

Chapter 8

Fraud and Abuse

South Country Health Alliance (SCHA) recognizes that fraud and abuse have significant impacts on the cost of health care and health insurance to our members, providers and communities.

Health care fraud and abuse is a serious concern for South Country Health Alliance and the entire health care industry. While most health care providers, suppliers, practitioners, and patients are honest, a small minority commit health care fraud and abuse that costs Medicare, Medicaid, and other government health care programs billions of dollars each year. Part of SCHA's mission is to prevent, detect, investigate, and report health care fraud and abuse. SCHA works with members and providers to address issues and concerns about fraud and abuse.

SCHA administers health insurance plans that strictly involve state and federal public dollars. Because of this, SCHA is subject to certain laws designed to contain fraud, waste and abuse of these public dollars.

LEGAL REQUIREMENTS

SCHA is required by Minnesota Law to:

- File an annual anti-fraud plan with the Minnesota Department of Human Services (DHS)
- Have the plan on file with the Minnesota Department of Commerce
- Refer suspected fraud to law enforcement

REPORTING FRAUD, WASTE AND ABUSE

To report suspected fraud or abuse committed against SCHA:

- Submit an anonymous report to South Country Health Alliance at 1-866-722-7770 (toll free) or
- Submit an anonymous report to "Report-it" at 1-877-778-5463 or on-line at reportit.net (login is SCHA, password is Owatonna)

Rules and Regulations

You can access Minnesota statutes and rules referred to in this manual at www.leg.state.mn.us/leg/statutes.htm. The Code of Federal Regulations is available at <http://www.gpoaccess.gov/cfr/index.html>.

FRAUD AND ABUSE OVERVIEW

Participating providers should notify SCHA of any situations where provider billing fraud may have occurred, or where members have engaged in fraudulent or abusive activity. Examples of the former include billing for services not rendered, or misrepresentation of claim data (such as upcoding or unbundling).

Member abuse includes falsification of enrollment information, altering or fabricating claims, lending your ID card to someone to use, or prescription drug forgery. Following are more specific definitions and examples.

Fraud

Fraud consists of any acts that constitute a crime against SCHA or other health care programs, or attempts or conspiracies to commit those crimes, including but not limited to the following:

- Theft
- Perjury
- Aggravated forgery
- Making a false statement, claim or representation to SCHA or other health care program when the person knows or should reasonably know the statement, claim or representation is false

Abuse

Abuse is a pattern of practice that is inconsistent with sound fiscal, business or health service practices, and those practices result in unnecessary costs to SCHA or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health services, including but not limited to the following:

- Continually submitting claims from which required information is missing or incorrect
- Continually submitting claims that do not comply with the requirements to be a covered service
- Continually submitting claims for services not medically necessary
- Continually submitting claims using procedure codes that overstate the level or amount of health service provided
- Continually submitting claims for health services that are not reimbursable by SCHA
- Continually submitting or causing submission of false information for the purpose of obtaining (prior) authorization, inpatient hospital admission certification or a second medical opinion
- Continually billing SCHA for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability
- Continually failing to report duplicate payments from third-party payers for covered services provided to SCHA members that were billed to SCHA
Neglecting to keep financial records for the services provided to SCHA members as required by federal and state law
- Neglecting to maintain health records as required by federal and state law

- Neglecting to disclose or make available to SCHA a member's health record or a provider's financial records as defined in the provider contract
- Submitting a false or fraudulent application for provider status
- Neglecting to use generally accepted accounting principles or other accounting methods that relate entries on the member's health record to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule
- Payment of health plan funds to a second provider whom the primary provider knew was suspended or barred from participating in federal health care programs
- Receiving remuneration in return for the provision of health care services in violation of the Stark Law (42 U.S.C., sect. 1395nn) or the Anti-kickback Statute (42 U.S.C., sect. 1320a-7b(b))

CMS Requirements for Fraud, Waste and Abuse Compliance Training

This training requirement applies to all organizations that provide health care services or administrative services for Medicare-eligible individuals under the Medicare Advantage or Medicare Part D programs. It affects you as a provider of health care services to Medicare members. As a result of this CMS requirement, all employees of each provider organization will need to complete the initial required compliance training by December 31 of each calendar year, beginning in 2009. This training is now available online from the Minnesota Council of Health Plans at www.mnhealthplans.org/tools/links.cfm.

Provider organizations will be responsible for administering the training to employees and tracking the organization's completion of it. Within 30 days of the organization completing the FWA Compliance Training, an officer or director from the provider organization will need to attest to the organization's completion of the training by completing and returning the attestation form to SCHA.

SCHA has sent out details about this training directly to each contracted provider organization, including the attestation form for an officer or director of the organization to complete and return to SCHA.

If the organization has contracted with other entities to provide health care services or administrative services on behalf of Medicare Advantage or Part D members, it will need to make the compliance training materials available to those entities. In addition, it will need to attest that the organization has required attestation forms from those entities that they—as well as any entities that they contract with that are responsible for the administration or delivery of services to Medicare members—have completed the FWA Compliance Training.

Upon request, the organization may be asked to provide attestation forms from those entities, as well as copies of their training logs and those of the organization. As a result, organizations must retain a copy of all documentation related to this training for the required record retention period of 10 years and are encouraged to remind the other entities to keep their records for the required 10 years.

SOUTH COUNTRY FRAUD AND ABUSE INVESTIGATIONS

In 2009, as part of its anti-fraud plan, SCHA developed An Investigations Team to investigate allegations of fraud and abuse committed against SCHA. The mission of this team is to prevent, identify, investigate, report and, when appropriate, recover money from health care fraud and abuse. The Investigations Team is authorized to conduct post-payment reviews to ensure compliance with SCHA requirements. To accomplish this, the team monitors use of health services by members and the delivery of health services by our participating providers.

SCHA Investigation Process

South Country conducts routine audits of participating providers to monitor compliance with contractual agreements and administrative protocols. Information is collected from sources such as:

- Government agencies.
- Third-party payers, including Medicare and Medicaid.
- Professional review organizations.
- Members and their responsible relatives.
- Providers and people employed by or under a provider contract.
- Professional associations and boards of providers and their peers.

A fraud and abuse investigation may include:

- Examination of health service and financial records.
- Examination of equipment, materials, prescribed drugs or other items used in a member's health service.
- Examination of claims payments made
- Examination of prescriptions written for members.
- Interviews of anyone with information pertinent to the allegation of fraud or abuse.
- Verification of the professional credentials of a provider, the provider's employees and entities under contract with the provider.
- Determination of whether the health care provided was medically necessary.
- Suspension of claims payment until the investigation is complete.

Following completion of the investigation, the Investigation Team will determine whether:

- The provider is in compliance with the requirements of the contract and administrative protocols.
- The evidence of fraud, theft or abuse supports administrative, civil or criminal action.

After completing the determination, the Investigation Team will take one or more of the following actions:

- Close the investigation when no further action is warranted.
- Impose administrative sanctions.
- Seek monetary recovery.

- Refer the investigation to the appropriate state regulatory agency.
- Refer the investigation to the appropriate local law enforcement officials for review pursuant to Minnesota law.

SCHA may impose these sanctions on providers who commit fraud and/or abuse:

- Placing restrictions on the provider
- Referral to the appropriate state licensing board
- Suspension or termination of the provider contract
- Suspension or termination of the participation of any person or corporation with whom the provider has any ownership or controlling interest
- Requiring a contract that stipulates specific conditions of participation
- Review of the provider's claims before payment
- Suspending payments to the provider

Important Note: SCHA has the authority to seek monetary recovery and to administer sanctions concurrently. SCHA will notify a provider in writing of intent to recover money or impose sanctions.

RECORD KEEPING REQUIREMENTS

Access to Records

South Country's Investigations Team has the right to access records pursuant to the provider contract and the member's consent signed in accordance with Minn. Stat. § 144.335.

During the term of an agreement with SCHA and for six years following its termination, the provider shall give SCHA and its authorized agents—including the Investigations team – access to all information and records related to health services provided according to the agreement, to the extent permitted by law and without further authorization by any member.

The provider shall submit copies of records requested by SCHA **within 14 days** from the date of such request, or sooner if necessary to comply with laws related to the resolution of member complaints or to cooperate with an investigation by SCHA.

If the provider fails to comply, SCHA has the right to withhold reimbursement for health services until the provider fully complies and SCHA and/or its authorized agents have reviewed the information and records.

Health Records

Health records are any electronically stored data, and written documentation of the nature, extent and medical necessity of a health service provided to a SCHA member by a provider and billed to SCHA.

Health records must be created and maintained as a condition of payment by SCHA. Each occurrence of a health service must be completely, promptly, accurately and legibly documented in the member's health record. The information must be maintained

in an orderly fashion and easily accessible. SCHAs funds that are paid for services not documented in the health record are subject to monetary recovery.

RULES AND REGULATIONS CONCERNING FRAUD, WASTE AND ABUSE

FEDERAL LAWS

Federal laws regarding fraud and abuse include, but are not limited to:

- The Federal False Claims Act [42 U.S.C. §1396a(a)]
- The Program Fraud Civil Remedies Act [31 U.S.C. §§ 3801-3812]
- Deficit Reduction Act of 2005 [Pub. Law 109-171, §6032]
- Medicaid Integrity Program [42 C.F.R. §455]
- Federal Anti-kickback Statute [42 U.S.C. §1320a-7b(b)]
- Civil Monetary Penalties Law [42 U.S.C. §1320a-7a]
- Health Care Fraud [18 U.S.C. §1374]
- False Statement Re Health Care [18 U.S.C. §1035]

Federal False Claims Act

The False Claims Act (“FCA”) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. Anyone who knowingly submits or causes someone else to submit a false or misleading claim for government funds is liable to the federal government for civil damages. The law is set forth at 31 U.S.C. §§3729-3733. A claim is broadly defined to mean any request for money or property made to an entity where a portion of the requested money or property would come from the US Government.

In sum, the FCA prohibits:

- Knowingly presenting, or causing to be presented to the Government a false claim for payment;
- Knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
- Conspiring to defraud the Government by getting a false claim allowed or paid;
- Falsely certifying the type or amount of property to be used by the Government;
- Making or delivering a document certifying receipt of property for Government use without completely knowing that the information on the receipt is true;
- Knowingly buying or receiving Government property from an unauthorized officer of the Government; and
- Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

The terms “knowing” or “knowingly” are defined as when a person, who with respect to information, has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of the information.

Violations of the Federal FCA may lead to civil penalties of \$5,500 to \$11,000. Fines may also include treble damages up to three times the amount of the original penalty and the violator can be excluded from participating in the Medicare and Medicaid programs. No proof of specific intent to defraud is required to establish liability under the FCA.

Under the FCA, at 31 U.S.C. §3730, a whistleblower may bring a civil action on behalf of the government for a violation of the FCA (this type of action is called a “qui tam” lawsuit). After filing with Department of Justice, the government can pursue the claim on its own, or decline to intervene and allow the whistleblower to continue. If the whistleblower’s case goes forward, no one else can bring a separate action later. The whistleblower also has protection from possible retaliation by his or her employer or fellow employees. Any person who is harassed or discriminated against because of his or her involvement in a qui tam action has the right to be made “whole.” The whistleblower’s damages may include reinstatement of their job position, two times back pay, plus interest, and compensation for any special damages including reasonable litigation and attorneys’ fees.

Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act of 1986, set forth at 31 U.S.C. §§ 3801-3812, provides administrative remedies, including civil penalties and assessments, that may be imposed against people making false claims and statements to federal agencies. The Act provides that any person who makes, presents or submits a claim to an “authority” (an executive department or an establishment, a military department or the U.S. Postal Service) that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil penalty of up to \$5000 per false claim or statement and up to twice the amount claimed in lieu of damages. No proof of specific intent to defraud is required to establish liability under this chapter. Section 6034 of the Deficit Reduction Act (“DRA”) established the Medicaid Integrity Program (“MIP”) which increased the Center for Medicare and Medicaid Services’ (“CMS”) resources to prevent and respond to Medicaid fraud and abuse.

Stark Anti-Kickback Statute

The Anti-Kickback Statute is found at 42 U.S.C. §1320a-7b(b). In general, the Anti-Kickback Statute prohibits:

- knowing and willful solicitations or receipt of remunerations in return for referring an individual or purchasing a type of service or
- knowing and willful offer or payment of remuneration to refer an individual or for purchasing a type of service for which a Federal health care program may pay. (But note that certain transactions that would be prohibited are allowed under the “Safe Harbors.”)

The prohibition applies to both parties in the arrangement. Both civil and criminal penalties may be applied. Criminal penalties include up to five years in prison plus \$25,000 in fines. Civil penalties include up to \$50,000 in fines and three times the lost dollar amount.

Federal False Statements Relating to Healthcare Matters

In any matter involving a “health care benefit program,” 18 U.S.C. §1035 states that whoever knowingly and willfully:

Falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or
Makes a materially false, fictitious, or fraudulent statement or representation; or
Makes or uses any materially false writing or document, knowing it contains a materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, may be fined and imprisoned for up to five years.

Federal Healthcare Fraud

As part of HIPAA, the U.S. Criminal Code was amended to include a prohibition against committing any scheme to defraud a federal healthcare program or making any false or fraudulent representations. It is a crime to knowingly and willfully execute, or attempt to execute, a scheme or artifice to defraud any healthcare benefit program, or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any health care benefit program. The Healthcare Fraud offenses created by HIPAA are found at 18 U.S.C. §1347. Penalties include a fine and imprisonment of up to ten years.

MINNESOTA LAWS

Minnesota laws regarding fraud and abuse include, but are not limited to:

- Surveillance and Utilization Review Program – MN Department of Human Services [Minn. Rule 9505.2200]
- Theft of Medical Assistance funds [Minn. Stat. 609.466]
- State Attorney General investigative powers [Minn. Stat. 8.31]
- Whistleblower protections under Minn. Stat. § 181.932

The **Surveillance and Utilization Review Program** is managed by the Minnesota Department of Human Services (DHS) as set forth at Minn. Rule 9505.2200. The program seeks to identify fraud, theft and abuse in the administration of the program, and investigate vendors or recipients of medical assistance to monitor compliance with program requirements, as authorized under the federal Medicaid Integrity Program at 42 C.F.R. §455.

Theft of Medical Assistance Funds is addressed by Minn. Stat. §609.466, which provides that any person who, with the intent to defraud, presents a claim for reimbursement, a cost report or a rate application, relating to the payment of medical assistance funds to a state agency, which is false in any way, is guilty of an attempt to commit theft of public funds.

The Attorney General, under Minnesota Statutes section 8.31, is authorized to investigate violations of the law of this state respecting unfair, discriminatory, and other unlawful practices in business, commerce, or trade.

Disclosure of information by employees, contractors or agents

An employer shall not discharge, discipline, threaten, otherwise discriminate against, or

penalize an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because:

- The employee, in good faith, reports a violation or suspected violation of any federal or state law or rule adopted pursuant to law to an employer or to any governmental body or law enforcement official;
- The employee is requested by a public body or office to participate in an investigation, hearing, inquiry;
- The employee refuses an employer's order to perform an action that the employee has an objective basis in fact to believe violates any state or federal law or rule or regulation adopted pursuant to law, and the employee informs the employer that the order is being refused for that reason; or
- The employee, in good faith, reports a situation in which the quality of health care services provided by a health care facility, organization, or health care provider violates a standard established by federal or state law or a professionally recognized national clinical or ethical standard and potentially places the public at risk of harm.