Provider Training: Compliance Program and Fraud, Waste, and Abuse

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What is Compliance?

Compliance is an organization's responsibility to act in accordance with applicable laws, regulations, policies, procedures, and other explicit standards.

Compliance is important for many reasons, but most importantly, it ensures funds are used appropriately to provide quality services to your community.

Organizations create or have a compliance program to implement compliance plans and institute internal controls.

While the fundamental elements of a compliance program are generally the same, the specific components of a compliance program depend on the organization's size and needs.

Your Role in Healthcare Provider Compliance

When you drive compliance, you ensure that the business you conduct is within the boundaries of the law, and guides your practice in acting ethically, legally and responsibly.

When you make ethical decisions and commit to doing the right thing, you build trust with your patients, managed care organizations, stakeholders, and regulators.

- All of us must:
  - Act fairly and honestly
  - Act with integrity, transparency, and accountability
  - Adhere to high ethical standards in all of your practices
  - Comply with all applicable laws, regulations, State Medicaid and CMS requirements
  - Report suspected violations
  - Do the right thing!

Provider Responsibilities

As a health care provider, you are responsible for:

- being a vital part of the effort to prevent, detect, and report noncompliance, fraud, waste, and/or abuse identified;
- complying with all applicable statutory, regulatory, Medicaid and Medicare healthcare program requirements, including adopting and implementing an effective compliance program;
- reporting any violations of laws that you may be aware of; it is your obligation and duty to report; and
- following your organization’s Code of Conduct, a tool that articulates your and your organization’s commitment to standards of conduct and ethical rules of behavior.

Effective Compliance Programs consist of 7 Elements:

Written Standards, Policies, and Procedures

Compliance Leadership and Oversight

Training and Education

Effective Lines of Communication

Enforcement of Disciplinary Standards

Risk Assessment, Auditing, and Monitoring

Responding to Detected Offenses and Developing Corrective Action Initiatives

7 Elements of Compliance Programs

1. **Written Policies, Procedures, and Standards of Conduct**
   - These articulate the organization's commitment to comply with all applicable Federal and State standards and describe the compliance expectations according to the Standards of Conduct.
   - Entities should assess how their operations may present risk areas specific to them and design policies and procedures that address these risks.

2. **Compliance Officer, Compliance Committee, and High-Level Oversight.**
   - The organization must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated and resolved by the compliance program.
   - The organization's senior management and governing body must be engaged and exercise reasonable oversight of the organization's compliance program.

3. **Effective Training and Education**
   - This covers the elements of the compliance plan as well as preventing, detecting and reporting suspected or actual Fraud, Waste and Abuse.
   - Tailor training and education to the different employees and their responsibilities and job functions.

7 Elements of Compliance Programs

4. **Effective Lines of Communication**
   - Make effective lines of communication accessible to all.
   - Ensure Confidentiality and provide methods for anonymous and good-faith issues reporting at all organizational levels.
   - Having “effective lines of communication” means that several avenues to report compliance concerns are available.

5. **Well-Publicized Disciplinary Standards**
   - The organization must enforce standards through well-publicized disciplinary guidelines.

6. **Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks**
   - Conduct routine monitoring and auditing of the Organization’s operations to evaluate compliance with Federal and State requirements as well as the overall effectiveness of the compliance program.

7. **Procedures and System for Prompt Response to Compliance Issues**
   - The Organization must use effective measures to respond promptly to non-compliance, undertake appropriate corrective action, and report to government agencies, as required.

A Provider's Compliance Responsibilities and Awareness

As a provider you should be aware of high-risk areas to ensure your part in maintaining compliance. This includes, but is not limited to:

- **Beneficiary Notices**
- **Billing practices**
- **Conflicts of Interest**
- **Monthly Exclusion Screening**
- **Documentation Requirements**
- **Ethics**
- **Formulary Administration**
- **HIPAA**
- **Quality of Care**

Non-Compliance & Impact

What is Non-Compliance

Non-compliance is conduct that does not conform to regulations, laws, State, and Federal health care program requirements or to the Absolute Total Care's ethical and business policies.

Effects of noncompliance:

Damage to the patient:

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Hurdles to care

Damage to everyone:

- Higher insurance copayments
- Higher premiums
- Lower benefits for individuals/employers
- Lower profits

Fraud, Waste & Abuse Overview

Healthcare Fraud, Waste and Abuse

A compliance program contains measures to prevent, detect and correct FWA. We all have a role to play in detecting FWA. Be alert for suspicious activities and report anything you notice.

Compliance programs are designed to ensure that we meet all legal, regulatory and business requirements, both domestic and international. They reflect our commitment to reduce the potential for non-compliance with these requirements.

Fraud, Waste and Abuse Definitions

Fraud is the intentional deception or misrepresentation an individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes "reckless disregard" of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

For the purposes of this training, fraud is intentionally submitting false information (including situations in which you should have known the information was false) to get money or a benefit.

The complete definition has three primary components:

- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit

Waste includes practices that, directly or indirectly, result in unnecessary costs to federally funded programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

- Prescribing more prescriptions than necessary
- Conducting excessive and/or unnecessary laboratory tests
- Scheduling and billing unnecessary office visits

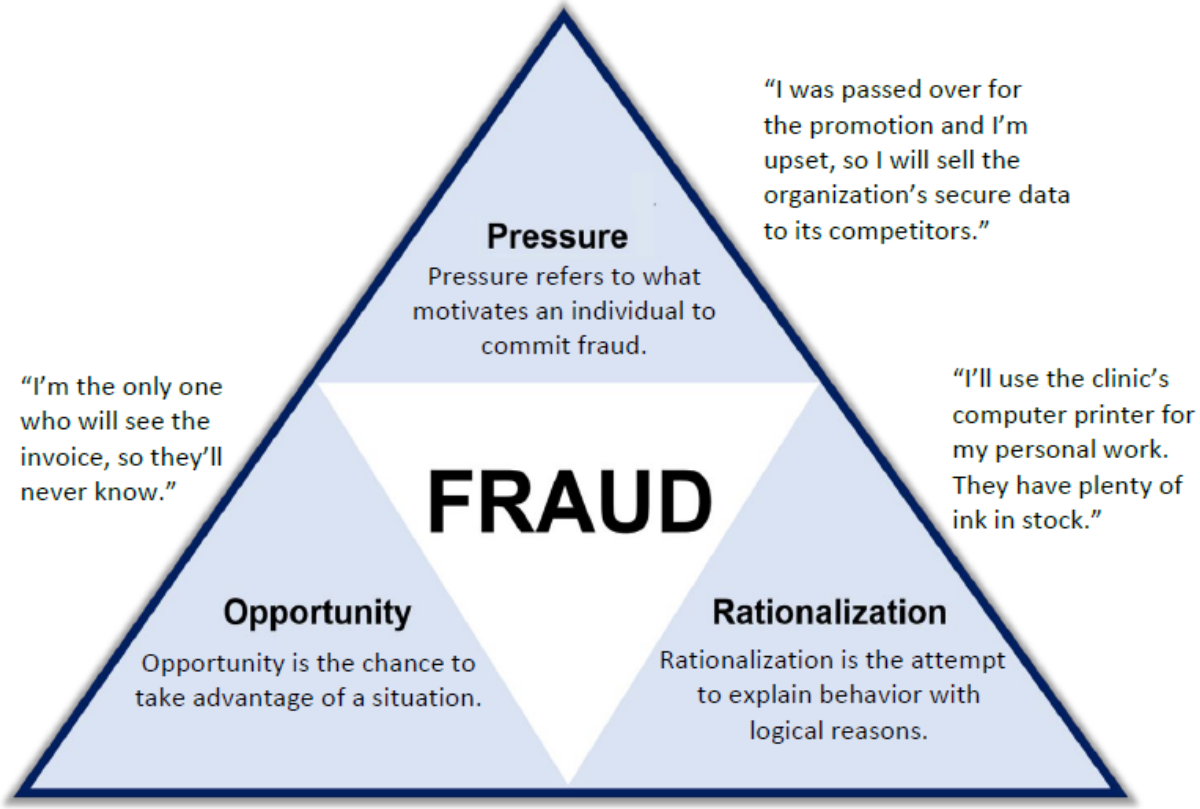
Abuse includes actions that may, directly or indirectly, result in unnecessary costs to federally funded programs. Abuse involves paying for items or services when there is no legal entitlement to that payment resulting in:

- Unnecessary costs to the healthcare system,
- Improper payment,
- Payment for services that fail to meet professionally recognized standards of care, or
- Services that are medically unnecessary.

The Fraud Triangle

- The Fraud Triangle illustrates the three elements that are present in environments where fraud occurs.

- What Can My Organization Do To Prevent Fraud?
- Your organization can establish a compliance program to proactively avoid the vulnerabilities in The Fraud Triangle. Additionally, your organization can identify issues early and, as part of your compliance program, build robust internal controls to prevent them.



Adapted from Donald Cressey's *The Fraud Triangle*

What are Some Examples of Health Care Fraud?

Below are a few examples of fraud that can happen with health care providers:

- Submitting false claims, such as claims for services that were not provided;
- Inflating costs reported on cost reports;
- Diverting prescription drugs;
- Offering or receiving kickbacks for patient referrals; and
- Providing medically unnecessary care.

Health Care Fraud Enforcement and Other Standards: Overview of Certain Federal Laws

False Claims Act

The False Claims Act (FCA) (31 U.S.C. § § 3729-3733) allows the Federal Government to recover damages and penalties from entities that knowingly submit, or knowingly cause to be submitted, false or fraudulent claims to the Federal Government, including to Medicare or Medicaid.

Basically, the FCA protects the Government from being overcharged, mischarged, or sold shoddy goods or services. The FCA defines "knowingly" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information.

The FCA prohibits filing a claim for an item or service that was not actually provided as claimed. Every time you submit a claim, you are, essentially, certifying that all the criteria for payment for that item or service on that claim have been met.

The ACA also expanded the range of health plan business subject to the FCA and compliance must now be a significant concern in “non-government” lines of business (ex. Commercial insurance). Under Section 1313 of the Affordable Care Act, payments made by, through or in connection with an Exchange are subject to the FCA if the payments include any federal funds.

False Claims Act Continued

Depending on the circumstances, some examples of potential False Claims Act violations in the health care fraud context include:

Upcoding,	Billing for unnecessary services,	Billing for services or items that were not provided’	Billing for services performed by an excluded individual.

Failure to return overpayments may lead to liability under the False Claims Act. Under section 1128J(d) of the Social Security Act, persons who have received an overpayment from a Federal health care program must report and return the overpayment within 60 days of the date the overpayment was identified. Failure to do so may make the overpayment a false claim.

Violation of the False Claims Act may lead to exclusion from Federal health care programs, along with Criminal fines, Imprisonment, and Civil legal action for penalties and damages

Federal Anti-Kickback Statute

- The Federal Anti-Kickback Statute (AKS) (42 U.S.C. § 1320a-7b(b)) is a criminal law that prohibits the knowing and willful exchange, offer to exchange, solicitation, or receipt of anything of value in an effort to influence, induce, or reward the referral of Federal health care program business, including the referral for Medicare, Medicaid, or IHS items and services, and arranging for or recommending such items and services.
- Examples of improper kickback relationships include the following:
  - A diagnostic lab offers a nurse practitioner $100 for each Medicare referral.
  - An oncologist takes family vacations paid for by a pharmaceutical company in exchange for prescribing the company's drug in lieu of alternatives.
  - A medical equipment company and a physician agree that the physician can establish a rent-free office in a space owned by the medical equipment company if the physician refers Medicaid patients to the company.
- It is important to understand that submitting a claim to Medicare, Medicaid, or another Federal health care program that was the result of a kickback scheme, in addition to violating the criminal AKS, can also lead to liability under the False Claims Act (FCA).

Stark Law

- The Prohibition on Certain Physician Referrals (42 U.S.C. § 1395nn) is frequently referred to as the “Stark Law,” after Peter Stark, the former member of congress credited for the law’s enactment.
- The Stark Law prohibits physicians from referring Medicare and Medicaid patients for “designated health services” (e.g., inpatient and outpatient hospital services, home health care services, clinical laboratory services, physical therapy, speech therapy, etc.) to entities with which the physician or an immediate family member has a financial relationship (ownership, investment, or compensation).
- Additionally, the entities are prohibited from presenting or causing to be presented claims to Medicare or Medicaid (or billing another individual, entity, or third-party payer) for those referred services.
  - For example, under the Stark Law, a general physician is prohibited from referring a patient to a physical therapy office that is owned by his wife unless an exception applies.
  - As another example, a physician who is an employee of a hospital, and refers patients to that hospital, may not be paid above fair market value by the hospital.

Civil Monetary Penalties Law

- The Civil Monetary Penalty Law (CMPL) (42 U.S.C. § 1320a-7a) protects the Government from a variety of improper conduct, including the submission of false claims related to HHS grant programs, Federal contracts, or Federal health care programs.
- The Office of Inspector General (OIG) has the authority to seek penalties and exclusion from Federal health care programs against an individual or entity based on a wide variety of prohibited conduct related to Federal health care programs, HHS grants, and HHS contracts. The amount of civil monetary penalties imposed by the Government depends on the conduct but can be up to $20,000 per claim for the submission of false claims. In addition to that amount, the Government may seek to recover up to three times the amount of damages, or loss to the program.

These violations include, but are not limited to:

- Submitting false claims;
- Violating Medicare assignment provisions or the physician agreement;
- Providing false or misleading information expected to influence a decision to discharge a patient;
- Failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency condition or in labor;
- Making false statements on applications or contracts to participate in a Federal health care program.

Exclusion Provisions

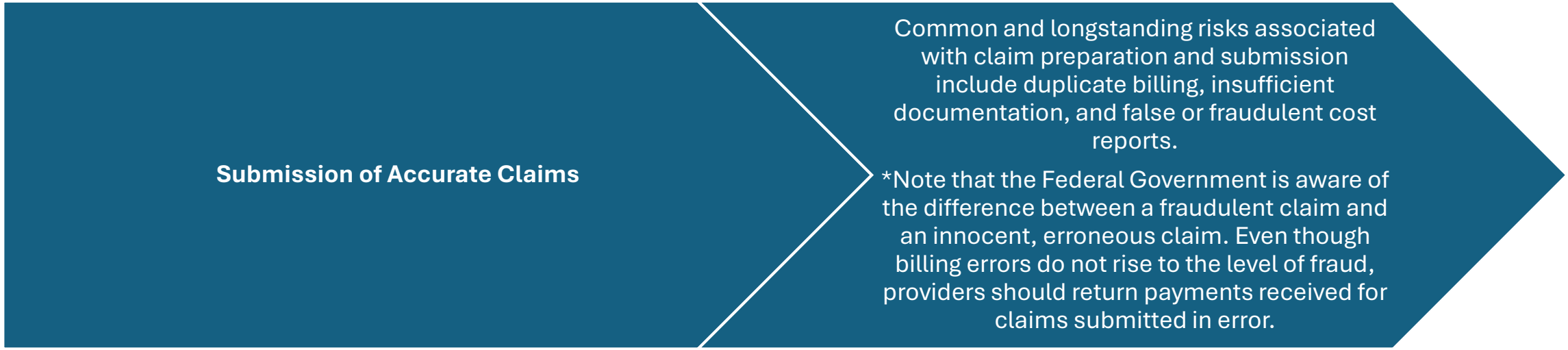
- The OIG can exclude health care providers from Federal health care programs if the provider has committed certain acts such as fraud or patient abuse.
- OIG has authority (42 U.S.C. § 1320a-7) to exclude an individual or entity from participation as a provider or supplier in Federal health care programs, including Medicare, Medicaid, and IHS, among others.
- The effect of an OIG exclusion is that no Federal health care program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person. The exclusion and the payment prohibition continue to apply to an individual even if he or she changes from one health care profession to another while excluded. This payment prohibition applies to all methods of Federal health care program payment, whether from itemized claims, cost reports, fee schedules, capitated payments, a prospective payment system, other bundled payment, or other payment system and applies even if the payment is made to a State agency or a person that is not excluded.
- There are two general types of exclusion:
- **Mandatory Exclusions**
- Mandatory exclusions are exclusions that OIG ***must*** impose. Conduct that would result in a mandatory exclusion includes criminal convictions relating to Medicare or Medicaid fraud, patient abuse or neglect, and felony convictions related to controlled substances.
- **Permissive Exclusions**
- Permissive exclusions are exclusions that OIG, in its discretion, ***may*** impose. Conduct that could result in a permissive exclusion includes misdemeanor offenses related to health care fraud, misdemeanor offenses related to controlled substances, loss of professional license in certain circumstances, and defaulting on student loans.
- **The Effects of Exclusion**
- The effect of exclusion is that no payment shall be made by Medicare, Medicaid, IHS, or any other Federal health care program for services furnished, ordered, or prescribed by a person or entity who is excluded. This prohibition on payment applies even when the excluded person would only indirectly receive payment, for example, when a hospital bills Medicare for services provided by an excluded nurse.

Criminal Health Care Fraud Statute

- The Criminal Health Care Fraud Statute is primarily found in **18 U.S. Code § 1347**, which makes it a crime to knowingly and willfully execute a scheme to defraud a healthcare benefit program.
- This statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:
  - Defraud any health care benefit program
  - 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

Conviction under the statute doesn't require proof the violator knew the law or had specific intent to violate it.

An Example of an Identified Liability



Legal Consequence Awareness

Healthcare FWA is on the rise. Anti-fraud and abuse laws protect insurers, their employees and members, as well as public health benefit programs and taxpayer dollars.

Legal Consequences

There are legal consequences for committing fraud, waste and abuse. The actual consequence depends on the violation. The following are potential penalties:

- Civil Monetary Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Healthcare programs

Preventing Fraud, Waste, and Abuse What Are My Responsibilities?

- You play an important role in preventing, detecting, and reporting potential FWA.
  - You must comply with all applicable statutory, regulatory, and other requirements, including adopting and using an effective compliance program.
  - You have a duty to report any compliance concerns and suspected or actual violations.
  - You have a duty to follow your organization's code of conduct that describes your and your organization's commitment to standards of conduct and ethical rules of behavior.

How Do I Prevent Fraud, Waste, and Abuse?

Look	Look for suspicious activity
Conduct	Conduct yourself in an ethical manner
Ensure	Ensure accurate and timely data and billing
Ensure	Ensure coordination with other payers
Know	Know FWA policies and procedures, standards of conducts, laws, regulations, and CMS guidance
Verify	Verify all information you receive.

Reporting FWA

With your help, we can increase the detection and prevention of fraud, waste, and abuse to improve the quality, safety, and value of Health and Human Services (HHS) programs. If you suspect fraud, waste, or abuse, you may report the information that suggests dishonest or illegal activities involving HHS programs.

One method of reporting fraud, waste, or abuse is to contact the OIG Hotline. OIG protects certain current and former HHS employees; HHS employment applicants; and HHS contractors, subcontractors, personal services contractors, grantees, and subgrantees who disclose information to OIG through mechanisms such as the OIG hotline.

Another method of reporting is to self-disclose if you suspect the law or program requirements have been violated. OIG's Health Care Fraud Self-Disclosure Program provides a framework for disclosing, coordinating, evaluating, and resolving potential violations of law.

*Please reach out to your Compliance Officer for specific guidance on reporting FWA in your organization

Where to Report

Absolute Total Care

- **Phone**: Absolute Total Care Fraud and Abuse Hotline 1-866-685-8664 (all calls are confidential)
- **Mail:**
  Absolute Total Care
  Compliance Department
  100 Center Point Circle
  Columbia SC 29210
- **Email**: ATC.Compliance@centene.com

South Carolina Department of Health and Human Services

- **Phone**: 1-888-364-3224
- **Mail**:
  SCDHHS Division of Program Integrity
  P.O. Box 8206
  Columbia, SC 29202
- **Email**: fraudres@scdhhs.gov

Federal

- Medicare
- Phone: 1(800)-447-8477 TTY
- Fax: 1800-223-8164
- Online: OIG.HHS.gov/fraud/report-fraud
- Mail: U.S. Department of Health and Human Services
  ATTN: OIG Hotline Operations
  P.O. Box 23489
  Washington, DC 20026

Resources

- The OIG Hotline Operations website accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs.
- The OIG Compliance Resources Portal includes educational materials such as compliance toolkits, videos, podcasts, and advisory opinions.
- The OIG General Compliance Program Guidance
- The OIG HEAT Provider Compliance Training
- The OIG Fraud Information website includes information such as OIG's Consumer Alerts; criminal, civil, or administration legal actions; a tips and complaints Hotline; and a list of fugitives wanted for health care fraud, abuse, or child support obligations. The website also details OIG's areas of focus including grant and contract fraud. Additionally, the website gives information about OIG's Whistleblower Protections, Fraud Risk Indicators, State False Claims Act reviews, and Operation Care that helps protect the health and well-being of HHS beneficiaries, including residents in long-term care facilities such as nursing homes.
- General Questions Regarding Certain Fraud and Abuse Authorities
- MEDICAID INTEGRITY PROGRAM - EDUCATIONAL RESOURCES - The resources on these pages cover important topics in Medicaid program integrity.
- CMS Laws against Health Care Fraud Fact Sheet
- CMS Combating Medicare Parts C & D Fraud, Waste, and Abuse Training
- South Carolina Department of Health and Human Services – To report fraud call (1-888-364-3224) or follow the link to report online. This website also offers lists of South Carolina Medicaid Excluded/Terminated Providers (updated: 08/14/2025) and LEIE - List of Excluded Individuals and Entities
- The South Carolina Office of Inspector General is charged with investigating and detecting fraud, waste, abuse, mismanagement, misconduct, violations of state or federal law, and wrongdoing in the Executive Branch. To report fraud, waste, abuse, mismanagement, or misconduct within or involving a state agency, call the SC Office of Inspector General at 1-855-723-7283 (I-855-SC-Fraud), or visit the SC Office of Inspector General's website to file a complaint online.

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The information provided is only intended to be a general summary. It is not legal advice nor a substitute for independent review of the applicable laws, statutes, or regulations.

We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents and consult independent legal counsel.