Medicare Compliance and Fraud, Waste and Abuse (FWA) Training

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Overview & Objectives

- **What:** Compliance & Fraud Waste & Abuse (FWA) program requirements
  - Things you need to be aware of and implement into your practices.

- **Why:** Compliance programs help raise awareness and provide mechanisms to detect, prevent, correct non-compliance & FWA
  - You must report non compliance and FWA

- **How:** Training and education
  - You can demonstrate training through completion of this training or an equivalent training
  - You must be able to ensure that training was completed for each of your staff and that you have a process for new hires.

- **Who:** All First tier, Downstream and Related entities (FDR's) , including providers and delegated entities.
  - Medicare Providers are deemed for FWA training based on their Medicare participation, but not deemed for Compliance Training.

- **When:** Complete this training by annually by December 31st of each year.

Key Terms and Acronyms

Original Medicare

- Medicare Part A - Hospital Insurance, which pays for inpatient care, skilled nursing facility care, hospice, and home health care.
- Medicare Part B - Medical Insurance: pays for doctor's services, and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs.

Medicare Advantage Organizations (MAO)

- Medicare Part C – is also know as Medicare Managed care, where coverage is through an MAO for coverage that would otherwise be through original Medicare under Part A and Part B.

Medicare Prescription Drug Sponsors

Medicare Part D is Medicare Prescription Drug coverage which helps pay for prescription drugs, certain vaccines and certain medical supplies (e.g. needles and syringes for insulin).

- Part D coverage be through an MAO that adds Part D benefits, which is called a Medicare Advantage Prescription Drug Plan (MAPD), OR
- Part D coverage may be through a Prescription Drug Plan Sponsor (PDP)

Key Terms and Acronyms

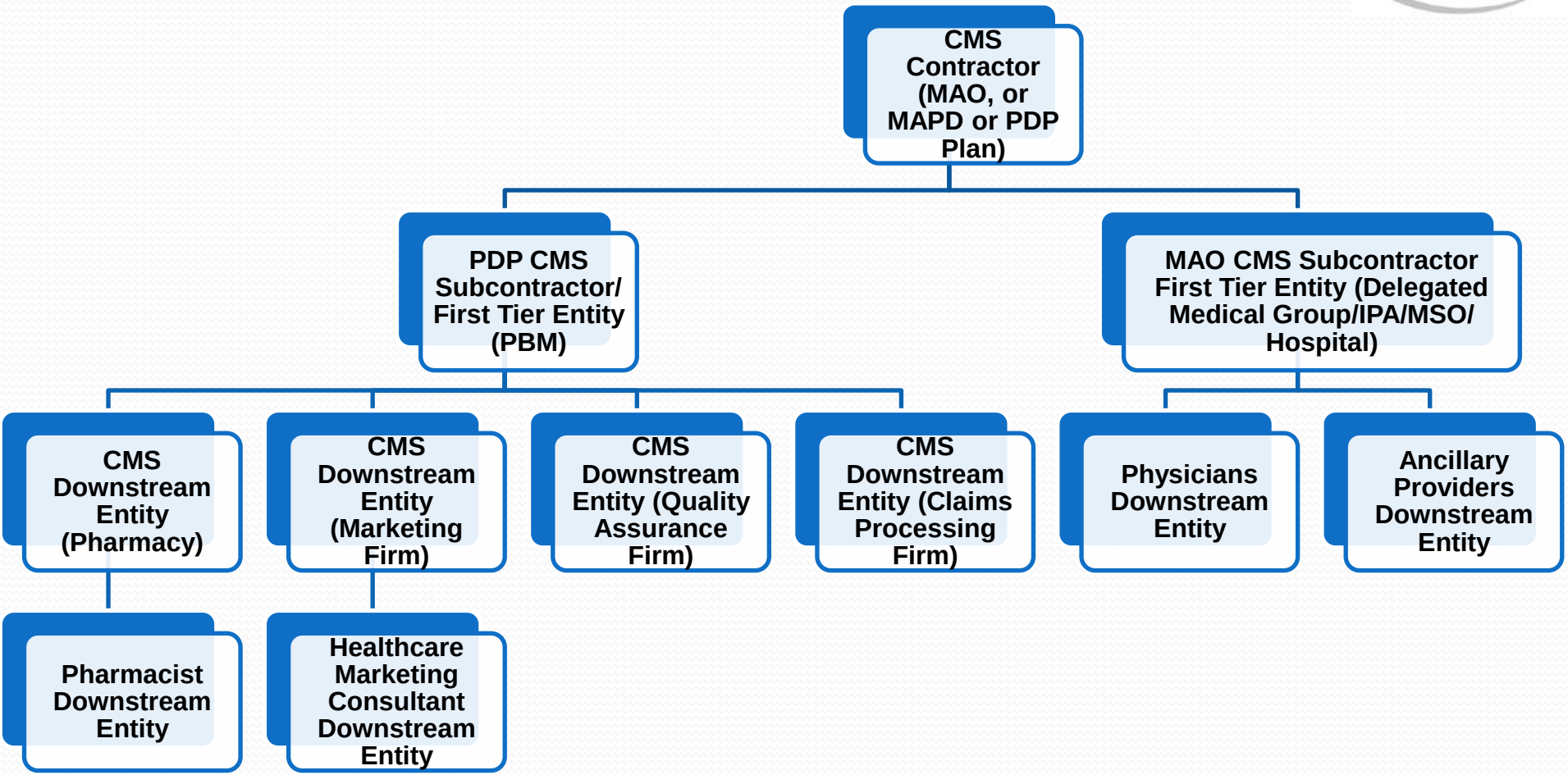
First Tier, Downstream and Related Entities (FDR's) are entities contracted or subcontracted with an MAO or PDP Sponsor as defined below:

- **First Tier Entity:** A party contracted with an MAO or PDP Plan to provide administrative or health care services for MAO or PDP Plan members. Examples include: IPA's, Medical Groups, Management Services Organizations (MSO) Pharmacy Benefit Managers (PBM), hospitals, health clinics, directly contracted physicians, ancillary providers, brokers, field marketing organizations, agents, enrollment or claims processing entities.

- **Downstream Entity:** A party contracted with a First Tier Entity to provide administrative or health care services on behalf of the MAO or PDP Plan. Examples include subcontractors of an IPA /MSO/ hospital subcontractors such as physicians, claims processing firms, ancillary providers, PBM subcontractors such as pharmacies, subcontractors with of General Agencies or Field Marketing Organizations.

- **Related Entity:** A party connected MAO or PDP Plan by common ownership or control and performs some of the MAO or PDP management functions under contract or delegation.

First Tier and Downstream Example



Compliance

- As of January 1, 2011, Federal Regulations require that MAO's and PDP Plans have not just a compliance program, but to have an **effective** program designated to deter FWA. This includes compliance program requirements for annual training on compliance and FWA.
  - Refer to CFR 42 CFR 423.504(b)(4)(vi)(C) and 42 CFR 422.503(b)(4)(vi)(C) for details on required training and education for General Compliance and FWA.
  - Additional regulatory guidance is in the CMS Part D Manual, under Chapter 9 http://www.cms.gov/Manuals/iom/ItemDetail.asp?ItemID=CMS019326

- This course was developed through ICE to support a standard training & education program that combines general compliance and FWA training. Alternate training programs from MAO or PDP Plans, IPA's, Medical Groups, Hospitals, PBM's and other entities may be used to meet the overall compliance and FWA training requirements if they address both general compliance requirements and fraud, waste and requirements.

Training Requirements

Compliance and FWA Training is required for all new hires & annually thereafter.

- This is not intended to replace training on HIPAA Privacy, Security and breach reporting

(Acceptable to use ICE training or alternate equivalent training or to customize this based on your audience)

Require Annual Compliance and FWA Training

- Health Plan Staff that work with MA or Part D programs
- Pharmacy Benefit Managers (PBMs)
- Pharmacies and pharmacists
- Subcontractors such as claims processing firms
- Dentists
- IPA's / Medical Groups
- Optometrists

Require Annual Compliance Training but may be deemed as Medicare Providers for FWA

- Hospitals
- SNFs
- Physicians (PCP's and Specialists)
- Ancillary providers (DME, Radiology, Lab etc.)
- Home Health Providers

Seven Key Compliance Plan Elements

1. Written Standards of Conduct:
   - Develop & distribute written Standards of Conduct
     - Adopting the MAO / PDP plan standards or adopting company standards of your own that meet the requirements
     - Plan standards can be referred to on the MAO or PDP website / portal.
   - Policies & Procedures to promote your commitment to compliance & address prevention of potential fraud, waste, and abuse.

2. Designation of a Compliance Officer and Compliance Committee:
   - A Compliance Officer is appointed to oversee a Compliance Committee accountable to Senior Management / the Board
     - The Compliance Officer is charged with the responsibility and authority of operating and monitoring the compliance program.

3. Effective Compliance Training:
   - Development and implementation of regular, effective education, and training -- for employees, contractors, providers and the Board.

4. Effective Lines of Communication:
   - Between the compliance officer and employees, managers, directors members of the compliance committee, and first tier, downstream and related entities.

Seven Key Compliance Plan Elements

5. Internal Monitoring and Auditing:
   - Measuring and evaluating risks
     - using risk evaluation techniques, self reporting, & audits to monitor compliance,
     - oversight activity, reporting and audits designed to verify required prevention measures are in place, such as required training & standards
     - Oversight to identify other compliance risks to assist in the reduction of identified problem areas.

6. Disciplinary Mechanisms:
   - Policies to consistently enforce standards
     - Policies for dealing with compliance issues, and with individuals, or entities that are excluded from participating in Medicare or Government programs.

7. Procedures for responding to Detected Offenses / Corrective Action:
   - Policies to respond to detected offenses
     - This includes initiating prompt and **effective** corrective action resulting in sustained compliance and prevention of similar issues.

(Refer to the Appendix for additional resources)

Reasons to Implement a Compliance Plan

1. Adopting a Compliance Program concretely demonstrates the organization has a strong commitment to honesty and responsible corporate integrity
2. Compliance programs reinforce employees innate sense of right and wrong
3. An effective compliance program helps an organization fulfill its legal duty to the government
4. Compliance programs are cost effective
   - expenditures are insignificant in comparison to the disruption and expense of defending against a fraud investigation
5. A compliance program provides a more accurate view of employee and contractor behavior relating to fraud and abuse
6. A compliance program provides guidance and procedures to promptly correct misconduct
7. An effective compliance program may mitigate False Claims Act liability or other sanctions imposed by the government by preventing non-compliance, fraud, waste and abuse.

Fraud, Waste & Abuse Defined

- **Fraud:** Fraud is the intentional misrepresentation of data for financial gain.
- Fraud occurs when an individual knows or should know that something is false and makes a knowing deception that could result in some unauthorized benefit to themselves or another person.[1]

- **Waste:** Waste is overutilization: the extravagant, careless or needless expenditure of healthcare benefits or services that results from deficient practices or decisions.[1]

- **Abuse:** Abuse involves payment for items or services where there was no intent to deceive or misrepresent but the outcome of poor insufficient methods results in unnecessary costs to the Medicare program.[2]

Source:

1. CMS Glossary; CMS Medicare Learning Network (MLN)

2. Medicare Physician Guide: A Resource for Residents, Practicing Physicians, & Other Health Care Professionals, Tenth Edition (October 2008)

Quick Reference Chart

Examples of Fraud[1]	Examples of Abuse[2]	Examples of Waste
• Billing for services not furnished • Billing for services at a higher rate than is actually justified • Soliciting, offering or receiving a kickback, bribe or rebate • Deliberately misrepresenting services, resulting in unnecessary cost, improper payments or overpayment • Violations of the physician self-referral ("Stark") prohibition Source: 1. Medicare Physician Guide: A Resource for Residents, Practicing Physicians, & Other Health Care Professionals, 10th Edition (10/08)	• Charging in excess for services or supplies • Providing medically unnecessary services • Providing services that do not meet professionally recognized standards • Billing Medicare based on a higher fee schedule than is used for patients not on Medicare Source: 2. CMS Medicare Fraud and Abuse Web-based Training (April 2007)	• Over-utilization of services • Misuse of resources

Best Practices for Preventing FWA

- Develop a compliance program
- Perform regular internal audits & monitoring against regulatory standards
  - Review for outliers / deviations form the norm
  - Confirm UM decisions, coding and claims are timely/accurate.
  - Confirm prompt refunds of overpayments (within 60 days)
- Ensure effective training & education is occurring, minimally for:
  - New hires and annually for Current Staff
  - Confirm Training occurs on HIPAA Privacy and breach reporting
  - Provide Training updates and Policy Updates when regulations change
  - Provide refresher Training on policies as part of any Corrective Action Plan
- Establish effective lines of communication with colleagues and staff members.
  - Ensure ALL staff are aware on how to report potential FWA or compliance concerns
  - Take action! If you identify an FWA issue – you must report it.
  - Ask about potential compliance issues in exit interviews when staff leave.
- Remember: The Provider, Hospital, IPA and the MAO or PDP plan are each ultimately responsible for all claims and encounters that are submitted for payment with your name on the claim

Penalties and Consequences of FWA

(Refer to detailed information on various regulations in the Appendix)

Repayment / Restitution is just the start

- ***False Claims Act : $5,500 up to 11,000 per claim plus up to triple the amount of the claim in damages***
  - Criminal and/or civil prosecution *&* Imprisonment
  - Suspension/loss of provider license / Medicare Provider number
  - Exclusion from the Medicare program / Government Contracts
- AntiKickback
  - MAO / PDP enrollment freeze and sanctions under CMS authority up to $25,000 per beneficiary impacted ant-kickback violation
  - Providers: up to five years in prison and fines of up to $25,000
    - If a patient suffers bodily injury as a result of any kickback scheme, such as unnecessary procedures, the prison sentence may be 20+ years
- HIPAA Privacy and Security Breaches
  - Payment for credit monitoring and restoration services
  - Various State and Federal Monetary penalties

Types of FWA

- **MAO or PDP Fraud**
- **Member Fraud**
- **Provider Fraud**
- **Pharmacy Fraud**

- **Each carries a set of implications that we need to be aware of as part of our daily activities to help prevent FWA**

MAO / PDP PLAN - FWA

Failure to Provide Medically Necessary Services

- Fails to provide medically necessary items or services that the organization is required to provide (under law or under the contract) to a Part C or Part D plan enrollee, and that failure adversely affects (or is likely to affect) the enrollee.

Inappropriate Enrollment/Disenrollment

- Improperly reporting enrollment and disenrollment data to CMS to inflate prospective payments. For example, Sponsor fails to effect timely disenrollment of beneficiary from CMS systems upon beneficiary's request.

Marketing Schemes

- Offering beneficiaries a cash payment as an encouragement to enroll in a Plan.
  - Gifts that are above the CMS allowed $15 exemption, gifts convertible to cash, or "meals" (anything beyond the light snacks that guidance allows)
- Unsolicited door-to-door marketing.
- Use of unlicensed agents, where required by state law.
- Enrollment of individual in a Medicare Plan without knowledge or consent.
- Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS

Formulary or Coverage Decisions

- Making inappropriate formulary decisions or coverage decisions based on inducements
- Delaying access to necessary covered drugs

Beneficiary (Member) FWA

The following are examples of fraud by Medicare beneficiaries (members):

Identity Theft

- Using a different member's I.D. card to obtain prescriptions, services, equipment, supplies, doctor visits, and/or hospital stays.
  - Individuals who "loan" their ID card could mean they get the wrong blood type in their medical record or other significant risks to care.

Doctor Shopping

- Visiting several different doctors to obtain multiple prescriptions for painkillers or other drugs. Might point to an underlying scheme (stockpiling or black market resale).

Improper Coordination of Benefits

- Beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies to "game" the system

Prescription Fraud

- Resale of Drugs or Black Market
  - Falsely reporting loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.
- Falsifying or modifying a prescription

Provider FWA

Kickbacks: Soliciting, offering, or receiving a kickback, bribe, or rebate

- for example, paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment.

Inducements: Such as copay waivers or free services to retain patients

- Caution required when dispensing free medications from pharmacy companies. Should have consistent policies reviewed by legal.

False Claims: Billing for services not rendered or supplies not provided

- for example, billing for appointments the patient failed to keep.
- Billing for a “gang visit” in which a physician visits a nursing home billing for 20 nursing home visits without furnishing any specific service to individual patients.

Double billing

- such as billing both Medicare and the beneficiary, or billing both Medicare and another insurer.

Date of Service: Misrepresenting the date services were rendered

Identity: Misrepresenting the identity of the individual who received the services.

Provider FWA

Rendering Provider: Misrepresenting who rendered the service

- Such as billing for an office visit when the only services were an injection by a medical assistant.

False Coding or Services: billing for a covered item or service when the actual item or service provided was a non-covered item or service.

Unnecessary Care: Providing unnecessary procedures or prescribing unnecessary drugs.

- This includes appropriate review that patients meet the Certification of Medical Necessity requirements

Altering Medical Records: Erroneous or false or late entries in the medical record

- Late entry in the record, such as an addendum must be entered sequentially in the record according to coding rules

Delay in Care: Delay in authorizing or providing access to medically necessary care

- Physician office errors in non timely submission of auth requests can result in delay in care.
- Regulations measure the 72 hours for expedited and the 14 days for standard pre service requests based on the date and time the patient makes the request

Patient Dumping: Encouraging disenrollment for high cost patients to costs and defer care to original Medicare when in a capitated model.

Provider Prescription Drug FWA

Over Prescribing: Over-prescription of false prescription of narcotics

Selling Prescriptions: Participating in illegal remuneration schemes, such as selling prescriptions.

Inducements: Prescribing medications based on illegal inducements, rather than the clinical needs of the patient.

- Such as pharmacy manufacturer incentives, trips, or discounted services

Not Medically Necessary: Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider.

Theft – Identity Fraud: Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing log-in information.

Falsifying Justification: Falsifying information in order to justify coverage, such as ruling out lower cost generics –especially

Dilution or Illegal Importation: Diluted substances or substituted provider administered drugs that may be either less than effective or contraindicated or illegal importation of drugs used or sold as covered drugs.

Pharmacists FWA

False Billing:

- Billing for prescriptions that are never picked up
- Billing for a brand name when generics are dispensed,
- Billing for non-covered prescriptions as covered items

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Splitting prescriptions

- for example, by splitting a 30-day prescription into 4 7-day prescriptions to get additional copayments and dispensing fees.

Steering & Kickbacks:

- Engaging in unlawful remuneration, such as remuneration for steering a beneficiary toward a certain plan or drug, or for formulary placement.

Overcharging:

- Failing to offer negotiated prices.
- Collecting higher copays than specified

Short Fills

- Prescription drug shorting
  - Providing less than the prescribed quantity and bills for the fully-prescribed amount.

Pharmacists FWA

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Bait and switch pricing

- when a beneficiary is led to believe that a drug will cost one price, but at the point of sale, the beneficiary is charged a higher amount.

Forging and altering prescriptions

- Modification to scripts or dosage
- Modifications to allowable refills

Expired Drugs or Tainted Drugs:

- Dispensing drugs that are expired or have not been stored or handled in accordance with manufacturer and FDA requirements.

Manipulating the True Out-of-Pocket cost

- when a pharmacy falsely pushes a beneficiary through the coverage gap, into catastrophic coverage before they are eligible, or keeps a beneficiary in the coverage gap so that catastrophic coverage never occurs.

Pharmaceutical Wholesaler FWA

Counterfeit Drugs:

- Counterfeit and adulterated drugs through black and grey market purchases
  - This includes but is not limited to fake, diluted, expired, and illegally imported drugs.

Diverters

- Brokers who illegally gain control of discounted medicines intended for places such as nursing homes, hospices and AIDS clinics. Diverters take the discounted drugs, mark up the prices, and rapidly move them to small wholesalers. In some cases, the pharmaceuticals may be marked up six times before being sold to the consumer.

Inappropriate documentation of pricing information

- Submitting false or inaccurate pricing or rebate information to or that may be used by any Federal health care program.

Pharmaceutical Manufacturer FWA

Kickbacks, inducements, and other illegal remuneration:

- Inappropriate marketing and/or promotion of products
- Inducements offered if the purchased products are reimbursable by any of the federal health care programs such as discounts, inappropriate product support services, educational grants, research funding, etc.

Records Management: Lack of integrity of data to establish payment and/or determine reimbursement, such as missing or Inappropriate documentation of pricing information

Formulary and formulary support activities

- inappropriate relationships with P & T committee members,
- payments to PBMs for formulary placement

Inappropriate relationships with physicians

- "Switching" arrangements, when manufacturers offer physicians cash payments or other benefits each time a patient's prescription is changed to the manufacturer's product from a competing product.
- Incentives offered to physicians to prescribe medically unnecessary drugs.
- Consulting and advisory payments, payments for detailing, business courtesies and other gratuities, and educational and research funding.
- Improper entertainment or incentives offered by sales agents.

Off Label Use: Illegal promotion of off-label drug usage

Billing for Free Samples: Illegal usage of free samples to physicians knowing and expecting those physicians to bill the federal health care programs for the samples.

Required Reporting

Violations of the code of conduct, ethics or any fraud, waste or abuse must be reported. Not reporting fraud or suspected fraud can make you a party to a case by allowing the fraud to continue.

- Your organization should have internal mechanisms for reporting compliance & FWA concerns (your compliance office or compliance hotline)
- Your report may be anonymous
- You may also report concerns to the respective Medicare Advantage Organization or Part D Plan sponsor
- 1-800-MEDICARE.
- Fraud or suspected fraud may also be reported anonymously as outlined by any health plans on their web portals or your internal reporting mechanisms, or the MEDICS.

Everyone has the right and responsibility to report possible fraud, waste, or abuse.

Remember: You may report anonymously and retaliation is prohibited when you report a concern in good faith.

Include Policies, Procedures and Training on Whistleblower Protections

Whistleblower: An employee, former employee, or member of an organization who reports misconduct to people or entities that have the power to take corrective action.

A provision in the False Claims Act allows individuals to:

- Report fraud anonymously
- Sue an organization on behalf of the government and collect a portion of any settlement that results

Employers cannot threaten or retaliate against whistleblowers.

Remember to Protect Confidentiality

Carefully handle all data than can identify the member -

- This includes any of the elements noted below:
  - Social Security , Medicare ID (HICN) or **Health Plan Member ID number**
  - Member Name, Address, Phone, Date of Birth
  - Medical Record Number / Patient Account Number
- Review your internal HIPAA training
- Review your internal policies and practices for reporting of any security and privacy breach to your respective HIPAA security or privacy officer
- Reporting MUST be done immediately if you become aware of or suspect a breach may have occurred.

Aetna Hotline Information

- **Aetna's Fraud Hot Line toll-free number: 1-800-338-6361**
  This hot line is available to Aetna customers: employees, plan sponsors, members, providers, pharmacies to ask questions or report a potential fraud incident. Messages are retrieved daily from this voicemail box Mon-Fri by Aetna Special Investigation Unit (SIU) personnel for immediate follow up. This process allows callers can remain anonymous.
- **Aetna SIU Email: aetnasiu@aetna.com**
- **Aetna SIU Fax: (860) 975-9719**
- Aetna's AlertLine toll-free number: 1-888-891-8910 (**available seven days a week, 24 hours a day). This line can be used to report a business conduct, integrity or compliance problem or violation. You may also anonymously report compliance problems by writing to: Corporate Compliance, P.O. Box 370205, West Hartford, CT 06137-0205**.

Entities / Individuals Excluded form Medicare or Government Programs

- Compliance Programs must carefully monitor payments go to proper entities. This includes payments to employees, providers, contractors and subcontractors
- Medicare Advantage Organizations, Part D Sponsors and contracted entities are required to check the OIG and General Services Administration (GSA) exclusion lists for **all new employees** and at least once a year thereafter to validate that employees and other entities that assist in the administration or delivery of services to Medicare beneficiaries are not included on such lists.
  - OIG List of Excluded Individuals/Entities (LEIE): **http://exclusions.oig.hhs.gov/search.html**
  - General Services Administration (GSA) database of excluded individuals/ entities: **http://epls.arnet.gov/**

- Under the HITECH Act, if payments are made to an excluded / sanctioned provider, overpayment recovery must occur within 60 days of your being aware of the overpayment to mitigate potential False Claims Act (FCA) liability.
  - You need an effective program to sweep your claims files monthly for Part C & D for retro exclusions to trigger prompt recovery.

Thank you for participating and expanding compliance program effectiveness by ensuring you and your organization adopt the learning's into your individual compliance programs and business practices.

Appendix

The attached materials include were designed to assist with your Compliance Program Development

Compliance Program Summary Expectations

- Conduct business activities and interactions ethically and with integrity.
- Conduct business activities in full compliance with all applicable statutory and regulatory prohibitions against fraud, waste, and abuse.
- Report potential FWA issues
- Establish policies and procedures to prevent, detect, and require reporting of potential fraud, waste, or abuse.

Compliance Program Tips

Ensure policies, procedures, training and monitoring are in place to prevent FWA including:

1. Charging for services or supplies beyond those received?
2. Providing medically unnecessary services?
3. Billing for items or services that should not be paid for by Medicare?
4. Billing for a prescription that was left but never picked up?
5. Billing for services at a higher rate than is actually justified?
6. Misrepresenting services resulting in unnecessary cost to the Medicare program, improper payments to providers, or overpayments, such as including codes that are not reflected in a medial record or claim.

- **Eliminate Risks to Individuals**
- Unnecessary procedures may cause injury or death.
- Falsely billed procedures create an erroneous record of the patient's medical history.
- Diluted or substituted drugs may render treatment ineffective or expose the patient to harmful side effects or drug interactions.
- Prescription narcotics on the black market contribute to drug abuse and addiction

Relevant Laws

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully solicit, receive, offer or pay remuneration (including any kickback, bribe or rebate) in return for:

- Referrals for the furnishing or arranging of any items or service reimbursable by a Federal health care program
- Purchasing, leasing, ordering or arranging for the purchasing or leasing of an item or service reimbursable by a Federal health care program

- **Remuneration** is defined as the transfer of anything of value, directly or indirectly, overtly or covertly in cash or in kind. When this happens, both parties are held in criminal liability of the impermissible “kickback” transaction.

The False Claims Act, or FCA was enacted in 1863 to fight procurement fraud in the Civil War. The FCA has historically prohibited knowingly presenting or *causing to be presented* to the federal government a false or fraudulent claim for payment or approval.

Relevant Laws

Self-Referral Prohibition Statute (Stark Law):

- Prohibits A physician from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship - unless an exception applies.

- An entity from presenting or causing to be presented a bill or claim to anyone for a designated health service furnished as a result of a prohibited referral.

The Beneficiary Inducement Statute

- prohibits certain inducements to Medicare beneficiaries. i.e. waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or fails to collect coinsurance or deductible amounts after making reasonable collection efforts.

Relevant Laws

Health Insurance Portability and Accountability Act (HIPAA):

- Transaction standards
- Minimum security requirements
- Minimum privacy protections for protected health information
- National Provider Identifier numbers (NPIs).

American Recovery and Reinvestment Act of 2009 (HITECH Act):

- Expands government authority to Act related to HIPAA issues:
  - Accountability for Business Associates
  - higher penalties to deter illegal activities by individuals:
    - Higher penalties mean violations are “not” just considered the “cost of doing business”

Excluded Entities and Individuals:

- First tier, downstream and related entities may not employ or contract with entities or individuals who are excluded from doing business with the federal government.

Case Studies – HIPAA implications

UCLA Case involving data security challenges and creation of access controls on the chain of information.

- 68 Workers improper accessed records
- 1 employee reviewed Farrah Fawcett's records on 104 days!
- Indictment by Federal Grand Jury
  - Up to 10 years prison time for selling information

Expansion of Privacy Rule

- Octomom - Bellflower Hospital fined $437,500 for loss of records
  - 15 Fired, 8 Disciplined
- Violators to pay higher penalties under new regulations

Case Studies HIPAA Implications

(*Laptops & electronic PHI – encryption mitigates risk*

North Dakota – Humana required to pay $50,000 to offset costs of investigation of PHI disclosure

Oregon – Providence Health System employee had backup tape stolen from his car with information on 365,000 patients.

- Ordered to pay for credit monitoring and credit restoration services and enhance HIPAA security program.

Web Resources

Resource	Link
Centers for Medicare and Medicaid Services (CMS)	www.cms.gov
Chapter 6 – Protecting the Medicare Trust Fund	http://www.cms.gov/MLNProducts/downloads/chapter6.pdf
Fraud & Abuse General Information	http://www.cms.gov/FraudAbuseforProfs/
Federal Register citations 42 CFR 422.50342, 422.50442, CFR 423.50442 and 423.505	http://www.cms.gov/quarterlyproviderupdates/
Federal Bureau of Investigation	*http://www.fbi.gov/*
Health Insurance Portability and Accountability Act (HIPAA)	http://www.cms.gov/HIPAAGenInfo/01_Overview.asp
Medicare Fraud and Abuse Brochure	http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf
Medicare Learning Network (MLN)	www.cms.gov/MLNGenInfo/
Medicare Managed Care Manual	http://www.cms.gov/Manuals/IOM/

Web Resources

Resource	Link
HITECH ACT	**http://www.hipaasurvivalguide.com/hitech-act-text.php**
Office of Inspector General Department of Health and Human Services	**http://oig.hhs.gov/ (refer to OIG Guidance on Compliance Plans)**
National Health Care Anti-Fraud Association	**http://www.nhcaa.org**
Part D Prescription Drug Benefit Manual	**http://www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage**
Physician Self Referral Law	**www.cms.gov/PhysicianSelfReferral**
Red Flag Rule	http://www.ftc.gov/bcp/edu/microsites/redflagsrule/index.shtml
Social Security Administration	**www.ssa.gov/oig/guidelin.htm**
Social Security Laws	**www.ssa.gov/OP_Home/ssact/comp-ssa.htm**

Web FWA Resources

Federal government web sites are sources of information regarding detection, correction, and prevention of fraud, waste, and abuse:

Resource	Link
Department of Health and Human Services Office of Inspector General:	http://oig.hhs.gov/fraud/hotline/
Centers for Medicare and Medicaid Services (CMS):	http://www.cms.hhs.gov/FraudAbuseforProfs/
CMS Information about the Physician Self Referral Law:	www.cms.hhs.gov/PhysicianSelfReferral
CMS Prescription Drug Benefit Manual	http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf
Medicare Learning Network (MLN) Fraud & Abuse Job Aid	http://www.cms.hhs.gov/MLNProducts/downloads/081606_Medicare_Fraud_and_Abuse_brochure.pdf