Sharp HealthCare's 2014 Compliance Education

Fraud and Abuse: Prevention, Detection and Reporting Module 2

Learning Objectives

By the end of this module, you will:

- Recognize the importance of preventing workplace fraud and Medicare fraud and abuse.
- Enhance your knowledge on how fraud and abuse affects Sharp HealthCare and you.
- Understand your responsibility to prevent fraud and abuse.
- Know the various options available for reporting potential acts of fraud and abuse.

Workplace Fraud and Abuse

What is Workplace Fraud?

Workplace fraud is:

- The use of one's occupation for personal enrichment through the deliberate misuse or misapplication of the employing organization's resources or assets.

Simply put, workplace fraud is a scheme in which a person defrauds his or her employing organization.

Workplace Fraud

Workplace fraud is everywhere; it does not discriminate in its occurrence. And while anti-fraud controls can effectively reduce the likelihood and potential impact of fraud, the truth is that no organization is immune to this threat.

Workplace Fraud

Workplace fraud is an expensive and growing problem that negatively impacts organizations and its employees. Organizations lose an estimated 5% of annual revenues to fraudulent activities.

- Fraud is an organization-wide issue.
- Fraud is not just a departmental issue.
- Sharp has a zero tolerance policy towards fraud.
- Fraud is punishable up to and including termination.

(**Source**: ACFE 2014 Report to the Nations on Occupational Fraud and Abuse.)

Workplace Fraud

The longer frauds last, the more financial damage they cause. Passive detection methods (confession, notification by law enforcement, external audit and by accident) tend to take longer to bring fraud to management's attention, which allows the related loss to grow.

Workplace Fraud

Consequently, proactive detection measures; such as:

- Hotlines, management review procedures, internal audits, and employee monitoring mechanisms are vital in catching frauds early and limiting their losses.

Workplace Fraud

Most workplace fraudsters exhibit certain behavior traits that can be warning signs of their fraud, such as:

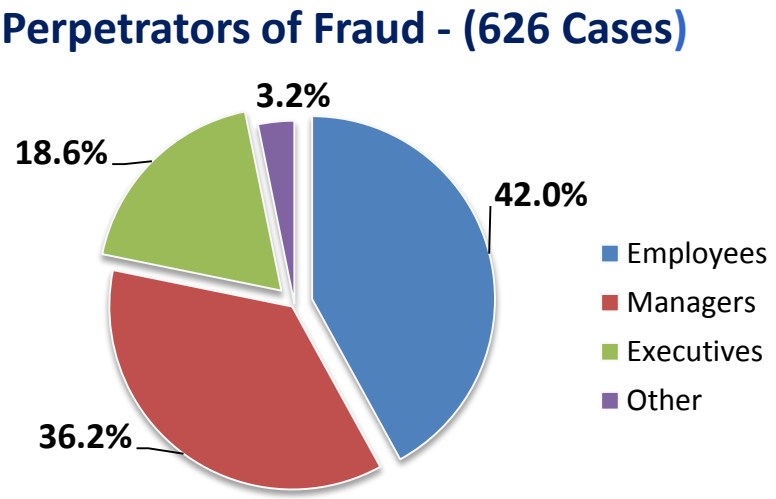
- Living beyond their means and/or having unusually close associations with vendors or customers.

All sharp employees need to recognize these warning signs that, when combined with other factors, might indicate fraud.

Who Commits Workplace Fraud?

Anyone is capable of committing fraud.

- Those who actually commit fraud generally rationalize that:
  - *they are just borrowing*
  - *they deserve it*
  - *its no big deal*
- These individuals will continue to commit fraud until they get caught.



(**Source**: 2014 Global Fraud Study- Association of Certified Fraud Examiners (ACFE))

Examples of Workplace Fraud:

- Abusing authority
- Committing official or moral misconduct
- Falsifying information
- Misusing Sharp's time, equipment or information
- Soliciting gifts from outside sources
- Stealing or embezzling Sharp's property or money
- Violating conflict of interest standards

<u>Example</u>:

Employee falsifying work related documents or time cards = **FRAUD**

Source: OIG Hotline Operations https://forms.oig.hhs.gov/hotlineoperations/posters/OIG%20Hotline%20Ops%20Poster%20-%20Employee%20Fraud.pdf

How Workplace Fraud Hurts the Organizations

- The average company loses five percent of its revenue to fraud each year. If Sharp's revenue losses from fraud equal that of the average US company (5%), Sharp could potentially lose approximately $140 million annually due to fraud.

(**Source**: ACFE 2013)

How Workplace Fraud Hurts the Organizations

Fraud also hurts organizations by causing:

- Decreased productivity
- Investment of time & money spent on investigations
- Lost resources
- Lowered morale
- Possible punishment
- Negative impact on organization's reputation

How Workplace Fraud Hurts Sharp HealthCare Employees

Fraud perpetrated by another individual can negatively affect others by:

- Decreased trust throughout the organization.
- Increased scrutiny from regulatory agencies.
- Loss of time and resources to address fraudulent acts.
- Fewer resources available to provide needed care and facilities to our community.

Overview of Medicare Fraud and Abuse

Medicare Fraud and Abuse is a Serious Problem

- Most Medicare providers/contractors are honest and well-intentioned.
- However, $4.3 billion was recovered in 2013 for Medicare Fraud.
- Fraud and abuse persists because some people perceive Medicare as easy money with minimal risk of being caught.

What is Medicare Fraud?

- Making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist.
- This includes obtaining something of value through
  - Misrepresentations or
  - concealment of material facts

OIG Fraud Case Example:

On April 14, 2014, a North Hollywood woman who worked in the health care industry was sentenced to 76 months in federal prison for orchestrating a scheme that submitted nearly $25 million in fraudulent bills to Medicare for services and supplies that were medically unnecessary and sometimes were never provided. She formerly owned a durable medical equipment (DME) company and worked at a number of medical clinics in Los Angeles.

2013 HHS News Release

On May 3, 2013, Adventist Health System agreed to pay $14.1 million to settle claims that they violated the False Claims Act. It resolves allegations that Adventist Health improperly compensated physicians who referred patients, by transferring assets, including medical and non-medical supplies, at less than fair market value.

2013 HHS News Release

On July 29, 2013, Beth Israel Deaconess Medical Center paid $5.3 million to settle civil allegations that it violated the False Claims Act by improperly admitting patients and then billing for inpatient stays with respect to services that should have been provided in an outpatient setting, resulting in overpayment by Medicare for unnecessary hospital stays.

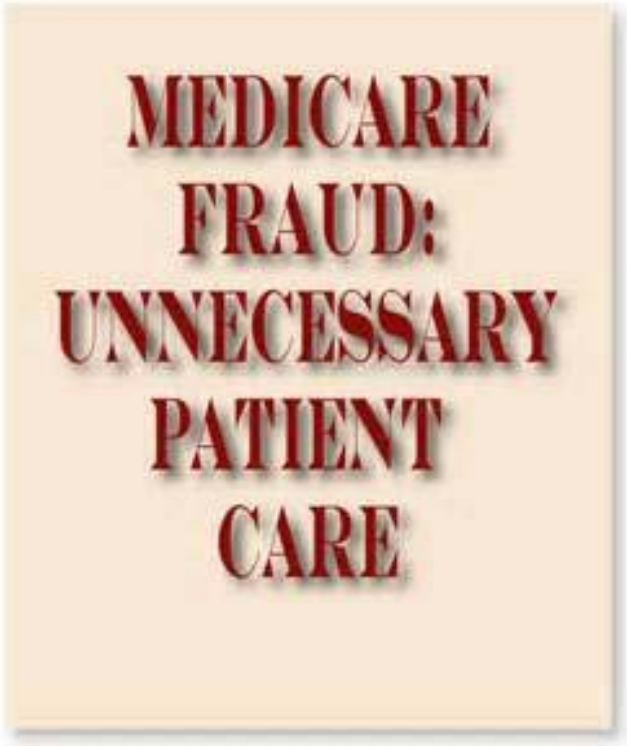
2013 HHS News Release

On January 31, 2013, the medical director of a clinic in Long Beach, California, was sentenced to 42 months' imprisonment and ordered to pay $2.9 million in restitution for issuing bogus prescriptions that led to fraudulent Medicare claims of over $3 million. The doctor and his co-schemers recruited Medicare patients for office visits that typically included unnecessary tests and procedures. The medical director, who was a doctor, also generated fraudulent prescriptions for medical equipment, power wheel chairs and enteral nutritional supplies, prescriptions that were sold to medical supply companies that used the fraudulent documents to bill Medicare for millions of dollars of unnecessary and undelivered medical supplies.

What is Medicare Abuse?

Medicare Abuse describes practices that:

- Result in unnecessary costs,
- Are not medically necessary,
- Are not professionally recognized standards, and
- Are not fairly priced.



Office of Inspector General (OIG) Abuse Case Example

A Durable medical supplier was paid $5,049 for a power wheelchair.

The documentation did not support medical necessity according to the applicable National Coverage Determination (NCD) and Local Coverage Determination (LCD). Neither the diagnoses submitted nor the face-to-face evaluation received from the physician's office supported the inability to self-propel. No other valid rationale was offered as to why a power mobility device versus another mobility device was reasonable and necessary.

2013 HHS News Release

On March 28, 2013, a California Durable Medical Equipment (DME) company owner was sentenced to 156 months imprisonment and ordered to pay $8.2 million in restitution, after a jury convicted her of multiple counts of health care fraud and anti-kickback violations. At trial, the government presented evidence that the defendant paid marketers to recruit Medicare beneficiaries to seek expensive DME, such as motorized wheel chairs, that they did not need. The defendant or the marketers she relied on, often paid doctors to write the fraudulent prescriptions.

Overview of Medicare Fraud and Abuse: Laws

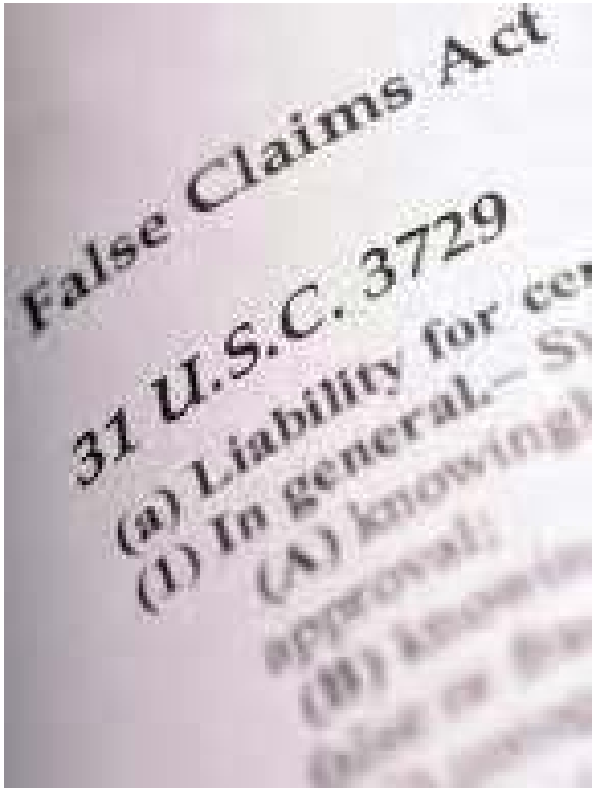
Major Medicare Fraud and Abuse Laws

False Claims Act
Anti-Kickback Statute
Physician Self-Referral Law
Criminal Health Care Fraud Statute

What is the False Claims Act (FCA)?

Protects the Federal Government from: Overcharges or overpayment for substandard goods or services.

The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted a false or fraudulent claim OR acts in deliberate ignorance or reckless disregard of the truth related to the claim.



What is the Anti-Kickback Statute?

The Law prohibits knowingly and willfully:

Offering, paying, soliciting, or receiving remuneration to induce or reward referrals of items/ services reimbursable by a Federal health care program.

Examples of Kickbacks:

- Cash for referrals.
- Free rent or below fair market value rent for medical offices.
- Free clerical staff.
- Excessive compensation for medical directorships.

What is the Physician Self-Referral Law (Stark Law)?

The Stark Law prohibits referring Medicare beneficiaries for designated health services such as lab, physical therapy, or home health services to an entity in which the physician (or an immediate family member) has an ownership/investment interest or a compensation arrangement.

Stark Law and the Affordable Care Act (ACA) for Imaging Services

The ACA applies further protections for Magnetic Resonance Imaging (MRI), or Computerized Tomography (CT):

- The referring physician must provide the beneficiary with a list of 5 alternative suppliers within a 25 mile radius of the physician's office location at the time of the referral. The suppliers must provide the imaging services ordered.

What is the Criminal Health Care Fraud Statute?

Prohibits knowingly and willfully executing, or attempting to execute, a scheme such as:

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 connection with the delivery of or payment for health care benefits, items or services.

Medicare Fraud and Abuse: Penalties

Types of Penalties

Civil Monetary Penalties (CMPs)

Criminal sanctions

Exclusion

Civil Monetary Penalties (CMPs)

- Fines range from $10,000 to $50,000 per violation.
- Fines can also include an assessment of up to 3 times the amount that was:
  - Claimed for each item/service, or
  - For the remuneration offered, paid, solicited, or received.

Criminal Sanctions and Penalties

Criminal convictions are also available when prosecuting health care fraud and may include imprisonment, fines or both.

Mandatory Exclusions from HHS Office of Inspector General (OIG)

- Exclusions means that, for a designated period, Medicare, Medicaid, and other Federal health care programs will not pay the provider for services performed or for services ordered by the excluded party. These exclusions are imposed for a minimum of 5 years with the possibility of permanent exclusion.

Further Mandatory Exclusions by HHS OIG:

Exclusions may include removal of participation in all Federal health care programs if health care providers and suppliers are convicted of:

- Medicare fraud,
- Patient abuse or neglect,
- Felonies for other health care-related fraud, theft, or other financial misconduct, or
- Unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Permissive Exclusions by HHS OIG

The OIG may issue permissive exclusions for various actions. Permissive exclusions vary in length.

Some examples include:

- Misdemeanor convictions related to healthcare fraud
- Misdemeanor convictions related to controlled substances
- Conviction related to fraud in a non-health care program
- Obstruction of an investigation

Excluded Individuals/Entities

Providers and contracting entities must check exclusion status before employment or contractual relationships.

Lists of excluded providers can be found at:

OIG List of Excluded Individuals/Entities (LEIE).
General Services Administration (GSA).
Excluded Parties Listing System (EPLS).

Excluded Individuals/Entities

- No payment will be made by any federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity.
- This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services and anyone else.

Medicare Fraud and Abuse: Prevention

CMS is Working to Prevent Medicare Fraud and Abuse

- Enhanced Medicare enrollment protections such as:
  - Fees
  - Screening categories
  - Revalidation
- Automated prepayment claims edits
- Predictive analytics technologies.
- Suspension of payments.
- Education.

The Providers' Role To Prevention:

- To provide only medically necessary, high quality services.
- To properly document all services.
- Correctly bill and code for services.

Medicare Fraud and Abuse: Detection

CMS Partners with State and Federal Law Enforcement Agencies for Investigations:

OIG	HHS Office of Inspector General
FBI	Federal Bureau of Investigation
DOJ	Department of Justice
MFCUs	Medicaid Fraud Control Units
HEAT	Health Care Fraud Prevention and Enforcement Action Team

CMS Contracts with Other Entities To Conduct Investigations

PSCs/ ZPICs – Program Safeguard Contractors/Zone Program Integrity Contractors

MEDICs – Medicare Drug Integrity Contractor

Medicare Carriers, FIs, MACs – Fiscal Intermediaries/ Medicare Administrative Contractors

Additional CMS Contract with Other Entities

- **MA Plans and PDPs** - Medicare Advantage/ Plans and prescriptions Drug Plans
- **Recovery Audit Program Recovery -** (RAC)
- **Auditors**
- **Contractors** - Comprehensive Error Rate Testing (CERT)

PSCs, ZPICs, MEDICs

Identify cases of suspected fraud and abuse.

Refer cases of suspected fraud to OIG.

Refer cases of suspected abuse to:

- Appropriate Medicare Contractor, and/or
- OIG

May take concurrent action.

PSCs, ZPICs, MEDICs

- Investigates fraud and abuse in Federal Government programs, and partners with the OIG through HEAT.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

- Gathers Government resources to:
  - Help prevent waste, fraud, and abuse in the Medicare and Medicaid Programs, and
  - Crack down on fraud perpetrators who abuse the system.
- Reduces health care costs and improves the quality of care.
- Highlights best practices by providers and public sector employees.
- Builds upon existing partnerships between the DOJ and OIG.
- Maintains the “Stop Medicare Fraud” website.

Medicare Fraud and Abuse: Reporting

Reporting Suspected Fraud and Abuse

To report confirmed or suspected violations, you may do any of the following:

- Contact Paul Belton, Sharp HealthCare's Corporate Compliance Officer at (858) 499-3138 or paul.belton@sharp.com.
- Contact your entity Compliance Liaison.
- Contact your manager.
- Report the incident to the Sharp Confidential Hotline at (800) 350-5022.
- Complete a Compliance Report at http://www.mycompliancereport.com.
- Complete a Quality Variance Report (QVR).

Exit Instructions

We hope this course has been informative and helpful.

Please take the

Module 2 Quiz