Fraud, Waste, and Abuse

(FWA)

As a First Tier, Downstream and Related Entity (FDR), you are responsible for recognizing behavior or activities that may be considered fraud, waste, or abuse (FWA). Awareness is the first step in detecting, preventing, and reporting FWA incidents.

CMS defines fraud as *knowingly and willingly executing or attempting to execute, a scheme to defraud any health care benefit program*. Fraud also means to obtain by false or fraudulent pretenses, representations, or promises, any money or property owned or under the custody or control of any health care benefit program. In other words, fraud is intentionally submitting false information to the government or a government contractor in order to get money or a benefit. Some examples of fraud include:

- Double billing or billing for services that were not provided
- Falsification of eligibility information to obtain coverage or receive services
- Forging or altering prescriptions or billing for a brand name drug when a generic drug was provided
Unlike fraud, instances of waste and abuse do not involve intentionally or knowingly misrepresenting information to get money or a benefit. Instead, waste and abuse are activities that do not demonstrate sound practice and result in unnecessary costs to the health care system. Examples of waste and abuse are:

- Providing services that are not medically necessary
- Over-utilization or misuse of services

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent or knowledge. You can prevent FWA by:

- Making sure you are up to date with laws and regulations
- Ensuring any information you submit is accurate and timely
- Verify all information provided to you
- Having policies and procedures in place to address fraud, waste, and abuse
- Being aware of suspicious activity.

Detecting Fraud, Waste, and Abuse

Potential fraud, waste, and abuse can occur with any entity associated with the business of providing health care insurance. Fraudulent activities are deception, misrepresentation, or concealment by the entity to obtain something of value for which they would not otherwise be entitled. The following are some indicators of potential fraud, waste, and abuse for the various entities:

**Indicators for potential member FWA**

- Does the prescription look altered or possibly forged?
- Did the member withhold information when completing an enrollment application?
- Is the member filling/receiving numerous identical prescriptions, possibly from different physicians?
- Is the person picking up the prescription or obtaining the healthcare service the actual member?
- Is the prescription appropriate based on the member’s other prescriptions?
- Is the member applying for insurance ineligible? Does their information look altered (i.e. their Medicare card)?
Indicators for potential **provider FWA**
- Is the provider submitting a bill for services not provided or for free services?
- Is the diagnosis for the member supported by medical records?
- Is the provider performing unnecessary services?
- Is the provider writing prescriptions for a higher quantity than medically necessary?
- Is the provider writing prescriptions for an unusually high number of controlled substances?
- Is the provider billing for a more expensive service than was actually provided?
- Are services being performed and billed by appropriate, qualified entities?

Indicators for potential **pharmacy or pharmacy benefit manager FWA**
- Are dispensed drugs expired, diluted, or illegal?
- Are generic drugs being provided when the prescription is written for a brand drug?
- Are bills being submitted for prescriptions that were not dispensed?
- Are prescriptions being filled with fewer drugs than what was prescribed?
- Are multiple payers being billed for the same prescription?

Indicators for potential **agent/broker FWA**
- Are multiple individuals joined to form a nonexistent group to obtain health insurance coverage?
- Are members being enrolled who do not meet the eligibility requirements?
- Is required information being withheld on enrollment applications?
- Is the agent completing and signing enrollment applications for the member?

Indicators for potential **wholesaler or manufacturer FWA**
- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler distributing recalled or defective equipment or supplies?
- Is there an inappropriate or illegal relationship between the wholesaler or manufacturer and a provider?
- Is the wholesaler or manufacturer receiving kickbacks, inducements, or other illegal remuneration?

Indicators for potential **health plan FWA**
- Did the health plan fail to provide or pay for medically necessary services?
- Is there illegal advertising or sales activity?
- Are inappropriate enrollment/disenrollment practices occurring?
- Are there cash inducements or other incentives to enroll in the health plan?
- Are there “bait and switch” tactics being used?
Reporting Fraud, Waste, and Abuse

When potential FWA behavior is detected, you are required to report the suspected incident. You do not need to determine whether the incident is fraud, waste, or abuse, you just need to report it. Your organization’s Code of Conduct should clearly state this obligation. The Code of Conduct should also clearly state that there will not be any retaliation for good faith reporting.

Security Health Plan is committed to the timely identification and reporting of FWA. Security Health Plan will report any suspected activity to the appropriate federal and state regulatory agency including CMS, the Office of the Inspector General (OIG), and the Office of the Commissioner of Insurance (OCI). Security Health Plan will work and cooperate with any agency to provide the assistance necessary to investigate and resolve any reported incident.

Correcting Fraud, Waste, and Abuse

Fraud, waste and abuse should not only be reported, but measures should be put in place to ensure that such behavior does not occur again. Security Health Plan has several mechanisms in place to investigate and correct FWA. These mechanisms include interviews, medical record and claims reviews, and information systems reports. Correcting the problem ensures that all entities are in compliance with laws, regulations, and requirements. Plans specific to the issue will be developed to correct the incident. These plans may include:

- Process improvements
- Policy and procedure development or revisions
- Training or retraining of staff
- Suspension or termination of the contractual relationship
- Criminal or civil litigation

Security Health Plan also will involve the appropriate state, federal, or local authorities and law enforcement agencies as necessary and required. The consequences of committing fraud, waste, or abuse can be significant. The potential penalty will depend on the violation but in addition to criminal or civil penalties, convictions, or fines, penalties may include imprisonment, loss of license, and exclusion from federal health care programs.

Security Health Plan has multiple avenues for reporting potential FWA. You can contact Security Health Plan in one of the following ways:

**Security Health Plan Compliance Hotline**
715-221-9570
855-274-5540 (toll free)

**Security Health Plan Compliance Officer**
715-221-9676

**Security Health Plan Compliance email**
szp.compliance@securityhealth.org

**FWA Investigation Form**

If you wish to remain anonymous, you should use the Compliance Hotline number to report your incident.
Laws Related to Health Care Fraud

There are a number of laws that apply to health care fraud. The following information is just a summary. For details about specific laws, consult the applicable statute or regulation.

**Civil False Claims Act (31 U.S.C. §3729-3733)** prohibits:
- Presenting a false claim for payment or approval
- Making or using a false record or statement in support of a false claim
- Conspiring to violate the False Claims Act
- Falsely certifying the type/amount of property to be used by the Government
- Certifying receipt of property without knowing if it's true
- Buying property from an unauthorized government officer
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

**Civil damages and penalties:**
- The penalties may be triple the damages the government sustained. Civil money penalty between $5000 and $10,000 for each claim.

**Criminal Penalties (18 United States Code §1347):**
- If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or life.

**Anti-Kickback Statute (42 U.S.C. §1320a-7b(b))** prohibits:
- Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

**Penalties:**
- Fine of up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment.

**Stark Statute or the Physician Self-Referral Law (42 U.S.C. §1395nn)** prohibits:
- A physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her immediate family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

**Damages and penalties:**
- Medicare claims related to an arrangement that does not comply with Stark are not payable. Up to a $15,000 fine for each service provided. Up to a $100,000 fine for entering into an arrangement or scheme.

**Exclusion from Federal Health Care Programs (42 U.S.C. §1395(e)(1) and 42 C.F.R. §1001.1901)** prohibits:
- Payment for any item or service furnished, ordered, or prescribed by an individual or entity excluded for participation in federal health care programs by the Office of the Inspector General (OIG).

- Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.
- Instituted safeguards to prevent unauthorized access to protected health care information.
- Established minimum privacy and security requirements for individually identifiable protected health information (PHI).