UPMC HEALTH PLAN

Provider Fraud, Waste & Abuse Training

UPMC Health Plan Fraud, Waste & Abuse Department

Definitions of Fraud, Waste & Abuse

- **FRAUD**: An intentional deception or misrepresentation made by a person or entity, with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person.

- **WASTE**: The overuse of services or other practices that, directly or indirectly, result in unnecessary costs.

- **ABUSE**: Includes action 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.

Healthcare Fraud Laws

- The following are notable laws which address healthcare fraud.
  - False Claims Act
  - Whistleblower Protection
  - Anti-Kickback Statute
  - Affordable Care Act
  - Physician Self-Referral Prohibition Statute (Stark Law)

False Claims Act

- 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.

- Damages and Penalties:
  - Civil Money Penalties increased as of August 1, 2016 to fines between $11,000 - $21,563 per false claim.
  - Damages may be tripled.
  - If convicted, the individual shall be fined, imprisoned, or both. If the violations result in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code § 1347

False Claims Act Violations

- Billing for items or services not provided.
- Unbundling
- Upcoding

Whistleblower Protection/Anti-Kickback Statute

Whistleblower Protection

- The False Claims Act allows Whistleblower Protection for employees, former employees, or members of an organization who report suspected misconduct to people or entities that have the power to take corrective action.

Anti-Kickback Statute

- The Anti-Kickback Statute makes it a felony for healthcare professionals, entities, and vendors to knowingly offer, pay, solicit, or receive reimbursement of any kind to induce or reward referrals of business under a healthcare program.
- Penalties and damages may include a fine of up to $25,000, imprisonment up to 5 years per violation and exclusion from participating in certain healthcare programs.

Affordable Care Act/Stark Law

Affordable Care Act

- The Affordable Care Act strengthened healthcare fraud and abuse detection. Highlights include:
  - Made obstructing a fraud investigation a crime.
  - Created new healthcare fraud enforcement tools.
  - Authorized stronger civil and monetary penalties for persons who knowingly make or use a false record or statement material to a false or fraudulent claim for payment.
  - Penalties include possible exclusion from participation in federal healthcare programs.

Stark Law

- Prohibits physicians from referring patients for certain designated health services to an entity with which the physician or member of the physician's immediate family has a financial relationship.
- Penalties include possible exclusion from participation in federal healthcare programs and a monetary penalty of up to $100,000 for each violation.

Provider Prohibited Acts-Criminal and Civil Remedies

- The Provider Prohibited Acts, Criminal and Civil Remedies Acts includes the following
  - It shall be unlawful for any person to:
    - Knowingly or intentionally present for allowance or payment any false or fraudulent claim.
    - Solicit or receive or to offer or pay any remuneration, including any kickback, bribe or rebate, directly or indirectly, in cash or in kind from or to any person in connection with the furnishing of services.
    - Submit a duplicate claim for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source.
    - Submit a claim for services, supplies or equipment which were not rendered to a recipient.
    - Submit a claim for services, supplies or equipment which includes costs or charges not related to such services, supplies or equipment rendered to the recipient.

62 P.S. § 1407

Provider Prohibited Acts-Criminal and Civil Remedies (cont)

- Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are unneeded by the recipient.
- Submit a claim which misrepresents the description of services, supplies or equipment dispensed or provided.
- Submit a claim for a service or item which was not rendered by the provider.
- Dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient, except in emergency situations.
- Enter into an agreement, combination or conspiracy to obtain or aid another to obtain reimbursement or payments for which there is not entitlement.
- Commit any of the prohibited acts described in section 1403(d)(1), (2), (4) and (5)[1].

62 P.S. § 1407

How do I prevent Fraud, Waste & Abuse

- Make sure you are up to date with laws, regulations and policies.
- Ensure medical record documentation is kept in accordance with UPMC Health Plan and CMS guidelines.
- Ensure data/billing is both accurate and timely.
- Self-Audit and Self-Report any identified overpayments.

Audit Process

- UPMC Health Plan may conduct an audit of your billing and medical record documentation.
- UPMC Health Plan will send you a request for medical record documentation by mail.
- As part of your Participating Provider Agreement, you are contractually obligated to provide medical record documentation to UPMC Health Plan.

Audit Process

The Auditor will review the documentation as well as the following:

- Center for Medicare Services (CMS) guidelines
- Current Procedural Terminology (CPT) coding guidelines
- UPMC Health Plan Policies
- Where applicable; Local and National Coverage Determinations
- Medical Necessity of service

Once the audit is complete, a post audit notification letter will be sent.

Self-Audit Websites

- Self-Audit Requirements for Medicaid and Medicare:
- http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicalassistanceproviderselfauditprotocol/index.htm
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R425PI.pdf

Best Practices

Best practices to help prevent Fraud, Waste & Abuse include:

- Develop and follow the elements of a compliance program.
- Self-Audit claims for accuracy, and Self-Report overpayments.
- Review medical records for accurate documentation of services rendered.
- Take action if you identify a problem.
- Ask for photo identification when registering patients at the point of service.

Reporting Fraud, Waste & Abuse

- You can report suspected fraud, waste, or abuse to UPMC Health Plan through any of the following:

- Email: specialinvestigationsunit@upmc.edu

- Fraud Hotline: 1-866-FRAUD-01

- U.S. Mail:
  UPMC Health Plan
  Special Investigations Unit
  Personal and Confidential
  P.O. Box 2968
  Pittsburgh, PA 15230