

# **Sharp Community Medical Group 2019 Compliance Education**

## **General Compliance and Fraud, Waste and Abuse**

# Disclosure

This Compliance and Fraud, Waste and Abuse (FWA ) training presentation was created by Sharp Healthcare and customized by SCMG.

Sharp Community Medical Group (SCMG), as a delegated provider organization, is required to give Compliance and FWA training to employees and contracted providers because we provide administrative services for United Healthcare/Senior, Health Net Seniority Plus and Care 1st Medicare Advantage (MA) beneficiaries.

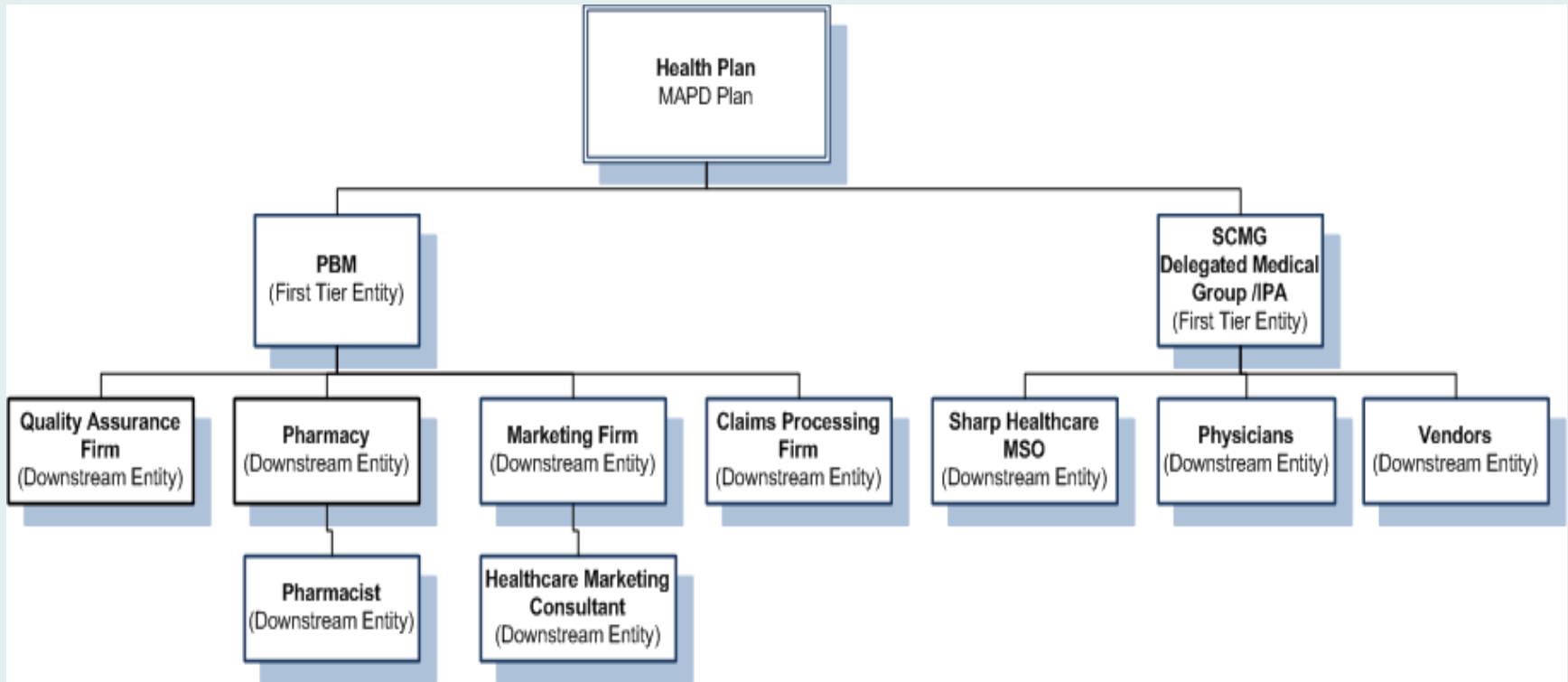
SCMG has sent you this material as part of our oversight process to implement the compliance training and education requirements found in the CMS Medicare Regulations.

# Learning Objectives:

In this module you will learn about the following:

- Elements of a Compliance Program
- The privacy requirements for California and federal laws.
- Responsibilities addressing Protected Health Information
- The importance of workplace fraud and Medicare fraud and abuse laws.
- How fraud and abuse affects Sharp Community Medical Group and you.
- Your responsibility to prevent fraud and abuse.
- Various options available for reporting potential acts of fraud and abuse.

# Where Do I Fit in the Medicare Program?



# CMS Requirements

- As of January 1, 2011, Federal Regulations require that MAO's and PDP Plans have an **effective** compliance program designated to deter FWA. This includes compliance program requirements for annual training on compliance and FWA.
- Refer to 42 CFR 422.503(b)(4)(vi)(C) and 42 CFR 423.504(b)(4)(vi)(C) for details on required training and education for General Compliance and FWA.
- Additional regulatory guidance can be found in Chapter 9 of the Prescription Drug Benefit Manual.
- [http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManual\\_Chapter9\\_FWA.pdf](http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf)

# What are my responsibilities?

- You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.
  - **FIRST** you are required to comply with all applicable statutory, regulatory, and other Part C or Part D requirements, including adopting and **implementing an effective compliance program.**
  - **SECOND** you have a duty to the Medicare Program to report any violations of laws that you may be aware of.
  - **THIRD** you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

# Compliance Program Requirements

- At a minimum, a compliance program must include the 7 core requirements:
  1. Written Policies, Procedures and Standards of Conduct;
  2. Compliance Officer, Compliance Committee and High Level Oversight;
  3. Effective Training and Education;
  4. Effective Lines of Communication;
  5. Well Publicized Disciplinary Standards;
  6. Effective System for Routine Monitoring and Identification of Compliance Risks; and
  7. Procedures and System for Prompt Response to Compliance Issues
- 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual (“IOM”), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9

# Reasons to Implement a Compliance Program

1. Compliance Programs reinforce employees innate sense of right and wrong.
2. An effective compliance program helps an organization fulfill its legal duty to the government.
3. Adopting a Compliance Program concretely demonstrates the organization has a strong commitment to honesty and responsible corporate integrity.
4. Compliance Programs are cost effective. **Expenditures are insignificant in comparison to the disruption and expense of defending against a fraud investigation.**
5. A Compliance Program provides a more accurate view of employee and contractor behavior relating to fraud and abuse.
6. A Compliance Program provides guidance and procedures to promptly correct misconduct.
7. An effective Compliance Program may mitigate False Claims Act liability or other sanctions imposed by the government by preventing non-compliance, fraud, waste and abuse.



# State Privacy Laws



California Department of Public Health (CDPH) enforces California Privacy laws and requires licensed facilities, like Sharp hospitals to:

- Protect the privacy of patients' medical information.
- Prevent unlawful or unauthorized access, use or disclosure.
- Report unlawful or unauthorized access, use or disclosure of medical information within 15 business days after breach detection unless there is a delay by law enforcement.

# Federal Privacy Laws:

## What is HIPAA Privacy?

**The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires all providers and employees to:**

- Secure patients' PHI (physically and electronically).
- Adhere to the minimum necessary standard for use and disclosure of PHI.
- Specify patients' rights for access, use and disclosure of their PHI.

# PHI

## PHI is:

- Health information related to a patient's past, present or future physical and/or mental health or condition.
- Includes **at least one of the 18 personal identifiers** (Please refer to the next slide).
- Transmitted in any format: written, spoken, or electronic (including videos, photographs, and x - rays).

# PHI Identifiers

- Name
- Postal address
- All elements of dates except year
- Telephone number
- Fax number
- Email address
- URL address
- IP address
- Social security number
- Account numbers
- Medical record number
- Health plan beneficiary number
- Device identifiers and their serial numbers
- Vehicle identifiers and serial number
- Biometric identifiers (finger prints)
- Full face photos and other comparable images
- Any other unique identifying number, code or characteristic
- License numbers

It is your responsibility to be aware of PHI Identifiers and safeguard them.

# State Privacy Law Basics:

## According to State Privacy Laws:

- A patient's "medical information" is any individually identifiable information derived from a healthcare provider regarding a patient's medical history, mental or physical condition or treatment.

## Examples of unlawful access, use or disclosure of medical information:

- Accessing friends, co-workers, and all family members (including spouses, children and parents etc.) patient's medical information.
- Faxing or providing medical information to the wrong patient, hospital or company.

# PHI Breach



The term “Breach” means:

The unauthorized acquisition, access, use or disclosure that compromises the security or privacy of PHI.

# Unauthorized Access of Medical Information



The term “Unauthorized” means:

The inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by California’s Confidentiality of Medical Information Act (CMIA).

# California Medical Information Act (CMIA)

- CMIA prohibits disclosure of medical information by a provider of health care, or health care service plan without prior written authorization.





# Example of a Privacy Breach

An employee or medical staff member **peeking** at a patient's medical record merely to satisfy his or her own curiosity; even if the employee or medical staff member does not disclose any medical information about the patient to any other person.



# Workplace Fraud and Abuse

# Workplace Fraud

Workplace **fraud** is:

- The intentional dishonest and deceptive action of defrauding a business either directly or indirectly whether or not for personal gain.
- Most often this action is taken against businesses because the criminal mind believes they can successfully steal, hide, or use the assets for value.



# Workplace Fraud

Workplace fraud is an expensive and growing problem that negatively impacts organizations and its employees. Organizations lose an estimated 5% of annual revenues to fraudulent activities.

- Fraud is an organizational wide issue.
- Fraud is not just a departmental issue.
- Sharp Community Medical Group has a zero tolerance towards fraud.



(Source: ACFE 2014 Report to the Nations on Occupational Fraud and Abuse.)

# Workplace Fraud

The longer frauds last, the more financial damage they cause. Passive detection methods (confession, notification by law enforcement, external audit and by accident) tend to take longer to bring fraud to management's attention, which allows the related loss to grow.



# Workplace Fraud

Consequently, proactive detection measures; such as:

- Hotlines, management review procedures, audits, and employee monitoring mechanisms are vital in catching frauds early and limiting their losses.

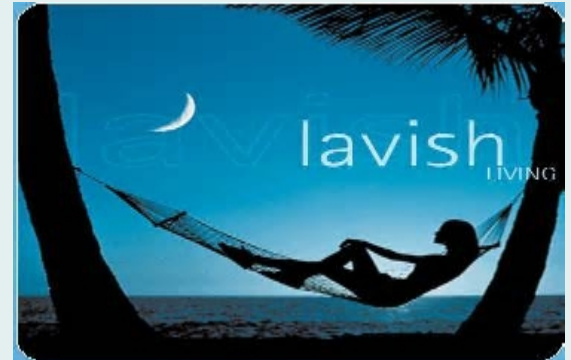


# Workplace Fraud

Most workplace fraud perpetrators exhibit certain behavior traits that can be warning signs of their fraud, such as:

- Living beyond their means and/or having unusually close associations with vendors or customers.

All employees need to recognize these warning signs that, when combined with other factors, might indicate fraud.



# Examples of Workplace Fraud:

- Abusing authority
- Committing official or moral misconduct
- Falsifying information
- Misusing Company time, equipment or information
- Soliciting gifts from outside sources
- Stealing or embezzling Company property or money
- Violating conflict of interest standards



## Example:

Employee falsifying work related documents or time cards = **FRAUD**

Source: OIG Hotline Operations <https://forms.oig.hhs.gov/hotlineoperations/posters/OIG%20Hotline%20Ops%20Poster%20-%20Employee%20Fraud.pdf>



# How Workplace Fraud Hurts Organizations

Fraud also hurts organizations by causing:

- Decreased productivity
- Investment of time & money spent on investigations
- Lost resources
- Lowered morale
- Possible punishment
- Negative impact on organization's reputation



# How Workplace Fraud Hurts Organization Employees



Fraud perpetrated by another individual can negatively affect others by:

- Decreased trust throughout the organization.
- Increased scrutiny from regulatory agencies.
- Loss of time and resources to address fraudulent acts.
- Fewer resources available to provide needed care to your patients.

# Overview of Medicare Fraud and Abuse

# Medicare Fraud and Abuse is a Serious Problem

- Most Medicare providers/contractors are honest and well-intentioned.
- However, \$3.35 billion was recovered in 2015 for Medicare fraud.
- Fraud and abuse persists because some people perceive Medicare as easy money with minimal risk of being caught.



# What is Medicare Fraud?



- Making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist.
- Making or accepting false referrals in exchange for reimbursement by Medicare.

# What is Medicare Abuse?

## **Medicare Abuse describes practices that:**

- Result in unnecessary costs,
- Are not medically necessary,
- Are not professionally recognized standards, and
- Are not fairly priced.

## **An example of Medicare Abuse:**

- Billing for Home Health services that were never provided.
- Billing for medically unnecessary services such as psychotherapy and infusion therapy.

# Major Medicare Fraud and Abuse Laws

- False Claims Act
- Anti-Kickback Statute
- Physician Self-Referral Law
- Criminal Health Care Fraud Statute

These bodies of law speak to the civil and criminal sanctions the government can impose upon individuals and entities who commit fraud and abuse of the Medicare Program.

# What is the False Claims Act (FCA)?

- Protects the Federal Government from:  
Overcharges or overpayment for substandard goods or services.

The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted a false or fraudulent claim OR acts in deliberate ignorance or reckless disregard of the truth related to the claim.

## **Example:**

- Billing Medicare for a claim for medical services that were never provided or unsubstantiated.

## **Penalties:**

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



# What is the Anti-Kickback Statute?

The Law prohibits knowingly and willfully:

- Offering, paying, soliciting, or receiving remuneration to induce or reward referrals of items/ services reimbursable by a Federal health care program.

## **Example:**

A physician is not allowed to rent a medical office below fair market value in exchange for referrals that can be billed for Medicare.

**Penalties:** Fines can range from \$10,000 - \$50,000.

Civil monetary penalties can amount up to three times the amount of the claims.

Criminal penalties can include fines, imprisonment, or both.

# What is the Physician Self-Referral Law (Stark Law)?

The Stark Law prohibits referring Medicare beneficiaries for designated health services such as lab, physical therapy, or home health services to an entity in which the physician (or an immediate family member) has an ownership/investment interest or a compensation arrangement.

## **Example:**

A physician refers a patient to an orthopedic department in which the physician has an ownership interest.

## **Penalties:**

Penalties for violating Stark Laws can include fines, repayment of claims, and potential exclusions from participating in the Medicare Program.

# What is the Criminal Health Care Fraud Statute?

Prohibits knowingly and willfully executing, or attempting to execute, a scheme such as:

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;

In connection with the delivery of or payment for health care benefits, items or services.

## **Example:**

Multiple physicians in a medical group intentionally billing Medicare for unnecessary therapy services for all their patients.

## **Penalties:**

Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

# Types of Penalties

In addition to civil and criminal sanctions, the Medicare program can apply administrative penalties for certain fraud and abuse violations.

## **For Example:** Exclusion

Under the exclusion statute, the OIG **must** exclude from participation in all Medicare programs providers and suppliers convicted of:

- Medicare fraud;
- Patient abuse or neglect;
- Felony convictions related to fraud;
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

# Mandatory Exclusion from HHS Office of Inspector General (OIG)

- Exclusion means that for a designated period, Medicare, Medi-Cal, and other federal health care programs will not pay the provider for services performed or for services ordered by the excluded party. These exclusions are imposed for a minimum of 5 years with the possibility of permanent exclusion.

# Excluded Individuals/Entities

- No payment will be made by any federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity.
- This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services.



# Medicare Fraud and Abuse: Prevention

# CMS is Working to Prevent Medicare Fraud and Abuse

- Enhanced Medicare enrollment protections such as:
  - Fees
  - Screening categories
  - Revalidation
- Automated prepayment claims edits.
- Predictive analytics technologies.
- Suspension of payments.
- Education.





# What is expected of me?

Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which SCMG operates.

- Review the SCMG Standards of Conduct and Policies and Procedures to identify this obligation and tell you how to report suspected noncompliance
- **Everyone** is required to report violations of Standards of Conduct and suspected noncompliance.
- There can be **NO** retaliation against you for reporting suspected noncompliance in good faith
  - **Compliance is EVERYONE'S responsibility**

# The Providers' Role To Prevention:



- To provide only medically necessary, high quality services.
- To properly document all services.
- Correctly bill and code for services.

# Medicare Fraud and Abuse: Detection and Enforcement

# CMS Partners with State and Federal Law Enforcement Agencies for Investigations:

<b>OIG</b>	HHS Office of Inspector General
<b>FBI</b>	Federal Bureau of Investigation
<b>DOJ</b>	Department of Justice
<b>MFCUs</b>	Medicaid Fraud Control Units
<b>HEAT</b>	Health Care Fraud Prevention and Enforcement Action Team

# CMS Contracts with Other Entities To Conduct Investigations

PSCs/ ZPICs – Program Safeguard Contractors/Zone Program Integrity Contractors

MEDICs – Medicare Drug Integrity Contractor

Medicare Carriers, FIs, MACs – Fiscal Intermediaries/ Medicare Administrative Contractors

QIOs – Quality Improvement Organizations

# Additional CMS Contract with Other Entities

- **MA Plans and PDPs** - Medicare Advantage/ Plans and prescriptions Drug Plans
- **Recovery Audit Program**- Recovery Auditors (RA)
- **Auditors**
- **Contractors** - Comprehensive Error Rate Testing (CERT)

# PSCs, ZPICs, MEDICs

Identify cases of suspected fraud and abuse.



Refer cases of suspected **fraud** to OIG.

Refer cases of suspected **abuse** to:

- Appropriate Medicare Contractor, and/or
- OIG

May take concurrent action.

# PSCs, ZPICs, MEDICs

- Investigates fraud and abuse in Federal Government programs, and partners with the OIG through HEAT.





# Health Care Fraud Prevention and Enforcement Action Team (HEAT)

- Gathers government resources to:
  - Help prevent fraud, waste, and abuse in the Medicare and Medicaid Programs, and
  - Crack down on fraud perpetrators who abuse the system.
- Reduces health care costs and improves the quality of care.
- Highlights best practices by providers and public sector employees.
- Builds upon existing partnerships between the DOJ and OIG.
- Maintains the “Stop Medicare Fraud” website.

# Reporting Suspected Fraud and Abuse

- To report a confirmed or suspected violation, you may do any of the following:
- Contact Paul Belton, Sharp HealthCare's Corporate Compliance Officer at (858) 499-3138 or [paul.belton@sharp.com](mailto:paul.belton@sharp.com).
- Contact the Sharp Community Medical Group Compliance Liaison at (858) 499-4498 or [irene.black@sharp.com](mailto:irene.black@sharp.com)
- Report the incident to the Sharp Confidential Hotline at (800) 350-5022.
- 1-800-MEDICARE
- The HHS OIG Hotline: 1-800-HHS-TIPS (1-800-447-8477)  
TTY users 1-800-377-4950 or via fax 1-800-223-8064

# CONGRATULATIONS!

You have completed the SCMG customized CMS required training course on the Compliance Program and preventing and detecting Fraud, Waste and Abuse.

SCMG is committed to abiding by the laws, rules and regulations that govern our business. Our compliance program cannot operate without the cooperation of our associates, vendors, business partners, and first tier, downstream and related entities.



# Thank You

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SCMG is committed to abiding by the laws, rules and regulations that govern our business. **To demonstrate that SCMG is compliant with this requirement you must complete the attestation acknowledging you have completed the SCMG Fraud, Waste and Abuse Training 2019.**

Thank you for completing the required SCMG Fraud, Waste and Abuse Training 2019.