Fraud, Waste and Abuse

Detecting and Preventing Fraud, Waste and Abuse

Harvard Pilgrim is committed to detecting, mitigating and preventing fraud, waste and abuse. Providers are also responsible for exercising due diligence in the detection and prevention of fraud, waste and abuse as well, in accordance with our Fraud, Waste and Abuse (FWA) policies.

Under the CMS regulation, Harvard Pilgrim is required to have an effective FWA program in place. Harvard Pilgrim has implemented a FWA program to prevent, detect, and report health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. Harvard Pilgrim will use a number of processes and procedures to identify and prevent fraud and abuse. Providers engaged in fraud and abuse may subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, civil and/or criminal prosecution, fines and other penalties.

In December 2007, CMS published a final rule that requires health plans to apply certain training and communication requirements to all entities they partner with to provide benefits or services in the Part C or Part D programs.

To meet CMS requirements for Medicare Advantage Organizations and Part D Sponsors, this section covers general fraud, waste and abuse training guidelines for Harvard Pilgrim‘s first tier, downstream, and related entities (“FDR”).

Definitions

First Tier Entity

Any party that enters into a written agreement with the health plan to provide administrative or health care services for the health plan‘s enrollees.
Examples include, but are not limited to, pharmacy benefit manager (PBM), contracted hospitals or providers.

Downstream Entity

Any party that enters into a written agreement below the level of the arrangement between a sponsor and a first-tier entity for the provision of administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.
Examples include, but are not limited to, pharmacies, claims processing firms, billing agencies.

Related Entity

Any entity that is related to the health plan by common ownership or control and, 1) performs some of the sponsor‘s management of functions under contract of delegation; 2) furnishes services to Medicare enrollees under an oral or written agreement; or 3) leases real property or sells materials to the sponsor at a cost of more than $2500 during a contract period.

Fraud

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to her or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law. Fraud is determined by both intent and action and involves intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Examples of fraud:

- Billing for services not rendered or provided to a member at no cost
- Upcoding services
- Falsifying certificates of medical necessity
- Knowingly double billing

- Unbundling services for additional payment
- Routinely waiving member coinsurance, copayments or deductibles

Waste

Waste includes activities involving payment or an attempt to receive payment for items or services where there was no intent to deceive or misrepresent, but the outcome of poor or inefficient billing or treatment methods cause unnecessary costs.

Examples of waste:

- Inaccurate claims data submission resulting in unnecessary rebilling or claims
- Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed
- Overuse, underuse and ineffective use of services

Abuse

Abuse means provider practices that are inconsistent with generally accepted business or medical practices and practices that result in an unnecessary cost to the Medicare program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples of abuse:

- Providing and billing for excessive or unnecessary services
- Billing Medicare patients at a higher rate than non-Medicare patients

Provider & First Tier, Downstream and Related Entities (FDR) Policies and Procedures

- Harvard Pilgrim's providers, including FDRs (includes anyone who has involvement in the administration or delivery of Parts C and D benefits), should have policies and procedures to address fraud, waste and abuse, including reporting mechanisms and methods to respond to detected offenses.
- Harvard Pilgrim encourages providers and other FDRs to report any suspected fraud, waste and/or abuse to the Harvard Pilgrim Special Investigations Unit (SIU), the Medicare Compliance Officer, or through the Compliance hotline, 1-877-824-7123. The reports may be made anonymously.

Pertinent Statutes

False Claims Act

The Federal False Claims Act of 1985 creates criminal and civil liability for the submission of a claim for payment to the government that is known to be false in whole or in part. Several states have also enacted false claims laws modeled after the Federal False Claims Act. A "claim" is broadly defined to include any submissions that results, or could result, in payment. Violations of Medicare laws and the Medicare Fraud and Abuse Statute also constitute violations of the False Claims Act.

Significantly, the False Claims Act permits a person with knowledge of fraud against the United States Government, referred to as the "qui tam plaintiff," to file a lawsuit on behalf of the government against the person or business that committed the fraud (the defendant). If the action is successful, the qui tam plaintiff is rewarded with a percentage of the recovery.

Claims "submitted to the government" include claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer health care benefits.

Liability can also be created by the improper retention of an overpayment. Examples include:

- A provider who submits a bill for medical services not provided
- A government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements
- An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare Plan Sponsor

Whistleblower and Whistleblower Protections

The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.

Individuals who file such suits are known as “whistleblowers”. The Federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.

Anti-Kickback Statute

Harvard Pilgrim is committed to conducting its business activities in full compliance with applicable federal and state laws. In support of this commitment, Harvard Pilgrim must ensure that all providers adhere to the federal anti-kickback statute (the “Anti-Kickback Policy”), which applies to all covered persons.

The anti-kickback statute states that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, hospital incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, to influence the referral of federal health care program business may face charges, including felony charges. Discounts, rebates or other reductions in price may violate the anti-kickback statute because such arrangements involve remuneration to induce the purchase of items or services payable by the Medicare Program. See 42 CFR Parts 1001 – 1005; Sections 1001.951 and 1001.952.

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI).

HIPAA Privacy - The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.

HIPAA Security - The Security Rule outlines specific protections and safeguards for electronic PHI.
If a provider or other FDR becomes aware of a potential breach of protected information, they must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.

Examples of Potential Fraud, Waste, and Abuse

Potential FWA committed by: Pharmaceutical Manufacturer

- Illegal Off-label Promotion - Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotion campaigns
- Illegal Usage of Free Samples - Providing free samples to providers knowing and expecting those providers to bill the federal health care programs for the sample
- Billing for items or services not rendered or not provided as claimed
- Submitting claims for equipment or supplies and services that are not reasonable and necessary
- Double billing resulting in duplicate payment
- Billing for non-covered services as if covered
- Knowing misuse of provider identification numbers, which results in improper billing
- Unbundling (billing for each component of the service instead of billing or using all inclusive code)
- Failure to properly code using coding modifiers
- Altering medical records
- Improper telemarketing practices
- Compensation programs that offer incentives for items or services ordered and revenue generated
- Inappropriate use of place of service codes
- Routine waivers of coinsurance
- Clustering
- Upcoding the level of service provided

Potential FWA committed by: Skilled Nursing Facility ("SNF"), Inpatient and Other Facilities

- SNFs improperly upcoding care classification resident Resource Utilization assignments to gain higher reimbursement
- SNF improperly utilizing therapy or other services to inflate the severity of the care classification to obtain additional reimbursement
- DME or supplies offered by DME provider that are covered by the Medicare Part A benefit in the facility payment
- Failure to follow the same day rule
- Abuse of partial hospitalization payments
- Same day discharges and readmissions
- Improper billing for observation services
- Improper reporting of pass through costs
- Billing on an outpatient basis for inpatient only procedures
- Submitting claims for medically unnecessary services by failing to follow local policies
- Improper claims for cardiac rehabilitation services

Potential FWA Committed by Providers and Others

- Chiropractor intentionally billing Medicare for physical therapy and chiropractic treatments that were never actually rendered for the purpose of fraudulently obtaining Medicare payments
- Psychiatrist billing Medicare, Medicaid, the Plan, and private insurers for psychiatric services that were provided by his/her nurses rather than him/herself
- Provider certifies on a claim form that he/she performed laser surgery on a Medicare beneficiary when he/she knew that the surgery was not actually performed on the patient
- Provider instructs his/her employees to tell the Office of Inspector General (OIG) investigators that the provider personally performs all treatments when, in fact, Medical Technicians do the majority of the treatment and the provider is rarely present in the office
- Provider, who is under investigation by the Federal Bureau of Investigations (FBI) and the Plan, alters records in an attempt to cover up improprieties
- Neurologist knowingly submits electronic claims to the Medicare carrier for tests that were not reasonable and necessary and intentionally upcodes office visits and electromyograms to Medicare
- Podiatrist knowingly submits claims to the Medicare and Medicaid programs for non-routine surgical procedures when he/she actually performed routine, non-covered services such as the cutting and trimming of toenails and the removal of corns and calluses
- Performing tests on a beneficiary to establish medical necessity

Potential FWA Committed by Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS)

- DME provider billed for items or services not provided to the beneficiary
- Continued billing for rental items after they are no longer medically necessary
- Resubmission of denied claims with different information in an attempt to be improperly reimbursed
- Providing and/or billing for substantially excessive amounts of DME items or supplies
- Upcoding a DME item by selecting a code that is not the most appropriate
- Providing a wheelchair and billing for the individual parts (unbundling
- Delivering or billing for certain items or supplies prior to receiving a provider's order and/or appropriate certificate of necessity
- Completing portions of the certificate of necessity that is reserved for completion by the treating providing only
- Cover letters to encourage providers to order medically unnecessary items or services
- Improper use of KX modifier
- Providing false information on the DMEPOS supplier enrollment form
- Knowing misuse of a supplier number, which results in improper billing
- Furnishing more visits than medically necessary
- Duplicate billing for the same service

- Submission of claims for home health aide services to beneficiaries that did not require any skilled qualifying service
- Provision of personal care services by aides in assisted living facilities when such is required by the assisted living's State licensure
- Providing services at no charge to an assisted living center

Identifying and Reporting Fraud, Waste, and Abuse

Harvard Pilgrim's Processes for Identification of Fraud Waste and Abuse

Harvard Pilgrim has software and monitoring programs designed to identify indicators for fraud, waste and abuse, including, but not limited to:

- Multiple billing: Several payers billed for the same services (e.g. billing medications under Part A or Part B and then billing again under Part D
- Billing for non-covered services
- Duplicate Billing
- Unbundling of charges
- Up-coding
- Fictitious providers
- Billing of unauthorized services
- Billing with the wrong place of service in order to receive a higher level of reimbursement
- Claims data mining to identify outliers in billing
- Billing for services or supplies not provided
- Improper use of KX modifier
- Failure to follow the same day rule (hospital)
- Abuse of partial hospitalization payments
- Billing on an outpatient basis for inpatient only procedures

Reporting Obligations and Mechanisms

If a provider or other FDR is made aware of potential misconduct or a suspected fraud, waste, or abuse situation, it is their right and responsibility to report it. Providers, Vendors and Delegates can call the Harvard Pilgrim's SIU Department, the Medicare Compliance Officer, or the Compliance Hotline at 1-877-824-7123. Callers are encouraged to provide contact information should additional information be needed. However, you may report anonymously and retaliation is strictly prohibited if a report is made in good faith.

The following additional FWA resources are available for review:

- CMS' Prescription Drug Benefit Manual, Chapter 9
  www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf
- Code of Federal Register (see 42 CFR 422.503 and 42 CFR 422.504)
  www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms4124fc.pdf
- Office of the Inspector General
  www.oig.hhs.gov/fraud.asp
- Medicare Learning Network (MLN) Fraud & Abuse Job Aid
  www.cms.hhs.gov/MLNProducts/downloads/081606_Medicare_Fraud_and_Abuse_brochure.pdf

Marketing Prohibitions

Providers shall comply with all Medicare Marketing Guidelines as set forth by the Centers for Medicare and Medicaid Services (CMS).

At minimum, participating Providers should observe the following:

- Participating Provider groups are prohibited from distributing printed information comparing benefits of different health plans, unless the materials have consent from all of the Plans listed, and received prior approval from the Centers for Medicare and Medicaid Services (CMS).
- When communicating with members or prospective members concerning enrollment decisions, providers must remain neutral and act based on an objective assessment of the needs and interests of the individual.

- Providers shall not accept enrollment applications or offer inducement to persuade beneficiaries to join plans.
- Providers may not offer anything of value to induce plan enrollees to select them as a provider.
- Provider offices or other places where health care is delivered shall not accept applications for health plans, except in the case where such activities are conducted in common areas in the health care setting.
- Medicare Marketing Guidelines
  www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

Repayment Rule

Under the Patient Protection and Affordable Care Act (PPACA), effective providers are required to report and repay overpayments to the appropriate Medicare administrative or other contractor (Fiscal Intermediary or Carrier) within the latter of (a) 60 days after the overpayment is identified, or (b) the date of the corresponding cost report is due, if applicable.

Any overpayment that is retained by the provider after the deadline to report/return the overpayment is an obligation under the federal False Claims Act (FCA), meaning that knowingly failing to report and return the overpayment as required may subject the provider to liability and penalties under the FCA, including exclusion of participation in the Federal Program and Civil Monetary Penalties.

Questions, Additional Information and Contracts

Harvard Pilgrim does not prohibit network health care professionals from advising or advocating on behalf of patients. If you have general questions about Harvard Pilgrim's StrideSM (HMO) plans, call Harvard Pilgrim Provider Services at 888-609-0692 (8 a.m. to 5 p.m.) or write to:

Harvard Pilgrim Health Care
StrideSM Medicare Advantage Provider Inquiries
P.O. Box 151287
Tampa, FL 33684-1287

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12/15/14	reviewed; administrative edits
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09/29/21	updated Compliance Hotline telephone number