SECTION XIII: Fraud, Waste and Abuse

FRAUD, WASTE AND ABUSE

The Centers for Medicare & Medicaid Services (CMS) requires that ONECare provide compliance related training materials to health plans' contracted First tier, down stream and related entities (FDRs) and their employees who are involved in the administration or delivery of Medicare benefits. The training is performed as part of initial contracting and must be completed September 30th annually. As a contracted provider you and your staff are considered to be an FDR. There are two attestations ONECare providers must submit to meet this requirement.

The first required attestation pertains to Fraud, Waste & Abuse, and General Compliance Training. The second required attestation pertains to Policies & Procedures, Anti-Fraud Plan, Standards of Conduct for Providers, and HIPAA Training. Providers who have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse. Providers that meet the FWA certification still must train on general compliance. ONECare makes available FWA and Compliance Training online for those that do not have their own alternate equivalent training at https://www.care1st.com/az/providers/compliance.asp?healthplan=onecare (click on "FDR/General Compliance Information" and scroll to "FWA/General Compliance Training Materials"). The principal officer with contract signatory authority must submit an Attestation on behalf of its ONECare providers/staff at the time of contracting and additionally, no later than September 30 annually. The attestation and instructions for submitting it are found at the above link.

If a ONECare provider does not have internet access or have questions, please contact the Compliance Department at 602-778-8345 or via email at ComplianceDepartmentAZ@care1st.com (please do not email protected health information, unless it is sent ***securely***).

Fraud, Waste and Abuse Reporting

CMS requires providers to immediately report suspected fraud and abuse. Members or providers who intentionally deceive or misrepresent in order to obtain a financial gain or benefit they are not entitled to must be reported to the Office of Inspector General (OIG) & the health plan's corporate compliance officer. Any suspected fraud, waste, or abuse within the Medicare program, should be referred to ONECare or the the Department of Health and Human Services Office of Inspector General using the contact information below. Fraud cases may involve beneficiaries, pharmacies, physicians or other providers, health plans, or other organizations.

SECTION XIII: Fraud, Waste and Abuse

It is imperative that ONECare providers continue to partner with ONECare to ensure that the reported millions of dollars lost to fraud and abuse does not originate with Arizona providers. Members and providers who act fraudulently hurt honest providers and exhaust limited resources available to serve those in need.

To report fraud and abuse to ONECare, contact the Compliance Department via:

Phone:
602.778.8345
Compliance Hotline (available 24/7; Anonymous)
866.364.1350
Mail:
ONECare
Attn: Compliance Department
2355 E. Camelback, Ste. 300
Phoenix, AZ 85016
Fax:
602.778.1814

Please remember to submit as much information as possible regarding the reported matter.

To report Medicare Fraud to the Department of Health and Human Services Office of Inspector General (OIG), contact the OIG Hotline via:

Phone: 800.HHS.TIPS (800.447.8477)

Fax: 800.223.8164

Online Referral Submission: https://forms.OIG.HHS.gov/hotlineoperations/index.aspx

TTY: 800.377.4950

Mail:
Office of Inspector General
Department of Health and Human Services
Attn: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026

SECTION XIII: Fraud, Waste and Abuse

ANTI-FRAUD PLAN

Most of the initial legislation and enforcement of health care fraud and abuse has been in the Medicare/Medicaid and Hospital (Stark) areas. However, health care fraud and abuse in managed care is beginning to receive attention and inquiry.

The federal Deficit Reduction Act of 2005 requires any entity, such as ONECare to establish written policies for its employees, subcontractors and agents that give detailed information about federal and state false claims laws and whistleblower protections, and the organization's (ONECare's) policies and procedures for detecting and preventing fraud, waste and abuse.

ONECare's Anti-Fraud Plan addresses these requirements of federal and state laws and is a useful tool on the subject of fraud, waste and abuse. The Anti-Fraud Plan is available at the following location: https://www.care1st.com/az/providers/compliance.asp; then, click on "FDR/General Compliance Information".

DEFICIT REDUCTION ACT

ONECare providers are required to train their staff on the following aspects of the Federal False Claims Act provisions:

- The False Claims Act, Including Examples of False Claims and Remedies
- Federal Whistleblower Protections

FEDERAL FALSE CLAIMS ACT

The Federal False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program including Medicaid and Medicare.

The FCA establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" means that a person, with respect to information:

- had actual knowledge of falsity of information in the claim, or
- acted in "deliberate ignorance" of whether or not the information was true, or
- acted in "reckless disregard" of the truth or falsity of the information in a claim.

It is not necessary that the person had a specific intent to defraud the government.

SECTION XIII: Fraud, Waste and Abuse

The False Claims Act prohibits seven types of conduct:

1. **False Claim:** Filing false or fraudulent claims. A Claim includes any request or demand for money that is submitted to the U.S. government or its contractors (like ONECare). So a provider or hospital claim, or a vendor billing, submitted to ONECare involving Medicaid or Medicare programs counts as a claim.
2. **False Statement:** Making or using false statements or records.
3. **Conspiracy:** Conspiring with others to submit false claims that are actually paid by the government.
4. **Delivery of Less Property:** Delivering less property than the amount stated on the receipt or certificate.
5. **Delivery of Improper Receipt:** Delivering a receipt for property without knowing whether the information on the receipt is true.
6. **Unauthorized Seller:** Knowingly buying or receiving property from a government employee or official who is not authorized to sell it.
7. **Reverse false claims:** A reverse false claim involves using a false statement to conceal, avoid or decrease the amount of an obligation.

EXAMPLES OF A FALSE CLAIM

1. Billing for procedures not performed
2. Violation of another law, for example a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs for referrals)
3. Falsifying information in the medical record or in a claim
4. Improper bundling or coding of charges, and
5. Misrepresentation by a member or provider to seek benefits provided by Care1st or other Medicaid or Medicare contractor/health plan.

REMEDIES

1. Violation of the False Claims Act is punishable by a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages that the Government sustains because of the violation
2. A federal false claims action may be brought by the U.S Attorney General
3. An individual also may bring what is called a qui tam action for violation of the False Claims Act. This means the individual files a civil action on behalf of the government
4. An individual who files a qui tam action receives an award only if, and after, the Government recovers money from the defendant as a result of the lawsuit. Generally, the court may award the individual between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the Government's participation in the suit and the extent to which the individual substantially contributed to the prosecution of the action

5. A statute of limitations provides the amount of time that may pass before an action may no longer be brought for violation of the law. Under the False Claims Act, the statute of limitations is six years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation was committed

FEDERAL WHISTLEBLOWER PROTECTIONS

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Clams Act, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for such relief. (31 USC 3730(h))

REMEDIES

A person who violates one of the provisions above is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.