HealthcareSource Contingent Talent Management℠

Compliance (Fraud, Waste and Abuse)

Core Competency Inservice

January 2020

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Introduction

In a highly regulated, high-risk industry like healthcare, compliance is especially important. Healthcare compliance is the process of following rules, regulations, and laws that relate to healthcare practices.

Compliance in healthcare can cover a wide variety of practices and observe internal and external rules. But most healthcare compliance issues relate to patient safety, the privacy of patient information, and billing practices.

We have all seen examples in the news of a company, or its representatives, misrepresenting the company's assets, making misleading statements about what business the company is in, mishandling client's money or misrepresenting services provided to clients. To ensure that Medicare/Medicaid providers are up front, honest, and respectable they are required to have a formal Compliance Program. Medicare/Medicaid (CMS) believes that the establishment of an effective compliance program will protect the Medicare Trust Fund by significantly reducing the risk of unlawful or improper conduct and will likely lead to other efficiencies. The CMS program is structured on a seven-point plan. Each provider's plan must include:

- A written employee code of conduct to include standard policy and procedure rules and regulations
- The designation of a Compliance Officer and Compliance Committee.
- A staff education plan on compliance programs.
- Effective lines of communication for staff to report compliance issues, or concerns, including a hotline.
- An effective way to audit and monitor the program.
- A consistent enforcement of guidelines for non-compliance.
- A way to enforce policies for investigations of reported non-compliance that include, guidelines for investigations and reporting to CMS.

Benefits of a Good Compliance Program

Complying with industry standards and regulations helps healthcare organizations continue to improve the quality of care.

Healthcare organizations are also held to strict standards, regulations, and laws from the federal and state levels. Violations of these laws can result in lawsuits, hefty fines, or the loss of licenses.

Having a good compliance program will:

- Convey to staff and clients that the company conducts business in an ethical manner and is committed to quality customer/patient care
- Increase the potential of proper submission and payment of claims
- Reduce billing mistakes
- Improve the results of reviews conducted on Medicare claims
- Avoid the potential for fraud, waste and abuse
- Promote patient safety and ensure delivery of high-quality patient care

How are Individuals Involved

Individuals can make the choice to stand against illegal and unethical situations by simply, conducting themselves with respect and integrity, and following the companies' Code of Conduct.

If the individual feels that the company's values have been compromised in any way, then he or she takes integrity to a higher level and speaks up to remedy the situation.

Compliance keeps operations running smoothly and makes sure everyone follows proper procedures and understands expectations.

But compliance in healthcare comes with even higher stakes than in other industries. If a doctor or nurse doesn't follow proper procedure, they can end up injuring a patient or another staff member. Ultimately, healthcare compliance is about providing safe, high-quality patient care.

What Should be Reported

- Theft
- Fraudulent or inaccurate financial reporting
- Abuse of company resources
- Violation of environment, health, or safety laws
- Improper gifts or gratuities
- Alcohol or drug abuse
- Bribery or kickbacks
- Harassment or discrimination
- Threats of violence

Fraud, Waste and Abuse in the Medicare Program

There are differences among fraud, waste, and abuse (FWA). One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.

Fraud

Fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit. The Health Care Fraud Statue makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years and is subject to criminal fines up to $250.000.

Examples of actions that may constitute Medicare fraud include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep

- Billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

Waste

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Examples of actions that may constitute Medicare waste include:

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory tests

Abuse

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of actions that may constitute Medicare abuse include:

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Civil False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

Whistleblowers: A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded: Person who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent, of the money collected.

Criminal Health Care Fraud: Persons who knowingly make a false claim may be subject to criminal fines and imprisonment.

Exclusion

- 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 OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).
- The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.

Summary

There are differences among fraud, waste, and abuse (FWA). One of the primary differences is intent and knowledge. Fraud requires the person have intent to obtain payment and knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment but intent to defraud and knowledge of wrongful actions are lacking. Laws and regulations exist that prohibit FWA.

Penalties for violating these laws may include:

- Civil Monetary Penalties
- Civil prosecution
- Criminal conviction, fines, or both
- Exclusion from all Federal health care program participation
- Imprisonment
- Loss of professional license

What do I do when issues arise?

When reporting an issue, stick to the chain of command. If the floor supervisor doesn't resolve an issue, continue reporting the issue in this order:

- Go to the floor supervisor
- Go to the floor supervisor's supervisor
- Go to the HR director
- Go to the Director of Quality Services
- Go to the Administrator
- Call the Compliance Line

If after exhausting all other avenues, you still have concerns about quality of care or safety, you then have the right to call The Joint Commission, Department of Health, CMS, or any other regulatory agency of the facility.

References

Medicare Fraud and Abuse: A Serious Problem that Requires Your Attention, Accessed Nov 2014.

"Medicare Parts C and D General Compliance Training." CMS.Gov. January 2019.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf