Health Net®

"To help people be healthy, secure and comfortable."

Medicare General Compliance and Fraud, Waste, and Abuse Training

July 2011

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Overview and Objectives

- **What**: Compliance & Fraud, Waste, and Abuse (FWA) program requirements – you need to be aware of these requirements and implement them into your practices.
- **Why:** Compliance Programs help raise awareness and provide mechanisms to detect, prevent, and correct non-compliance and FWA.
- **Who:** All First Tier, Downstream, and Related Entities (FDR's), including providers and delegated entities. This also includes office staff and other personnel associated or employed by the FDR.
  - Medicare Providers are deemed for FWA training based on their Medicare participation, but not deemed for Compliance Training.
- **How:** Training and Education
  - You must be able to ensure that training was completed for each of your staff and that you have a process for new hires
  - First tier entities are responsible for their downstream entities' completion of the training. First tier entities must have documentation that the training was distributed to all of its downstream entities readily available for audit upon request from Health Net or CMS in the form of a mailing list, fax list, or other equivalent format.
- **When**: Complete this training annually by December 31st of each year.

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Key Terms and Acronyms

Original Medicare

- Part A – Hospital insurance, which pays for inpatient care, skilled nursing facility care, hospice, and home health care.
- Part B – Medical insurance, which pays for doctor's services, and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs.
- Part C – Medicare Advantage Plans (MA): combines Part A and Part B health benefits through managed care organizations. Some plans include Part D (MAPD plans).
- Part D – Prescription Drug Insurance: helps pay for prescription drugs, certain vaccines and certain medical supplies (e.g. needles and syringes for insulin). This coverage is available as a Prescription Drug Plan (PDP).

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Key Terms and Acronyms

Medicare Advantage Organization (MAO)

- A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Medicare Prescription Drug Plan Sponsors

- An entity that has a contract with the Federal Government to offer Medicare Prescription Drug Coverage.
  - Part D coverage can 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).

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Key Terms and Acronyms

First Tier Entity:

- Any party that enters into a written arrangement acceptable to CMS with Health Net to provide administrative services or health care or pharmacy services for a Medicare eligible individual under a MA or Part D Plan.
    - Examples include: IPA's, Medical Groups, Pharmacy Benefit Managers (PBM), hospitals, health clinics, directly contracted physicians, ancillary providers, agents/brokers, field marketing organizations (FMOs), enrollment or claims processing entities.

Downstream Entity:

- Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between Health Net and a first tier entity. These written arrangements continue down to the level of ultimate provider of health, pharmacy and/or administrative services to members.
    - Examples include: subcontractors of a Medical Group, such as physicians, claims processing firms, PBM subcontractors such as Pharmacies, and subcontractors of field marketing organizations.

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Key Terms and Acronyms

Related Entity

- Any entity that is related to Health Net by common ownership or control and performs some of Health Net's management functions under contract or delegation, and furnishes services to Medicare enrollees under an oral or written agreement.

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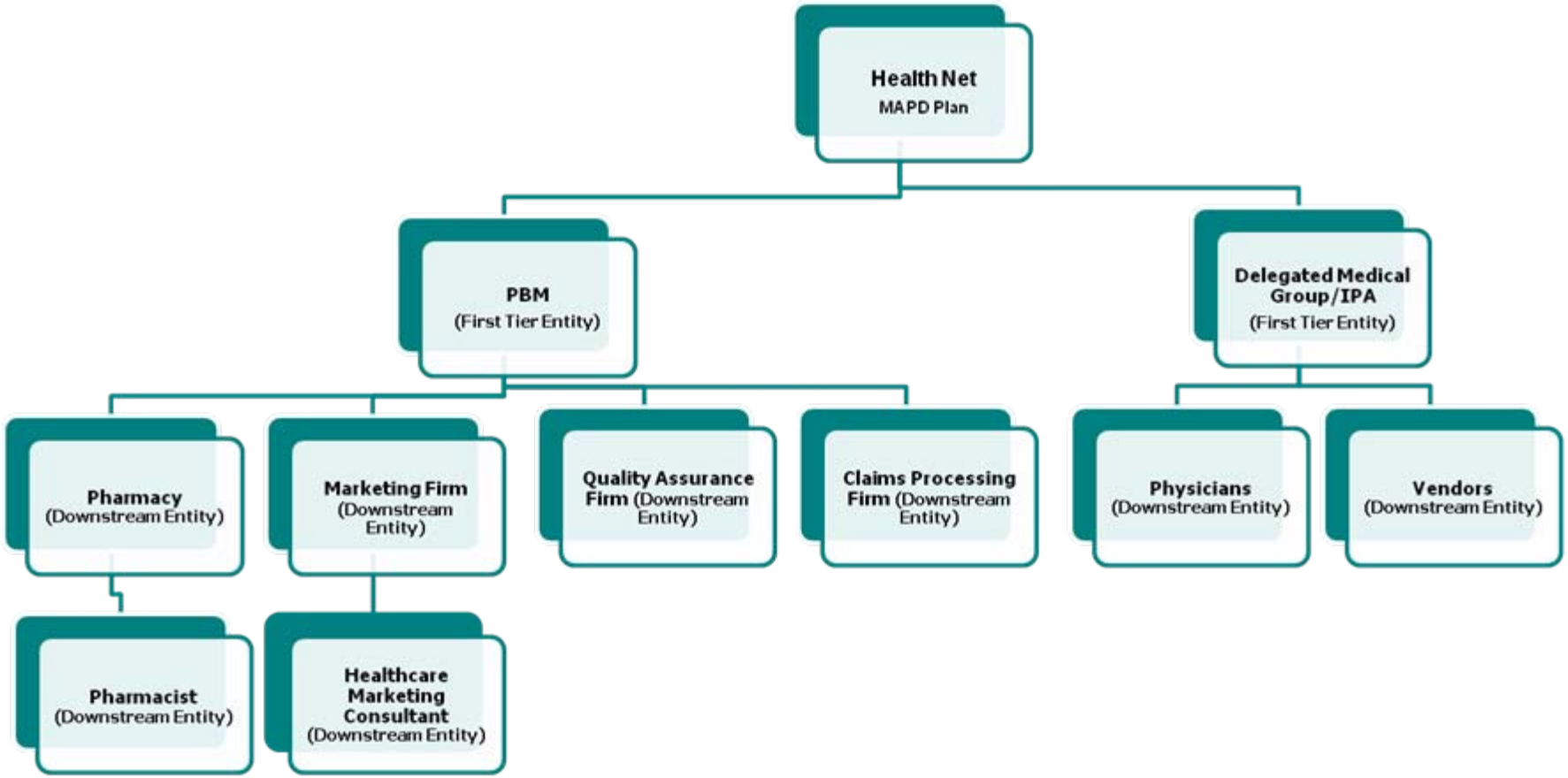
Example of First Tier and Downstream Entities



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CMS Requirements

- As of January 1, 2011, Federal Regulations require that MAO's and PDP Plans have an **effective** compliance program designated to deter FWA. This includes compliance program requirements for annual training on compliance and FWA.
  - Refer to 42 CFR 422.503(b)(4)(vi)(C) and 42 CFR 423.504(b)(4)(vi)(C) for details on required training and education for General Compliance and FWA.
  - Additional regulatory guidance can be found in Chapter 9 of the Prescription Drug Benefit Manual.

  http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf

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CMS Requirements

Medicare Advantage Organizations and Part D Sponsors must provide compliance and FWA training to first tier entities and first tier entities must ensure that compliance and FWA training is distributed to their downstream entities (and such distribution must be documented).

First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse; however, Compliance training is still required for all FDR's, even if deemed for FWA training.

Require Annual Compliance and FWA Training – Health Plans, Vendors, Contractors, Subcontractors, Medical Groups, Pharmacy Benefit Managers (PBMs), Pharmacies and Pharmacists, Dentists, and 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.

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Instructions

- Health Net has sent you this material as part of our oversight process to implement the compliance training and education requirements found in the CMS Medicare Regulations.
- This training combines general compliance and FWA training. Therefore, this course must be taken by all first tier, downstream, and related entities, whether or not the provider is considered deemed for FWA training.
- If you have questions regarding this process or you need additional compliance training materials, please contact your designated Health Net contact.

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Seven Elements of a Compliance Program

1. Written policies, procedures, and standards of conduct articulating the organization's commitment to comply with all federal and state regulations.
2. Designation of a Compliance Officer and Compliance committee accountable to senior management.
3. Effective training and education between the Compliance Officer and the organization's employees, and first tier, downstream, and related entities.
4. Effective lines of communication between the Compliance Officer and the organization's employees, members of the compliance committee, and first tier, downstream, and related entities.
5. Enforcement of standards through well-publicized disciplinary guidelines.
6. Procedures for effective internal monitoring and auditing.
7. Procedures for ensuring prompt responses to detected offenses and development of corrective actions

Element #1: Policies, Procedures and Standards of Conduct

1. **Written policies, procedures**, and standards of conduct articulating the organization's commitment to comply with all applicable Federal and State standards.

   - Adopt Health Net's Code of Business Conduct & Ethics, or adopt your own standards that meet the requirements.
   - Health Net's Code of Business Conduct & Ethics is available on Health Net's website, www.healthnet.com, under the Investor Relations page.
   - Policies and procedures that support the Medicare Compliance Program are available on the Provider Portal of Health Net's website, at www.healthnet.com/provider.

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Element #2: Compliance Officer & Compliance Committee

2. **Designation of a compliance officer** and compliance committee, who report directly and are accountable to the organization's chief executive or other senior management.

   - Health Net has a designated Medicare Compliance Officer with the authority to oversee the Medicare Compliance Program.
   - Health Net's Compliance Officer is Gay Ann Williams
   - The Medicare Compliance Officer routinely reports to the Audit Committee of the Board of Directors to ensure it is knowledgeable about the content and operation of the compliance program.
   - The Medicare Compliance Officer chairs the Medicare Compliance Committee. A key focus of the Medicare Compliance Committee is to raise and address compliance issues, escalate compliance issues to Senior Management and the Board of Directors, and to provider oversight of the Medicare Advantage and Part D programs.

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Element #3: Effective Training and Education

3. **Effective training and education** between the Compliance Officer and the organization's employees, the MA organization's chief executive officer, or other senior administrator, managers and governing body members, and the MA organizaiton's FDRs.

    - Health Net develops and implements regular, effective education and training for employees, contractors, providers, and the board.

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Element #4: Effective Lines of Communication

4. **Effective lines of communication,** ensuring confidentiality, between the Compliance Officer, members of the compliance committee, the MA organization's employees, managers, and governing body, and the MA organization's first tier, downstream, and related entities.

   - Potential or suspected violations of the Code of Business Conduct and Ethics, Health Net policies, regulations or laws must be reported and may result in appropriate disciplinary action, up to and including termination of employment.
   - Members, vendors, contractors, agents, directors, and FDR's may report potential or suspected violations by contacting the 24 hour Health Net Fraud Hotline or the Health Net Integrity Line (contact information is provided later in this slide deck).

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Element #5: Well Publicized Disciplinary Standards

5. Well publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals.

- To help communicate a strong and explicit organizational commitment to compliance goals and standards, Health Net's senior officials are directly involved in the development and review of standards of conduct.
- Disciplinary guidelines concerning violations are described in Health Net's Code of Business Conduct and Ethics, Medicare Compliance Plan, policies, procedures and compliance trainings.
- Any violation of the standards established in the Compliance Plan by an associate subcontractor, director, or a first tier, downstream, or related entity could result in disciplinary action up to and including termination of employment or termination of the contractual arrangement.
- Health Net does not tolerate retaliation against those who make good-faith reports of potential or suspected violations.

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Element #6: Routine Monitoring and Identification of Compliance Risks

6. Establishment and implementation of an effective system for **routine monitoring and identification of compliance risks.**

- Health Net's Medicare Compliance Program includes robust FWA preventative measures and procedures for effective internal monitoring and auditing to confirm compliance with Medicare regulations, sub-regulatory guidance, contractual agreements, and all applicable state and federal laws.
- Health Net develops and implements a risk based audit plan. Risks are identified through various sources including, but not limited to: the OIG work plan, external and internal audits, internal monitoring and metrics reporting, compliance issues identified by CMS, and compliance issues identified internally.

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Element #7: Prompt Response to Compliance Issues

7. Establishment and implementation of procedures and a system for **promptly responding to compliance issues as they are raised**, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

- Violation of the standards contained in the Compliance Plan may result in disciplinary or corrective action against those Associates, subcontractors, directors or first tier, downstream, or related entities who participate in non-compliant, illegal, fraudulent, improper, dishonest, or unethical activities.

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Reasons to Implement a Compliance Program

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.
    1. 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.

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Remember to Protect Confidentiality

- Carefully handle all data that can identify the member, which 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.

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Fraud, Waste and Abuse Defined

Fraud: An intentional act of deception, misrepresentation, or concealment in order to gain something of value. 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.

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

Abuse: Excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss.

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Quick Reference Chart

Examples of Fraud	Examples of Abuse	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	•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	•Over-utilization of services •Misuse of resources

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Types of FWA

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

Each carries a set of implications that you need to be aware of as part of your daily activities to help prevent FWA.

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MAO or PDP Fraud

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 inducement to enroll in a Plan.
- Unsolicited door-to-door marketing
- Enrollment of individual in a Plan without the beneficiary's knowledge or consent

Formulary or Coverage Decisions

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

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Beneficiary (Member FWA)

Identity Theft

- Using a different member's ID card to obtain prescriptions, services, equipment, supplies, doctor visits, and/or hospital stays.

Doctor Shopping

- Visiting several different doctors to obtain multiple prescriptions for painkillers or other drugs. May be an indication of 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 on the 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

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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

- Copay waivers or free services for all patients, in order to retain them. Caution is required when dispensing free medications from pharmaceutical companies.

False Claims

- Billing for services not rendered or supplies not provided. Examples include billing for appointments that patient failed to keep or billing for a “gang visit” in which a physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients.

Double Billing

- A provider conducts a pre-op and an office based surgery. The provider bills for both an office visit and the surgery. Since the Pre-op (billed as an office visit) is including the surgery costs, billing for services separately would cause duplicative payments for the same service.

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Provider FWA

Date of Service

- Misrepresenting the date services were rendered

Identity

- Misrepresenting the identity of the individual who received the services.

Rendering Provider

- Billing under a participating physician's ID, when an unlicensed physical therapist rendered the services.

False Code 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.

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Provider FWA

Altering Medical Records

- Erroneous, false, or late entries in the medical record. Addendums must be entered sequentially in the record according to coding rules.
- Services denied as not a covered benefit and the provider goes back into the record and inappropriately enters diagnosis codes that would enable the services to be covered.

Delay in Care

- Delay in authorizing or providing access to medically necessary care. Examples include a Physician office who submits an authorization request untimely can result in a delay in care.

Patient Dumping

- Encouraging disenrollment for high cost patients to costs and deferring care to original Medicare when in a capitated model.

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Provider Prescription Drug FWA

Over Prescribing

- Over-prescribing 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.

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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

Splitting Prescriptions

- 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

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Pharmacists FWA

Short Fills

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

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 or 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

- 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 the catastrophic coverage never occurs.

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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 Services

- Inappropriate relationships with Pharmacy & Therapeutics (P&T) committee members
- Payments to PBMs for formulary placement

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Pharmaceutical Manufacturer FWA

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.
- Providing kickbacks disguised as consulting or advisory payments.
- 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 samples.

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Required Reporting

- Health Net has adopted processes to receive, record and respond to compliance questions, reports of potential or actual non-compliance, and FWA from contractors, agents, directors, enrollees, and FDRs. Health Net maintains confidentiality to the extent possible, allows callers to remain anonymous if desired and ensures non-retaliation against those who report suspected misconduct in good faith.
- 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.
- Everyone has the right and responsibility to report compliance issues and possible fraud, waste, or abuse.

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Questions/Reporting Potential Fraud, Waste, or Abuse

There are several mechanisms for reporting potential or actual non-compliance and FWA issues:

- Call Health Net's Medicare Compliance Officer:

  Gay Ann Williams

  21650 Oxnard Street, Mail Stop: CA-102-22-07

  Woodland Hills, CA 91367

- Call Health Net's **FRAUD, WASTE & ABUSE HOTLINE:**

1-800-977-3565

Calls to the Health Net Fraud Hotline can be made anonymously. Calls are never traced or recorded

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Questions/Reporting Potential Fraud, Waste, or Abuse

- Call the **Health Net Integrity Line: 1-888-866-1366**

  The Health Net Integrity Line accepts calls regarding legal and ethical concerns. This toll-free resource is available 24 hours a day, seven days a week.

  Calls to the Health Net Integrity Line can be made anonymously. Calls are never traced or recorded.

- Your organization's compliance office or compliance hotline
- 1-800-MEDICARE
- The Medicare Drug Integrity Contractor (MEDIC)
- The HHS OIG Hotline: 1-800-HHS-TIPS (1-800-447-8477), (TTY users 1-800-377-4950) or via email at HHSTips@oig.hhs.gov

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Best Practices for Preventing FWA

- Develop a compliance program
- Ensure effective training and 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.
- Perform regular internal audits & monitoring against regulatory standards
  - Review for outliers, deviations from the norm
  - Confirm utilization management decisions, coding and claims are timely/accurate
  - Confirm prompt refunds of overpayments (within 60 days)

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Consequences of Fraud, Waste or Abuse Schemes

Administrative Sanctions

- Revocation of Medicare provider number or denial of Medicare provider number application.
- Suspension of provider payments.
- Name added to the OIG List of Excluded Individuals/Entities (LEIE).
- License suspension or revocation.

Civil and Criminal Penalties

- Civil Monetary Penalties up to $25,000 assessed for each Medicare Advantage enrollee adversely affected.
- Establishment of a Corporate Integrity Agreement with the OIG, including periodic audits by the Federal government.
- Conviction under the False Claims Act carries penalties of $5,500 to $11,000 for each false claim, with a potential liability of treble damages if the government proves it suffered a loss.
- Prison sentence of 20+ years, if a patient suffers bodily injury as a result of the fraudulent scheme.

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Whistleblower Protections

An important provision in the False Claims Act protects individuals who act as whistleblowers.

Whistleblower: An employee, former employee, member of an organization, or any person who reports misconduct to people or entities that have the power to take corrective action. Whistleblowers are protected against retaliation if they report misconduct in good faith.

Under the False Claims Act, individuals who have knowledge of fraud or misconduct in government programs may:

- Report fraud anonymously
- Sue an organization for submitting false claims on behalf of the government, and collect a portion of any settlement that may result.

Employers cannot threaten or retaliate against whistleblowers.

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Entities/Individuals Excluded from Medicare or Government Programs

- Compliance Programs must carefully monitor that payments are distributed 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
    - 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 being aware of the overpayment to mitigate potential False Claims Act (FCA) liability.
    - Entities should sweep claims files monthly for Part C & Part D for retro exclusions to trigger prompt recovery.

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Relevant Laws

The False Claims Act

The False Claims Act ("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.

The FCA was recently amended through the American Recovery and Reinvestment Act of 2009 (ARRA) to expand the scope of liability and give the government enhanced investigative powers. FCA liability now extends to subcontractors working on government-funded projects, as well as those who submit claims for reimbursement to government agents and state agencies.

The Anti-Kickback Statute

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any 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.

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Relevant Laws

The Beneficiary Inducement Statute

The Beneficiary Inducement Statute prohibits any person from offering inducements to Medicare beneficiaries that the person knows ***or should have known*** would influence the beneficiary's selection of a provider. Such inducements may be in the form of:

- waiver of coinsurance
- waiver of deductible amounts
- failing to collect coinsurance or deductibles
- Transfers of Items or services for free

Self-Referral Prohibition Statute (Stark Law)

With few exceptions, the Stark Law prohibits physicians from referring Medicare patients to an entity with which the physician or the physician's immediate family member has a financial relationship.

The Stark Law also prohibits 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.

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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 (NPI)

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

- Expands government authority 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

- FDR's may not employ or contract with entities or individuals who are excluded from doing business with the federal government.

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Web Resources

Resource	Link
Centers for Medicare and Medicaid Services	http://www.cms.gov
Fraud & Abuse General Information	http://www.cms.gov/fraudabuseforprofs/
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

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Web Resources

Resource	Link
Medicare Learning Network (MLN) Fraud & Abuse	https://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf
Medicare Managed Care Manual	http://www.cms.gov/Manuals/IOM/
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 Programs) http://oig.hhs.gov/fraud/hotline/
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

Web Resources

Resource	Link
Physician Self Referral Law	http://www.cms.gov/physicianselfreferral
Social Security Administration	http://www.ssa.gov/oig/guidelin.htm
Social Security laws	http://www.ssa.gov/OP_Home/ssact/comp-ssa.htm

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Thank You

Health Net is committed to abiding by the laws, rules and regulations that govern our business. Health Net's compliance program cannot operate without the cooperation of our associates, vendors, business partners, and first tier, downstream and related entities.

Thank you for completing this CMS required training course on the Compliance Program and preventing and detecting fraud, waste and abuse.

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