

Fraud, Waste, and Abuse Training

including CMS Combatting Medicare Part C & D FWA



Agenda

1 Objections & Importance of Training

2 What is Fraud, Waste, and Abuse (FWA)

3 Examples of Fraud

4 FWA Laws and Regulations

5 Reporting Potential FWA

6 CMS Combatting Medicare FWA

After completing this course, you should

- ▶ Learn the definitions of fraud, waste, and abuse (FWA).
- ▶ Identify common types of dental FWA, including upcoding, billing for services not rendered, or misrepresentation of services.
- ▶ Learn about the different FWA laws.
- ▶ Understand your responsibilities in reporting actual or suspected FWA.



1

Importance of Training

Compliance is everyone's responsibility!

FWA affects everyone, including you! This training helps you detect, correct, and prevent FWA. **You are part of the solution.**



billions of dollars are improperly spent due to fraud, waste, and abuse (FWA) every year.



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 FWA?



fraud

Knowingly and intentionally submitting claims or records to gain unauthorized payments (e.g., billing for a filing never done).



waste

unnecessary or excessive use of resources (e.g., ordering unneeded dental x-rays)



abuse

practices that **cause harm or undue costs** (e.g., miscoding a cleaning to get a higher reimbursement)



what is fraud?

Fraud is *knowingly & 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.



examples

Knowingly and intentionally billing for services not furnished or supplies not provided.

Knowingly and intentionally Billing for missed patient appointments.

Knowingly and intentionally altering claims forms, records, or receipts to receive 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.



examples

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.



examples

billing for unnecessary medical services.

charging excessively for services or supplies.

misusing codes on a claim, such as upcoding or unbundling codes.



3 Types of Dental Fraud, Waste, & Abuse



Examples of Fraud

common types of dental fraud



misrepresenting services not performed

It would be fraud to bill for a procedure that was not performed; but 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 on the prep date; but most insurances consider the crown "complete" only after it is cemented.

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

Most dentists send in for payment for dentures on the impression date; but most insurance consider the dentures "complete" only after the member receives their final dentures.



3

Examples of Fraud

common types of dental fraud



\$ billing for services not 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 but bills for additional dental services which were not performed, including fluoride and sealants.



common types of dental fraud

DEFINITION

Copay - Set amount you pay for a covered product or service.

Example

You have a \$20 copay for a visit with your provider. What does this mean? Every time you see your provider, you will pay \$20.

Deductible – amount you pay for covered services before your insurance kicks in.

Example

You have a deductible of \$2,000, which means your insurance will not pay for anything until you pay \$2,000 in health care costs. If a hospital stay costs \$3,000 – you will pay \$2,000 and your insurance will pay \$1,000 or in accordance with your plan benefits.



waiver of copayments & deductibles

- Copayments & deductibles are essential to the cost structure of contracts between an insurance carrier & the coverage purchaser (e.g., employer for employees).
- Waiving copayments could encourage more usage or misuse of the coverage than would normally occur.
- Routinely waiving copayments in federal health care programs may be unlawful. There are some exceptions with financial hardships forms or may even be allowable in some states and certain conditions.



Examples of Fraud

common types of dental fraud



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.



Examples of Fraud

common types of dental fraud



Unbundling or improper use of coding

What is unbundling, it is the improper practice of billing separately for procedures that should be billed as a single service under one code – often to increase reimbursement.

Example A patient receives a standard prophylaxis (D1110), but insurance carrier is billed for periodontal scaling & root planning (D4341).

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

Periodontal Scaling & 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.



Examples of Fraud

common types of dental fraud



misrepresenting patient identifiers

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

Medical **identity theft** refers to the misuse of a person's identity to obtain health care goods and services.

A victim learns of the theft only when s/he receives a statement from an insurance company for services rendered. An average of \$13,000 out-of-pocket is spent by the victim to resolve.



Examples of Fraud

common types of dental fraud



not disclosing primary/additional 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)



Examples of Fraud

common types of dental fraud



^ upcoding

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

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important dental service terms



Prophylaxis
Preventive Cleaning

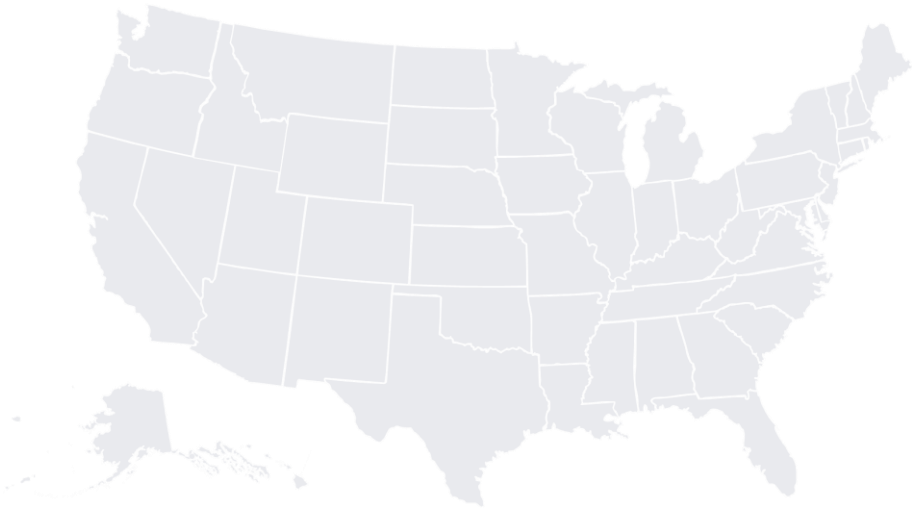


Scaling
Cleans the teeth to remove deposits above & below gum



Root Planning
Smooths rough root surfaces so gum can heal

State & Federal False Claims Laws

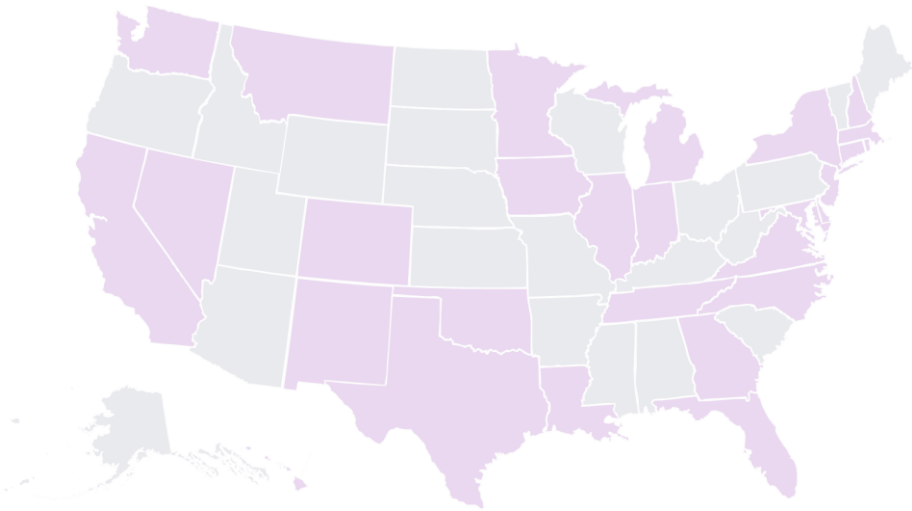


The Federal False Claims Act

- 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.
- **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.
- 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 to prove that the law has been violated.



State & Federal False Claims Laws



The following 29 states all have state false claims laws:

- **California** (CA False Claims Act, Cal. Gov't Code §§12650 et seq.)
- **Colorado** (CO Medicaid False Claims Act, Colo. Rev. Stat. §§25.4-4-303.4 et seq.)
- **Connecticut** (CT False Claims Act, Conn. Gen. Stat. §§17b-301a-17b-301p)
- **Delaware** (DE False Claims & Reporting Act, sec. 1201(a) of the DE False Claims and Reporting Act, Del. Code Ann. tit. 6, §§ 1201 et seq.)
- **The District of Columbia** (DC False Claims Act, DC Code §§ 2-381.01 et seq.)
- **Florida** (FL False Claims Act, Fla. Stat. Ann. §§68.081 et seq.)
- **Georgia** (GA False Medicaid Claims Act, Ga. Code Ann. § 49-4-168 et seq.)
- **Hawaii** (HI False Claims Act, Haw. Rev. Stat. Ann. §§661-21 et seq.)
- **Illinois** (IL False Claims Act, 740 Ill. Comp. Stat. Ann. 175/1 et seq.)
- **Indiana** (IN False Claims Act and Whistleblower Protection Act, Ind. Code §§5-11-5.5 et seq.)
- **Iowa** (IA False Claims Act, Iowa Code §685.1 et seq.)
- **Louisiana** (LA Medical Assistance Program Integrity Law, La. Rev. Stat. Ann. §§6438.1 et seq.)
- **Maryland** (MD False Health Claims Act, Md. Code Ann. Health-Gen. §§2-601 et seq.)
- **Massachusetts** (MA False Claims Act, Mass. Ann. Laws ch. 12, §§5 et seq.)
- **Michigan** (MI Medicaid False Claims Act, Mich. Comp. Laws. Serv. §§400.601 et seq.)
- **Minnesota** (MN False Claims Act, Minn. Stat. §§15C.01 et seq.)
- **Montana** (MO False Claims Act, Mont. Code Ann. §§17-8-401 et seq.)
- **Nevada** (NV Submission of False Claims to State or Local Government Act, Nev. Rev. Stat. Ann. §§357.010 et seq.)
- **New Hampshire** (NH False Claims Act, N.H. Rev. Stat. Ann. §§16761-b et seq.)
- **New Jersey** (NJ False Claims Act, N.J. Stat. Ann. §§ 2A32C-1 et seq.)
- **New Mexico** (NM Medicaid False Claims Act, Stat. Ann. §§27-14-1 et seq., & NM Fraud Against Taxpayers Act, Stat. Ann. §§44-9-1 et seq.)
- **New York** (NY False Claims Act. N.Y. State Fin. Law §§188 et seq.)
- **North Carolina** (NC False Claims Act, N.C. Gen. Stat. §§1-605 et seq.)
- **Oklahoma** (OK Medicaid False Claims Act, Okla. Stat. tit. 63, §§5053 et seq.)
- **Rhode Island** (RI False Claims Act, R.I. Gen. Laws §§9-1.1-1 et seq.)
- **Tennessee** (TN False Claims Act, T.C.A §§ 4-18-101 et seq., & the TN Medicaid False Claims Act, T.C.A. §§ 71-5-181 et seq.)
- **Texas** (TX Medicaid Fraud Prevention Act, Tex. Hum. Res. Code Ann. §§36.001 et seq.)
- **Virginia** (VA Fraud Against Taxpayers Act, Va. Code Ann. §§8.01-216.1 et seq.)
- **Washington** (WA Medicaid Fraud Act, RCW 74.66.005 et seq.)



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.



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Deficit Reduction Act

Purpose



The Deficit Reduction Act (DRA) of 2005, signed into law February 8, 2006, contained several provisions intended to bolster Medicaid fraud and abuse enforcement.

These 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.



Deficit Reduction Act

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% of the federal government's share of any recovery.

Office of Inspector General (OIG) is responsible for determining whether a state has adopted a false claims act that meets these requirements.

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 to ensure that the requisite information is being provided to employees, contractors and agents.



Anti-Kickback Statute Law & Legal Definition



The Anti-Kickback Statute (AKS) is a federal criminal law. It prohibits offering or accepting kickbacks to generate health care business.

The AKS 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 AKS, 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).



Did you know?

The Anti-Kickback Statute is the popular name for the **Medicare and Medicaid Fraud and Abuse Statute**, 42 U.S.C. § 1320a-7b (b); and only applies to Federal Health Care Programs which includes both Medicare and Medicaid.



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Anti-Kickback Statute Law Prohibits



What does the Anti-Kickback Statute prohibit?

Under the Anti-Kickback Statute, you may not knowingly or willfully:

- Offer, pay, solicit, or receive anything of value to induce or reward for referrals for dental services covered by federal programs.



In some industries, it is acceptable to reward those who refer business to you. In health and dental 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.

Example: 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 and Civil Penalties

? What are penalties under the law?

Criminal

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.**



Civil & Administrative

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 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 Safe Harbors (“Exceptions”)

? What are safe harbors?

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.

Safe harbors include the following concepts:

42 C.F.R. Sect. 1001.952

- Investment interests in publicly traded companies & small private entities
- Renting and leasing of space or 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 & 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 and Legal Definition



Did you know?

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

- 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.



Employee Misconduct

Fraud and dishonesty



CMS § 453.12 Meaning of fraud or dishonesty.

- The term “fraud or dishonesty” encompasses all risks of loss that might arise through dishonest or fraudulent acts in handling of funds as delineated in §§ 453.8 and 453.9.
- As such, the bond must provide recovery for loss occasioned by such acts even though no personal gain accrues to the person committing the act and the act is not subject to punishment as a crime or misdemeanor, provided that within the law of the State in which the act is committed, a court would afford recovery under a bond providing protection against fraud or dishonesty.
- As usually applied under State laws, **the term “fraud or dishonesty” encompasses** such matters as **larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, wrongful conversion, willful misapplication or any other fraudulent or dishonest acts resulting in financial loss.**

Employee Dishonesty

are dishonest acts committed by an “employee”, whether identified or not, acting alone or in collusion with other persons, with the intent to cause the company to sustain loss and obtain financial benefit for the “employee” or any person or organization intended by the “employee” to receive that benefit.



5

Reporting Fraud, Waste, and Abuse

Reports of suspected or actual fraud, waste, and abuse may be made anonymously and are kept confidential to the extent allowed by law.



Compliance Hotline

888-704-9833

Available 24 hours, 7 days a week



Compliance Web Inquiry

www.libertydentalplan.com/About-Liberty/Compliance

Available 24 hours, 7 days a week



Compliance Email

siu@libertydentalplan.com
compliancehotline@libertydentalplan.com

Available 24 hours, 7 days a week



Mail

Liberty Dental Plan, Attn Compliance Officer
1730 Flight Way, Suite 125, Tustin, CA 92782



Compliance Fax

714-389-3529

Available 24 hours, 7 days a week



Report Directly

Make a report directly with your supervisor, Human Capital, SIU, Chief Compliance Officer, or any Liberty executive leader

All persons who report compliance issues and who participate in the compliance program in good faith are protected against intimidation and retaliation.



Liberty incorporates the Centers for Medicare & Medicaid Services' (CMS) Medicare Part C & D General Compliance Training into Liberty Compliance Training program.

CMS created this training module to assist Medicare Part C plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual general compliance training requirements under [42 CFR § 422.503\(b\)\(4\)\(vi\)\(C\)](#) and [Section 50.3 of Compliance Program Guidelines](#).



**Combatting Medicare
Parts C & D
Fraud, Waste, and Abuse**