EmblemHealth

Chapter 36: Fraud and Abuse

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Chapter Summary

This chapter includes information on identifying and preventing fraudulent claims.

What is Fraud and Abuse

Fraud is defined as 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 money or property owned by, or under the custody or control of, any health care benefit program.

The federal False Claims Act widens the definition to also include reckless conduct, "deliberate ignorance" of the truth or falsification of information, and "reckless disregard" of the truth or falsity of the information.

EXAMPLES OF FRAUD

- False or fabricated filings of claims.
- Billing for goods and services never delivered or rendered. This includes billing for no-shows or canceled appointments.
- Billing for more services than provided.
- Upcoding of services. This includes, but is not limited to, billing for new or premium durable medical equipment (DME), prosthetics/orthotics, or supplies while substituting substandard or inexpensive DME.
- Billing for services performed by a lesser-qualified person, unless permitted by your contract, state laws and regulations, and/or CMS guidelines.
- Billing for services under one provider's name for services rendered by another provider, unless following our Submitting Claims for Non Credentialed Practitioner in a Group Arrangement policy in the Claims chapter.
- Misrepresentation of services rendered, diagnosis, place of service, date of service, and/or provider to justify reimbursement.
- Billing for non-covered services as covered services.
- Medical documentation not supportive of, or inconsistent with, the service being billed.
- Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment. This includes fabrication and recreation of medical records.
- Double billing to gain duplicate payment (e.g., billing two insurers the full amount without disclosing Coordination of Benefits (COB) information).
  Altering a claim form to obtain a higher payment amount.
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- Unbundling services, e.g., billing separately for a panel of tests when a single test was requested.
- Billing procedures over a period of days or weeks when the actual treatment occurred during a single visit (i.e., split billing).
- Improper coding practices, e.g., misuse of CPT codes.
- The acceptance of, or failure to return, monies paid on claims known to be false, fabricated, or received in error.
- Kickbacks or schemes that involve collusion between a provider and a member.
- Members providing false information for potential gain.
- Billing an elective hospital admission as if it were an emergency.

ABUSE

Abuse is defined as any provider or member practice that is inconsistent with sound or established fiscal, business, insurance, or medical practices. It results in an unnecessary cost to EmblemHealth. Each incident need not be intentional to be considered abuse. Consistent patterns of abuse may be indicative of fraud.

EXAMPLES OF ABUSE OR IMPROPER BILLING

- Medical documentation that does not support the services billed.
- Excessive charges for services or supplies.
- Failure to collect deductibles, coinsurances, and copays.
- High utilization of procedures that are not medically necessary.
- Providing experimental services, or services or treatments that fail to meet professionally recognized standards.
- Requesting preauthorization under a network location and billing under an out-of-network location.

An entity performing such acts may include a practitioner, a hospital, an agency, an organization, or any other institutional provider, employee(s) of a provider, group of providers, billing service, member, or person in a position to file a claim for health benefits.

EmblemHealth Special Investigations Unit (SIU)

EmblemHealth's Special Investigations Unit (SIU) addresses concerns of fraud and abuse affecting members and practitioners. The SIU monitors, reviews, and investigates potential cases of fraud, waste, and abuse (FWA). The SIU also ensures proper payment has been requested and reimbursed for the submitted services. Our SIU respects the partnerships we have with our network providers and works with our providers to curb FWA.

We ask each of our medical professionals and facilities to be a part of our fraud-fighting team. We can work together to identify and prevent potentially inappropriate and/or fraudulent billings by doing the following:

- Monitor claims for compliance with billing and CPT coding guidelines.
- Adhere and conform to Standard Medical Record Guidelines.
- Educate all staff members responsible for medical records and/or billings.
- Refer suspected FWA issues to EmblemHealth's Special Investigations Unit.

The SIU conducts reviews by using the following methods:

- Data analysis of submitted claims.
- Review of medical records and corresponding claims.
- On-site visits.

When the SIU identifies improper or fraudulent billings, it sends written documentation to the provider outlining its findings. When necessary, the SIU holds meetings to address the provider's concerns and arranges for repayment of amounts paid on fraudulent claims.

Reporting Potential/Suspicious Activity

To report suspicious activity, contact the SIU in one of the following ways:

Email:
kofraud@emblemhealth.com

Toll-free hotline:
1-888-4KO-FRAUD(888-456-3728)
All calls are confidential, and the caller may remain anonymous. A trained investigator will discuss the nature of the concern.

Mail:
EmblemHealth
Attention: Special Investigations Unit
55 Water Street
New York, NY 10048

False Claims Act and Medicaid Fraud Programs

The Deficit Reduction Act of 2005 requires health care entities to educate contractors and agents, including providers, about the federal False Claims Act. In addition, New York State requires Medicaid providers to develop and implement compliance programs aimed at detecting fraud, waste, and abuse in the Medicaid program. For educational resources in promoting best practices and awareness of Medicaid fraud, waste, and abuse, visit the Center for Program Integrity.

Providers should ensure their personnel are familiar with the requirements below.

False Claims Act

Neither EmblemHealth nor our providers may submit false or fraudulent claims to the federal government. The federal False Claims Act makes it illegal to:

- Knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government.
- Knowingly make, use, or cause to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspire to defraud the government by getting a false or fraudulent claim allowed or paid.
- Have possession, custody, or control of property or money used or to be used by the government and, intending to defraud the government, either willfully conceal the property or deliver or cause to be delivered less property than the amount for which the person receives a certificate or receipt.
- Authorize the making or delivering of a document that certifies receipt of property used or to be used by the

government and, intending to defraud the government, make or deliver the receipt without completely knowing the information on the receipt is true.
- Knowingly buy or receive as a pledge of an obligation or debt, public property from an officer or employee of the government or member of the Armed Forces who may not lawfully sell or pledge the property.
- Knowingly make, use, or cause to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

"Knowingly" includes acting not only with actual knowledge, but also with deliberate ignorance or reckless disregard of the facts. To impose liability, it is not necessary for the court to find a specific intent to defraud. Simply presenting a false claim is a violation, even if the claim has not been paid and no money has been expended.

The federal government may impose fines of up to $11,000 per claim and treble damages (i.e., three times the amount of actual damages) for federal False Claims Act violations.

In addition to the federal False Claims Act, New York State (NYS) and New York City (NYC) have each enacted a False Claims Act. All three prohibit the items set forth above, and all three can impose treble damages for each violation. A civil penalty between $6,000 and $12,000 may be imposed for each violation of the NYS False Claims Act and a civil penalty between $5,000 and $15,000 may be imposed for each violation of the NYC False Claims Act. In each instance, the court is authorized to reduce the fine to two times the amount of damages if the alleged violator:

(i) provided full information to the Commissioner of Investigation, or the investigating agency or official(s), within 30 days of receiving the information;
(ii) cooperated with any subsequent government investigation; and
(iii) at the time the individual provided information about the violation, no action had commenced with respect to the violation and the individual did not have any actual knowledge that an investigation was underway.

It should be noted, the NYS False Claims Act does not apply to claims, records, or statements made under the tax law.

WHISTLEBLOWER PROTECTIONS UNDER THE FALSE CLAIMS ACT

The federal False Claims Act allows private parties, known as "qui tam relators," to bring an action on behalf of the United States. The Act provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment because of their furtherance of an action under the federal False Claims Act. Remedies include reinstatement with seniority comparable with what the individual would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained because of the discrimination, including litigation costs and reasonable attorney fees.

Employers are prevented from taking any retaliatory actions (i.e., discharge, suspension, or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment) against an employee who discloses or threatens to disclose to a supervisor or a public body an activity, policy, or practice of the employer that is in violation of a law, rule, or regulation, the violation of which creates and presents a substantial and specific danger to public health or safety or that constitutes health care fraud. An employee who has been the subject of a retaliatory personnel action may institute a civil action for relief within one year after the alleged retaliatory personnel action was taken.

NEW YORK STATE MEDICAID FRAUD DETECTION

Chapter 442 of the Laws of 2006, which established the New York State Office of the Medicaid Inspector General (OMIG), also created a new Social Services Law § 363-d that requires Medicaid providers to develop and implement compliance programs aimed at detecting fraud, waste, and abuse in the Medicaid program. Each provider covered by the requirements must develop and adopt an effective compliance program based on a set of minimum core requirements. Provider compliance programs shall, at a minimum, be applicable to billings to, and payments from, the medical assistance program but need not be confined to such matters. The law contains only the minimum requirements for such plans. Effective January 1, 2007, OMIG, in consultation with the Department of Health (DOH), is authorized to impose additional requirements for compliance plans beyond the basic statutory requirements.

Additional requirements, minimum standards, etc., may be found at the Office of the Medicaid Inspector General’s website

at omig.ny.gov. In addition, a new Part 521, entitled "Provider Compliance Programs," is added to Title 18 of the Codes, Rules, and Regulations of the State of New York.

ANTI-KICKBACK STATUTE

The Anti-Kickback Statute, 42 USC Section 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 (including the Medicare Program).

New York State also has an Anti-Kickback Statute. For more information, see Education Law §§6530(18),6530(19), Social Services Law §366-d and 18NYCRR 515.2.

STARK STATUTE (PHYSICIAN SELF-REFERRAL LAW)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an

- entity when the physician (or a member of his or her family) has:
- An ownership/investment interest or
- A compensation arrangement

Exceptions may apply. For more information, refer to 42 USC Section 1395nn.

New York State anti-referral law applies to practitioners, which also includes nurses, physician assistants, midwives, etc. For more information, see New York State Public Health Law § 238-a (2) (c).