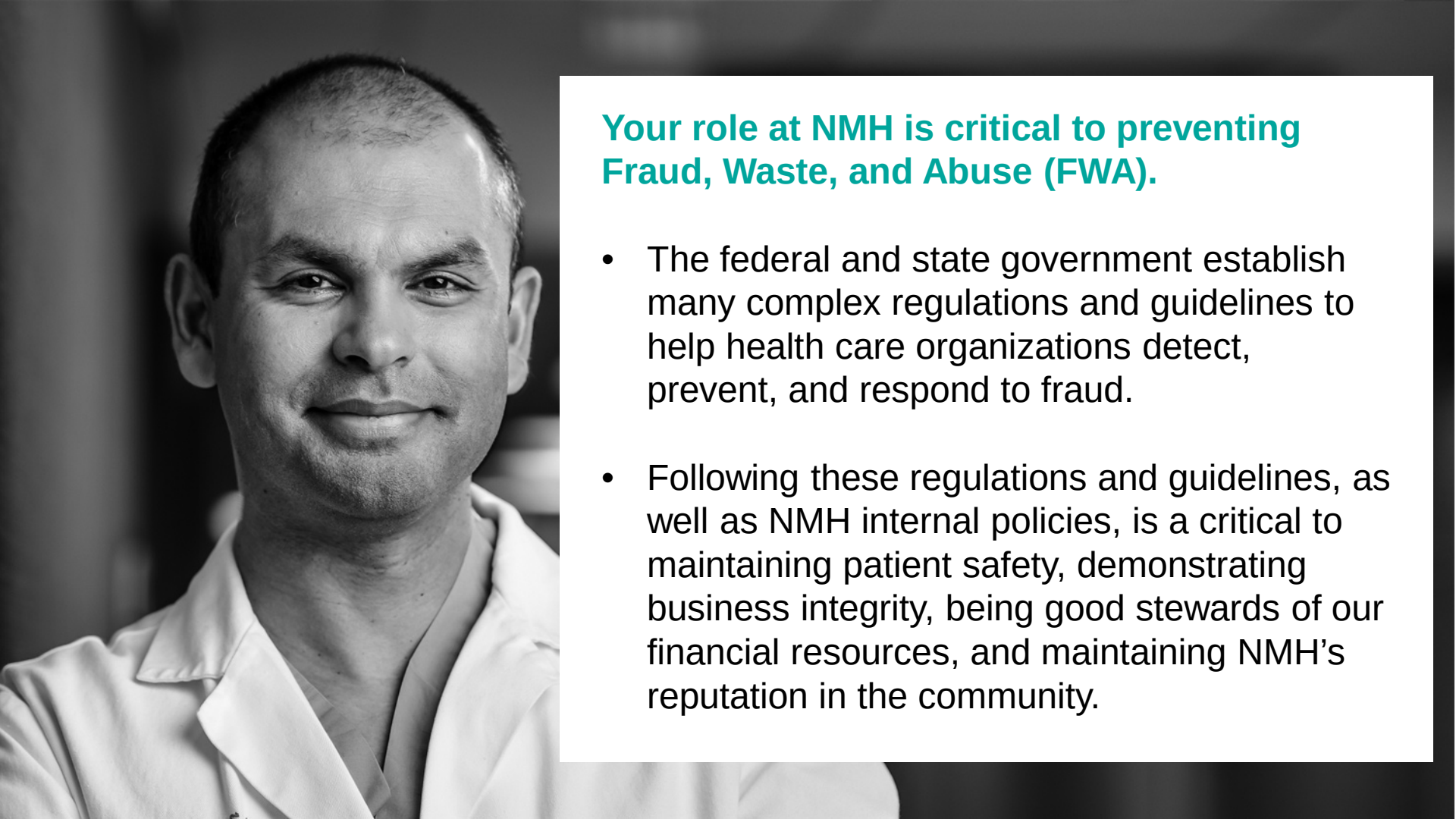

## Your role at NMH is critical to preventing Fraud, Waste, and Abuse (FWA).

- The federal and state government establish many complex regulations and guidelines to help health care organizations detect, prevent, and respond to fraud.

- Following these regulations and guidelines, as well as NMH internal policies, is a critical to maintaining patient safety, demonstrating business integrity, being good stewards of our financial resources, and maintaining NMH's reputation in the community.

# FWA Detection and Prevention is part of the NMH Compliance Program.

- Detecting and preventing FWA is a responsibility of all NMH team members.
- The Compliance Department serves as a resource to the organization that provides tools and processes to identify and prevent FWA.
- Prevention requires collaboration between:
  - NMH team members and vendors
  - Vendors and affiliated health care providers
  - State and federal agencies
  - Customers (Patients)

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# Fraud, Waste, and Abuse Defined

**For us to meet the fraud control expectations established by government agencies, we must be able to identify FWA in our health care environment.**

**The following slides will help you understand the meaning of these terms.**

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# Fraud Defined

**Fraud is when someone intentionally executes or attempts to execute a scheme to inappropriately obtain money or property from a government health care program (such as Medicare).**

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# Waste Defined

**Waste means incurring unnecessary costs under a government health care program as a result of deficient management, practices, systems, or controls.**

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# Abuse Defined

**Abuse occurs when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any government health care program. Abuse includes any practice that:**

- Is inconsistent with providing medically necessary services;
- Provides services that do not meet professionally recognized standards; or
- Provides services that are not fairly priced.

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# Examples of FWA

It is impossible to list all types of potential fraud, but the following list provides examples of activities that have been found to be FWA in other organizations:

- Billing for goods and services that were never provided to a customer.
- Conducting excessive office visits or writing excessive prescriptions.
- Misrepresenting the service that was provided to a customer.

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# Examples of FWA (continued)

- Billing for a higher level than the service than was actually delivered.
- Incorrectly billing non-covered services or prescriptions as covered items.
- Using multiple billing codes instead of one billing code for a drug panel test in order to increase reimbursement (“unbundling”).

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# Examples of FWA (continued)

- Laboratories charging individually for tests that should have been billed as a panel at a lower rate.
- Automatically running a lab test whenever the results of some other test fall within a certain range, even though the second test was not specifically ordered.
- Billing for services performed by an improperly supervised or unqualified employee.

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# The Fraud Continuum

Because fraud, waste and abuse are so broadly defined, errors and mistakes can be violations of the law. This is why you need to pay close attention to your duties to avoid errors that could be considered fraud.

The Centers for Medicare and Medicaid (CMS) investigates all causes of improper payments – from unintentional errors to intentional fraud. The next slide explains the fraud continuum.

Not all improper payments are fraud (i.e., intentional misuse of funds). In fact, the vast majority of improper payments are due to unintentional errors. **The most common error is lack of clinical documentation.**

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# The Fraud Continuum

**Unintentional Error:** A mistake caused by poor reasoning, carelessness, or insufficient knowledge, and is made without the intent to deceive.

**Poor Control Environment:** When a workplace fails to prevent undesirable acts from occurring, it is called a poor control environment. This means that standard processes and checks are not followed to be sure work is done in a consistent and compliant manner. Examples include lack of separation of duties, proper authorization, or adequate documentation for transactions.

**Intentional Fraud:** Occurs when someone commits an act knowingly and with the intention to deceive.


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# What is the intent?

**The seriousness of the fraud is determined by the intent behind the fraud.**

- Was the mistake an unintentional error?  Or was it the result of intentional fraudulent behavior?
- If the mistake was an unintentional error, could it have been prevented with environmental controls (e.g., better policies directing documentation, better delineation of duties to ensure appropriate decision making)?

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# FWA Laws

The federal and state governments have a long history of regulating health care practices to prevent fraud, waste and abuse.  These include:

- False Claims Act
- Anti-Kickback Statute
- Physician Self-Referral Statute (Stark)
- Exclusion Statute
- Civil Monetary Penalties Law

You do not need to know all the details of these laws in order to do your part in preventing FWA.  However, by the end of this training, you will have a general understanding of how these laws impact your role at NMH.

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# False Claims Act

**This law makes it illegal for any person to knowingly make a fraudulent claim for payment to the federal or state government.**

- You **do not have to intend to defraud the government to violate this law**. You can be liable for violating this law if you act with **deliberate ignorance or reckless disregard** of the law.

- The False Claims Act generally applies to any type of government claim for payment, but the federal government aggressively pursues False Claims Act enforcement within the health care industry.

> False Claims Act violations can be fined up to three times the amount of the false claim, plus $21,916 per claim. And fines add up quickly because each separate claim submitted to the government can be a separate ground for liability.

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# Anti-Kickback Statute

**The Anti-Kickback Statute makes it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a government health care program (such as Medicare or Medicaid).**

- Remember that both the “giver” and the “receiver” of an inappropriate inducement or reward are liable under the Anti-kickback statute. This is why all NMH business must be conducted in a fair and transparent manner.

Anti-kickback violations can result in prison sentences and fines and penalties of up to $74,792 per kickback plus three times the amount of the underlying transaction.

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# Stark Law

**The Self-Referral Prohibition Statute is also commonly known as the Stark Law.**

- This law prohibits physicians from referring Medicare or Medicaid patients to an entity with which the physician or a physician's immediate family member has a financial relationship — unless an exception applies.
- This is a complex law with severe penalties for non-compliance, so **every** contractual arrangement between NMH and a physician must be reviewed by Provider Services and Compliance/Legal. All relationships must be appropriately documented.

Penalties for physicians who violate the Stark Law may include fines of up to $24,253 for each service performed in violation of the law, repayment of claims, and potential exclusion from all Federal Health Care Programs.

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# Exclusion Statute

**Under the Exclusion Statue, the federal Health and Human Services Office of the Inspector General must exclude providers and suppliers convicted of any of fraud, waste or abuse from participation in federal health care programs (such as Medicare and Medicaid).**

- As a Medicare/Medicaid provider, NMH must not employ, contract, or otherwise do business with any excluded individual or entity.

- The federal government maintains exclusion lists, and NMH is obligated to routinely screen these lists to ensure it does not do business with any excluded individual or entity.

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# Civil Monetary Penalties Law

The Civil Monetary Penalties Law authorizes penalties for a variety of health care fraud violations. Violations that may justify penalties include:

- Presenting a claim that you know, or should know, is for an item or service not provided as claimed or that is false or fraudulent.
- Presenting a claim you know, or should know, is for an item or service that Medicare will not pay.
- Violating the Anti-kickback Statute.

> Penalties may be assessed up to three times the amount claimed for each item or service, or up to three times the amount of payment offered, paid, solicited or received.

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# FWA Committed by Customers

In addition to the types of errors or intentional bad acts that may constitute FWA committed by health care providers, Medicare/ Medicaid beneficiaries may also commit FWA. If you see any of these situations occur, report the activity to the compliance department.

- **Drug diversion** occurs when someone uses drugs, medications, and other pharmacy supplies for reasons other than their original or intended purpose.
- **Member fraud** occurs when a member carries out a fraudulent activity by falsifying member enrollment data or identity theft.
- **Identity fraud** occurs when someone pretends to be someone else by assuming that person's identity; often, this is done to access resources, obtain credit, or obtain other benefits in that person's name.

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# What are your FWA Prevention Responsibilities?

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

1. You must comply with all applicable regulatory requirements, including participating in compliance program activities.
2. You have a duty to the to report any suspected or actual non-compliance that you may know of.
3. You have a duty to follow NMH's Code of Conduct. The Code of Conduct can be found on the Compliance intranet webpage.
4. When in doubt, ask questions. The Compliance Department is a resource for all NMH team members.

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# Reporting Fraud, Waste, and Abuse

- **All NMH Team Members are expected to report any known or potential concerns of FWA.**
- **All reported compliance concerns are investigated by the Compliance Department. Investigations are handled confidentially.**
- **NMH prohibits any form of retaliation against a team member who reports a FWA concern in good faith.**

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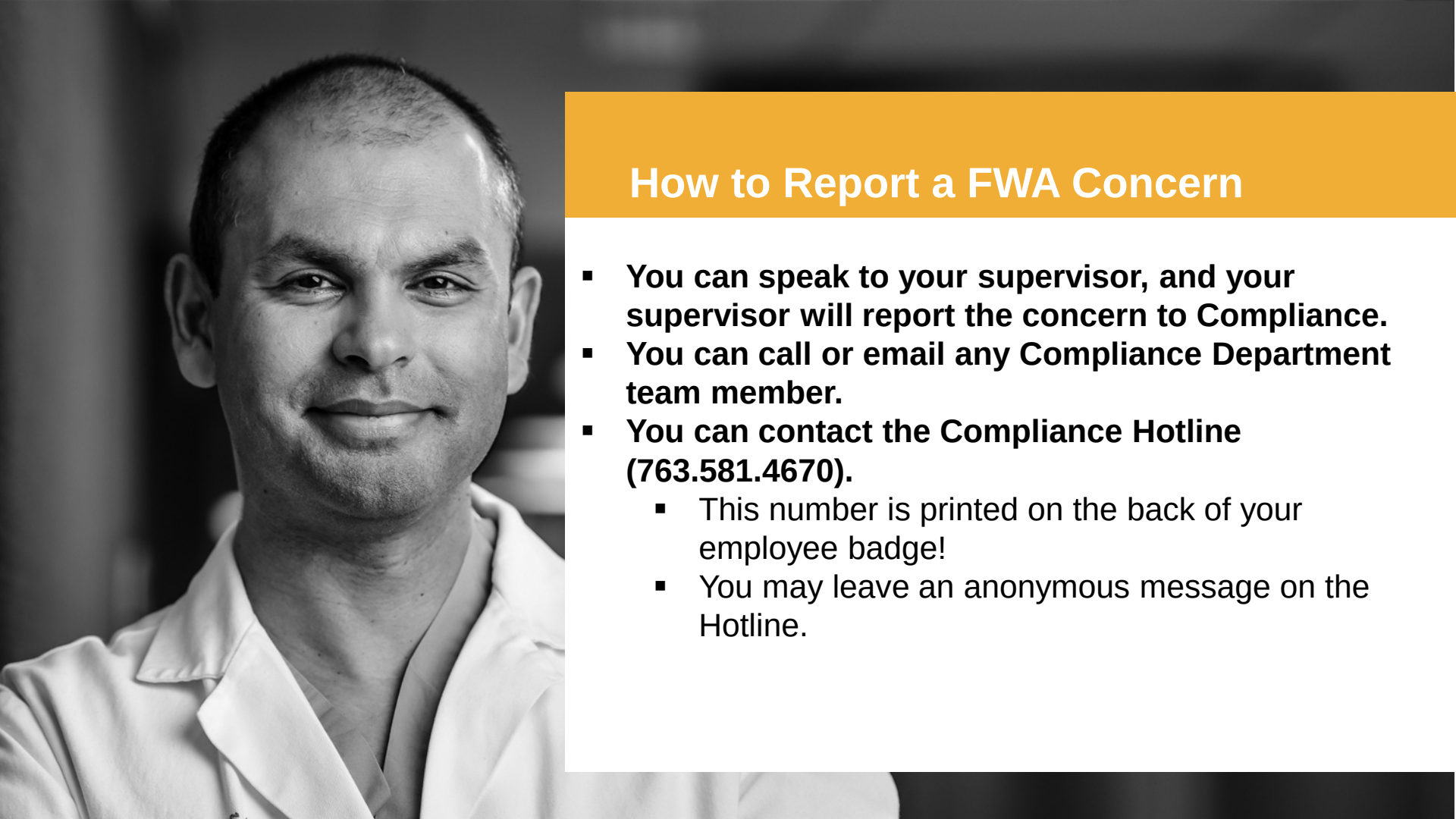

## How to Report a FWA Concern

- **You can speak to your supervisor, and your supervisor will report the concern to Compliance.**
- **You can call or email any Compliance Department team member.**
- **You can contact the Compliance Hotline (763.581.4670).**
  - This number is printed on the back of your employee badge!
  - You may leave an anonymous message on the Hotline.


# Compliance Contacts

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