PROTECTING YOURSELF FROM FRAUD, WASTE, AND ABUSE

BASIC COMPLIANCE TRAINING FOR CASE MANAGEMENT STAFF

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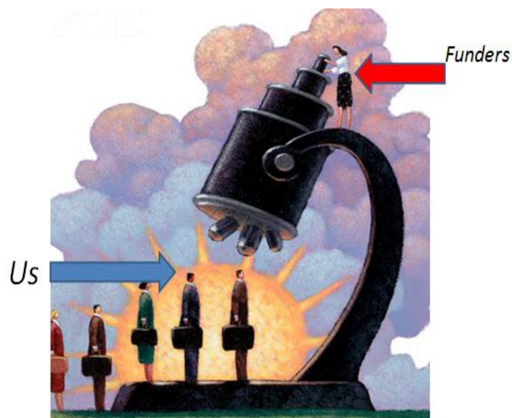
Agenda

- Introduction and Training Goals
- Discuss the Importance of FWA Awareness in the CM Profession
- FWA Definitions
- Apply Learning in Case Examples
- Red Flags of FWA
- Discussion of Applicable Laws and Expectations – Discuss Case Example



Training Goal

To prevent and detect overpayment related concerns and assist with their resolution

Introduction Statement

This training is intended to provide you with best case management practices as they relate to Federal fraud, waste, abuse and related laws.

Introduction Statement - Continued

Although State FWA laws and individual funder requirements are often derived from Federal FWA laws…

Introduction Statement - Continued

…this training is not intended to address requirements that are specific to your State or requirements that are specific to your individual funders.

Why Should You Be Concerned With FWA?

- Your Funding Source – Healthcare Dollars
- Funder Mandate – Return of Overpayments
- Funders are Scrutinizing CM Providers More Than Ever!

Knowledge is POWER

- Power to Protect:
  - The Individuals You Serve
  - Your Reputation, Your Job, and Your Career
  - Your Employer's Reputation

What do Case Management Funders Expect?

- Accurate Documentation
- Accurate Billing

So, What's the Big Deal?

Inaccurate Documentation

and

Inaccurate Billing

Unnecessary Costs

Unnecessary Costs = Overpayments

- Fraud
- Waste
- Abuse

So – What is FWA, Anyway?

- Fraud - Unnecessary Costs Caused by a Deliberate Act of Deception for Reasons of Personal Gain

Can Fraud be Caused by An Honest Mistake?

No

So – What is FWA, Anyway? Continued

- Waste – Unnecessary costs caused by an Overuse or a misuse of resources

So – What is FWA, Anyway? Continued

- Abuse – Unnecessary costs caused by bad business practices

	Fraud	Waste	Abuse
Unnecessary Cost	X	X	X
Deliberate Deception (Intent)	X		
Personal Gain	X		
Overuse of Service		X	
Bad Business Practice			X

You Decide… 1st Case

- Compliance Investigation Determined
  - CM billed for a service that didn't occur and claimed travel reimbursement
    - CM states that she writes notes and completes travel form prior to the contact
  - 29 of 33 billed phone calls were not billable.

You Decide… What's the Verdict?

- Unnecessary Costs?
- Deliberate Act of Deception?
- Personal Gain?

You Decide… 2nd Case

- Compliance Investigation Determined
  - CM was ending service notes and projecting the end time of the contact.
  - No content in note for the services provided for the forecasted end time.

You Decide… What's the Verdict?

- Unnecessary Costs?
- Deliberate Act of Deception?
- Personal Gain?

You Decide… 3rd Case

- Compliance Investigation Determined
  - CM repeated billing for service planning
    - "Spoke with treatment team…"
    - "Spoke with parents…"
    - "Revising service plan…"
    - + Billing for the time it took to write the service notes

You Decide… What's the Verdict?

- Unnecessary Costs?
- Deliberate Act of Deception?
- Personal Gain?

Video

Why Are CM's Vulnerable to Situations Involving FWA?

Program Funding

VS

Fee For Service Funding

Red Flags of FWA

- Overlapping Services
- Rounding Up of Time to Reach a Billable Unit
- Documentation Which Doesn't Substantiate the Units Billed
- Billing for Non Billable Services
- Billing for Services Which Didn't Occur

Red Flags of FWA - Continued

- Submitting Duplicate Notes
- Submitting for Travel Reimbursement:
  - Overstated
  - Collecting for Travel Which Didn't Occur

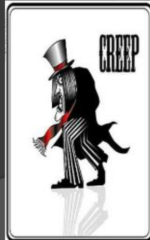
What is the name of the ***federal*** governmental agency charged with identifying, auditing, and investigating fraud, waste, abuse, and mismanagement involving healthcare funds?

What Does the OIG Say?

"Each time a staff submits a note, the staff affirmatively represents that the service is both truthful and that the service was provided consistent with program requirements."

CREEP – The OIG Definition

- "Work practice habits which cause inflated reimbursement amounts".
  - Overbilling
  - Padded billing
  - Rounding up of time to reach a billable unit.



Federal Laws Impacting Case Management

- False Claims Act
  - Whistle Blower Provision
- Anti-Kickback Statute
- MA Exclusions

MA Exclusions

1. Criminal Charges Lead to Exclusion from Participation in Federal Health Care Programs
2. Providers Must Prevent Payment to Excluded
3. If Excluded:
   a) Can Not Provide Service Reimbursed by Federal Health Care Dollars or DPW Funds
   b) May Lose Clinical License
4. Monthly Screening of Employees and Contractors

The False Claims Act – What is it?

- The False Claims Act prohibits any person from:
  - Causing a false claim to be presented (staff that provide billable services)
  - Knowingly presenting a false claim (fiscal billing staff)

Local Psychiatrist Violates False Claims Act

- Pled guilty to billing for services during a time he was out of the Country.
- Investigated by: OIG, FBI, US Attorneys Office
- Total false claim billing amount: $322.75
- Total penalty amount: $95,000 plus 2 years probation, and 80 hours community service.
- EXCLUDED: Can no longer provide service to:
  - Consumers with Medicare or Medicaid
  - Consumers funded by any funds originating from DPW
    - To include SAM, Inc.
    - SAM contract terminated

False Claim Act - Penalties

- Penalties for Submitting False Claims to Federal Healthcare Programs
  - Up to 3 times the false claim amount in penalties.

PLUS

  - $5,500 to 11,000 per false claim

False Claims Act
Continued

- Requirements
  - Repayment of overpayments
  - Self Audits
- Whistleblower Provision
  - Encourages Reporting of Actual Knowledge
  - Prevents Retaliation

DOJ Memo – Sept 2015

"One of the most effective ways to combat corporate misconduct is by seeking accountability from the individuals who perpetrated the wrongdoing. Such accountability is important for several reasons: it deters future illegal activity, it incentivizes changes in corporate behavior, it ensures that the proper parties are held responsible for their actions, and it promotes the public's confidence in our justice system."

REPORT FRAUD

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Media Materials:
National Health Care Fraud Takedown 2016

OIG Home Page

- Largest health care fraud "takedown" in history in June 2016.
- 300 defendants - $900 million in false billings to Medicare and Medicaid.
- Takedowns protect Medicare and Medicaid and deter fraud.
- The money taxpayers spend fighting fraud is an excellent investment:
  - For every $1.00 spent on health care-related fraud and abuse investigations in the last three years, more than $6.10 has been recovered.

Key Takeaways

- Your documentation and billing must be exact.
- Ask yourself: *"Is my effort resulting in an expense to my employer or a funder? If so, could I conceivably have created an unnecessary cost?"*
- When in doubt – report! – Transparency is Key!
  - If you realize you may have caused an unnecessary cost.
  - If you suspect a colleague has or will cause an unnecessary cost.

Video

Questions