

# Chapter 8

## Fraud and Abuse

Health care fraud and abuse is a serious concern for South Country Health Alliance (SCHA) and the entire health care industry. While most health care providers, suppliers, practitioners, and patients are honest, a small minority commit health care fraud and abuse that costs Medicare, Medicaid, and other government health care programs billions of dollars each year. SCHA has the responsibility to prevent, detect, investigate, and report health care fraud and abuse.

SCHA administers health insurance products that strictly involve state and federal public dollars. Because of this, SCHA is subject to certain laws designed to contain the fraud, waste and abuse of these public dollars.

### LEGAL REQUIREMENTS

#### SCHA is required by to:

- Comply with all state and federal program integrity requirements
- Refer suspected fraud to the Minnesota Department of Human Services, the federal Health and Human Services Office of Inspector General (OIG), and law enforcement

### REPORTING FRAUD, WASTE AND ABUSE

#### To report suspected fraud or abuse committed against SCHA:

- Submit a report to [compliance@mnscha.org](mailto:compliance@mnscha.org);
- Submit a report to SCHA at 1-866-722-7770 (toll free); or

Submit an anonymous report to “Report-it” at 1-877-778-5463 or on-line at [www.reportit.net](http://www.reportit.net) (login is SCHA, password is Owatonna)

### FRAUD AND ABUSE OVERVIEW

Participating providers should notify SCHA of any situations where provider billing fraud may have occurred, or where members have engaged in suspected fraudulent or abusive activity. Examples of the former include billing for services not rendered, or misrepresentation of claim data (such as upcoding or unbundling).

Member abuse includes falsification of enrollment information, altering or fabricating claims, lending identification cards to someone to use, or prescription drug forgery. Following are more specific definitions and examples.

#### **Fraud** (42 CFR §455.2; Minnesota Rules, Part 9505.2165, subpart 4)

Fraud means an intentional deception or misrepresentation made by a person with the

knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Fraud consists of any acts that constitute a crime against SCHA or other health care programs, or attempts or conspiracies to commit those crimes, including but not limited to the following:

- Theft
- Perjury
- Aggravated forgery
- Medical assistance fraud
- Financial transaction card fraud
- Making a false statement, claim or representation to SCHA or other health care program when the person knows or should reasonably know the statement, claim or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status.

**Abuse** (42 CFR § 455.2; Minnesota Rules, Part 9505.2165, subpart 2)

Abuse is a pattern of practice that is inconsistent with sound fiscal, business or health service practices, and those practices result in unnecessary costs to SCHA or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health services, including but not limited to the following:

- Continually submitting claims from which required information is missing or incorrect
- Continually submitting claims that do not comply with the requirements to be a covered service
- Continually submitting claims for services not medically necessary
- Continually submitting claims using procedure codes that overstate the level or amount of health service provided
- Continually submitting claims for the same health service provided to the same recipient
- Continually submitting claims for health services that are not reimbursable by SCHA
- Continually submitting or causing submission of false information for the purpose of obtaining (prior) authorization, inpatient hospital admission certification or a second medical opinion
- Continually billing SCHA for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability
- Continually failing to report duplicate payments from third-party payers for covered services provided to SCHA members that were billed to SCHA  
Neglecting to keep financial records for the services provided to SCHA members as required by federal and state law
- Neglecting to maintain health records as required by federal and state law
- Neglecting to disclose or make available to SCHA a member's health record or a provider's financial records as defined in the provider contract
- Submitting a false or fraudulent application for provider status

- Neglecting to use generally accepted accounting principles or other accounting methods that relate entries on the member's health record to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule
- Payment of health plan funds to a second provider whom the primary provider knew was suspended or barred from participating in federal health care programs
- Receiving remuneration in return for the provision of health care services in violation of the Stark Law (42 U.S.C., sect. 1395nn) or the Anti-kickback Statute (42 U.S.C., sect. 1320a-7b(b))

### **Checking the Federal and State Exclusions Lists**

Providers are required to check all owners, managing employees, board members, employees or anyone else who works for the provider against the federal and state exclusion lists prior to hiring and monthly thereafter. Documentation of checking the exclusion lists prior to hiring must be kept in individuals personnel file. Documentation of monthly exclusion screening can be maintained in an electronic exclusion report. Providers must notify SCHA immediately upon learning that any such person or entity is under investigation or has been excluded from federal or state health care program participation. Databases to be monitored include:

- Office of Inspector General (OIG) Excluded Individuals/Entities (LEIE)  
<https://exclusions.oig.hhs.gov/>
- Excluded Parties List System (EPLS, within the HHS System for Award Management (SAM))  
<https://www.sam.gov/portal/public/SAM/>
- Minnesota Health Care Programs (MHCP) Excluded Individuals and Providers List  
[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-295094](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-295094)

### **CMS Requirements for Fraud, Waste and Abuse Compliance Training**

Effective January 1, 2016 the Centers for Medicare & Medicaid Services (CMS) updated the requirements for the annual education and training related to fraud, waste and abuse for plans first tier, downstream and related entities (FDR). This training is required for all FDR employees and must be completed by December 31 each year.

The training options that would satisfy this requirement are as follows:

1. Complete the CMS web-based training modules for Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance directly online through the Medicare Learning Network (MLN) (<https://learner.mlnlms.com/Default.aspx>); or
2. Download, view, or print the content of the CMS standardized training modules for Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare

Parts C and D General Compliance from the CMS website and incorporate into your existing compliance training materials/systems. The CMS training content **cannot** be modified.

If you have any questions or concerns about the FWA training requirement, please contact the SCHA Compliance Officer at [compliance@mnscha.org](mailto:compliance@mnscha.org).

## **SOUTH COUNTRY FRAUD AND ABUSE INVESTIGATIONS**

A fraud and abuse investigation may include:

- Examination of health service and financial records.
- Examination of equipment, materials, prescribed drugs or other items used in a member's health service.
- Examination of claims payments made.
- Examination of prescriptions written for members.
- Interviews of anyone with information pertinent to the allegation of fraud or abuse.
- Verification of the professional credentials of a provider, the provider's employees and entities under contract with the provider.
- Determination of whether the health care provided was medically necessary.
- Suspension of claims payment until the investigation is complete.

Following completion of the investigation, SCHA will determine whether:

- The provider is in compliance with the requirements of the contract and administrative protocols; or
- There is evidence of fraud, theft or abuse that supports administrative, civil or criminal action.

After completing the determination, SCHA will take one or more of the following actions:

- Close the investigation when no further action is warranted.
- Impose administrative sanctions.
- Seek monetary recovery.
- Refer the investigation to the appropriate state regulatory agency.
- Refer the investigation to the appropriate local law enforcement officials for review pursuant to Minnesota law.
- Report as necessary to regulatory agencies.

SCHA may impose these sanctions on providers who commit fraud and/or abuse:

- Placing restrictions on the provider
- Referral to the appropriate state licensing board
- Suspension or termination of the provider contract
- Suspension or termination of the participation of any person or corporation with whom the provider has any ownership or controlling interest
- Requiring a contract that stipulates specific conditions of participation
- Review of the provider's claims before payment
- Suspending payments to the provider

**Important Note:** SCHA has the authority to seek monetary recovery and to administer sanctions concurrently. SCHA will notify a provider in writing of intent to recover money or impose sanctions.

## **RECORD KEEPING REQUIREMENTS**

### **Access to Records**

SCHA has the right to access records pursuant to the provider contract and the member's consent signed in accordance with Minn. Stat. §144.293.

During the term of an agreement with SCHA and for ten years following its termination, the provider shall give SCHA and its authorized agents access to all information and records related to health services provided according to the agreement, to the extent permitted by law and without further authorization by any member.

The provider shall submit copies of records requested by SCHA **within 14 days** from the date of such request, or sooner if necessary to comply with laws related to the resolution of member complaints or to cooperate with an investigation by SCHA.

If the provider fails to comply, SCHA has the right to withhold reimbursement for health services until the provider fully complies and SCHA and/or its authorized agents have reviewed the information and records.

### **Health Records**

Health records are any electronically stored data, and written documentation of the nature, extent and medical necessity of a health service provided to a SCHA member by a provider and billed to SCHA.

Health records must be created and maintained as a condition of payment by SCHA. Each occurrence of a health service must be completely, promptly, accurately and legibly documented in the member's health record. The information must be maintained in an orderly fashion and easily accessible. SCHA funds that are paid for services not documented in the health record are subject to monetary recovery.

## **RULES AND REGULATIONS CONCERNING FRAUD, WASTE AND ABUSE**

### **FEDERAL LAWS**

Federal laws regarding fraud and abuse include, but are not limited to:

- The Federal False Claims Act [31 U.S.C. §§3729-3733]
- The Program Fraud Civil Remedies Act [31 U.S.C. §§3801-3812]
- Deficit Reduction Act of 2005 [Pub. Law 109-171, §6032]
- Medicaid Integrity Program [42 C.F.R. §455]
- Federal Anti-kickback Statute [42 U.S.C. §1320a-7b(b)]
- Stark Law [42 U.S.C. §1395nn]
- Civil Monetary Penalties Law [42 U.S.C. §1320a-7a]
- Health Care Fraud [18 U.S.C. §1347]

- False Statement Relating to Health Care [18 U.S.C. §1035]

## **Federal False Claims Act**

The False Claims Act (“FCA”) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. Anyone who knowingly submits or causes someone else to submit a false or misleading claim for government funds is liable to the federal government for civil damages. The law is set forth at 31 U.S.C. §§3729-3733. A claim is broadly defined to mean any request for money or property made to an entity where a portion of the requested money or property would come from the US Government.

In sum, the FCA prohibits:

- Knowingly presenting, or causing to be presented to the Government a false or fraudulent claim for payment or approval;
- Knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
- Conspiring to defraud the Government by getting a false claim allowed or paid;
- Falsely certifying the type or amount of property to be used by the Government;
- Making or delivering a document certifying receipt of property for Government use without completely knowing that the information on the receipt is true;
- Knowingly buying or receiving Government property from an unauthorized officer of the Government; and
- Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

The terms “knowing” or “knowingly” are defined as when a person, who with respect to information, has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of the information.

Violations of the Federal FCA may lead to civil penalties of \$5,500 to \$10,000. Fines may also include treble damages up to three times the amount of the original penalty and the violator can be excluded from participating in the Medicare and Medicaid programs. No proof of specific intent to defraud is required to establish liability under the FCA.

Under the FCA, at 31 U.S.C. §3730, a whistleblower may bring a civil action on behalf of the government for a violation of the FCA (this type of action is called a “qui tam” lawsuit). After filing with Department of Justice, the government can pursue the claim on its own, or decline to intervene and allow the whistleblower to continue. If the whistleblower’s case goes forward, no one else can bring a separate action later. The whistleblower also has protection from possible retaliation by his or her employer or fellow employees. Any person who is harassed or discriminated against because of his or her involvement in a qui tam action has the right to be made “whole.” The whistleblower’s damages may include reinstatement of their job position, two times back

pay, plus interest, and compensation for any special damages including reasonable litigation and attorneys' fees.

### **Program Fraud Civil Remedies Act**

The Program Fraud Civil Remedies Act of 1986, set forth at 31 U.S.C. §§3801-3812, provides administrative remedies, including civil penalties and assessments, that may be imposed against people making false claims and statements to federal agencies. The Act provides that any person who makes, presents or submits a claim to an "authority" (an executive department or an establishment, a military department or the U.S. Postal Service) that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil penalty of up to \$5000 per false claim or statement and up to twice the amount claimed in lieu of damages. No proof of specific intent to defraud is required to establish liability under this chapter. Section 6034 of the Deficit Reduction Act ("DRA") established the Medicaid Integrity Program ("MIP") which increased the Center for Medicare and Medicaid Services' ("CMS") resources to prevent and respond to Medicaid fraud and abuse.

### **Anti-Kickback Statute**

The Anti-Kickback Statute is found at 42 U.S.C. §1320a-7b(b). In general, the Anti-Kickback Statute prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business. The prohibition applies to both parties in the arrangement. Both civil and criminal penalties may be applied. Criminal penalties include up to five years in prison plus \$25,000 in fines. Civil penalties include up to \$50,000 in fines and three times the lost dollar amount.

### **Stark Law**

The Stark Law is found at 42 U.S.C. §1395nn. The Stark Law prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies. It also prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral.

Civil penalties include overpayment/refund obligations, False Claims Act liability, monetary penalties for knowing violations and assessment up to three times the amount claimed.

### **Federal False Statements Relating to Healthcare Matters**

In any matter involving a "health care benefit program," 18 U.S.C. §1035 states that whoever knowingly and willfully:

- Falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or
- Makes a materially false, fictitious, or fraudulent statement or representation; or
- Makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than five years, or both.

## **Federal Healthcare Fraud**

As part of HIPAA, the U.S. Criminal Code was amended to include a prohibition against committing any scheme to defraud a federal healthcare program or making any false or fraudulent representations. It is a crime to knowingly and willfully execute, or attempt to execute, a scheme or artifice to defraud any healthcare benefit program, or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any health care benefit program. The Healthcare Fraud offenses created by HIPAA are found at 18 U.S.C. §1347. Penalties include a fine and imprisonment of up to ten years.

## **MINNESOTA LAWS**

Minnesota laws regarding fraud and abuse include, but are not limited to:

- Surveillance and Utilization Review Program – MN Department of Human Services [Minn. Rule 9505.2200]
- Theft of Medical Assistance funds [Minn. Stat. 609.466]
- State Attorney General investigative powers [Minn. Stat. 8.31]
- Whistleblower protections under [Minn. Stat. §181.932]
- Minnesota False Claims Act [Minn. Stat. §15C.01 et seq.]

The **Surveillance and Integrity Review Program** is managed by the Minnesota Department of Human Services (DHS) as set forth at Minn. Rule 9505.2200. The program seeks to identify fraud, theft, abuse, or error in the administration of the program, and investigate vendors or recipients of medical assistance to monitor compliance with program requirements, as authorized under the federal Medicaid Integrity Program at 42 C.F.R. §455.

**Theft of Medical Assistance Funds** is addressed by Minn. Stat. §609.466, which provides that any person who, with the intent to defraud, presents a claim for reimbursement, a cost report or a rate application, relating to the payment of medical assistance funds to a state agency, which is false in whole or in part, is guilty of an attempt to commit theft of public funds and may be sentenced accordingly.

**The Attorney General**, under Minn. Stat. §8.31, is authorized to investigate violations of the law of this state respecting unfair, discriminatory, and other unlawful practices in business, commerce, or trade.

## **Disclosure of information by employees, contractors or agents**

An employer shall not discharge, discipline, threaten, otherwise discriminate against, or penalize an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because:

- The employee, in good faith, reports a violation or suspected violation of any federal or state law or rule adopted pursuant to law to an employer or to any governmental body or law enforcement official;
- The employee is requested by a public body or office to participate in an investigation, hearing, inquiry;

- The employee refuses an employer's order to perform an action that the employee has an objective basis in fact to believe violates any state or federal law or rule or regulation adopted pursuant to law, and the employee informs the employer that the order is being refused for that reason; or
- The employee, in good faith, reports a situation in which the quality of health care services provided by a health care facility, organization, or health care provider violates a standard established by federal or state law or a professionally recognized national clinical or ethical standard and potentially places the public at risk of harm.

### **The Minnesota False Claims Act**

The Minnesota False Claims Against the State Act (“MFCASA”) is a civil statute designed to help Minnesota combat fraud and recover losses resulting from fraud. (Minn. Stat. §§ 15C.01 to 15C.16). The MFCASA became effective on July 1, 2010.

#### Violations of the MFCASA include:

- (1) knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval;
- (2) knowingly making or using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
- (3) knowingly conspiring to commit a violation of clause (1), (2), (4), (5), (6), or (7);
- (4) has possession, custody or control of public property or money used, or to be used, by the state or a political subdivision and knowingly delivering or causing to be delivered less than all of that money or property;
- (5) is authorized to make or deliver a document certifying receipt for money or property used, by the state or a political subdivision and intending to defraud the state or a political subdivision, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- (6) knowingly buying public property from an officer or employee of the state or political subdivision who lawfully may not sell or pledge the property; and
- (7) knowingly making or using a false record or statement material to an obligation to pay the state or political subdivision or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a political subdivision.

#### What are the Qui Tam Provisions and Whistleblower Protections?

The MFCASA contains provisions that allow individuals (or qui tam plaintiffs) to file a lawsuit to enforce the MFCASA on behalf of the state or the local government. Once filed, the Minnesota Attorney General or an attorney for a city or county may choose to intervene and conduct the lawsuit. If an attorney for a government entity conducts the lawsuit, the qui tam plaintiff shall receive between 15% and 25% of the proceeds of any recovery, in proportion to which the qui tam plaintiff’s contribution to the action. If the qui tam plaintiff conducts the lawsuit, he or she will receive between 25% and 30% of any recovery, as the court determines reasonable. If an attorney for the government does not intervene in the lawsuit at the outset but intervenes subsequently, the qui tam

plaintiff may receive between 15% and 30% of any recovery. In addition, the court may require the defendant to pay reasonable costs, attorney fees, and expert consultant fees to the qui tam plaintiff. The MFCASA protects employees who are discharged, demoted, suspended, threatened, harassed, denied promotion, or otherwise discriminated against in terms of their employment, because they took lawful steps to disclose information with regard to a MFCASA suit or to bring or testify in such a suit. Such employees are entitled to damages and other relief, including reinstatement, twice the amount of lost compensation, interest on lost compensation, special damages sustained as a result of the discrimination, and, if appropriate, punitive damages.

#### What are the Penalties?

The MFCASA establishes financial penalties of \$5,500 to \$11,000 for each violation plus three times the amount of damages sustained by the state or political subdivision as a result of the violation. In addition, persons found to have violated the MFCASA may be liable to the state or to the qui tam plaintiff for the costs of the action. If a court finds that the person who committed the violation cooperated with the state investigation of the violation, including furnishing the state with all information known about the violation within 30 days, the court may lower the amount to two times the amount of damages sustained by the state.