Fraud and Abuse: Your Rights and Responsibilities

Corporate Compliance

Objectives:

The Education is intended to educate MHS employed and non-employed staff on:

1) Definitions of fraud and abuse
2) Types of fraud
3) Overview of fraud and abuse related to the Medicare and Medicaid programs
4) Fraud red flags
5) Your responsibility to report suspected fraud and/or abuse
6) Your right to be protected from retaliation for reporting legitimate issues
7) How to report suspected fraud and abuse

What is Fraud?

- Fraud – as defined by Black's Law Dictionary (9th ed. 2009):
  - "A knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment."
- Basic definition:
  - Any intentional or deliberate act to deprive another of property or money by guile, deception, or other unfair means.

Types of Fraud

- Bribery
- Extortion
- Conflicts of interest
- Forgery
- Theft of money or property
- Breach of fiduciary duties
- Theft of trade secrets
- Misrepresentation of material facts
- Concealment of material facts

Healthcare Fraud and Abuse – What is the difference?

Fraud related to healthcare billing

- Submitting or attempting to submit a claim for payment for health services that contains false or misleading information.
  - **Remember** - The intent to defraud does not matter, only the knowing submission of material information.

Abuse related to healthcare billing

- Conduct that goes against or is inconsistent with accepted, sound medical, business, or fiscal practices resulting in greater reimbursement.

Types of Fraud

Healthcare Fraud

- Providers
  1. Billing for services not rendered or goods not provided
  2. Duplicate submission of claims for the same services in order to receive additional payment.
  3. Misrepresenting the services that were provided
  4. Billing separately for services that are bundled together (unbundling)
  5. Billing for more expensive procedures that what was actually performed (up-coding)
  6. Performing medically unnecessary services.
  7. Falsifying certificates or treatment plans.
  8. Accepting bribes or kickbacks for referrals
  9. Waiving patient co-pays or deductibles and over-billing the insurance carrier.
  10. Inflating or falsifying cost reports

Types of Fraud

Healthcare Fraud

- Members
  1. Using a member ID that does not belong to you
  2. Adding someone to a policy that is not eligible for coverage
  3. Failing to remove someone from a policy when that person is no longer eligible
  4. Doctor shopping – visiting several doctors to obtain multiple prescriptions.

Medicare

Started in 1965, under Title XVIII of the Social Security Act

- Federally funded program for:
  - Senior citizens 65 and older
  - Persons under 65 with long term disabilities
  - Persons of any age with end-stage renal disease
- Consists of 4 parts:
  - Part A: Covers hospital care, skilled nursing, Home Health and Hospice
  - Part B: Covers doctors' services and outpatient care such as: physical and occupational therapy, doctor visits, supplies, ambulance, and labs.
  - Part C: Insurance under Medicare Advantage programs
  - Part D: Prescription drug coverage

Medicaid

- Program originated in 1965
- Funded by both federal and state governments; administered by the state
- Programs are for low-income and financially needy
- Benefits are determined by the state

MultiCare participates in both the Medicare and Medicaid programs!

Program Oversight

CMS – Centers for Medicare and Medicaid

www.cms.gov

Duties:

- Operational Direction
- Policy Guidance
- Oversight

OIG – Office of the Inspector General

www.oig.hhs.gov

Duties:

- Investigate suspected fraud and abuse

DSHS – Department of Social and Health Services

www.hrsa.dshs.wa.gov

Duties:

- Provide oversight and coverage of the state Medicaid program

Federal False Claims Act
31 USC Section 3729

- Enacted in 1863 to fight profiteering by government suppliers; allows the government to recover money for the submission of false claims.
- Establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the US government for payment.
  - Knowingly:
    - Has actual knowledge of falsity of information on the claim
    - Acts in reckless disregard or deliberate ignorance of the truth or falsity of the information on the claim

Penalties:

- Civil penalties of up to $11,000 per false claim, plus 3 times the amount of damages sustained by the government.

Federal False Claims Act
31 USC Section 3729

What is a Claim?

- A claim is any request or demand for money, whether or not the U.S. has title to the money, that is submitted to the US Government or to a contractor on the Government's behalf

Examples:

1. A Hospital Bill/Claim (UB-04)
2. A Physician Bill/Claim (CMS-1500)

Fraud Red Flags

Warning signs that fraud may be being committed

- Life style changes (expensive cars, jewelry, homes, etc.)
- Significant personal debt or credit problems
- Refusal to take vacation or sick leave for fear of detection
- High employee turnover in areas most vulnerable to fraud
- Lack of segregation of duties
- Refusal of promotions for fear of detection
- Rewriting records under the guise of neatness in presentation
- Borrowing money from co-workers

MultiCare Practices

- We have an active Corporate Compliance Program as well as an Anti-Fraud Committee
- We have a compliance Hotlines for reporting issues/concerns
- We investigate reported issues/concerns
- We perform audits
  - routine audits as part of the compliance program
  - special audits based on reported issues
- We provide ongoing education
- We conduct exit interviews with departing employees to identify outstanding concerns
- We ask for feedback on educational sessions

Reporting Issues and Concerns

Your Responsibilities are outlined in the MHS Standards for Business Conduct – If you see or suspect Fraud and/or abuse you should:

- Discuss the issue with your supervisor, and if not comfortable discussing this issue with your supervisor, go to another resource.
- Discuss with a higher-level manager, and if not comfortable discussing this issue with a higher-level manager, go to another resource.
- You may always report these issues/concerns to the Compliance Hotline, HR, or Legal. All reporting can be done anonymously.

Compliance Hotline:

253-459-8300 , 866-264-6121 or email compliance@multicare.org

You can also contact the government directly with your issues and concerns

Reporting Issues and Concerns

From the MHS Policy '**Compliance Program: Reporting and Investigating Concerns of Violations**'

- It is MHS Policy to ensure that no employee is penalized for raising, in good faith, any issue or concern.
- MHS will not permit or condone retribution towards an employee reporting violations or concerns conscientiously and in good faith.

MHS takes compliance very seriously.

MHS has a ZERO tolerance policy for retaliation/retribution!

Reporting Issues and Concerns

- Every MHS employee has a duty to report!
  - If you identify any compliance issues, fraud situations, or other inappropriate or illegal activity, REPORT IT!
  - Every MHS employee has an obligation to report the wrong doing immediately.

Failure to report a concern may result in disciplinary action!

Questions

- If you have questions about your rights and responsibilities, please use the reporting channels.
  - You are stewards of MultiCare's reputation and assets.
  - We are committed to compliant and ethical behaviors.

Additional information on fraud prevention at MultiCare can be found in the Anti-Fraud policy as well as the Fraud and Abuse: False Claims, Payments and Records policy.

Acknowledgement

I acknowledge that I have learned about my responsibilities to MultiCare as they relate to fraud prevention, accurate and honest billing and reporting of issues and concerns.

SUBMIT   START OVER

You must click submit to complete this module. If you are not ready to acknowledge then go back through the module and return again to this acknowledgement.