Independence care system

Fraud, Waste, and Abuse Compliance Program

2015

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Introduction

Independence Care System (ICS) is committed to preventing and detecting instances of fraud, waste, and abuse in accordance with the rules and regulations set forth by state and federal governance including 42 C.F.R. § 422.503 (b)(4)(vi),42 C.F.R. § 423.504(b)(4)(vi), 31 U.S. Code § 3729 (False Claims Act), 10 NYCRR § 98-1.21, 42 U.S. Code § 1320 (a) – (h), the Deficit Reduction Act of 2005, Chapter 9 of the CMS Prescription Drug Manual, and Chapter 21 of the Medicaid Managed Care Manual. Through the Fraud, Waste, and Abuse Compliance Program, ICS aims to reinforce the associated policies and procedures with members, employees, providers, and First-Tier, Downstream and Related Entities (FDR's).

The Compliance Department has developed policies and procedures to prevent and detect fraud, waste, and abuse (FWA). The Compliance Department is responsible for reducing or eliminating Medicare Parts C and D benefit costs due to FWA; reducing or eliminating fraudulent or abusive claims paid for with federal and state dollars; preventing illegal activities; and assisting the appropriate authorities providing information needed to develop successful prosecutions.

Definitions

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. This includes practices that are not consistent with the goals of providing members with services that are medically necessary, meet professionally recognized standards, and priced fairly. Examples of abuse include but are not limited to the following:

- Billing for services that were not medically necessary
- Using organizational resources for personal matters
- Failure to offer negotiated prices

Fraud is typically characterized as the intentional act of submitting false statements or making misrepresentations of fact to obtain a federal health care payment for which no entitlement would otherwise exist. According to the federal Anti-Kickback Statute, it may include soliciting, paying, and/or accepting remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs. Examples of this may include but are not limited to:

Provider Fraud

- Billing for services not provided
- Billing that appears to be a deliberate application for duplicate payments for the same services
- Billing for non-covered services as services
- Intentional incorrect reporting of diagnoses or procedures to maximize payment

Member Fraud

- Providing false information when applying for programs or services
- Forging or selling prescription drugs
- Using transportation benefit for non-medical related business
- “Loaning” or using another’s insurance card

Employee Fraud

- Falsification of a member’s medical records
- Working remotely from home but engaging in activities unrelated to work
- Using company funds to purchase non-expensed personal items
- Submitting false qualifications for employment advancement

First Tier Downstream and Related Entity (FDR) is defined in accordance with Section 10 of Chapter 11 of CMS’ Managed Care Manual, Medicare Advantage Application Procedures and Contract Requirements. As such, a First Tier Entity is defined as any party that enters into a written arrangement with ICS to provide administrative or health care services for our members. A Downstream entity is any

party that enters into a written arrangement between ICS and a First Tier Entity. A Related Entity is a party that is related to ICS by common ownership or control and:

- Performs some of ICS's organization management functions under contract or delegation;
- Furnishes services to ICS members under an oral or written agreement; or
- Leases real property or sell materials to ICS at a cost of more than $2,500 during a contract period.

Substantiated Incidents are defined as confirmed FWA incidents that can be supported by objective evidence in determining whether such an incident occurred. Examples of objective evidence include but are not limited to the following:

- Claims records detailing a provider's billing history
- Written letters from member's physician
- Case manager notes and encounter records
- Evaluation reports from licensed professionals
- Uniform Assessment System for New York

Unsubstantiated Incidents are defined as alleged incidents of FWA that have not been supported by objective evidence. Examples of objective evidence include but are not limited to the following:

- Rumors or allegations of FWA activity by a member, provider, or employee of ICS
- Speculation regarding a member's level of activity or medical condition
- Accusations of abuse by members, providers, or employees of ICS that have not been initially reported and investigated by ICS

Waste is the inappropriate utilization and/or inefficient use of resources. Instances of waste are typically unintended by the associated party and would be considered abuse if found to be purposeful in nature. Examples of wasteful behavior include but are not limited to the following:

- Unintentional duplication of claims
- Excessive ordering of services beyond what is needed
- Performing unnecessary diagnostic procedures
- Persistent extended wait times at doctor's appointments

Reporting Fraud, Waste, and Abuse at ICS

Overview

ICS investigates all allegations of fraud, waste, and abuse through its internal compliance hotline following strict procedures and timelines. ICS members, employees, providers, and FDRs are encouraged to report concerns or suspicious activity to their respective supervisor without fear of retaliation or intimidation. Prohibited retaliation or intimidation includes, but is not limited to, suspending, demoting, failing to consider for promotion, harassing, or reducing the compensation of any reporting party due to the party's intended or actual filing of a report. ICS members, employees, providers, and FDRs are notified that they are protected from retaliation for False Claims Act complaints in addition to any other applicable anti-retaliation protections. ICS members, employees, providers, and FDRs should immediately report any such retaliation to the Compliance Officer.

ICS members, employees, providers, and FDRs are also able to voice such concerns to the Center for Medicare and Medicaid Services, and the appropriate State and Federal regulators.

All reasonably suspected incidents of FWA should be reported to the compliance department within **10 business days** of occurrence. Once a report has been submitted, a member of the compliance department will respond directly to the reporter within **1 business day** of receipt.

ICS employees should understand that the compliance hotline is designed solely for the reporting of fraud, waste, abuse, and other compliance problems; it is not intended for complaints relating to the terms and conditions of an employee's employment. Any such complaints should be directed to the Director of Human Resources. ICS requires FDRs to notify their employees that they should report compliance or FWA issues through the compliance hotlines.

ICS members, providers, employees and FDR's should report reasonably suspicious activity to the organization in the following manner:

Mail

All written correspondence should be sent to the following address:

Independence Care System
Attention: Compliance Officer
257 Park Avenue South, 2nd Floor
New York, NY 10010

All correspondence mailed to the compliance officer is automatically forwarded to the Vice President of Compliance and Regulatory Affairs.

Telephone

The compliance hotline may be reached toll-free at 1-855-ICS-TIPS (1-855-427-8477) and is available 24 hours a day. Messages left on the hotline's voicemail are checked on a daily basis.

E-mail

Contact ICS Compliance via e-mail at complianceofficer@icsny.org

The Compliance Officer inbox should be checked on a daily basis. Access to the Compliance Officer inbox can be made available through Microsoft Outlook by putting in a request through the ICS Help Desk ticketing system.

ICS members, employees, providers, FDRs, and employees of FDRs can report confirmed fraudulent activity externally to:

- Office of Inspector General (OIG) at 1-800-HHS-TIPS (1-800-447-8477), TTY 1-800-377-4950, fax to 1-800-223-8164, or by mail:

  US Department of Health and Human Services Office of Inspector General
  ATTN: OIG HOTLINE OPERATIONS
  P.O. Box 23489
  Washington, DC 20026

- Center for Medicare and Medicaid (CMS) at 1-800-633-4227or by mail:

  Medicare
  ATTN: Beneficiary Contact Center
  P.O. Box 39
  Lawrence, KS 66044

- National Benefit Integrity Medicare Drug Integrity Contractor via faxing a Fraud Referral Form (http://www.healthintegrity.org/docs/NBI_Contract_HI_MEDIC_ComplaintForm_20131109.pdf) to (410) 819-8698 or mailing it to:

  Health Integrity, LLC
  Attn: NBI MEDIC
  28464 Marlboro Avenue
  Easton, MD 21601-2732

- New York State Office of the Medicaid Inspector General (OMIG) at 1-877-87-FRAUD (1-877-873-7283), electronically at: http://www.omig.ny.gov/index.php/fraud/file-an-allegation or by mail:

  NYS OMIG – Bureau of Medicaid Fraud Allegations
  800 North Pearl Street
  Albany, NY 12204

ICS will broadcast confidential reporting mechanisms to all employees and contractors and requires FDRs and providers to do the same. If an FDR or provider does not maintain their own confidential reporting mechanism, they must broadcast information about ICS's confidential hotline and encourage

all employees and contractors to report potential compliance issues including fraud, waste, abuse, conflict of interests, and violations of compliance policies and/or any applicable regulation. Furthermore, in accordance with the False Claims Act ((31 U.S.C. §§ 3729–3733), ICS will not retaliate or intimidate ICS employees who report reasonably suspected incidents of FWA.

ICS employees should understand that the compliance officer e-mail is designed solely for the reporting of fraud, waste, abuse, and other compliance problems; it is not intended for complaints relating to the terms and conditions of an employee's employment. Any such complaints should be directed to the Director of Human Resources. ICS requires FDRs to notify their employees that they can report compliance or FWA issues through the compliance officer e-mail.

All correspondence from the ICS Compliance Hotline and Compliance Officer e-mail should be logged using the appropriate tracking measure. Spam messages and instances of dead air on the ICS Compliance Hotline are not required to be logged.

Investigating Fraud, Waste, and Abuse Incidents

Overview

Investigations of reasonably suspected FWA incidents within ICS are subject to strict confidentiality standards until incidents are determined to be substantiated. A substantiated incident of FWA would include objective evidence supporting the allegation. For example, if a provider is charging ICS for services at a rate higher than what was originally negotiated, a review of the claims history would determine if the allegation can be substantiated.

If a confirmed fraudulent incident were to occur, ICS must immediately report the incident to the appropriate State and Federal regulators including CMS, OIG, NYSDOH, and/or OMIG. If a criminal act was undertaken during the incident, ICS must report it to the appropriate law enforcement agencies and fully cooperate with all matters related to the investigation.

Once a reasonably suspected incident has been reported to the Compliance, it should be appropriately logged with the following information:

- Type of Incident
- Date of occurrence
- Name of suspected party
- Date of report
- Name of Reporter

Differentiation between fraud and waste may be difficult to determine under certain circumstances. For example, a reasonably suspected incident of double billing from a provider may turn out to be a billing error rather than an intentional fraudulent act. Therefore, it is important to investigate such matters without bias or pre-judgment and with the proper support, cooperation, and communication of all affected parties. In doing so, the matter of intent can be surmised and a subsequent determination of either fraud or waste can be confidently made.

During an investigation, it is necessary to collect the appropriate objective evidence for substantiation of a reasonably suspected incident. Evidence collected should be placed in a case file associated with the suspected incident. A case file would consist of both a physical and electronic folder organized in an orderly manner. The following forms of evidence may include, but are not limited to:

- Relevant e-mail correspondences
- Contact history and logs
- Member claims history
- Billing history and/or receipts of payment
- Encounter notes from Care Compass
- Physician notes and orders
- Investigator notes from interviews with relevant parties
- Signed affidavit attesting to the suspected FWA incident

FWA Investigative Methodology

As ICS continues to grow, it will become increasingly important to have standardized methods of investigation when reasonably suspected FWA incidents are reported. Since these incidents can occur in a variety of ways, a basic investigative process should be implemented to establish consistency and objectivity. The following steps should be taken when attempting to substantiate FWA activity:

Initial Analysis

The initial analysis should look at the reasonably suspected incident in question and determine what immediate steps need to be taken for resolution. Thorough examination should include identifying the cause of the reasonably suspected incident, the parties involved, the department it affects, and the type of damage that has occurred. It is through this process in which points of contact are identified to facilitate evidence collection. Upon completion, the information should be presented to the Compliance Officer with a following discussion on next steps for investigation.

Planning and Leading

The plan for investigation should be outlined including lines of communication, timetables for information collection, case file creation, and leading and advising those involved. Identifying the type of information required to substantiate a reasonably suspected FWA incident and who needs to be contacted to acquire such information is highly advisable. The investigation plan should be presented to the Compliance Officer for approval before investigative inquiries begin.

Fact-Finding

The crux of substantiation depends upon the collection of objective data to either support or refute the reported reasonably suspected FWA incident. The fact-finding process should be conducted in an unbiased manner with legitimate and reliable sources of data. This may include interviewing affected parties, collection of electronic data via authorized requests for access, examination of medical charts, or analysis of quality performance metrics. Such information requires the cooperation of the investigator's point-of-contact and it is the investigator's responsibility to ensure validity and reliability by using credible sources. Careful note-taking and documentation of contacts is essential throughout this process.

Analyzing the Evidence

Examination of the collected evidence is paramount to any investigation and should be conducted in a careful and concise manner. It is important to identify which pieces of evidence can either substantiate or refute the reasonably suspected claim while recognizing any further information that would be required. Conflicting evidence should be noted and further examined to determine reliability. Evidence analysis should be bias-free and the investigator should not form any pre-conceived notions regarding the motivation of the reported reasonably suspected FWA incident. Such theory-crafting may derail an investigation by ignoring relevant evidence that does not support the investigator's opinion and focusing upon evidence that may lead to a dead end.

Reporting

Presentation of the facts collected as well as the investigative process should be considered when reporting findings. Expert opinions, if available, should be cited appropriately as well as any documentation that was made available to the investigator. If data analysis was performed, it should be presented in a clear and concise manner with an explanation as to how it was utilized during evidence review. Be mindful of the audience receiving investigative reports as they may have not had the available background information about the reported reasonably suspected FWA incident to fully appreciate the investigator's report.

Following-Up

Once the investigation has been reported to the relevant parties, it is important to consider what regulatory measures must be applied if necessary. Questions to consider: Is law enforcement required for this incident? Are there any associated fines that must be considered? Are there any disciplinary actions that should be taken by ICS? What can be done to prevent future FWA incidents? With these thoughts in mind, consider who within the organization needs to be contacted and made aware of any necessary changes in the workflow process. If an organizational process was at fault, it would be advisable to recommend that an internal audit be performed post-hoc to ensure that the incident is isolated.

Documentation of FWA Incidents

When a reasonably suspected incident of FWA is reported and logged, an initial report must be created by the investigator within 1 – 2 business days of initial contact. The initial report should include the name of the reporter, the name of the suspected party, the type of FWA incident, the date of occurrence, and whether the incident has been substantiated. Following this information should be a brief summary of the reasonably suspected incident with concluding remarks detailing how the investigator will proceed forward in substantiating the case.

Once the initial report has been submitted, the investigator must collect evidence substantiating the allegation within 10 – 15 business days. Upon completion of this task, an investigation report must be created with information regarding the process of the investigation as well as an inventory of collected evidence. All correspondences with relevant parties must be described in the report along with investigative actions and any difficulties that may have arisen during the collection of evidence. The investigator must conclude the report with further steps of the investigation including steps toward remediation.

At the conclusion of the investigation, a closing report must be created by the investigator within 5 – 10 business days of the investigation report. The closing report must include details surrounding the conclusion of the investigation including whether the reasonably suspected incident was objectively substantiated, remediation, and disciplinary actions if applicable. Investigator remarks should also be included at the end of the closing report with suggestions on how to prevent such an incident from

occurring and lessons learned from the investigative experience. ICS reserves the right to re-open a closed FWA investigation if new and relevant information is provided by an internal or external party.

Throughout the investigation, the reporter of the reasonably suspected incident should be kept informed of further developments and may be asked to provide assistance under certain circumstances. All case reports should be directed toward the Compliance Officer and Compliance Committee upon completion.

Cooperation with other ICS Departments

Depending on the type of FWA incident that may have occurred, it would be necessary for the Compliance department to work with other departments at ICS throughout an investigation. This may include, but is not limited to, the following:

- Analyzing claims history with the Finance Department
- Data queries with Management Information Systems
- Facilitating contact with providers through Provider Relations or Care Management
- Reviewing disciplinary actions with Human Resources

Reporting to State and Federal Regulators

ICS is obligated to report confirmed fraudulent incidents to State and Federal regulators on an ongoing basis.

- Confirmed fraudulent incidents of to be reported to the Office of the Inspector General (OIG) immediately.
- Reasonably suspected FWA incidents involving any FDRs contracted by ICS should be reported to the National Benefit Integrity Medicare Drug Integrity Contract (NBI MEDIC) within 30 days of the incident's occurrence. If ICS is unable to investigate a reasonably suspected fraudulent incident within 60 days of report, it must be referred to the NBI MEDIC.
- Confirmed fraudulent incidents are reported to the New York State Department of Health (NYSDOH) and Office of the Medicaid Inspector General (OMIG) on a quarterly basis. Ongoing investigations of reasonably suspected FWA incidents are reported on a quarterly basis with updates being submitted in the following quarterly reports.

The following information must be presented when reporting to the:

- Name of individual or entity that committed, or is reasonably suspected of committing the fraud or abuse
- Source that identified the reasonably suspected fraud or abuse
- Type of provider, entity, or organization that committed, or is reasonably suspected of committing the fraud or abuse
- A description of the reasonably suspected fraud or abuse
- The approximate dollar amount of the reasonably suspected fraud or abuse

- Legal and administrative disposition of the case including actions taken by law enforcement officials to who case has been referred
- Other data/information as prescribed by NYSDOH

FWA Investigation Guidelines

Investigation of Provider and Out-of-Network Provider Fraud

When investigating reasonably suspected FWA incidents involving claims and billing practices, the expertise of a designated claims examiner should be requested by the Compliance department. Full cooperation with the claims examiner, the FWA investigator, and the provider is essential in determining whether a reasonably suspected FWA incident has occurred and how the incident should be classified. The FWA investigator should defer to the expertise of the claims examiner in such circumstances if they are unfamiliar with the claims process. Reasonably suspected incidents that involve unnecessary procedures, "up coding", or unbundling of services should be examined with the assistance of a medical coder who is familiar with diagnosis and CPT codes. Requests for information from the provider should be made with proper notice and documentation along within a timely manner.

Investigation of Member Fraud

Reasonably suspected incidents of fraud perpetrated by members should be handled in a sensitive manner as it may disrupt care services. Communication with the member should be facilitated through the IDT team leader or care manager if necessary. The assistance of the care manager is essential when collecting information and should be consulted throughout the investigation. Information may also be collected through careful examination of the member's medical record with emphasis on the service plan, encounter notes, nursing assessments, external documentation, and history of appeals or grievances.

Investigation of Employee Fraud

If an ICS employee is reasonably suspected of committing fraud, it is necessary to undertake the necessary confidentiality precautions to prevent workplace disruption. The reporter of the reasonably suspected incident should be interviewed privately and made aware that the nature of the investigation requires cooperation and confidentiality. The Human Resources department and the reported employee's supervisor should also be contacted and made aware of the investigation. If a reasonably suspected FWA incident is substantiated by supporting evidence, a corrective action plan should be issued to the employee and, if found to be in violation of the ICS Code of Conduct, disciplinary action should be taken. If an employee was found to be committing fraud or abuse that jeopardizes the welfare of an ICS member, the applicable state law enforcement and regulatory board must be contacted for further investigation.

Investigation of First Tier, Downstream, and Related Entities (FDRs) Fraud

If an FDR is reported to have a reasonably suspected FWA incident, it is necessary for all associated parties to work in full cooperation with timely responses to all requests and inquiries. The investigator should work with the Manager of Delegation Oversight to facilitate communication and provide subject matter expertise including contract terms, historical background, and on-site audit findings if available.

Reviewing the FDRs compliance and FWA training would also serve to ensure that the proper subject matter is being taught in accordance with CMS best practices.

Investigation of Provider and Pharmacy Claims

ICS is dedicated to the prevention and detection of fraudulent claim activity that may occur when providing necessary services and prescription drugs to our members. At the moment, ICS is exploring several methods of preventing and detecting fraudulent claims to maintain program integrity such as collaborating with our Finance Department and claims processor, and engaging in statistical analysis and data mining. Once a methodology has been selected, ICS will create an addendum to this Program Guide to explain the new procedures that will assist in the identification and investigation of fraudulent claims.

CMS has announced the release of a new tool for plan sponsors to use in their effort to fight Part D FWA called the Predictive Learning Analytics Tracking Outcome (PLATO). ICS will make use of this tool by reviewing historical actions taken against providers who may be reasonably suspected of fraudulent activities as well as taking into account any prescription drug event data that may be of interest. As the release of this tool is in its preliminary stages, the Compliance Department will be accessing this database as needed when investigating providers who are reasonably suspected of committing FWA within the service area.

In certain circumstances, an investigation of provider and pharmacy claims may require the assistance of an FDR as provider and pharmacy claims can only be collected from their records. In such cases, it is important to establish a line of communication with an appropriate FDR representative and formally request any necessary information pertaining to the investigation. Furthermore, the investigator should actively review all FWA newsletters and reports transmitted by an FDR when available and cross-reference any findings for reasonably suspected FWA. For example, MedImpact transmits an FWA newsletter on a monthly basis via their GPS Communication Client and posts quarterly FWA reports via MedOptimize. Access to FWA newsletters and reports may be requested by the investigator through the Manager of Delegation of Oversight.

Education and Training in Fraud, Waste, and Abuse

Who Should Be Trained in FWA?

ICS members, employees, providers, and FDRs must be trained in detecting and reporting reasonably suspected FWA incidents.

ICS employees must complete FWA training within **30 days of their start date** at the ICS New Hire Orientation. Furthermore, ICS employees must complete a FWA refresher on an annual basis to reinforce the fundamental facets of this program.

ICS contracted providers and FDRs must attest that their employees have received FWA training upon entering into a service agreement. ICS will accept FWA training based on the CMS standardized FWA training and education modules to meet this requirement. Furthermore, FDRs must be presented with information on ICS' FWA Program via the FDR Welcome Packet that is distributed upon contracting with ICS.

ICS must provide its members the resources to learn about FWA including guidelines on how to recognize such incidents and how to report them to the organization. Information about detecting FWA is available in the member handbook that is distributed to every ICS member on an annual basis. ICS's FWA policy may also be accessed online at the following web addresses:

For ICS Community Care Plus FIDA-MMP participants: www.icsny.org/care-plus/fraud-and-abuse-policy/

For ICS Community Care MLTC members: www.icsny.org/fraud-abuse-policy/

Documentation

FWA training must be documented for all ICS employees, providers, and FDRs by the Compliance Department. Such documentation must be kept on file for at least 10 years and may include the following:

- Records for training attendance
- Signed attestations
- Certificates of completion

Raising Awareness

In an effort to spread FWA awareness throughout the organization, ICS has implemented the following activities to encourage a culture of compliance among members and employees:

- Weekly reports of FWA incidents taking place within the United States
- Awareness events for ICS employees
- Advanced training opportunities and certifications
- *Compliance Matters*, a monthly column in the ICS Voice staff newsletter, discusses compliance-related topics including FWA

Governance and Penalties for Fraud, Waste, and Abuse Incidents

Federal laws governing Medicare fraud and abuse include the:

- False Claims Act (FCA);
- Anti-Kickback Statute (AKS);
- Physician Self-Referral Law (Stark Law);
- Social Security Act; and
- United States Criminal Code.

These bodies of law specify the criminal and/or civil remedies the government can impose upon individuals or entities that commit fraud and abuse in the Medicare Program, including Medicare Parts C and D, as well as the Medicaid Program. Violations of these laws may result in nonpayment of claims, Civil Monetary Penalties (CMPs), exclusion from participation in Federal health care programs, and criminal and civil liability. Liability can exist without proof of actual knowledge or a specific intent to violate the law.

False Claims Act (FCA)

The FCA protects the government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim.

> **Example**: A physician submits claims to Medicare for a higher level of medical services than actually provided or that the medical record documents.
>
> **Penalties**: Civil penalties for violating the FCA can include fines of $5,500–$11,000 per false claim and up to three times the amount of damages sustained by the government as a result of the false claims.

There is also a criminal FCA statute by which individuals or entities that submit false claims can face criminal penalties.

Anti-Kickback Statute (AKS)

The AKS makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program.

> **Example**: A provider receives cash or below fair market value rent for medical offices in exchange for referrals.

Penalties: Civil penalties for violating the AKS can include fines up to three times the amount of kickback. Criminal penalties for violating the AKS can include fines, imprisonment, or both.

If certain types of arrangements satisfy regulatory safe harbors, the AKS will not treat these arrangements as offenses. For more information on safe harbors, visit the United States (U.S.) Department of Health & Human Services (HHS) Office of Inspector General's (OIG) website at https://oig.hhs.gov/compliance/safe-harbor-regulations on the OIG website.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or member of his or her immediate family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Example: A provider refers a beneficiary for a designated health service to a business in which the provider has an investment interest.

Penalties: Penalties for physicians who violate the Stark Law include fines, repayment of claims, and potential exclusion from participation in all Federal health care programs.

For more information, visit http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral on the CMS website.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to:

- Defraud any health care benefit program; or
- 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 healthcare benefit program.

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting claims for power wheelchairs that were not medically necessary.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Additional Medicare Fraud and Abuse Penalties

Aside from the civil and criminal actions brought by law enforcement agencies, the Medicare Program has additional administrative remedies applicable for certain fraud and abuse violations.

Exclusions

Under the Exclusion Statute, the OIG must exclude from participation in all Federal health care programs providers and suppliers convicted of:

- Medicare fraud;
- Patient abuse or neglect;
- Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service; or
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG also has the discretion to impose exclusions on a number of other grounds.

Excluded providers cannot participate in Federal health care programs for a designated period. An excluded provider may not bill Federal health care programs (including, but not limited to, Medicare, Medicaid, and State Children's Health Insurance Program [SCHIP]) for services he or she orders or performs. At the end of an exclusion period, an excluded provider must affirmatively seek reinstatement; reinstatement is not automatic. The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE), at https://oig.hhs.gov/exclusions on the OIG website.

Civil Monetary Penalties Law (CMPL)

Under the CMPL, Civil Monetary Penalties (CMPs) apply for a variety of conduct. The CMPL authorizes penalties of up to $50,000 per violation, and assessments of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received. Violations that may give rise to CMPs include:

- Presenting a claim that you know or should know is for an item or service not provided as claimed or that is false and fraudulent;
- Presenting a claim that you know or should know is for an item or service for which Medicare will not pay; and
- Violating the AKS.

Appendix A: Suspected Fraud, Waste, and Abuse Reporting Form

All fields are optional. Reporters are encouraged to fill out as much information as possible in order to expedite the investigative process. Once completed, please e-mail the referral form to complianceofficer@icsny.org. If you have any questions on how to complete this form, please contact the ICS Compliance Officer Hotline at 1-855-ICS-TIPS (427-8477).

Reporter Information

Name		Date of Report	
Title or Relationship		Date of Incident	
Preferred Phone/E-mail			

Fraud, Waste and Abuse Type

☐ Member

☐ Provider (e.g. physicians, personal care aides, DME suppliers, adult day care programs or vendors)

☐ ICS Employee

☐ Other

If OTHER, please explain:

Description of Suspected FWA Incident: Please include dates of activity, parties involved, services affected, member ID's, and/or any information that may assist in the investigation.

For Internal Use Only

Receipt Date		Assigned To	