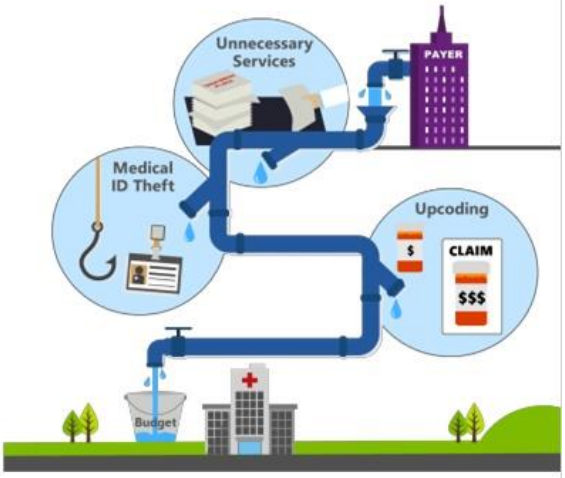
2020 Fraud, Waste and Abuse and Compliance Training

Defining 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.



Defining Waste and Abuse

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

Abuse includes actions that may, directly or indirectly, result in unnecessary costs. 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.

Differences Among Fraud, Waste and Abuse

There are differences among fraud, waste, and abuse. One of the primary differences is **intent** and **knowledge**.

- **Fraud** requires intent to obtain payment and the knowledge that the actions are wrong.
- **Waste and abuse** may involve obtaining an improper payment or creating an unnecessary cost, but does not require the same intent and knowledge.

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; or
- Presents a false claim for payment or approval.

For more information, refer to 31 United States Code (U.S.C.) Sections 3729-3733 on the Internet.

FCA, cont.

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

Non-Retaliation Policy: VIVA HEALTH will not punish individuals for reporting a possible violation in good faith, and there is no retribution for whistleblowers.

Health Care Fraud Statute

The Health Care Fraud Statute states that "Whoever knowingly and willfully executes, or attempts to execute, a scheme to … defraud any health care benefit program … shall be fined … or imprisoned not more than 10 years, or both."

- Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law.

For more information, refer to 18 U.S.C. Section 1346 on the Internet.

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).

For more information, refer to 42 U.S.C. Section 1320a-7b(b) on the Internet

Damages and Penalties

- Violations are punishable by:
  - A fine up to $25,000
  - Imprisonment up to 5 years

For more information, refer to the Social Security Act (the Act), Section 1128B(b).

Criminal Health Care Fraud

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000;
- Imprisonment for up to 20 years; or
- If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

For more information, refer to 18 U.S.C. Section 1347 on the Internet

Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest; or
- A compensation arrangement (exceptions apply).

For more information, refer to 42 U.S.C. Section 1395nn on the Internet.

Damages and Penalties

- Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable.
- A penalty of around $24,250 can be imposed for each service provided.
- There may also be around a $161,000 fine for entering into an unlawful arrangement or scheme.

For more information, visit the Physician Self-Referral webpage and refer to the Act, Section 1877.

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for a number of reasons, including:

- Arranging for services or items from an excluded individual or entity;
- Providing services or items while excluded;
- Failing to grant OIG timely access to records;
- Knowing of an overpayment and failing to report and return it;
- Making false claims; or
- Paying to influence referrals.

For more information, refer to 42 U.S.C. 1320a-7a and the Act, Section 1128A(a) on the Internet.

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 on the Internet.

The United States 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 website.

If looking for excluded individuals or entities, make sure to check both the LEIE and the EPLS since the lists are not the same.

For more information, refer to 42 U.S.C. Section 1320a-7 and 42 Code of Federal Regulations Section 1001.1901 on the Internet.

Preclusion

In 2019, CMS created a **Preclusion List** of prescribers, individuals, and entities that fall within either of the following categories:

1) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
2) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

CMS makes the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with prescriptions written by prescribers and providers on the list.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA created greater access to health care insurance; protection of privacy of health care data; and promoted standardization and efficiency in the health care industry.

HIPAA safeguards help prevent unauthorized access to PHI. As an individual with access to protected health care information, you must comply with HIPAA.

Damages and Penalties

Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

Report FWA

Everyone must report suspected instances of FWA. VIVA HEALTH's Code of Conduct clearly states this obligation. VIVA HEALTH will not retaliate against you for making a good faith effort in reporting.

Report any potential FWA concerns you have to VIVA HEALTH's compliance department. VIVA HEALTH's compliance department will investigate and make the proper determination.

Reporting FWA

Potential FWA may be reported anonymously by employees, first tier, downstream, and related entities, using the

- FWA Hotline: (800)601-2144
- Online Hotline Reporting: VIVA.Alertline.com

When in doubt, REPORT.

Reporting FWA Outside of Your Organization

If warranted, potentially fraudulent conduct must be reported to Government authorities, such as the Office of Inspector General (OIG), the Department of Justice (DOJ), or CMS.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.

Reporting FWA Outside Your Organization

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://forms.oig.hhs.gov/hotlineoperations/index.aspx

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.stopmedicarefraud.gov

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 non-compliance as well as Fraud, Waste, and Abuse (FWA). It must, at a minimum, include the seven core compliance program requirements.

1. Written Policies, Procedures, and Standards of Conduct

These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.

2. Compliance Officer, Compliance Committee, and High-Level Oversight

The Organization must designate a compliance officer and a compliance committee that will be accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program. The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

3. Effective Training and Education

This covers the elements of the compliance plan as well as prevention, detection, and reporting of FWA. This training and education should be tailored to the different responsibilities and job functions of employees.

4. Effective Lines of Communication

Effective lines of communication must be accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith reporting of compliance issues at Organization and First-Tier, Downstream, or Related Entity (FDR) levels.

5. Well-Publicized Disciplinary Standards

The Organization must enforce standards through well-publicized disciplinary guidelines.

6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks

Conduct routine monitoring and auditing of Organization's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

NOTE: The Organization must ensure that FDRs performing delegated administrative or health care service functions concerning the Organization's Medicare Parts C and D program comply with Medicare Program requirements.

7. Procedures and System for Prompt Response to Compliance Issues

The Organization must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

Reporting Non-Compliance or FWA

All violations or suspected violations must be reported to any one or combination of the following:

- Compliance Department
- Company's hotline

Reports may be made anonymously using the:

- Compliance/FWA Hotline: (800)601-2144
- Online Hotline Reporting: VIVA.Alertline.com

When in doubt, REPORT.

Non-Retaliation Policy

We all have a duty to report any violations or suspected violations of company policies, state or federal rules and regulations. Even if unsure of the facts, we have a duty to report suspected violations. VIVA HEALTH investigates, verifies, and takes appropriate action for each allegation regardless of how it was reported. There is no punishment for reporting a possible violation in good faith. VIVA HEALTH strives to make every effort, within the limits of the law, to keep the identity of the reporting individual confidential.