# Fraud and Abuse

The National Insurance Association of America (NIAA) and the National Health Care Anti-Fraud Association (NHCAA) estimate that the financial losses because of health care fraud are in the tens of billions of dollars each year. We cooperate with providers, facilities, and law enforcement agencies to identify and stop health care fraud and preserve health care quality and affordability.

Health care fraud is the intentional and unlawful practice of filing fraudulent or deceptive claims for reimbursement. The following practices have been identified by the NHCAA as examples of fraud:

- Falsifying a patient's diagnosis
- Accepting kickbacks for patient referrals
- Billing a patient more than the co-pay amount
- Billing for a higher level of treatment than was provided
- Performing unnecessary procedures to collect insurance payments
- Misrepresenting treatments as medically necessary when they are not

Inadvertent errors, such as occasionally reporting the wrong billing code, are not considered fraudulent.

Preventing Fraud

The following practices can help protect your office from intentional fraud:

- Verify that billing codes are accurate.
- Protect your prescription forms, which are often stolen during medical visits and used in pharmacy fraud schemes.
- Check patient histories to help prevent prescription medication fraud. Ask patients if they are seeing or have obtained prescriptions from other providers.
- Implement procedures to ensure that information, such as the nature of services provided, is accurately communicated to your billing staff and to any third-party firms and services.

**External Audit**

Our Special Investigations Unit (SIU) responds to fraud and abuse issues.

The SIU is responsible for:

- Providing internal and external training
- Conducting desk audits and on-site audits
- Conducting pre- and post-payment reviews
- Investigating possible fraudulent and abusive billing practices
- Responding to questions and complaints from members and providers who call our fraud hotline at 1 (800) 434-2277

False claims can be divided into two categories—fraudulent and abusive.

- Health care **fraud** occurs when someone intentionally misrepresents a fact on a health care claim for the purpose of receiving—or increasing—reimbursement from a health plan. Fraud also occurs when someone misrepresents the delivery of health care services or supplies.
- Health care **abuse** involves actions that are inconsistent with accepted, sound (medical or business) practices.

The following are examples of fraudulent, abusive or inappropriate billing for services, as well as common violations of provider agreements and member contracts:

- Billing for telephone calls
- Billing members for provider write-off amounts
- Billing separately for services included within a global fee or code
- Reporting excessive costs (e.g., falsely representing the actual cost)
- Billing for services or treatment provided to an employee as a condition of employment
- Billing members for amounts in excess of amounts determined by the health Plan for deductible, copayment and coinsurance
- A pattern of billing for services not rendered, not medically necessary, or in a manner that overstates the services rendered
- Advertising free or discounted services, then billing the health Plan for additional services that may or may not be medically necessary
- Billing for services performed by another provider, practitioner or laboratory (except if there is a written coverage arrangement in place)
- Not collecting all deductible, copayment or coinsurance amounts owed by the member. These charges cannot be written off by the provider.
- Submitting a claim to the health Plan for a service or treatment at a higher rate than would be charged in the absence of third-party reimbursement
- A pattern of billing that includes submitting incorrect or misleading diagnostic or procedure codes, which leads to incorrect processing services
- Billing for services or treatment performed on a family member, even those with different last names (a family member is defined as the provider's spouse, parent, child or eligible dependent)
- Submitting claims for charges that, in the absence of the member's insurance, there would be no obligation to pay, such as services provided by a family member (it is inappropriate to bill for services that, in the absence of insurance coverage, would become "professional courtesy")

**Provider Audits**

We may audit any claim for appropriate coding, payment per contract and payment per medical and reimbursement policy. We may request any combination of invoice, medical records or itemized bill to support audit. All documentation requested must be provided within the time frame specified in the audit letter.

If a pattern of fraudulent, abusive or inappropriate billing practices is discovered, we will take appropriate measures to investigate and stop such activity. Claims are denied retrospectively and refunds are requested for all charges considered to be the provider's responsibility.

Our auditors are trained coders, certified through the American Academy of Professional Coders (AAPC). Audits cover all disciplines, including; but not limited to:

- Hospitals
- Pharmacies
- Laboratories
- Ancillary health care providers
- Durable medical equipment suppliers
- Dentists and other dental professionals
- Physicians and other health care professionals

All audits comply with federal and state regulations pertaining to the confidentiality of member records.

When necessary, on-site audits are conducted within the timeframe specified in your agreement with us. In the event of an audit:

- Allow sufficient space within your office to review and copy records relevant to the scope of the audit
- Copies of relevant records may be removed from your office to compare with claims submitted to us; we never remove original records
- We protect the confidential nature of the member records as required by state and federal regulations.

**Federal False Claims Act**

The federal False Claims Act (FCA), 31 U.S.C.A. §§ 3729 – 3733, provides a mechanism to recover fraudulent or false medical claims paid with government funds. The law impacts providers, among others, who may have been overpaid by a government program. including Medicaid, Medicare, Medicare Advantage, Medicare Part D and TRICARE. We recommend all providers and their billing staff read the act in its entirety at **https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf**. The Fraud Enforcement Recovery Act (FERA) of 2009 at **https://www.congress.gov/111/plaws/publ21/PLAW-111publ21.pdf** amended the FCA. For your convenience, some of the changes have been noted below:

- **Intent** – Formerly, to file a false claim act, the FCA required proof of intent. This provision has been revised to reflect that a person can be found liable if he or she knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim.
    - "Material" is defined as "having the natural tendency to influence or being capable of influencing the payment or receipt of money or property."

    - "Knowingly" means that a person, with respect to information, has actual knowledge of information, acts in deliberate ignorance of the truth or falsity of information, or acts in reckless disregard of the truth or falsity of information.
- **Recipient of claim** – The FCA formerly applied only to a claim presented to an officer or employee of the government. Now, the amendment also attaches liability if a false or fraudulent claim is presented to an agent of the government or a government contractor (e.g., if a provider's office submits a fraudulent claim to a government program such as Asuris TruAdvantage).
- **Obligation to repay** – The amendment obligates providers to return overpayments. It is an FCA violation if a provider knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government. An obligation includes an established duty arising from the retention of an overpayment.
- **Liability for cost of recovery** – A new provision now imposes strict liability on FCA violators for the costs incurred by the government to recover penalties and damages.
- **Expanded conspiracy provision** – The amended FCA no longer applies only to conspiracy to get a false claim paid, but now includes conspiracy to violate any substantive provision of the FCA.
- **Expanded whistleblower protection** – Whistleblower protection now extends to employees, contractors and agents attempting to stop or report an FCA violation.
- **Extends statute of limitations for the government** – If a private person brings a lawsuit for violation of the FCA, the government can intervene in that lawsuit. For statute of limitations purposes, the government's complaint shall "relate back" to the original filing date of the lawsuit.

A person violating the FCA could be liable to the government for $5,000 to $10,000 per violation, plus three times the amount of damages the government sustains because of the violation.

Medicare Fraud and Abuse compliance training

Medicare general compliance training and fraud, waste, and abuse training must be completed within 90 days of hire and annually thereafter. Providers, employees, board members, agents and contractors who provide administrative services or health care services for or to Medicare Advantage members must complete this training. *Note*: Providers who have met the fraud, waste and abuse certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are deemed to have met the fraud, waste and abuse training and education requirements.

- This training is provided by the Centers for Medicare & Medicaid Services (CMS) free of charge at **www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html**.
- You must keep a copy of the training materials and maintain proof that each individual has completed the training.

**Prevent provider identity theft**
Provider identity theft can have a significant financial impact on providers and health plans. It is also potentially harmful to a provider's professional reputation. The CMS Center for Program Integrity (CPI) has developed a training video for providers that explains how to recognize, report and prevent the fraudulent use of a provider's medical information.

View the Partners in Integrity: Understanding and Preventing Provider Medical Identity Theft booklet on the CMS website at **https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/Downloads/understand-prevent-provider-idtheft.pdf**.

**Member ID Card/Identity Fraud**
Health care member ID card fraud is an increasing problem. Many cases of identity fraud are reported involving member ID cards that are misplaced, stolen or loaned to an acquaintance. Theft can also happen when a member's information is presented by someone else at his or her time of service.

When cases of member card fraud are discovered, we will seek reimbursement from the person(s) committing the fraud; however, if a provider is found negligent in obtaining the proper identification, restitution may be sought from the provider. To protect your practice from this type of deception, we recommend taking the following precautions:

- Photocopy the front and back of each patient's (or their guardian's) member ID card and driver's license at every visit.
- Take a digital photo of each patient when he or she checks in for their first visit. Include it as part of his or her permanent electronic record. Then refer to the picture each time that patient checks in.