Fraud, Waste, & Abuse Training

LIBERTY DENTAL PLAN®

Why Do I Need Training?

- Every year, **billions of dollars** are improperly spent because of **Fraud, Waste & Abuse (FWA).** It affects everyone - **including you**. This training helps you detect, correct, and prevent FWA. **You are part of the solution**
- **Compliance is everyone's responsibility!** As an individual who provides health or administrative services for Medicare and Medicaid enrollees, every action you take potentially affects Medicare and Medicaid enrollees, the Medicare and Medicaid Program, or the Medicare Trust Fund

What is Fraud?

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

What is Fraud?

The **Health Care Fraud Statute** makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program.

Health care fraud is punishable by imprisonment up to 10 years. It is also subject to criminal fines up to $250,000.

What is Fraud? Examples:

Examples of actions that may constitute Fraud include:

- Knowingly billing for services not furnished or supplies not provided
- Billing for missed patient appointments
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

What is Waste?

Waste includes practices that, directly or indirectly, result in unnecessary costs such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

What is Waste? Examples:

Examples of actions that may constitute Waste include:

- Conducting excessive office visits
- Performing more dental procedures than necessary for treating a specific condition
- Ordering excessive x-rays or laboratory tests

What is Abuse?

Abuse includes actions that may, directly or indirectly, result in unnecessary costs. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

What is Abuse? Examples:

Examples of actions that may constitute Abuse include:

- Unknowingly billing for unnecessary medical services
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Common Types of Dental Fraud

- Billing for services not performed
- Upcoding
- Waiver of copayments
- Waiver of deductibles
- Altering dates of service
- Unbundling or improper use of codes
- Mispresenting patient identities
- Not disclosing existing of additional or primary coverage

Billing for Services Not Performed Or Rendered

Billing for services not provided is a common type of fraud (in every profession). It happens when (for example) a dentist who merely examined the patient bills for more expensive dental services, including fluoride and sealants.

Misrepresentation of Services Not Performed

This situation seems self-explanatory but may be more complicated. Obviously, it would be fraudulent to bill for a procedure that you have not performed.

What about billing for a Crown at the preparation date rather than the cementation date?

When is the service actually performed?

Most dentists send in for payment for crowns at the prep time; but most insurance carriers consider the crown "complete" only after it is cemented.

What about billing for Dentures at the impression date rather than at the delivery date?

Upcoding

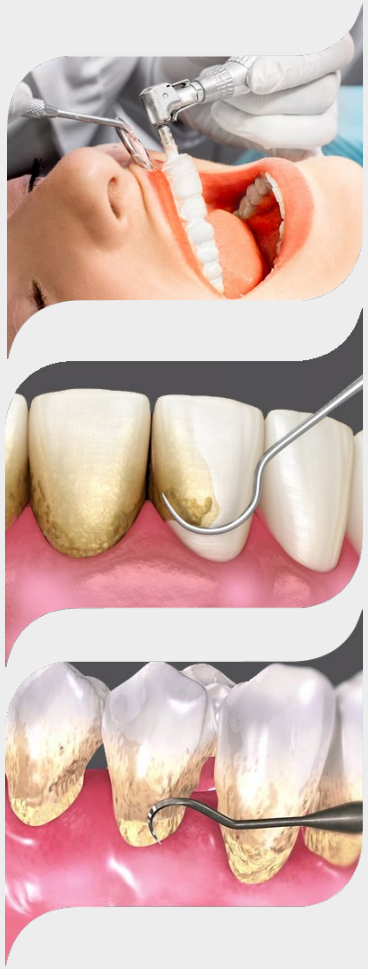
Refers to coding a procedure as having a **more extensive degree of difficulty** than **actually performed**.

For example: A patient receives a standard prophylaxis (D1110), but the insurance carrier is billed for periodontal scaling and root planning (D4341).

Prophylaxis (D1110) is only for people who do not exhibit any of the signs and symptoms of periodontal disease, including bone loss, bleeding, mobility, and recession. D1110 is, thus, **a preventive procedure** for patients who don't yet have periodontal disease and should only be used with patients who are periodontally healthy.

Periodontal Scaling and Root Planning (D4341) or deep cleaning, is a procedure involving removal of **dental plaque** and **calculus** (scaling or **debridement**) and then smoothing, or planning, of the (exposed) surfaces of the roots, removing **cementum** or **dentine** that is impregnated with calculus, toxins, or microorganisms, the etiologic agents that cause inflammation.

Important Dental Service Terms



Prophylaxis: Preventive Cleaning

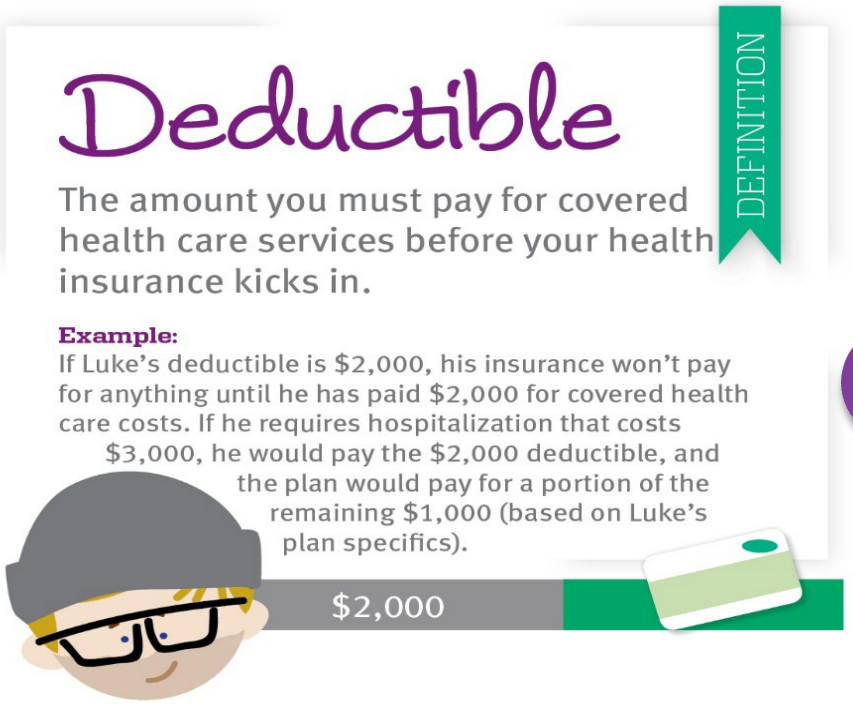
Scaling: Cleans the teeth to remove deposits above and below gum

Root Planning: Smooths rough root surfaces so gum can heal

Waiver of Copayments

- Patient copayments are an essential element to the cost structure of the contract between an insurance carrier and whomever is purchasing the coverage (such as an employer for employees)
- Waiving copayments is thought to encourage more usage of the coverage than would normally occur
- Routinely waiving copayments in health care programs paid with any portion of federal funds may be unlawful. There are some exceptions which include completing and submitting "financial hardship forms"

Waiver of Deductibles



As in the case of copayments, deductibles are considered to essential to an insurance carrier's contract cost structure.

In some states, waiving deductibles may be legal under certain conditions.

Altering Dates of Service

- The correct date a procedure is performed is important as related to patient eligibility requirements and waiting periods
- It is fraudulent to send in a claim for a treatment using a date other than the actual date of service
- If a patient asks a dentist to send in a claim using a date other than the actual treatment date and the dentist does so, both the dentist and the patient have committed fraud

Misrepresenting Patient Identifiers

Performing treatment on one patient and sending in a claim for that person as someone else is fraud.

Identity Theft

Medical identity theft refers to the misuse of a person's identity to obtain health care goods and services. A victim comes to know of the theft only when s/he receives a statement from an insurance company for services rendered.

The average medical identity theft victim pays $13,000 out-of-pocket to resolve it.

Not Disclosing Additional or Primary Coverage

Patients who are covered by more than one dental plan or a medical and dental plan may receive benefits from all plans, provided each plan knows about the others. Sending in **multiple claims to different carriers** as if they were each the **primary carrier is fraudulent**.

Types of Health Insurance Coverage:

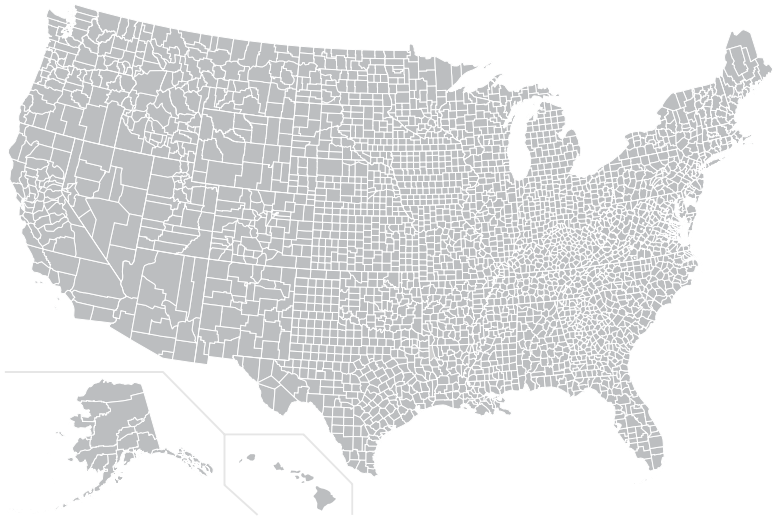
- Medicaid (MCD)
- Medicare (M)
- Medicare/Medicaid
- Point-of-Service Plan (POS)
- Preferred Provider Organization (PPO)
- TRICARE
- Unemployment Compensation Disability (UCD)
- Veterans Affairs Outpatient Clinic (VA)
- Workers Compensation Insurance (WC)

State & Federal False Claims Laws

The Federal False Claims Act is a law that prohibits a person or entity, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal government. The Act also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid.

State & Federal False Claims Laws

The Federal False Claims Act broadly defines the terms "knowing" and "knowingly." Specifically, knowledge will have been proven for purposes of the Federal False Claims Act if the person or entity: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.



State False Claims Laws

1. **California** The California False Claims Act Cal. Gov't Code §§12650 *et seq.*
2. **Colorado** The Colorado Medicaid False Claims Act, Colo. Rev. Stat. §§25.4-4-303.4 *et seq.*
3. **Connecticut** The Connecticut False Claims Act, Conn. Gen. Stat. §§17b-301a–17b-301p
4. **Delaware** The Delaware False Claims and Reporting Act, Section 1201(a) of the Delaware False Claims and Reporting Act, Del. Code Ann. tit. 6, §§ 1201 *et seq.*
5. **The District of Columbia** The District of Columbia False Claims Act, DC Code §§ 2-381.01 *et seq.*
6. **Florida** Florida False Claims Act, Fla. Stat. Ann. §§68.081 *et seq.*
7. **Georgia** The Georgia False Medicaid Claims Act, Ga. Code Ann. § 49-4-168 *et seq.*
8. **Hawaii** Hawaii False Claims Act, Haw. Rev. Stat. Ann. §§661-21 *et seq.*
9. **Illinois** Illinois False Claims Act, 740 Ill. Comp. Stat. Ann. 175/1 *et seq.*
10. **Indiana** The Indiana False Claims Act and Whistleblower Protection Act, Ind. Code §§5-11-5.5 *et seq.*
11. **Iowa** Iowa False Claims Act, Iowa Code §685.1 *et seq.*
12. **Louisiana** Louisiana Medical Assistance Program Integrity Law, La. Rev. Stat. Ann. §§6:438.1 *et seq.*
13. **Maryland** The Maryland False Health Claims Act, Md. Code Ann. Health-Gen.§§2-601 et seq.
14. **Massachusetts** The Massachusetts False Claims Act, Mass. Ann. Laws ch. 12, §§5 *et seq.*
15. **Michigan** The Michigan Medicaid False Claims Act, Mich. Comp. Laws. Serv. §§400.601 *et seq.*
16. **Minnesota** The Minnesota False Claims Act, Minn. Stat§§15C.01 *et seq.*
17. **Montana** The Montana False Claims Act, Mont. Code Ann. §§17-8-401 *et seq.*
18. **Nevada** Nevada Submission of False Claims to State or Local Government Act, Nev. Rev. Stat. Ann. §§357.010 *et seq.*
19. **New Hampshire** The New Hampshire False Claims Act, N.H. Rev. Stat. Ann. §§167:61-b *et seq.*
20. **New Jersey** The New Jersey False Claims Act, N.J. Stat. Ann.§§ 2A:32C-1 *et seq.*
21. **New Mexico** The New Mexico Medicaid False Claims Act, N.M. Stat. Ann. §§27-14-1 et seq., and The New Mexico Fraud Against Taxpayers Act, N.M. Stat. Ann. §§44-9-1 et seq.
22. **New York** The New York False Claims Act. N.Y. State Fin. Law §§188 et seq.
23. **North Carolina** The North Carolina False Claims Act, N.C. Gen. Stat. §§1-605 *et seq.*
24. **Oklahoma** The Oklahoma Medicaid False Claims Act, Okla. Stat. tit. 63§§5053 *et seq.*
25. **Rhode Island** The Rhode Island False Claims Act, R.I. Gen. Laws §§9-1.1-1 *et seq.*
26. **Tennessee** Tennessee False Claims Act, T.C.A §§ 4-18-101 et seq., and the Tennessee Medicaid False Claims Act, T.C.A. §§ 71-5-181 et seq.
27. **Texas** The Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code Ann.§§36.001 et seq.
28. **Virginia** Virginia Fraud Against Taxpayers Act, Va. Code Ann. §§8.01-216.1 *et seq.*
29. **Washington** The Washington Medicaid Fraud Act, RCW 74.66.005 *et seq.*

The Deficit Reduction Act
Law & Legal Definition

Private persons are permitted to bring civil actions for violations of the Federal False Claims Act on behalf of the United States (also known as "qui tam" actions) and are entitled to receive percentages of monies obtained through settlements, penalties and/or fines collected.

Persons bringing these claims, also known as relators or whistleblowers, are granted protection under the law.

Specifically, any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the Federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorneys' fees and costs.

The Deficit Reduction Act
Its Purpose

The Deficit Reduction Act of 2005 (the "**DRA**"), signed into law February 8, 2006, contained a number of provisions intended to bolster Medicaid fraud and abuse enforcement. These new provisions mean that there is likely to be an increase in fraud enforcement activities at the state level against those health firms involved directly or indirectly in Medicaid related claims.

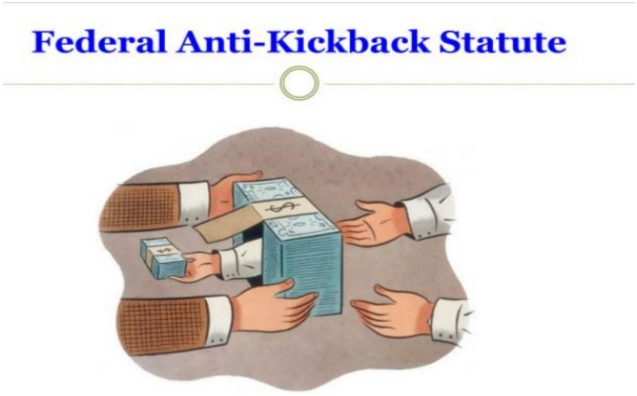
1. First, Congress authorized the establishment of a new **Medicaid Integrity Program with specific contractors to monitor fraud and abuse** in the various state Medicaid programs. For many years, the vast majority of states have had Medicaid Fraud Control Units (MFCU) to coordinate statewide efforts to uncover and prosecute fraud in the Medicaid context. Although the MFCUs will continue in combatting health care fraud, the DRA—with its development of the Medicaid Integrity Program—significantly expanded the federal government's role by establishing new contractors and funding for additional federal staff to address Medicaid fraud.

The Deficit Reduction Act
Its Purpose

2. Second, Congress adopted a provision that provides states with an incentive to adopt state false claims acts that substantially mirror the requirements of the Federal False Claims Act. States that **adopt a state false claims act** that satisfies these requirements can increase their share of the amounts recovered against providers for engaging in improper conduct. Specifically, if a state brings an action under its state false claims law against a Medicaid provider, then the state can be entitled to receive 10 percent of the federal government's share of any recovery.[1] Congress provided that the Office of Inspector General (OIG) would be responsible for determining whether a state has adopted a false claims act that meets these requirements and the OIG published in the Federal Register guidelines that it will apply in reviewing state false claims acts.[2]

The Deficit Reduction Act
Its Purpose

3. Third, The third fraud and abuse provision included in the DRA, which has received the greatest amount of attention is that, effective January 1, 2007, state Medicaid plans are required to ensure that any entity that receives or makes payments under the state plan of at least $5 million per year **must provide certain information to its employees**, contractors and agents concerning federal and state false claims act provisions, penalties and protections. As a result of this provision, entities that are subject to these requirements must review their corporate compliance programs, policies and procedures, and their employee handbooks (if such a handbook does, in fact, exist) to ensure that the requisite information is being provided to employees, contractors and agents.



Anti-Kickback Statute
Law & Legal Definition

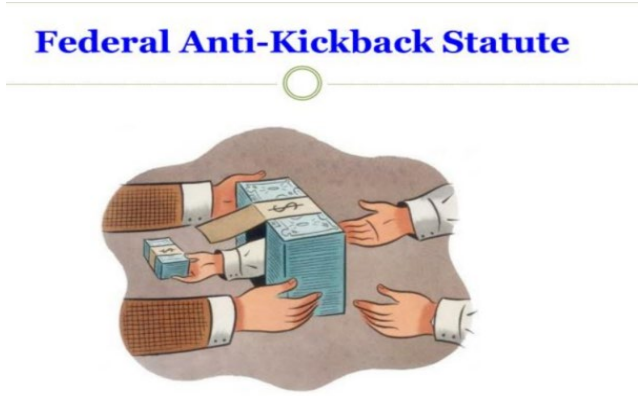
What is the Anti Kickback Statute?

The Anti-Kickback Statute is the popular name for The **Medicare and Medicaid Fraud and Abuse Statute**, 42 U.S.C. § 1320a-7b (b). The AKS is a federal criminal law. It prohibits offering or accepting kickbacks to generate health care business.

The Anti-Kickback Statute or AKS is a healthcare law that prohibits individuals and entities from a willful and knowing payment of "remuneration" or rewarding anything of value – such as position, property, or privileges – **in exchange for patient referrals** that involve payables by the Federal healthcare programs.
These payables include, but are not limited to, drugs, medical supplies, and healthcare services availed by Medicare or Medicaid beneficiaries.

Under the provisions of the Anti-Kickback Statute, the law **prohibits the soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or kind.**

Besides monetary reward, remunerations can be in the form of properties (hotel rentals, real estate), positions (excessive compensation for medical directorships), or privileges (opportunity to induce more recipients for income-generating jobs).

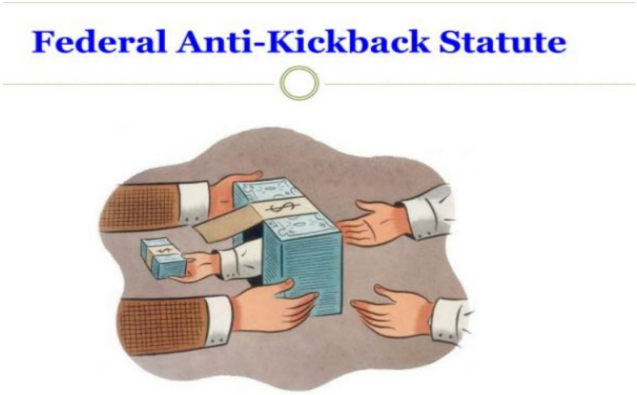


Anti-Kickback Statute Law Prohibits

What does the Anti-kickback Statute prohibit?

Under the Federal Anti-kickback Statute, you may not knowingly and willfully offer, pay, solicit or receive anything of value to induce or reward for referrals of Federal health care program business.

In some industries, it is acceptable to reward those who refer business to you. In health care however, it's a crime. The prohibition against kickbacks applies to those who pay for referrals and to those who receive them. Kickbacks can take various forms, for example, they can be bribes or rebates. They can be given in cash or in kind. Here is an example of an arrangement that would be problematic under the Federal Anti-kickback Statute. If a medical device manufacturer gives lavish vacations, gifts, or sham "consulting fees" to an oral surgeon to reward the dentist/physician for using its devices during oral surgery, this would violate the Anti-kickback statute.

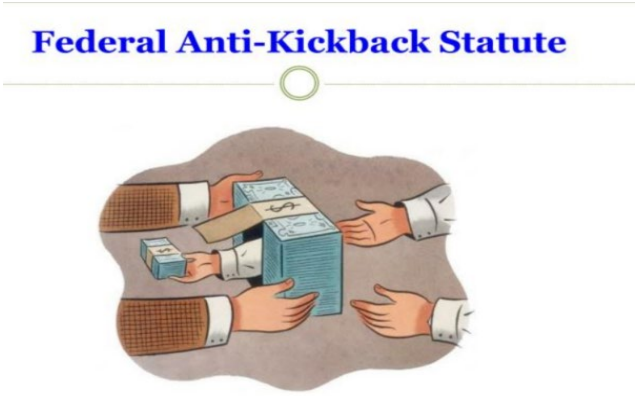


Anti-Kickback Statute
Criminal & Civil Penalties

What are the penalties under the law?

There are criminal and civil penalties for violating the law. Let's start with the criminal penalties. Violating the Anti-Kickback Statute is a felony, which means violators can go to jail. Conviction can result in fines up to $25,000 per violation, up to a 5-year prison term, or both.

Now let's go over the civil and administrative penalties. Kickback violations can lead to False Claims Act liability. The False Claims Act is a civil statute. It provides a way for the government to recover money, through a lawsuit in Federal court, when someone submits false or fraudulent claims to the government. A provider can be penalized up to **three times** the government program's loss, plus $11,000 **per claim**.



Anti-Kickback Statute Covers Medicare & Medicaid

What programs does the law cover?

The law only applies to Federal Health Care Programs which includes both Medicare & Medicaid.

Federal Anti-Kickback Statute

Anti-Kickback Statute

Safe Harbors
a.k.a. "Exceptions"

The law has numerous safe harbors also known as exceptions.

In healthcare, a safe harbor is a recognized exception to the Anti-Kickback Statute. While the Anti-Kickback Statute prohibits financial relationships between referral sources and business partners in general, safe harbors offer avenues to structure the exchange of remuneration in a legal fashion. Safe harbors **are regulations issued in intervals** since 1991 by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

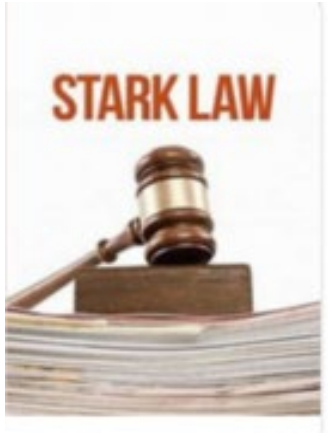
Federal Anti-Kickback Statute

Anti-Kickback Statute

Safe Harbors
a.k.a. "Exceptions"

Safe harbors are regulated in 42 C.F.R. Sect. 1001.952 and include the following concepts:

- Investment interests in publicly traded companies and small private entities
- Renting and leasing of space
- Renting and leasing of equipment
- Personal services and management agreements
- Employee compensation arrangements
- Sale of physician practice with separate standards for sales of practices from physician to physician or from physician to hospital and other entities
- Referral services such as vendor agreements
- Discounts for buyers, sellers, and offerors not acting as sellers
- Group purchasing organization that receives payment from a vendor for goods or services
- Practitioner recruitment
- Investments in group practices and solo practices
- Referral arrangements for specialty services
- Certain price reductions
- Electronic health records items and services involving non-monetary goods and services

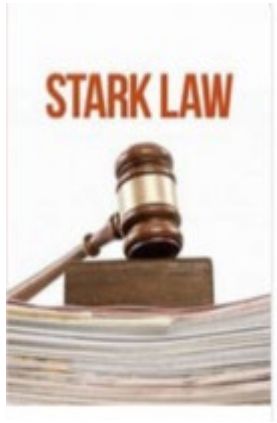


Stark Law
Physician Self-Referral Law
Law & Legal Definition
Applies to Medicare & Medicaid

The Physician Self-Referral Law- the Stark Law refers to Section 1877 of the Social Security Act (the Act) 42 U.S.C. 1395nn.

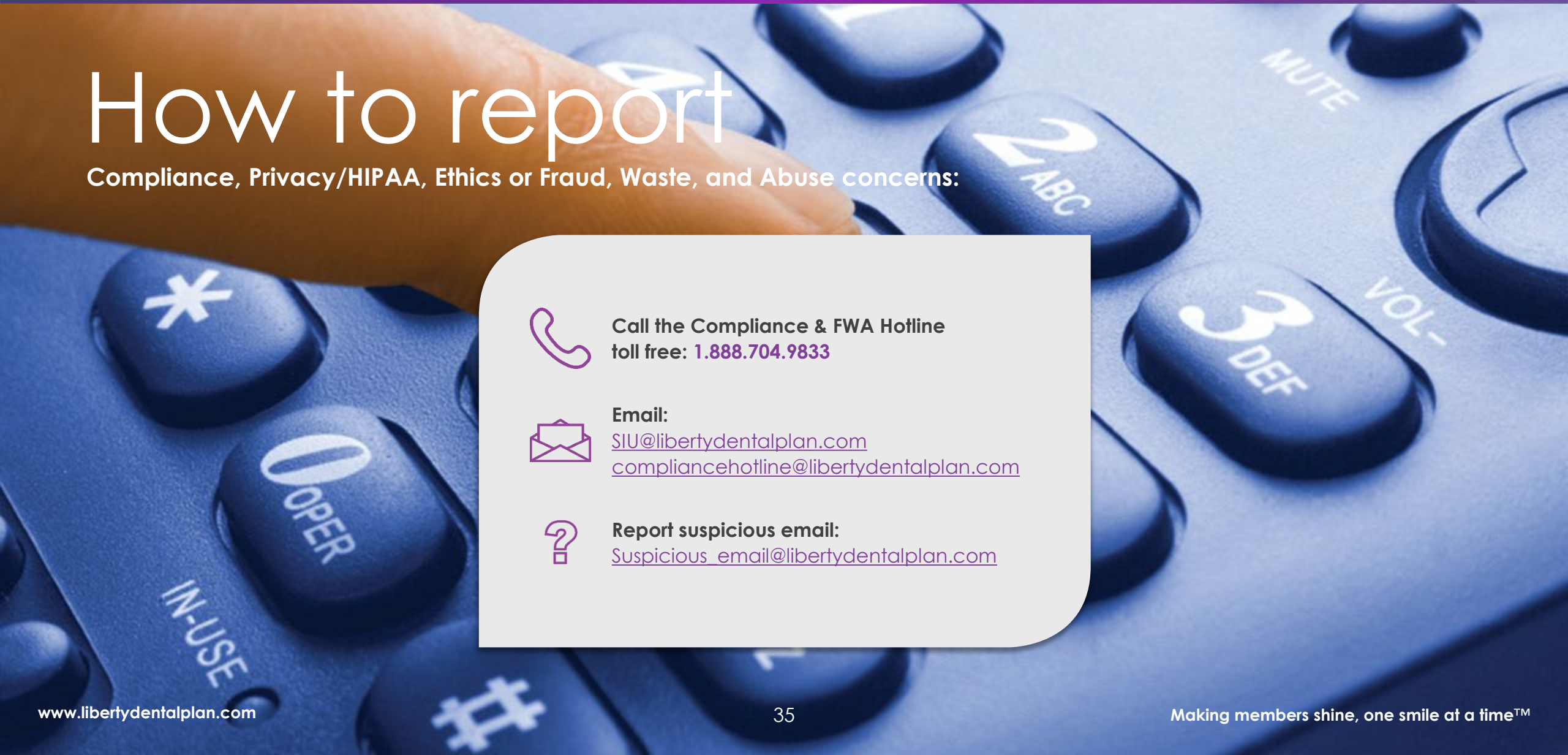
- The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians (including dentists) from referring patients to receive "designated health/dental services" payable by Medicare or Medicaid from entities with which the physician (including dentist) or immediate family member has a financial relationship.

- **Stark Law now insists that any medical professional who provides such a referral to a Medicare or Medicaid patient must concurrently provide written notice** of that **patient's right** to go elsewhere along with a list of nearby alternatives.



Stark Law
Physician Self-Referral Law
CMS Final Rule Updates

- Finalizing **new, permanent exceptions for value-based arrangements** to that will permit physicians and other health care providers to design and enter into value-based arrangements without fear that legitimate activities to coordinate and improve the quality of care for patients and lower costs would violate the physician self-referral law. This supports CMS' broader push to advance coordinated care and innovative payment models across Medicare, Medicaid, and private plans.
- Finalizing **additional guidance on key requirements of the exceptions to the physician self-referral law** to make it easier for physicians and other health care providers to make sure they comply with the law.
- **Finalizing protection for non-abusive, beneficial arrangements** that apply regardless of whether the parties operate in a fee-for-service or value-based payment system – such as donations of cybersecurity technology that safeguard the integrity of the health care ecosystem.
- **Reducing administrative burdens that drive up costs** by taking money previously spent on administrative compliance and redirecting it to patient care.



How to report

Compliance, Privacy/HIPAA, Ethics or Fraud, Waste, and Abuse concerns:

Call the Compliance & FWA Hotline
toll free: 1.888.704.9833

Email:
SIU@libertydentalplan.com
compliancehotline@libertydentalplan.com

Report suspicious email:
Suspicious_email@libertydentalplan.com