Aetna Better Health® of Illinois

Provider Fraud, Waste and Abuse Training

Welcome

We designed this training to assist you in helping Aetna Better Health detect, report, and prevent fraud, waste, and abuse.

Following these requirements protects our members from harm and helps to keep health care costs down.

Definitions

Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste: over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Criminal fraud: 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 of the money or property owned by, or under the custody or control of, any health care benefit program. (18 United States Code § 1347).

What does that mean?

Fraud

Intentionally submitted false information to the government or a government contractor to get money or a benefit.

Waste and abuse

Requesting payment for items and services when there is no legal entitlement to payment. Unlike fraud, the provider has not knowingly and intentionally misrepresented facts to obtain payment.

Differences between fraud, waste and abuse

There are differences between fraud, waste and abuse. One of the primary differences is intent and knowledge.

Fraud requires the person to have intent and obtain payment and knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment but does not require the same intent and knowledge.

What are my responsibilities as a provider?

You are a vital part of our effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.

First, you are required to comply with all applicable statutory, regulatory, including adopting and implementing an effective compliance program including billing for services accordingly to what was provided and to follow proper coding and guidelines etc.

Second, you have a duty to the program to report any violations of laws that you may be aware of.

Third, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

Your responsible for preventing fraud, waste, and abuse by (also applies to laboratories as mandated by 42 CFR 493):

- Developing a compliance program
- Monitoring claims for accuracy - ensure coding reflects services provided
- Monitoring medical records – ensure documentation supports services rendered
- Performing regular internal audits
- Establishing effective lines of communication with colleagues and members
- Asking about potential compliance issues in exit interviews
- Taking action if you identify a problem

Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

Elements to a Compliance Plan

An effective Compliance Plan includes seven core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote commitment to compliance and address specific areas of potential fraud, waste, and abuse.
2. Designation of a Compliance Officer: Designation of an individual and a committee responsible for and with authority for operating and monitoring the compliance program.
3. Effective Compliance Training: Development and implementation of a regular, effective education and training program.
4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem areas.
5. Disciplinary Mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities excluded from participating in the Medicaid program.

6. Effective Lines of Communication: Between the Compliance Officer and employees, managers, directors, and members of the compliance committee, as well as related entities.

How can I prevent fraud, waste and abuse?

- Make sure you are up to date with laws, regulations, and polices.
- Ensure data/billing is both accurate and timely
  - Monitor claims for accuracy, ensuring coding reflects services provided.
- Verify information provided by you
  - Monitor medical records, ensuring documentation supports services rendered
  - Perform regular internal audits
  - Be on the lookout for suspicious activity
  - Establish effective lines of communication with colleagues and staff members
- Make sure you understand and follow Aetna Better Health's policies and procedures.
- Comply with Aetna Better Health's compliance program.
- Ensure policies and procedures are in place at your facility to address fraud, waste, and abuse.

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and in responsible to investigate cases of alleged fraud, waste, and abuse. With a total staff of approximately 100 individuals, the SIU is comprised of experienced, full-time investigators; field fraud (claims) analysts; a full-time dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, are seeking information, or want to report potential fraud, waste, or abuse. The number is **1-800-338-6361**. The hotline has proven to be an effective tool, and Aetna Better Health encourages providers and contractors to use it.

Examples of fraud, waste, and abuse

- Billing for services and supplies that were never performed or provided.
- Billing for a higher-level treatment than was actually provided.
- Billing separately for services that are already included in the primary procedure.
- Health care provider not providing enough care or delaying needed care. This is done in order to maximize the health care provider's service funds.
- Billing for services or procedures that are not needed.
- Utilizing false or inflated diagnosis codes for encounter information to increase premiums.
- Writing scripts from brand name pharmaceuticals even though generic is stated in the plan formulary.
- Use of medical benefits by an unauthorized individual.

Reporting fraud, waste and abuse

Participating providers are required to report to Aetna Better Health all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse in the following ways:

- By phone to the confidential Aetna Better Health of Illinois Compliance Hotline at **1-866-536-0542**
- By phone to our confidential Special Investigation Unit (SIU) at **1-800-338-6361**

Note*:* If you provide your contact information, your identity will be kept confidential.

Laws you need to know about

The Illinois False Claims Act (IFCA) prohibits:

- Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval
- Knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim
- Conspire to commit a violation of the IFCA
- Have possession, custody, or control of property or money used, or to be used, by the State and knowingly deliver, or cause to be delivered, less than all the money or property
- Make or deliver a document certifying receipt of property used, or to be used, by the State and, intending to defraud the State, make or deliver the receipt without completely knowing that the information on the receipt is true

Anti-Kickback Statute

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Self-Referral Prohibition Statute (Stark Law)

Prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.

Exclusions

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General. (42 U.S.C. § 1395(e0(1), 42 C.F.R. §1001.1901).

HIPAA

Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)
Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry. Safeguards to prevent unauthorized access to protected health care information. As a provider who has access to protected health care information, you are responsible for adhering to HIPAA.

Consequences of committing fraud, waste or abuse

The following are potential penalties. The actual consequences depend on the violation.

- Civil money penalties
- Criminal convictions/fines
- Imprisonment

- Loss of provider license
- Exclusion from Federal Health Care Program

Personal Care Service (PCS) Providers
The major reason for improper payments involves fraud, waste, and abuse. Simple, infrequent billing mistakes may not necessarily constitute fraud, waste, or abuse; they may more than likely be human errors. When billing errors occur, PCS providers, like all providers, are required to disclose the errors and return any payments received for them. Some PCS providers are offering medically unnecessary services or more services than necessary—such as more hours than authorized to meet the member's needs—thereby wasting resources. It is important that PCS providers only offer necessary and authorized services.

Five common types of improper PCS payment:
- Claims paid without supporting documentation
- Services provided and billed that are not eligible for reimbursement according to State Medicaid plans, demonstrations, or waivers
- Services provided without required supervision
- Services provided by unqualified PCAs or PCAs without verification and documentation of their required qualifications
- Payments made for care provided while a member was in an institution, such as a hospital (not including payments to a PCA to retain services or during a period in which the individual is receiving covered respite care)

Improper Medicaid PCS payments costs taxpayers, strains state budgets, and could result in PCS waiver programs becoming limited and ultimately, discontinued.

Additional references

- Aetna Better Health's Provider Manual
- Code of Federal Regulations (C.F.R.), Title 21
- National Conference of State Legislatures (NCSL): **www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx**
- **www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-prevent-improperpayment-booklet.pdf**