Compliance Training

General Compliance and Fraud, Waste & Abuse - 2022

THIS TRAINING SESSION IS RECOMMENDED FOR:

All staff members in practices receiving payments from federally funded programs, such as Medicare and Medicaid. Many state-run Medicaid programs operate through payors, but still qualify as a Medicaid initiative, and require this training.

Training Objectives

The training objectives for this module are to:

- ensure an understanding of the concepts fraud, waste and abuse;
- identify responsibilities for prevention
- provide information on Medicare Parts C & D General Compliance;
- outline compliance program elements;
- identify applicable regulations;
- define reporting requirements.

This training module is intended to help downstream entities of Medicare and Medicaid health plans and programs, such as medical and dental practices, to comply with the training requirement for fraud, waste and abuse prevention. If your organization does not accept government reimbursements for patient care, then the training information does not apply to your practice. If your organization participates with any Medicare/Medicaid program, the OIG requirements apply to your practice, all of its providers and employees.

Every year billions of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – including you. This training helps you detect, correct, and prevent FWA. You are part of the solution, and compliance and combating FWA is everyone's responsibility. As an individual who provides health or administrative services for Medicare enrollees, your every action potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

Fraud, Waste and Abuse Awareness

Training for fraud and abuse is required upon hire and annually thereafter to ensure that health and dental care professionals in settings that participate with Medicare/Medicaid programs understand requirements for preventing fraud, waste and abuse in Federal programs.

Two departments within Health and Human Services (HHS) require training for healthcare providers and employees. The Centers for Medicare & Medicaid Services (CMS) and Office of the Inspector General (OIG) require new-hire and annual fraud and abuse training for healthcare organizations participating in Federally funded programs such as Medicare and Medicaid.

The OIG Guidance recommends that training include: awareness and the importance of a compliance program; the consequences of violating compliance requirements and policies implemented by the practice; the role of providers and employees in the operation of the compliance program, and an understanding that compliance is a condition of employment.

Definitions

As with any regulatory requirement, it is important to understand commonly used terms, laws and concepts.

Abuse - Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare 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.

Examples of abuse would include, but not be limited to:

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

Erroneous Claim – The definition of erroneous identifies something that is not correct, an inaccurate calculation, or not being in conformity with fact or truth. The OIG states that there is a difference between erroneous (innocent mistakes or billing errors) and fraudulent claims (intentionally or recklessly false claims) when it comes to enforcement. The OIG emphasizes that the majority of providers work ethically and that even ethical providers (and their staff) make unintentional or innocent billing mistakes and errors. Furthermore, the OIG emphasizes that they do not prosecute erroneous claims. They simply expect repayment once the error is discovered and corrected.

Fraud – Fraud is 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. In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

The Health Care Fraud Statute 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 for up to 10 years. It is also subject to criminal fines of up to $250,000.

Examples of fraud would include, but not be limited to:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments that the patient failed to keep;
- Billing for non-existent prescriptions; and
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Waste – Waste includes overusing services, or other 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 the treatment of a specific condition; and
- Ordering excessive laboratory tests.

Stark Statute (Physician Self-Referral Law)- The Stark law pertains to physician referrals under both Medicare and Medicaid and states that a physician cannot refer patients to an entity for the purpose of furnishing certain designated health services if the physician or an immediate family member has a financial relationship with that entity. The entity cannot bill for improperly referred services unless an exception or safe harbor applies. It is essential to realize that the Stark law has no state-of-mind requirement. The intention and motives of the parties involved are irrelevant. If statutory requirements are met, there is a violation, unless an exception or safe harbor applies.

The Stark law is targeted against over-utilization and improper patient steering, and is intended to increase market competition. Under the civil penalty, the entity that did the billing must refund the payments for improperly referred services. There is also a Civil Monetary Penalty (CMP) of up to $24,250 that may be imposed for each service provided. There may also be up to a $161,000 fine for entering into an unlawful arrangement or scheme.

False Claims Act- 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;
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government;
- Makes or uses a false record or statement supporting a false claim; or
- Presents a false claim for payment or approval.

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty. The Civil Monetary Penalty (CMP) may range from $5,500 to $11,000 for each false claim.

Anti-Kickback Statute - The Anti-Kickback Statute prohibits 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 the Medicare Program).

Violations of the Anti-Kickback Statute are punishable by a fine of up to $25,000, imprisonment for up to 5 years or both.

Whistleblowers - Individuals may report cases of fraud and abuse directly to the OIG or appropriate state agency (in the case of a state's False Claims Act). An individual should attempt to bring a potential fraud and abuse problem to the attention of the practice for investigation and corrective action. However, an individual has the right to report directly to a government agency, especially if they feel that the practice has failed to take appropriate corrective action.

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

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

Non-Retaliation - The False Claims Act (federal and state) includes specific provisions to protect whistleblowers from retaliation by their employers. Any private party who initiates or assists with a federal False Claims Act case against his/her employer is protected from discharge, demotion, suspension, threats, harassment and discrimination in the terms and condition of his or her employment if the employer's actions are taken in response to the employee's efforts on the case.

A private party who suffers retaliation for his or her assistance with a case against his/her employer is entitled to reinstatement, two times the amount of back pay, interest and compensation for special damages, including attorney's fees.

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). You can access the LEIE at https://exclusions.oig.hhs.gov. Exclusion is often the penalty applied to persons/organizations that commit fraud, waste or abuse in Medicare/Medicaid programs. Being excluded means that the person or entity may neither participate in nor bill any service to a Medicare/Medicaid program.

Operational Responsibilities for Compliance

The Practice/Organization – The practice or organization bears the majority of the responsibility for preventing fraudulent, wasteful and/or abusive claims. This is accomplished through the development and implementation of a compliance program as identified in the OIG guidance.

Providers and Employees - Each employee has a responsibility for their own personal conduct in regard to compliance with the policies and procedures of the practice. Many organizations have a code of conduct that establishes the intent of a practice to conduct its business with honesty, integrity, with fees that are appropriate for services provided by the practice, while ensuring that it complies with applicable state and federal statutes and regulations. A code of conduct will also define the conduct that is expected of employees, to help clarify legal and ethical issues, and, in many cases, provide employees with procedures for reporting wrongful conduct. You will often be asked to review and sign a code of conduct document upon hire into a health/dental care organization.

Each employee also has a responsibility to be aware of his/her surroundings, and the potential wrongful conduct of others that may place the practice at risk for violating federal or state laws. The organization's ability to prevent or detect wrongful conduct in a timely manner depends, in part, on the awareness of each employee. Any observation or suspicion of wrongful conduct or violation of policies and procedures should be brought to the attention of

designated personnel (a supervisor/manager, Compliance Committee, or Compliance Officer).

Good Faith – Bad Faith - Each employee has a responsibility to report suspected wrongful conduct and/or violations of policies and procedures in "good faith" as soon as they become aware of them. You are acting in "bad faith" if you report someone for violating his or her employee obligations when you know that he or she really is not. In other words, you would be acting in bad faith if you reported someone out of spite, jealousy, or for some other improper purpose. An accusation made in bad faith will subject you to disciplinary action, up to and including termination.

Reports of suspected misconduct can be made anonymously. However, as identified in the OIG guidance, it is not possible to guarantee that your identity will not be discovered or disclosed in the course of an investigation, particularly when it is necessary to share the results of an investigation with a government agency or other law enforcement personnel. While reports can be made anonymously, they may be more difficult to investigate.

When reporting suspected FWA, you should include:

- Contact information for the source of the information, suspects, and witnesses;
- Details of the alleged FWA;
- Alleged Medicare rules violated; and
- The suspect's history of compliance, education, training, and communication with your organization or other entities.

Potential Indicators of Fraud, Waste and Abuse

The following examples present issues that may be potential FWA:

- Does the beneficiary's medical history support the services requested?
- Is the person who is receiving the medical service the actual beneficiary (identity theft)?
- Does the provider bill the Sponsor for services not provided?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Is the provider's diagnosis for the member supported in the medical record?

Where to Report Suspected Fraud, Waste or Abuse

It is always recommended to start within your organization. Report to your supervisor, compliance officer, or via your hotline or other anonymous reporting method to try to get the issue rectified internally. You may also contact:

HHS Office of Inspector General:

- Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
- Fax: 1-800-223-8164
- Email: HHSTips@oig.hhs.gov
- Online: https://oig.hhs.gov/fraud/report-fraud/index.asp

For Medicare Parts C and D:

- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRx (1-877-772- 3379)

For all other Federal health care programs:

- CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048
- HHS and U.S. Department of Justice (DOJ): https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud

Corrective Action

Corrective actions may include:

- Adopting new prepayment edits or document review requirements;
- Conducting mandated training;
- Providing educational materials;
- Revising policies or procedures;
- Sending warning letters;
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment; or
- Terminating an employee or provider.

Seek Clarification - Regulations are complicated and subject to frequent change as well as interpretation. There will be instances when you may not be sure if your actions are compliant with current policies/laws/guidance. It is important to realize that asking for clarification is better than making an assumption and placing yourself and your organization at risk for violations. When in doubt, the correct action is to contact your supervisor or your compliance officer to obtain guidance.

General Compliance

The Centers for Medicare & Medicaid Services (CMS) requires Sponsors to implement and maintain an effective compliance program for its Medicare Parts C and D plans.

An effective compliance program should:

- Articulate and demonstrate an organization's commitment to legal and ethical conduct;
- Provide guidance on how to handle compliance questions and concerns; and
- Provide guidance on how to identify and report compliance violations.

What Is an Effective Compliance Program?

An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

- Prevents, detects, and corrects non-compliance;
- Is fully implemented and is tailored to an organization's unique operations and circumstances;
- Has adequate resources;
- Promotes the organization's Standards of Conduct; and
- Establishes clear lines of communication for reporting non-compliance.

An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as Fraud, Waste, and Abuse (FWA). It must, at a minimum, include the seven core compliance program requirements as outlined below.

Interactive Training Reminder

Compliance Training is an interactive training program in which you can address questions with other staff members or supervisors to obtain clarification for situations in your work setting.

Write down any questions that you have about the training topic and address them with your Training Coordinator or supervisor.

Compliance Program Elements

The OIG Guidance identifies a group of written policies that are designed to help a practice prevent fraudulent and abusive claims. An effective compliance program will include all of the following seven elements as outlined below:

- ***Written policies, procedures and standards*** of conduct. These items help to articulate your organization's commitment to comply with applicable Federal and State standards and describe compliance expectations.

- ***Compliance officer, committee and oversight*** – The compliance officer and committee are responsible for the activities and status of the compliance program, including any issues that are identified, investigated or resolved as part of the program. Senior management must be engaged in the process and are also responsible for oversight.

- ***Monitoring and Auditing*** – Commonly referred to as chart audits, auditing is the quality control mechanism for a practice's billing and charting processes. There are essentially two types of monitors. In the first, a practice conducts its own internal audits of claims to identify any problems, errors, or failures to follow the rules. Internal audits are also performed as a mechanism to verify the work of new employees.

  The second type of monitor is to have chart audits performed periodically by an outside entity. Use of an outside entity is a means to verify the practice has not overlooked any problems during its internal audits and has an effective Compliance Program.

- ***Effective Lines of Communication*** – Open communication allows your practice to take swift corrective action for billing and coding problems. The communication element may be accomplished by implementing a clear "open door" policy between physicians, compliance team leaders, and staff members. Having a method to communicate updates, changes in coding requirements, information from outside billing services (if applicable), and the general opportunity to freely address concerns promotes an effective level of communication.

- ***Response and Disclosure*** – A Compliance Program should provide for rapid response (i.e., investigation and corrective action) for problems with billing/coding or claims. Corrective action should also include self-reporting or disclosure of major problems to regulatory agencies for further investigation. The OIG has a specific protocol for self-reporting. Your compliance officer would handle self-reporting. Your job is to report potential issues to your compliance officer or supervisor, and they will determine whether an incident requires self-reporting.

- ***Training and Education*** – Training occurs at different levels and may take several forms. This training module is intended to provide awareness of the importance of compliance, individual responsibilities, and the consequences for non-compliance. This module covers both fraud, waste and abuse and general compliance.

In addition to this training on fraud, waste, abuse and general compliance, your organization should also ensure that individuals involved in billing/coding (including billers, coders, revenue cycle managers, scribes and providers) receive regular, updated training for changes in coding and billing procedures. This type of training will be an ongoing process. The OIG recommends 1.5 hours per person of annual billing/coding training as a minimum for applicable staff, and can take the form of internal meetings/trainings by your billing/revenue cycle manager, webinars, courses, etc.

- ***Disciplinary Action*** - A practice's enforcement and disciplinary procedures ensure that violations of OIG compliance program policies will result in consistent and appropriate actions. The OIG identifies sanctions, or disciplinary actions, as an effective means for maintaining compliance. The consequences of not complying with the practice's policies and procedures could result disciplinary action that includes:
  - Mandatory training or re-training;
  - Sanctions such as a verbal warning, written warning, or temporary suspension; or
  - Termination.

As part of the Medicare Program, you must conduct yourself in an ethical and legal manner. It's about doing the right thing!

- Act fairly and honestly;
- Adhere to high ethical standards in all you do;
- Comply with all applicable laws, regulations, and CMS requirements; and
- Report suspected violations.

Consequences

Failure to follow Medicare Program requirements and CMS guidance can lead to serious consequences including:

- Contract termination;
- Criminal penalties;
- Exclusion from participation in all Federal health care programs; or
- Civil monetary penalties.

Without programs to prevent, detect, and correct non-compliance, there is a risk of:

Harm to beneficiaries, such as:

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Other hurdles to care

Less money for everyone, due to:

- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower Star ratings
- Lower profits

Reporting

How to Report Potential Non-Compliance:

- Talk to a manager or supervisor;
- Call your ethics/compliance help line/hotline or use other reporting methods identified by your organization; or
- Report to the sponsor of a plan with which you participate.

Don't hesitate to report non-compliance. There can be no retaliation against you for reporting suspected non-compliance in good faith. Your organization must offer reporting methods that are:

· Anonymous;
· Confidential; and
· Non-retaliatory.

Refer back to the heading titled "Where to Report Suspected Fraud, Waste or Abuse" on pages E and F in the Fraud, Waste and Abuse section of this training for more detailed information on reporting.

RESOURCES

Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training
https://oig.hhs.gov/compliance/provider-compliance-training

OIG's Provider Self-Disclosure Protocol
https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf

Physician Self-Referral
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral

A Roadmap for New Physicians: Avoiding Medicare Fraud and Abuse
https://oig.hhs.gov/compliance/physician-education

Safe Harbor Regulations
https://oig.hhs.gov/compliance/safe-harbor-regulations

Compliance Education Materials: Compliance 101
https://oig.hhs.gov/compliance/101

Part C and Part D Compliance and Audits - Overview
https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits

For the Centers for Medicare & Medicaid Services (CMS) Glossary, visit:
https://www.cms.gov/apps/glossary

Compliance Training Test

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NAME: _____ DATE: _____

SIGNATURE: _____ EMPLOYMENT DATE: _____

Return your test to your supervisor or Compliance Coordinator upon completion. Individual tests will be maintained to document participation and understanding of the information. Review the training information to find the correct answers to any questions that may have been missed.

1 The government treats fraudulent claims and erroneous claims the same way, with the same penalties.

Select One **T** **F**

2 The following are all potential penalties for violating fraud, waste, and abuse (FWA) laws: civil monetary penalties, imprisonment, exclusion from Federal healthcare programs.

Select One **T** **F**

3 Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment, but the provider has NOT knowingly and/or intentionally misrepresented facts to obtain payment.

Select One **T** **F**

4 There are seven different elements to an effective OIG compliance program.

Select One **T** **F**

5 Civil Monetary Penalties are often levied against a billing and coding person who makes an error on a claim that gets submitted to Medicare/Medicaid.

Select One **T** **F**

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

Select One **T** **F**

7 Fraud is defined as any claim that contains erroneous information, from simple clerical errors to intentionally fraudulent submissions.

Select One **T** **F**

8 Bribes or kickbacks of any kind for referrals for services that are paid under a Federal healthcare program constitute fraud by the person making as well as the person receiving them.

Select One **T** **F**

9 The OIG recommends 1.5 hours per person of annual billing/coding training as a minimum for applicable staff, and can take the form of internal trainings by your billing/revenue cycle manager, webinars, courses, etc.

Select One **T** **F**

10 Some of the laws governing Medicare Parts C and D fraud, waste, and abuse (FWA) include the False Claims Act, the Anti-Kickback Statute, and the Health Care Fraud Statute.

Select One **T** **F**

Click Here to Take Your Quiz