Health Care Fraud and Abuse Training – 2020

Industry Collaboration Effort (ICE)

Acronyms

Acronym	Title Text
AKS	Anti-Kickback Statute
BMFEA	Bureau of Medi-Cal Fraud & Elder Abuse
CDI	California Department of Insurance
CFR	Code of Federal Regulations
CIA	Corporate Integrity Agreement
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
DMHC	Department of Managed Healthcare
DHCS	Department of Health Care Services
DOJ	Department of Justice
FBI	Federal Bureau of Investigation
FCA	False Claims Act
FDR	First-tier, Downstream, and Related Entity
FA	Fraud and Abuse
GSA	General Services Administration
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	U.S. Department of Health & Human Services
H&SC	CA Health & Safety Code
MAO / MA	Medicare Advantage Organization / Medicare Advantage
MA-PD / PDP	MA Prescription Drug / Prescription Drug Plan
MLN	Medicare Learning Network
NBI Medic	National Benefit Integrity Medicare Drug Integrity Contractor
OIG	Office of Inspector General
SIU	Special Investigations Unit
UPICs	Unified Program Integrity Contractors

Introduction

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- Throughout this training, the following will collectively be known as "Sponsors":
  - DMHC licensed healthcare service plans
  - Staff involved in Medicare Parts C and D
  - Staff of Medicare Advantage Organizations (MAOs)
  - Prescription Drug Plans (PDPs)
- According to the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), California Department of Insurance (CDI) and Centers for Medicare & Medicaid Services (CMS) regulations and program guidelines, Sponsors and their First Tier, Downstream, and Related Entities (FDRs) are responsible for establishing and executing an effective compliance program that includes an ***anti-fraud plan***.
- You need to complete Health Care Fraud and Abuse training promptly upon initial hire and annually thereafter, as required. Documented evidence of the completion of training must be maintained. Please contact your management team for more information.

Health Care Fraud & Abuse
PREVENT, DETECT, REPORT

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Overview

- **What**: Federal and state requirements you must know
- **Why**: Detect, prevent, and correct fraud and abuse; raise awareness
- **How**: Implement an effective compliance program
- **Who**: First tier, downstream, related entities (FDRs) and delegated entities
- **When**: Training must be completed upon hire/initial contract and annually thereafter

Training Objectives

- **Identify** fraud and abuse
- **Understand** fraud and abuse laws & penalties
- **Recognize** government agencies and partnerships dedicated to fighting fraud and abuse
- **Recognize** risk areas or ***red flags**** : claims, utilization management, member services, documentation and coding
- **How to report fraud and abuse**
- **What happens after detection?**

****Red flags*** are warnings or discrepancies that attract attention to potential fraud and abuse. Although not evidence of fraud and abuse, a pattern of red flags can increase suspicion and justify further investigation.

Red flags can be general or specific to a line of business and should be ***reported immediately***!

Health Care Fraud & Abuse:
A Serious Problem Requiring Your Attention

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- Health care fraud can cost taxpayers ***billions*** of dollars.
- To combat fraud & abuse, you must know how to protect your organization from potential abusive practices, civil liability, and possible criminal activity.

You play a vital role in protecting the integrity of Health Care.

Health Care Fraud and Abuse: Do Your Part, Get Informed!

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Committing Fraud Is Not Worth It

Medicare Trust Fund recovered approximately **$1.2 billion** **$232 million recovered** in Medicaid Federal money transferred to the Treasury	The Federal government convicted **497 defendants** of health care fraud	Department of Justice (DOJ) opened **1,139 new criminal** health care fraud investigations DOJ opened **918 new civil** health care fraud investigations

Consequences

HHS OIG Criminal Actions

FY 2016	765
FY 2017	766
FY 2018	679

2,712 Provider Exclusions From Medicare Program Participation

HHS OIG Civil Actions

FY 2016	690
FY 2017	818
FY 2018	795

NOTE: All statistics cover FY 2018 unless otherwise noted. Information provided from CMS Jan 2019 Medicare Fraud & Abuse Training

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Health Care Fraud & Abuse

- Part 1: What is Health Care Fraud?

Part 2: What is Health Care Abuse?

What is Health Care Fraud?

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Intentional Act for Gain:

- Knowingly submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain payment.
- Knowingly receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal or private health care programs
- Making prohibited referrals for certain designated health services
- Documenting a verbal denial falsely attributed to a medical professional

What is Health Care Fraud?

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Deception:

- Falsifying documents to indicate notifications approving, modifying, or denying requests for authorization were sent to the member &/or provider
- Altering claim audit files to fraudulently show compliance with health plan audits to hide failure to pay claims due to financial insolvency
- Submitting inaccurate financial reports related to outstanding claims liability
- Redirecting care from a contracted provider because of economic profile (cost) without regulatory approval

These actions represent the creation of false medical histories, which could potentially put patients at physical risk solely for the purpose of financial gain.

Red Flags

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- **Unusual provider billing practices or suspicious provider activity**
  - Altering dates of service
  - Unbundling or upcoding services
  - Offering to waive patient's co-payment or coinsurance
- **Discrepancy between diagnosis and treatment**
- **Resubmitting claims with unsupported coding changes** (i.e., *altering service code, altering/falsifying diagnosis*) to gain payment or change financially responsible party
- **Intentional misrepresentation** to get higher payment by altering claim forms, medical records, or receipts
- **Deliberate provision of unwarranted/non-medically necessary services for financial gain**
- **Patients questioning services provided**
  - Service not rendered
  - Does not know provider
- **Modification of the provider of service to a different provider**
- **Verbal denials**

Red Flag Alert – Economic Profiling

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What is it	• Any evaluation of a contracted provider based on the economic costs or utilization patterns.
How is it misused	• Results may be used to redirect or divert access to an unpublicized or unapproved narrow network of preferred providers to contain costs.
DMHC Requirements	• Follow economic profile policies filed by health plans OR submit delegate economic profile policies to health plan for DMHC filing, approval, and attestation. Follow rules as outlined in H&SC 1367.02.

Red Flag Alert – Verbal Denial Orders

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What is it	• Staff obtains a denial decision from a physician reviewer by phone and documents in the case file.
How is it misused	• May lead to fraud as it is processed without physician validation of signature or electronic identifier
DMHC Requirements	• Prohibit or discourage verbal denials as an intangible method of physician review.

What is Health Care Abuse?

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- **Abuse** describes practices that, either directly or indirectly, result in unnecessary costs to Health Care Programs. Abuse includes any practice inconsistent with providing patients medically necessary services, meeting professionally recognized standards of care, and charging fair prices.
- The difference between “fraud” and “abuse” depends on specific facts, circumstances, intent, and knowledge.

Both fraud & abuse can expose providers to criminal, civil, and administrative liabilities.

Red Flags

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- Billing for medical services that are
  - Unnecessary;
  - Inappropriate;
  - Unwarranted; or
  - Questionable/unproven treatments &/or care
- Rendering treatment/care which does not meet professionally recognized standards of care
- Rendering services or supplies which are not medically necessary

Medical necessity of a service is the overarching criterion for payment in addition to the CPT requirements for reporting the appropriate Evaluation and Management level of service.

Red Flags

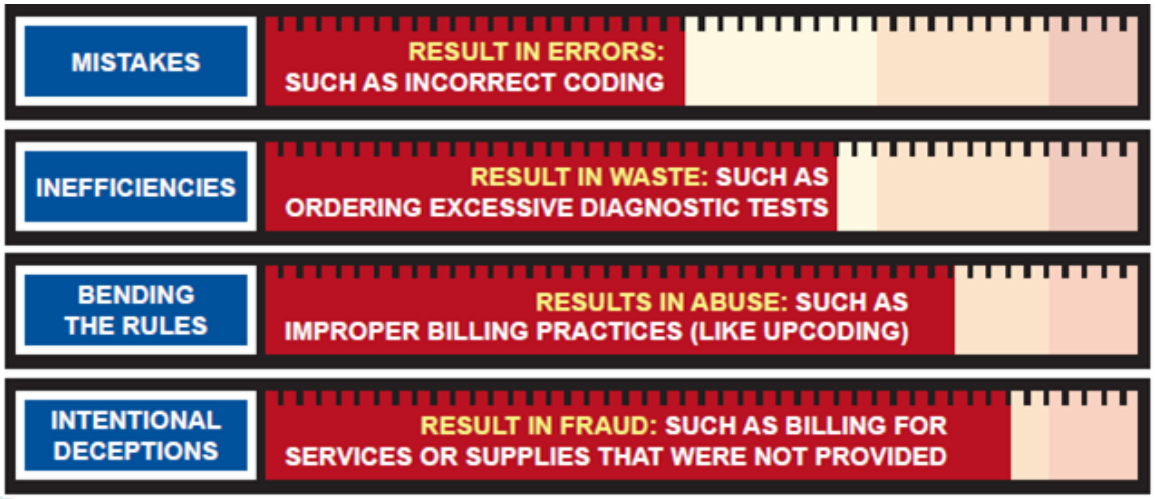
- Charging excessively for services or supplies.
- Rendering, referring, or recommending treatment/care, tests, services, or supplies which would not have been rendered or utilized in the absence of insurance
- Misusing claim codes, such as upcoding or unbundling codes.
- Health plan denies requested specialty care or hospitalizations in order to reduce medical loss ratio and maximize profit
- Provider or health plan deliberately and systematically deters member from receiving medically necessary services in order to maximize service funds or capitation revenue

Program Integrity

- Program integrity (PI) is simply “pay it right.”
- PI focus is on:
  - Paying the right amount to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries while taking aggressive actions to eliminate fraud, waste, and abuse.

Program integrity includes a range of activities targeting various causes of improper payments.

Possible Types of Improper Payments **Examples**:



Summary

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Fraud & Abuse	Drain billions of dollars from health care programs every year, putting patient health and welfare at risk by exposing them to unnecessary services, taking money away from care, and increasing costs
	Jeopardize quality health care and services and threaten the integrity of health care programs by fostering the misconception that health care means easy money
	Cost you as a health care provider and taxpayer Resulting in waste and unintentionally financing criminal activities

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Health Care Fraud & Abuse

- Laws and Penalties

Federal Laws

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False Claims Act (FCA)

Civil FCA 31 United States Code (U.S.C) Sections 3729-3733

Criminal FCA 18 U.S.C. Section 2817

- Imposes civil liability on a person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal government. Also called Lincoln Law.
- "*Should have known,*" "*knowing,*" *or "knowingly"* means deliberate ignorance or reckless disregard of the truth.

Anti-Kickback Statute (AKS)

42 U.S.C. Section 1320a – 7b(b)

- Prohibits knowingly and willfully offering, paying, soliciting, or getting remuneration in exchange for Federal health care program business referrals. The "*safe harbor*" regulations describe various payment and business practices that may satisfy regulatory requirements and may not violate AKS. https://oig.hhs.gov/compliance/safe-harbor-regulations/

Physician Self-Referral Law (Stark Law)

42 U.S.C. Section 1395nn

- Prohibits physicians from referring Medicare beneficiaries for designated health services to an entity where the physician (or an immediate family member) has ownership/investment interest or a compensation arrangement, unless an exception applies. See the Code List for Certain Designated Health Services (DHS) at https://www.cms.gov/Medicare

Federal Laws

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Criminal Health Care Fraud Statute
18 U.S.C. Section 1347

- Prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie for delivering, or paying for, health care benefits, items, or services to defraud a health care benefit program, or prescribed by an excluded individual or entity.

Social Security Act Exclusion Statute
42 USC 1320a-7

- Prohibits the excluded individual or entity from participating in all Federal health care programs. The exclusion means no Federal health care program pays for items or services given, ordered, or prescribed by an excluded individual or entity.
- Enforced by OIG & GSA.

Civil Monetary Penalties (CMPs)

- CMPs apply to a variety of conduct violations and assessing the CMP amount depends on the violation. Penalties up to *$100,000* (in 2018) per violation may apply. CMPs may also include an assessment of up to *3 times* the amount claimed for each item or service, or up to *3 times* the amount offered, paid, solicited, or received.

California State Laws

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Welfare Institutions Code 14107 [False Claims]	• Prohibits claim submission with intent to defraud to obtain greater compensation than legally entitled.
Welfare Institutions Code 14107 (a-b) [Anti-Kickback]	• Solicits or receives any kickback, bribe or rebate to either refer or promise to refer person for service or merchandise
CA Penal Code 550(a)(6-7) [False claims]	• Imposes liability to knowingly make or cause to be made any false or fraudulent claim for health care benefit or which was not used by or on behalf of the claimant

California State Laws

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Business & Professions Code 17200

- Any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising

CA Insurance Frauds Prevention Act ("IFPA") CA Ins. Code 1871.7

- Allows members of the public to file private qui tam suits against anyone who commits insurance fraud in the state.
- The Act states that employees suffering retaliation for their involvement in reporting insurance fraud "shall be entitled to all relief necessary to make the employee whole.

California False Claims Act (CFCA)

- A state law modeled after the Federal FCA. CFCA prohibits any person from submitting false or fraudulent claims valued at over $500 to state or local government.

DMHC Related Laws

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CA H&SC 1341 (a)	• DMHC to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.
CA H&SC 1386 (b) (7) [Fraud]	• Prohibits conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code
CA H&SC 1371.37 [Claim payment]	• A health care service plan is prohibited from engaging in an unfair payment pattern
CA H&SC 1367.02 [Economic Profiling]	• Medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. Prohibits fraud of concealing or restricting costly specialists from network unless economic profiling policies disclosed to the DMHC

Law or Statute	Examples:
FCA	• A physician knowingly submits claims for medical services not provided or for a higher level of medical services than actually provided
FCA	• Changing dates, medical records &/or condition/ diagnosis treated (e.g., service is not supported by the patient's medical record)
FCA	• Service is miscoded • Service is already covered under another claim
AKS	• A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals

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Law or Statute	Examples:
Physician Self-Referral Law (Stark Law)	• A provider refers a patient for a designated health service to a clinic where the physician (or an immediate family member) has an investment interest
Criminal Health Care Fraud Statute	• Several doctors and medical clinics conspired to defraud by submitting claims for medically unnecessary power wheelchairs
Exclusion Statute – Denial of Payment	• A hospital employs an excluded nurse who provides items or services to Federal health care program beneficiaries, even if the nurse's services are not separately billed and are paid as part of a Medicare diagnosis-related group payment the hospital receives • The excluded nurse violates their exclusion thereby causing the hospital to submit claims for items or services they provide
Economic Profiling	• A medical group redirects a referral from a contracted physician to a less costly physician without disclosure of process to the DMHC

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Red Flag

Examples:

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Health Care Fraud Red Flag

- Obstructing an investigation or audit by withholding or delaying information or documentation

Health Care Fraud Red Flag

- A medical group alters documents to pass an audit by changing dates on a case file to give appearance of compliance to timeframes

Health Care Fraud Red Flag

- A nurse writes a verbal denial for a decision that was not made by the doctor

Potential Penalties

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Civil Monetary Penalties Law (CMPL)

- Payment for each service in non-compliance
- Payment up to *3 times* the amount claimed
- Exclusion from health care programs
- May require mandatory compliance program

Criminal & Civil Liability

- Fines
- Imprisonment
- Recoupment
- Restitution
- Loss of license

Potential Sanctions

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OIG Corporate Integrity Agreement (CIA)

- Entity to carry out a compliance program
- Hiring of a compliance officer
- Development of written standards and policies
- Carry out an employee training program
- Annual audits and reviews

Mandatory Corrective Action

- Applicable measures to prevent reoccurrence
- Mandatory training or re-training
- Disciplinary action
- Termination

Federal Exclusion

Excluded individuals and entities are banned from participating in healthcare programs either directly or indirectly.

Exclusion from Federal Healthcare Programs

- Excluded individual or entity may face additional penalties for submitting or causing the submission of claims
- Federal health care programs do **not** pay for items or services given, ordered, or prescribed by an excluded individual or entity

OIG List of Excluded Individuals/Entities (LEIE)

- Public list of individuals and entities currently excluded
- **Health care providers that knowingly hire an excluded party are subject to potential FCA liability and CMPs.**

General Service Administration (GSA)

System for Award Management (SAM)

- SAM incorporated the Excluded Parties List System (EPLS) and includes information on entities:
  - Debarred or proposed for debarment
  - Disqualified from certain types of Federal financial and non-financial assistance and benefits or from getting federal contracts or certain subcontracts
  - Excluded or Suspended

Remember, employers must check OIG/GSA exclusions ***before*** making employment and contract decisions.
And check monthly thereafter.

Summary

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Laws & Penalties	The FCA, AKS, Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statute, the Social Security Act which includes the Exclusion Statute, and the CMPLs are the main Federal laws that address fraud & abuse.
	The California Law Codes: Welfare & Institutions Code, Penal Code, Business and Professions Code, and Insurance Code are the State laws that address fraud & abuse.
	DMHC Related Laws, such as economic profiling and patient rights, are included in the CA Health and Safety Codes.

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You Can Help Prevent Health Care Fraud & Abuse

Physician Relationships

- The U.S. health care system relies on third party payers to pay most medical bills on behalf of patients.

As a health care provider, you play a vital role in the fight against health care fraud & abuse.

Understanding Physician Relationships

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With Payers Related to:

- Accurate coding, billing, and documentation
  - Make sure documentation supports your claims for payment
- Payers trust you to provide medically necessary, cost-effective, quality care

With other Providers Related to:

- Investments
- Recruitment
- **Examples of potential problems:**
  - Improperly influence physician decision-making
  - Hospital may **not** offer money, free or below-market rent for medical office, or engage in similar activities designed to influence referral decisions

With Vendors Related to:

- **Transparency**
  - Federal Open Payments Program
- **Conflict of Interest**
  - The provider's ability to act in the best interest of a patient is affected by the provider relationship with other people, groups, or businesses
- **Examples of risk:**
  - Selling samples to patients
  - Inappropriate consultant agreements or other arrangements to buy physician loyalty

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Health Care Fraud & Abuse

- Prevention;
  Detection;
  Reporting; and
  Correcting

Best Practices for Preventing Fraud and Abuse

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- Develop a compliance program
- Effective education of physicians, providers, suppliers, and members
- Monitor claims for accuracy – ensure coding reflects services provided
- Monitor medical records – ensure documentation supports services rendered
- Institute system safeguards
- Perform regular internal audits

Best Practices for Preventing Fraud and Abuse

- Establish effective lines of communication
- Include questions about potential compliance issues in exit interviews
- Take action to correct identified problems
- ***Remember,*** as a provider you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim
- ***Ultimately,*** we are all responsible to speak up if we encounter a potential violation of laws, regulations, policies, or contractual obligations

Anti-Fraud & Abuse Plan

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- All health care service plans and providers should establish an antifraud plan as part of the Compliance Program or as a standalone policy

Purpose	Why
• Organize and implement an antifraud strategy to identify and reduce costs to plans, providers, subscribers, enrollees, and others caused by fraudulent activities	• To protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud & abuse

Entities that help Prevent, Detect, Report Fraud & Abuse

CMS
https://www.cms.gov/

- To prevent fraud & abuse, CMS works with individuals, entities, and law enforcement agencies, including:
  - Accreditation Organizations
  - Medicare beneficiaries and caregivers
  - Physicians, suppliers, and other health care providers
  - Office of Inspector General (OIG)
  - Federal Bureau of Investigation (FBI)
  - Contractors

Health Care Fraud Prevention Partnership (HFPP)
https://hfpp.cms.gov/

- The HFPP is a voluntary, public-private partnership between the Federal government, state agencies, law enforcement, private health insurance plans, and health care antifraud associations.
- Their goal is to foster a proactive approach to detect and prevent healthcare fraud through data and information sharing.
- The HFPP also performs sophisticated industry-wide analytics to detect and predict fraud schemes.

National Health Care Anti-Fraud Association (NHCAA)
https://www.nhcaa.org

- The NHCAA is a private-public partnership of private health insurers and public-sector law enforcement and regulatory agencies having jurisdiction over health care fraud committed against both private payers and public programs.
- Fosters a private-public partnership in combating health care fraud.
- Provides opportunities for information-sharing.
- Maintains a proactive approach in the fight against health care fraud.

Methods Used to Prevent, Detect, Report Fraud & Abuse

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CMS Claim-Reviewing Entities

- Comprehensive Error Rate Testing (CERT) Contractors
- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractors (UPICs)

If one of these entities contacts you, respond within the specified timeframe and with all requested documentation supporting the medical necessity of the service(s) on the claim. This ensures accurate payment of the claim(s) under pre/post-payment review and prevents payment recoupment for claims correctly paid.

Auditors Private & Public

- Identify suspected billing problems through:
  - Error rates
  - Vulnerabilities
  - Analysis of claims data
  - Evaluation of other information (e.g., complaints)
- Perform pre/post-payment claim reviews to detect improper under or overpayments

Analytical Entities Private & Public

- Promote integrity through audits, policy reviews, and identifying and monitoring program vulnerabilities.
- Collect and analyze provider and plan member activities to:
  - Identify billing patterns
  - Plan member usage patterns
  - Patterns representing a high risk of fraudulent activity

Investigating Entities of Fraud & Abuse

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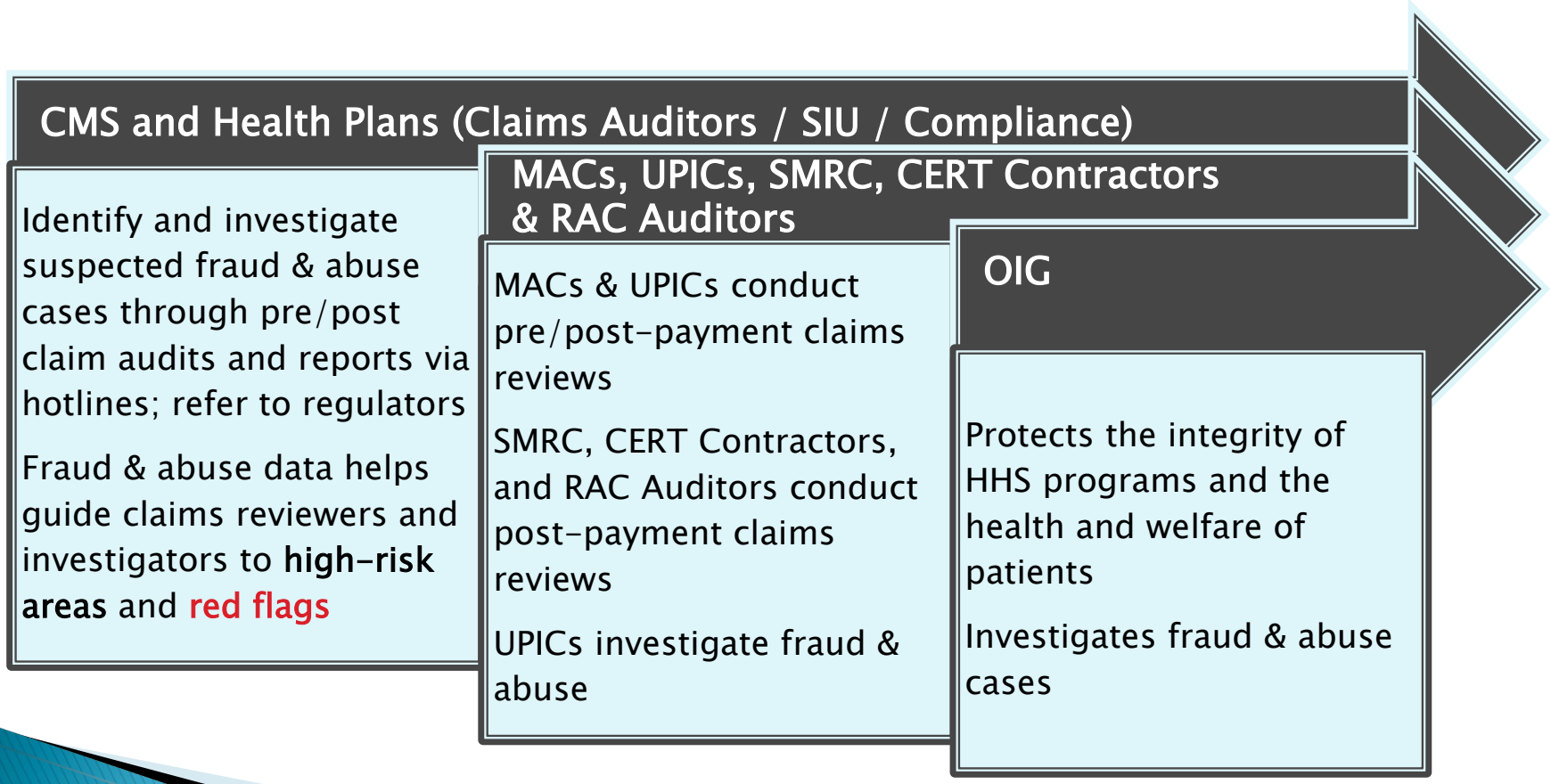

Investigating Entities of Fraud & Abuse

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Department of Justice (DOJ)

Investigates and prosecutes fraud & abuse in Federal programs

Partners with the OIG, FBI, and other Federal, State, and local law enforcement offices through HEAT

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

Established by DOJ and HHS to build & strengthen existing programs to combat and prevent fraud & abuse.

Investigates fraud & abuse cases

Medicare Fraud Strike Force Teams

Combines the FBI's investigative and analytical resources with the HHS-OIG's Criminal Division's Fraud Section, and the U.S. Attorney's Offices prosecutorial resources.

Report Suspected Health Care Fraud & Abuse

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Everyone has the right and responsibility to report suspected fraud & abuse.

- Every Sponsor must have a mechanism for reporting potential fraud and abuse by employees and FDRs.
- Each Sponsor must accept anonymous reports and cannot retaliate against you for making a good faith effort in reporting.
  - **Sponsors and FDRs must have a non-retaliation policy**
- Review your organization's materials for the ways to report fraud and abuse.

Report Suspected Health Care Fraud & Abuse

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Who to report to:

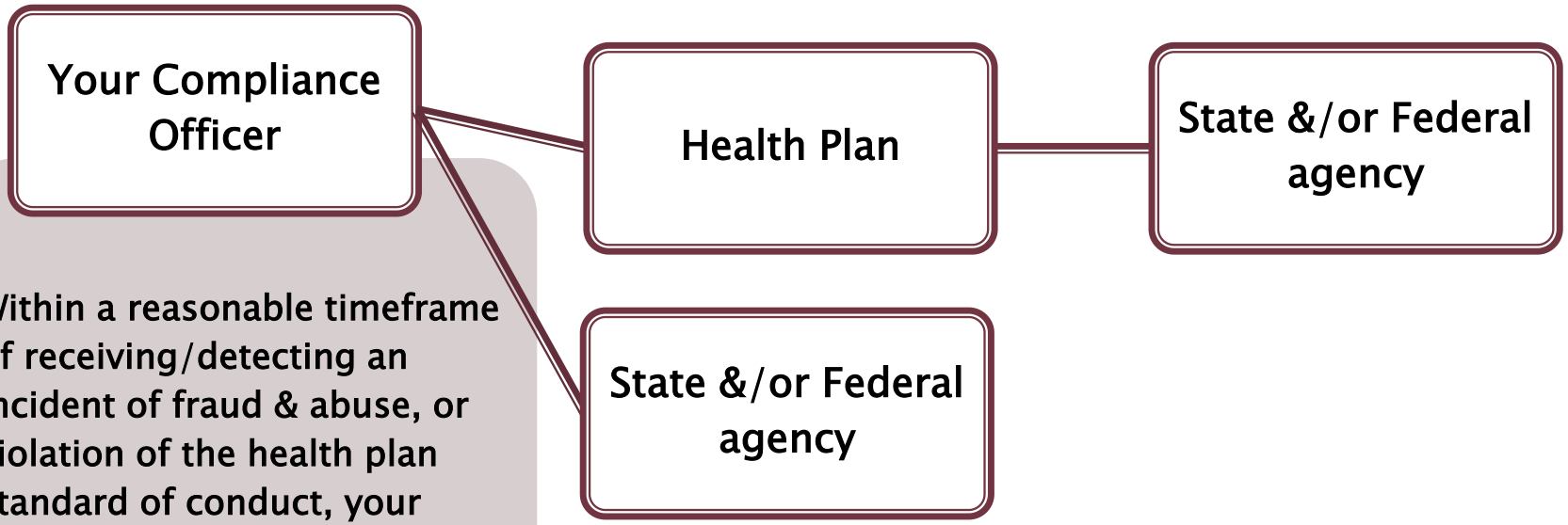
- Your organization's Compliance Officer
- The Compliance Officer, SIU, or Fraud Division of the applicable Sponsor or government regulatory agency

How to report:

- You can report suspected fraud & abuse by phone (organization's hotline), email, fax, mail, and/or on the Sponsor website (if available).
- All information about the individual/entity reporting is kept confidential to the extent allowed by law.
- You can report suspected fraud & abuse ***anonymously***; however, lack of contact information may prevent a comprehensive review of the complaint. Sponsors and the OIG encourage you to provide contact information for follow-up.

REPORTING PROCESS

You suspect inappropriate, unlawful, or noncompliant behavior/activity, Report to:



Within a reasonable timeframe of receiving/detecting an incident of fraud & abuse, or violation of the health plan standard of conduct, your Compliance Officer notifies the appropriate Sponsor of the open investigation and/or investigation findings.

Report Suspected Health Care Fraud & Abuse

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Sponsors and health care providers *must* report potentially fraudulent conduct to the appropriate regulatory authorities (i.e., OIG, DOJ, CMS) if warranted by investigative findings.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to the 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.

What happens after detection?

Once **fraud or abuse** has been detected, it must be *promptly corrected*.

Correcting the problem saves federally funded and private health care programs money and ensures you are in compliance with regulatory requirements.

HOW DO YOU CORRECT THE PROBLEM?

Develop a plan to correct the issue.

- Consult your organization's Compliance Officer or legal team to find out the process for the corrective action plan (CAP) development; plans will vary depending on specific circumstances.

In general:

- Design the corrective action to correct the underlying problem that results in fraud & abuse program violations and to prevent future noncompliance;
- Tailor the corrective action to address the particular fraud & abuse, problem, or deficiency identified. Include timeframes for specific actions;
- Document corrective actions addressing noncompliance or fraud & abuse committed by a Sponsor's employee or FDR's employee and include consequences for failure to satisfactorily complete the corrective action in the required time period; and
- Once started, ***continuously*** monitor corrective actions to ensure they are effective.

Summary

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Prevention

Detection

Reporting

Correction

Prevent fraud & abuse with:

- Effective Compliance Program
- Education and training
- Monitoring and auditing
- Antifraud plan
- Effective communication

Detection by:

- Pre/Post claims review
- Internal audits
- Analysis of claims data

Report:

Ultimately, we are all responsible to speak up if we encounter or suspect a potential violation of laws, regulations, policies, or contractual obligations.

You can report suspected fraud & abuse to your Compliance Officer/Department by phone (organization's hotline), email, fax, mail, and/or on their website (if available)

Correct:

Once **fraud or abuse** has been detected, it must be ***promptly corrected.***

Correcting the problem saves federally funded and private health care programs money and ensures you are in compliance with regulatory requirements.

Disclaimer

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This course was prepared as a service and is not intended to grant rights or impose obligations. This course may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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Contacts & Resources

- Reporting Mechanisms

Regulatory & Sub-Regulatory Resources

CMS Resources

Fraud, Waste, and Abuse and Non-Compliance Reporting Mechanisms

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All reports made are treated confidentially and you may choose to remain anonymous. Whistleblowers and persons who report suspected violations in good faith are protected against retaliation.

Government Authority	FWA / Ethics & Compliance Hotline	TTY; Email; or Mail	Online Tool
CMS Hotline	1-800-MEDICARE Or 1-800-633-4227	1-877-486-2048	https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud
HHS Office of Inspector General	1-800-HHS-TIPS Or 1-800-447-8477	TTY 1-800-377-4950 HHSTips@oig.hhs.gov	https://oig.hhs.gov/fraud/report-fraud/
HHS and US Department of Justice (DOJ)	N/A	N/A	https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud
For Medicare Parts C and D: National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)	1-877-7SafeRx Or 1-877-772-3379	N/A	N/A
State of California Bureau of Medi-Cal Fraud or Elder Abuse (BMFEA) Hotline	1-800-722-0432	Email using On-line Form: https://oag.ca.gov/bmfea/reporting	https://oag.ca.gov/bmfea/reporting
State of California Department of Health Care Services Hotline	1-800-822-6222	fraud@dhcs.ca.gov Medi-Cal Fraud Complaint - Intake Unit Audits and Investigations PO Box 997413, MS 2500 Sacramento, CA 95899-7413	https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

Fraud, Waste, and Abuse and Non-Compliance Reporting Mechanisms

All reports made are treated confidentially and you may choose to remain anonymous. Whistleblowers and persons who report suspected violations in good faith are protected against retaliation.

Sponsor	FWA / Ethics & Compliance Hotline	Email	Online Tool	Mail
Alignment	844-215-2444	compliance@ahcusa.com	www.reportlineweb.com/ahc	N/A
Blue Shield of California	855-296-9092 855-296-9083	stopfraud@blueshieldca.com corporate-compliance@blueshieldca.com	https://www.blueshieldca.com/bsca/about-blue-shield/fraud-prevention/report/home.sp	Blue Shield of California Special Investigations 3300 Zinfandel Drive Rancho Cordova, CA 95670
Brand New Day	866-255-4795 x4071	hotline@universalcare.com	N/A	Compliance Officer: 5455 Garden Grove Blvd., 5th floor Westminster, CA 92683
Central Health Plan of California	626-388-2392	compliance@centralhealthplan.com	N/A	1540 Bridgegate Drive Diamond Bar, CA 91765
Chinese Community Health Plan	415-955-8810	N/A	N/A	Compliance Officer 445 Grant Ave Suite 700 San Francisco, CA 94108
Cigna Health Plan	800-667-7145 800-472-8348	specialinvestigations@cigna.com	N/A	Cigna Special Investigations 900 Cottage Grove Road W3SIU Hartford, CT 06152
Community Health Group	800-651-4459	emarti@chgsd.com	N/A	Compliance Officer Community Health Group 2420 Fenton St., Ste. 100 Chula Vista, CA 91914

Fraud, Waste, and Abuse and Non-Compliance Reporting Mechanisms

All reports made are treated confidentially and you may choose to remain anonymous. Whistleblowers and persons who report suspected violations in good faith are protected against retaliation.

Sponsor	FWA / Ethics & Compliance Hotline	Email	Online Tool	Mail
Humana	**Ethics**: 877-584-3539 **Fraud**: 800-614-4126	ethics@humana.com siureferrals@humana.com	www.ethicshelpline.com Fax: 1-920-339-3613	Humana Special Investigation Unit 1100 Employers Blvd. Green Bay, WI 54344
Inland Empire Health Plan	866-355-9038	compliance@iehp.org	https://iehp.org/en/about/compliance-program	IEHP Compliance Officer P.O. Box 1800 Rancho Cucamonga, CA 91729
Inter Valley Health Plan	888-372-8325	N/A	http://www.reportlineweb.com/ivhp	Compliance Dept. PO Box 6002 Pomona, CA 91769
Molina Healthcare, Inc.	866-606-3889	N/A	https://molinahealthcare.Alertline.com	N/A
SCAN Health Plan	877-863-3362	FraudWaste&AbuseProg@scanhealthplan.com	https://www.scanhealthplan.com/scan-resources/report-an-issue/fraud-information-and-resources	Compliance Officer 3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806
United Healthcare	844-359-7736	N/A	https://secure.ethicspoint.com/domain/media/en/gui/51176/index.html	N/A
Vitality Health Plan		N/A	N/A	18000 Studebaker Rd., Suite 960 Cerritos, CA 90703
WellCare of California, Inc.	866-678-8355 866-364-1350	N/A	N/A	10803 Hope St., Suite B Cypress, CA 90630

Regulations and Sub-Regulatory Guidance:

Resources	Hyperlink URL
42 Code of Federal Regulations (CFR) Section 422.503	https://www.ecfr.gov/cgi-bin/text-idx?SID=c66a16ad53319afd0580db00f12c5572&mc=true&node=pt42.3.422&rgn=div5#se42.3.422_1503
42 CFR Section 423.504	https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5cff780d3df38cc4183f2802223859ba&mc=true&r=PART&n=pt42.3.423
Chapter 9 of the Medicare Prescription Drug Benefit Manual	https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf
Chapter 21 of the Medicare Managed Care Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf
CMS Compliance Program Policy and Guidance webpage	https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ComplianceProgramPolicyandGuidance.html
Federal False Claims Act	31 United States Code (U.S.C) Sections 3729-3733 18 U.S.C. Section 2817
Anti-Kickback Statute	42 U.S.C. Section 1320a – 7b(b)
Physician Self-Referral Law (Stark Law)	42 U.S.C. Section 1395nn

Regulations and Sub-Regulatory Guidance:

Resources	Hyperlink URL
Criminal Health Care Fraud Statute	18 U.S.C. Section 1347
Exclusion Statute	42 USC 1320a-7
Welfare & Institutions Code False Claims and Anti-Kickback	http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14107.
CA Penal Code False Claims	http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN&sectionNum=550.
CA Health and Safety Code H&SC Ch. 2.2, §1341; 1367; 1371; 1386	https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=HSC&division=2.&title=&part=&chapter=2.2.&article=
CA Business & Professions Code	http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=17200.
CA Insurance Frauds Prevention Act (IFPA)	http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=INS&division=1.&title=&part=2.&chapter=12.&article=1.
CA False Claims Act (CFCA)	https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=12650.&article=9.&highlight=true&keyword=False%20Claims%20Act

Additional Resources:

CMS Resources	Hyperlink URL
Compliance Education Materials: Compliance 101	https://oig.hhs.gov/compliance/101
Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training	https://oig.hhs.gov/compliance/provider-compliance-training
Office of Inspector General's (OIG's) Provider Self-Disclosure Protocol	https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp
Part C and Part D Compliance and Audits - Overview	https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits
Physician Self-Referral	https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral
Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254524.html
Safe Harbor Regulations	https://oig.hhs.gov/compliance/safe-harbor-regulations
Medicare Prescription Drug Benefit Manual	https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf
Medicare Managed Care Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

Post-Assessment Quiz

Industry Collaboration Effort

1. Allegations of fraud are limited to the intentional billing for services that do not meet professionally recognized standards
   A. True
   B. False
2. What are some of the penalties for violating fraud and abuse (FA) laws?
   A. Fines
   B. Imprisonment
   C. Exclusion from participation in all health care programs
   D. All of the above
3. All of these government agencies except one are involved in fraud and abuse prevention, which one?
   A. CMS
   B. OIG
   C. LDR
   D. DMHC

Post-Assessment Quiz

4. What is/are cause(s) for improper payment?
   A. Upcoding
   B. Billing for services not needed or not rendered
   C. Misrepresentation of facts
   D. All of the above

5. Abuse may be intentional or unintentional: improper practice that either directly or indirectly results in unnecessary costs to health care program.
   A. True
   B. False

6. It is acceptable to obtain a verbal denial from the medical director without follow-up electronic or written signature.
   A. True
   B. False

Post-Assessment Quiz

Industry Collaboration Effort

7. It is always acceptable for a medical group to suppress availability of high cost specialists in their system to encourage use of preferred providers.
   A. True
   B. False
8. The exclusion statute is a federal law which bans any provider or entity convicted of fraud from participating in any federally funded programs.
   A. True
   B. False
9. An example of Health Care fraud being an intentional act for gain is making prohibited referrals for certain designated services
   A. True
   B. False

Post-Assessment Quiz

Industry Collaboration Effort

10. It is acceptable for a provider to receive cash or below-fair market value rent for a medical office space in exchange for referrals
    A. True
    B. False

11. Which is NOT an example of Best Practices for Preventing Fraud and Abuse
    A. Developing a compliance program
    B. Providing effective education of physicians, providers, suppliers, and members
    C. When encountering a potential violation of laws, regulations, policies, or contractual obligations it is not our responsibility to report immediately
    D. Monitoring claims and medical records

12. When reporting Fraud, the group shall only report to their internal departments and regulators.
    A. True
    B. False

Post-Assessment Quiz

13. If economic profiling is practiced by the delegate, they must disclose to the plan and follow the economic profiling policy of the health plan or have their policy submitted to the DMHC for approval.
    A. True
    B. False

14. Red Flags are warnings or discrepancies that attract attention to potential fraud and abuse and do not require reporting until you have specific evidence of fraud and abuse.
    A. True
    B. False

15. Compliance programs and internal auditors must work collaboratively with the owners, operators and administrators of the provider group to ensure there is no conflict of interest.
    A. True
    B. False

Post-Assessment Quiz

16. When fraud is identified it must be reported internally and/or to affected Sponsors.

    A. True

    B. False

17. When preparing files for an audit, it is important to modify the dates on audit documents to ensure you are compliant with timeframes.

    A. True

    B. False

Post-Assessment Quiz

18. Once a corrective action plan (CAP) is started, the corrective actions must be monitored annually to ensure they are effective.
    A. True
    B. False
19. Ways to report potential Fraud and Abuse include:
    A. Telephone hotlines
    B. Mail drops
    C. In-person reporting to the compliance department / supervisor
    D. Special Investigations Units (SIUs)
    E. All of the above
20. Some of the laws governing health care fraud and abuse include the Health Insurance Portability and Accountability Act (HIPAA); the False Claims Act; the Anti-Kickback Statute; and the Health Care Fraud Statute.
    A. True
    B. False