MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA ● DEPARTMENT OF PUBLIC WELFARE

ISSUE DATE	EFFECTIVE DATE	NUMBER
September 7, 2007	January 1, 2007	99-07-13

SUBJECT:
Updated Regarding False Claims Provisions of Deficit Reduction Act of 2005 – Employee Education About False Claims Recovery

Michael Nardone, Deputy Secretary
Office of Medical Assistance Programs

IMPORTANT REMINDER: All Medical Assistance providers, regardless of method of claims submission will be required to register an NPI number with DPW. Learn more about the registration process and requirements at http://www.dpw.state.pa.us/Business/NPIinfo/

PURPOSE:

The purposes of this bulletin are to remind Medical Assistance (MA) providers, including MA Managed Care Organizations (MCOs) of the requirements of Section 6032 of the Federal Deficit Reduction Act (DRA) of 2005, P.L. 109-171 (S 1932) (Feb. 8, 2006), which pertains to employee education about false claims recovery; to notify entities subject to Section 6032 that the deadline for submission of their initial Attestation of Compliance has been changed to September 30, 2007; and to provide a revised Attestation form for use by entities.

SCOPE:

This Bulletin applies to any entity, including MA MCOs, that annually receives or makes payment of at least $5 million from the MA Program.

BACKGROUND/DISCUSSION:

On January 2, 2007, the Office of Medical Assistance Programs (OMAP) issued MA Bulletin 99-07-01 to notify MA providers, including MA MCOs, of the requirements of Section 6032 of the Deficit Reduction Act (DRA) of 2005, P.L. 109-171 (S 1932) (Feb. 8, 2006) which pertains to employee education about false claims recovery. Section 6032 imposes a new condition of payment on any entity that receives or makes payment of at least $5 million in annual MA payments (covered entity). As specified in MA Bulletin 99-07-01, Section 6032 requires a covered entity to:

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in Section 1128B(f) [42 U.S.C.A. § 1320a-7b(f)]);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

In MA Bulletin 99-07-01, we identified procedures for covered entities to follow in order to comply with Section 6032. In addition, we transmitted an Attestation Form for covered entities to sign and submit to the Department's Bureau of Program Integrity (BPI) to certify their compliance with Section 6032 of the DRA. We also established a deadline of December 31, 2007 for covered entities to submit their initial annual Attestation Form.

At the time we issued MA Bulletin 99-07-01, CMS had provided some minimal guidance and information to State Medicaid Agencies on compliance with Section 6032. We provided a link to CMS' initial guidance in our Bulletin. On March 22, 2007, CMS issued State Medicaid Director Letter (SMDL) #07-003 to provide its "final guidance" on section 6032.[1] In a series of Frequently Asked Questions (FAQs) transmitted with the SMDL, CMS expanded and clarified its interpretation of what entities are subject to Section 6032. According to CMS:

- Individuals and organizational units (governmental agencies, organizations, units, corporations, partnerships, or other business arrangements) can be entities for purposes of Section 6032.

[1] This Bulletin only references portions of CMS' guidance on Section 6032. If you are required to submit an Attestation of Compliance on behalf of a covered entity, you should review CMS' initial and final guidance on Section 6032. You can access CMS' initial and final guidance in their entirety and the Department of Justice official description of the Federal False Claims Act on CMS' website at: http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1197237&intNumPerPage=10.

- An entity is the largest separate organizational unit within an organization that furnishes Medicaid health care items or services, and includes all sub-units of that organizational unit that furnish Medicaid health care items or services, even if the components are separately incorporated or located in separate States. Depending on the corporate structure of an organization, an organizational unit may include multiple subsidiaries, locations and FEINs or provider numbers.

- If a corporate parent provides Medicaid health care items or services, it is an entity, and all payments made to components of the corporate organization that provide Medicaid health care services or items are considered in determining whether the $5 million threshold is met and the requirements of Section 6032 apply.

- Except for health systems, each organizational unit within an organization is viewed separately for purposes of determining whether the $5 million threshold is met and the other requirements of Section 6032 apply; i.e., whether the organizational unit is a covered entity.

- In the case of a health system, the entire organization is considered the entity for purposes of Section 6032 because all units and sub-units of a health system are "all integrally involved in furnishing Medicaid items or services." Consequently all Medicaid payments to the health system are considered in determining whether the health system is a covered entity.

- A separate organizational unit within an organization that does **not** furnish Medicaid health care items or services is not subject to Section 6032 even though other organizational units within the same organization are covered entities for purposes of Section 6032.

In addition to amplifying its guidance on what it considers to be an entity, CMS also clarified which payments should be considered for purposes of Section 6032. According to CMS, if an entity receives or makes payments during a Federal fiscal year (October 1 – September 30) that meet or exceed the $5 million threshold, the entity must comply as of January 1 of the next fiscal year. CMS also specified that only the actual payment amounts received from the State Medicaid agency are counted toward the threshold amount, not the amounts that were billed to the State Medicaid agency. CMS further specified that that patient pay amounts and amounts received from a Medicaid MCO ***do not*** count toward the threshold.

CMS also augmented its earlier guidance on how covered entities must comply with Section 6032 in regard to their contractors and agents. CMS clarified that a covered entity must disseminate its written policies and procedures to only those contractors or agents that perform billing or coding functions for the entity, furnish or authorize the furnishing of Medicaid health care items or services on behalf of the entity, or are involved in monitoring of health care provided by the entity. CMS also stated that the contractors that perform functions not associated with the provision of Medicaid health care items or services

(e.g., copy or shredding services, grounds maintenance, hospital cafeteria, or gift shop services) are excluded from the definition of contractor.

In addition to issuing guidance on Section 6032, CMS transmitted a preprinted State Plan Amendment (SPA) for States to complete and submit to incorporate provisions relating to Section 6032 into their Title XIX State Plans. On March 28, 2007, Pennsylvania submitted its proposed SPA to CMS. As required by CMS' preprinted form, we included a description of the methodology we would use to monitor compliance with Section 6032 and the frequency with which we would re-assess compliance on an ongoing basis. Specifically, we advised CMS that BPI would require each entity to annually certify that it complies with Section 6032 of the DRA by completing and submitting to BPI a form attesting compliance with Section 6032 of the DRA. We also advised CMS that the initial annual Attestation Form would be due no later than December 31, 2007 and, thereafter, the annual Attestation Form would be due on December 31st of each subsequent year.

Subsequently, CMS required the Department to make revisions to the SPA in order for it to be approved. Most significantly, CMS instructed the Department to change the deadline for the submission of the initial Attestation Form to September 30, 2007.

In light of the CMS' required revisions to the SPA and in consideration of the additional information contained in CMS' final guidance on Section 6032, we are revising the procedures announced in MA Bulletin 99-07-01. We are also providing a new Attestation Form for use by covered entities.

PROCEDURES:

Any entity, including an MA MCO, that receives or makes payments of at least $5 million from the MA Program during a Federal fiscal year (October 1 to September 30) is a Covered Entity and must comply with Section 6032.

To comply with Section 6032, a Covered Entity must ensure that it has implemented all of the following requirements:

1) The Covered Entity must establish written policies that provide detailed information about the Federal laws identified in Section 6032(A) and any Pennsylvania laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws, including 62 P.S. §§ 1407 (relating to provider prohibited acts, criminal penalties and civil remedies) and 1408 (relating to other prohibited acts, criminal penalties and civil remedies), the Pennsylvania Whistleblower Law, 43 P.S. §§ 1421-1428;

2) The Covered Entity's written policies and procedures must also contain detailed information regarding the Covered Entity's own policies and procedures to detect and

prevent fraud, waste and abuse in Federal health care programs, including the Medicare and MA Programs.

3) The Covered Entity must provide a copy of its written policies and procedures to its employees (including management) and to any of its contractors or agents that performs billing or coding functions for the Covered Entity, or that furnishes or authorizes the furnishing of Medicaid health care items or services on behalf of the Covered Entity, or that is involved in monitoring of health care provided by the Covered Entity.

4) If it maintains an employee handbook, the Covered Entity must include its written policies and procedures in its employee handbook.

Each Covered Entity must complete and submit an Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act. The Attestation must be signed by an individual who possesses all necessary powers and authority to execute the Attestation and make the representation contained in the Attestation on behalf of the Covered Entity and any and all MA providers included in the Covered Entity. The Covered Entity must identify each MA Provider included in the Covered Entity by providing the information specified on Attachment A—Identification Of MA Providers.

A Covered Entity is only required to submit one Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act and one Attachment A—Identification Of MA Providers, even if the Covered Entity includes more than one MA Provider.

The initial Attestation Forms for the Compliance Period beginning January 1, 2007 must be submitted on or before September 30, 2007. Attestation Forms for subsequent Compliance Periods will be due on December 31st of each subsequent year, beginning December 31, 2008.

Attestation Forms must be submitted to the Bureau of Program Integrity at:

General Delivery Address
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Program Integrity
PO Box 2675
Harrisburg, Pennsylvania 17105-2675

Federal Express Address
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Program Integrity
Petry Bldg. # 17
3rd Floor DGS Annex Complex
1116 East Azalea Drive
Harrisburg, Pennsylvania 17110-3494

NOTE: If you have already submitted an Attestation of Compliance for the initial Compliance Period using the form attached to MA Bulletin 99-07-01, you are **not** required to

submit the Attestation Forms transmitted with this Bulletin. If you wish to replace your submitted Attestation for the initial Compliance Period, however, you may complete and submit Attestation Forms transmitted with this Bulletin to the Bureau of Program Integrity on or before September 30, 2007.

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
August 15, 2011	August 15, 2011	99-11-05

SUBJECT

Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation

BY

Izannne Leonard-Haak, Acting Deputy Secretary
Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to:

1. Remind providers who participate in the Medical Assistance (MA) Program to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in Medicare, Medicaid or any other federal health care program.
2. Remind providers of the consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals or entities.
3. Advise providers to conduct self audits to determine compliance with this requirement and report any discovered exclusion of an employee or contractor, either an individual or entity, to the Department of Public Welfare's Bureau of Program Integrity (BPI).
4. Provide information to assist providers with compliance with regulatory requirements.

SCOPE:

This bulletin applies to all providers enrolled in the MA Program's Fee-for-Service (FFS) and the managed care delivery systems.

BACKGROUND:

The Department of Health and Human Services' Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in Section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including Sections 1128, 1128A, and 1156.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Bureau of Program Integrity
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 705-6872
Visit the Office of Medical Assistance Programs Web site at
http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/index.htm

When the HHS-OIG excludes a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. Section 1903(i)(2)(A),(B) of the Act (42 U.S.C.A. § 1396b(i)(2)(A),(B))[1]; and 42 Code of Federal Regulation (CFR) Section 1001.1901(b).[2] This payment ban applies to any items or services payable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. 42 CFR § 1001.1901(b).

Similarly, Pennsylvania law provides that the Department of Public Welfare does not pay for services or items rendered, prescribed or ordered on and after the effective date of a provider's termination from the MA Program. 55 Pa. Code §§ 1101.66(e). See also 55 Pa.Code § 1101.77(c): (i) a provider is not paid for services or items rendered on and after the effective date of his termination from the program; (ii) a participating provider is not paid for

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[1] 42 U.S.C.A. § 1396b(i) provides:
Payment …shall not be made—
….
(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished--
(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under subchapter V, XVIII, or XX of this chapter or under this subchapter [XIX] pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title [42 U.S.C.A.],
(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under subchapter V, XVIII, or XX of this chapter or under this subchapter [XIX] pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title [42 U.S.C.A.] and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

[2] 42 CFR § 1001.1901(b) provides, in pertinent part, that "no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished, on or after the effective date [of an exclusion], by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion."

services, including inpatient hospital care and nursing home care, or items prescribed or ordered by a provider who has been terminated from the program; (iii) a participating provider is paid for services or items prescribed or ordered by a provider who voluntarily withdraws from the program. Furthermore, a provider whose enrollment in the program has been terminated may not, during the period of termination: (i) own, render, order or arrange for a service for a recipient; or (ii) receive direct or indirect payments from the Department in the form of salary, equity, dividends, shared fees, contracts, kickbacks or rebates from or through a participating provider or related entity. 55 Pa. Code § 1101.77(c). See also 55 Pa. Code § 1101.42(c).

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not payable:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are paid directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs paid, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation paid by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment paid by a Medicaid program;
- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are paid, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and paid, directly or indirectly, by a Medicaid program;
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and paid, directly or indirectly, by a Medicaid program.

See 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs: http://oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (including managed care organizations (MCOs), prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management (PCCM) plans) that employ or enter into contracts with excluded individuals or entities to provide items or services

to Medicaid recipients. Section 1128A(a)(6) of the Act [42 U.S.C.A. § 1320a-7a(a)(6)][3]; and 42 CFR Section 1003.102(a)(2)[4]. The Federal civil monetary penalty is up to $10,000 for each item or service. In addition, an assessment may be imposed of not more than three times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. Moreover, the person may be excluded from participation in Federal health care programs, including Pennsylvania's MA Program.

The HHS-OIG imposes exclusions under the authority of Sections 1128 and 1156 of the Social Security Act. The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities (LEIE). The LEIE database, which is accessible to the general public and can be searched by the names of any individual or entity, provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number ("SSN") or Employer Identification Number ("EIN"). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

Whereas the LEIE contains only exclusion actions taken by the HHS-OIG, the General Services Administration's ("GSA") Excluded Parties List System ("EPLS") contains debarment actions taken by various Federal agencies, including exclusion actions taken by the HHS-OIG. The EPLS may be accessed at: http://epls.arnet.gov

The Department also maintains an on-line listing called the "Medicheck List" that identifies providers, individuals, and other entities who are precluded from participation in the MA Program. The Medicheck List may be searched by provider name, license number,

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[3] Any person (including an organization, agency, or other entity…) that-- … (6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in [42 U.S.C.A. § 1320a-7b(f)], for the provision of items or services for which payment may be made under such a program … shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service…. In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim…. In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs [ ] and to direct the appropriate State agency to exclude the person from participation in any State health care program.

[4] (a) The OIG may impose a penalty and assessment against any person whom it determines in accordance with this part has knowingly presented, or caused to be presented, a claim which is for—

….

(2) An item or service for which the person knew, or should have known, that the claim was false or fraudulent, including a claim for any item or service furnished by an excluded individual employed by or otherwise under contract with that person;

business name, or by using the "Search by" pull-down menu; also available is a complete Medicheck List, sorted by provider last name. The Medicheck List may be accessed at: http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicheckprecludedproviderslist/S_001152

DISCUSSION:

Under both State and Federal law, the Department and its MA MCOs are generally prohibited from paying for any items or services furnished, ordered, or prescribed by individuals or entities excluded from the MA Program as well as other Federal health care programs. Medicaid providers and managed care entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients when those individuals or entities are excluded from participation in any Medicare, Medicaid, or other Federal health care programs are subject to termination of their enrollment in and exclusion from participation in the MA Program and all Federal health care programs, recoupment of overpayments, and imposition of civil monetary penalties.

The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds.

All employees, vendors, contractors, service providers, and referral sources whose functions are a necessary component of providing items and services to MA recipients, and who are involved in generating a claim to bill for services, or are paid by Medicaid (including salaries that are included on a cost report submitted to the Department), should be screened for exclusion before employing and/or contracting with them and, if hired, should be rescreened on an ongoing monthly basis to capture exclusions and reinstatements that have occurred since the last search. Examples of individuals or entities that providers should screen for exclusion include, but are not limited to:

- Individual or entity who provides a service for which a claim is submitted to Medicaid;
- Individual or entity who causes a claim to be generated to Medicaid;
- Individual or entity whose income derives all, or in part, directly or indirectly, from Medicaid funds;
- Independent contractors if they are billing for Medicaid services;
- Referral sources, such as providers who send a Medicaid recipient to another provider for additional services or second opinion related to medical condition.

PROCEDURE:

In order to protect the MA Program against payments for items or services furnished, ordered, or prescribed by excluded individuals or entities; to establish sound compliance practices, and to prevent potential monetary and other sanctions, providers should:

1. Develop policies and procedures for screening of all employees and contractors (both individuals and entities), at time of hire or contracting; and, thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs;

2. Use the following databases to determine exclusion status;

   a. ***Pennsylvania Medicheck List:*** a data base maintained by the Department that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program: http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicheckprecludedproviderslist/S_001152

      If an individual's resume indicates that he/she has worked in another state, providers should also check that state's individual list.

   b. ***List of Excluded Individuals/Entities (LEIE)***: data base maintained by HHS-OIG that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. An individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although the Department makes best efforts to include on the Medicheck List all federally excluded individuals/entities that practice in Pennsylvania, providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program: http://oig.hhs.gov/fraud/exclusions.asp.

   c. ***Excluded Parties List System (EPLS)***: World wide data base maintained by the General Services Administration (GSA) that provides information about parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits: https://www.epls.gov/.

3. Immediately self report any discovered exclusion of an employee or contractor, either an individual or entity, to the Bureau of Program Integrity;

   - via e-mail through the MA Provider Compliance form at the following link:

     http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercomplianchotlineresponseform/index.htm.

- by U.S. mail at the following address:

  Bureau of Program Integrity
  Commonwealth of Pennsylvania
  P.O. Box 2675
  Harrisburg, PA 17105-2675

  or

- by fax at: 1-717-772-4655 or 1-717-772-4638

4. Develop and maintain auditable documentation of screening efforts, including dates the screenings were performed and the source data checked and its date of most recent update; and

5. Periodically conduct self-audits to determine compliance with this requirement.

HEALTH CARE COMPLIANCE PROGRAM TIPS

The Seven Fundamental Elements of an Effective Compliance Program

1. Implementing written policies, procedures and standards of conduct.
2. Designating a compliance officer and compliance committee.
3. Conducting effective training and education.
4. Developing effective lines of communication.
5. Conducting internal monitoring and auditing.
6. Enforcing standards through well-publicized disciplinary guidelines.
7. Responding promptly to detected offenses and undertaking corrective action.

Five Practical Tips for Creating A Culture of Compliance

1. Make compliance plans a priority now.
2. Know your fraud and abuse risk areas.
3. Manage your financial relationships.
4. Just because your competitor is doing something doesn't mean you can or should. Call 1-800-HHS-TIPS to report suspect practices.
5. When in doubt, ask for help.

Federal Health Care Fraud and Abuse Laws

The False Claims Act
- Statute: 31 U.S.C. §§ 3729–3733

The Anti-Kickback Statute
- Statute: 42 U.S.C. § 1320a–7b(b)
- Safe Harbor Regulations: 42 C.F.R. § 1001.952

The Physician Self-Referral Law
- Statute: 42 U.S.C. § 1395nn
- Regulations: 42 C.F.R. §§ 411.350–.389

The Exclusion Authorities
- Statutes: 42 U.S.C. §§ 1320a–7, 1320c–5
- Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)

The Civil Monetary Penalties Law
- Statute: 42 U.S.C. § 1320a–7a
- Regulations: 42 C.F.R. pt. 1003

Criminal Health Care Fraud Statute
- Statute: 18 U.S.C. §§ 1347, 1349

For more information on these laws, please visit:
http://oig.hhs.gov/fraud/PhysicianEducation/01laws.asp

To review OIG enforcement actions, please visit:
http://oig.hhs.gov/fraud/enforcementactions.asp

TIPS FOR SUCCESS IN THE OIG SELF-DISCLOSURE PROTOCOL

- Follow ALL the requirements in the Federal Register AND the 2008 Open Letter in your written submission. Common mistake = missing contractor information.

- Mail it to the address in the Federal Register:
  Assistant IG for Investigative Operations, HHS/OIG
  330 Independence Ave, SW, Room 5409, Washington, D.C. 20201

- Don't disclose prematurely. Your investigation and damages audit either needs to be completed or you commit to completing within three months after acceptance.

- Provide a complete description of the conduct and investigation:
  - What happened?
  - What is the time period?
  - Why did it happen?
  - Why is there potential legal liability for the conduct?
  - Who was involved?
  - How was the conduct discovered?
  - What corrective actions have been taken?

- Identify the fraud laws at issue. Just "Federal laws, rules, and regulations" or "the Social Security Act" is not sufficient.

- Pay attention to the sampling requirements in the Protocol at Section V.

- Stark-only conduct that does not also have a colorable kickback claim is not eligible for OIG's protocol.
  - CMS has created its own disclosure protocol for Stark-only conduct – http://www.cms.gov/PhysicianSelfReferral/

- Expect that disclosure will result in a settlement agreement for an amount that is a multiplier of damages. Simple overpayments are not appropriate for the SDP.

- Full cooperation is essential.

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

A Guide to Preventing and Reporting Fraud and Abuse in Medical Assistance

Most Medical Assistance (MA) providers are compliant with state and federal requirements for participation in the MA program. Unfortunately, a small number of MA providers engage in practices that are fraudulent or abusive of the program. Dollars lost to such practices are then unavailable for providing care to people in need. The Department of Public Welfare's Bureau of Program Integrity (BPI) in the Office of Administration is responsible for identifying, correcting, and preventing fraud and abuse in the MA program. This guide provides tips for providers on preventing and reporting fraud and abuse.

Fraud or Abuse?

Fraud and abuse are not the same. *Fraud* refers to criminal acts associated with knowingly or intentionally submitting false claims for payment. Fraud is also defined by Federal law as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

Fraudulent acts include:

- Knowingly or intentionally:
  - Presenting for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA.
  - Presenting for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA.
  - Submitting false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled for furnishing services or merchandise under MA. Submitting false information to obtain authorization to provide services or items under MA.
- Soliciting, receiving, offering or paying a remuneration, including a kickback, bribe or rebate, directly or indirectly, in cash or in kind, from or to a person in connection with furnishing of services or items or referral of a recipient for services and items.
- Submitting a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.
- Submitting a claim:
  - For services or items which were not rendered by the provider or were not rendered to a recipient.
  - For services or items which includes costs or charges which are not related to the cost of the services or items.

- For services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary.
- Which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient, or of the attending, prescribing, referring, or actual provider.
- For a service or item at a fee that is greater than the provider's charge to the general public.

- Except in emergency situations:
  - Dispensing, rendering, or providing a service or item without a practitioner's written order and the consent of the recipient.
  - Submitting a claim for a service or item which was dispensed or provided without the consent of the recipient.
  - Dispensing, rendering, or providing a service or item to a patient claiming to be a recipient without first making a reasonable effort to verify by a current Medical Services Eligibility card that the patient is an eligible recipient with no other medical resources.

- Entering into an agreement, combination or conspiracy to obtain or aid another in obtaining payment from the Department for which the provider or other person is not entitled, that is, eligible.

- Making a false statement in the application for enrollment or reenrollment in the program.

- Committing prohibited acts of shared health facilities, their owners, operators and administrators and providers practicing in the shared health facility (see §1102.81(a) for a comprehensive list).

A provider who commits a prohibited at act is referred to the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section for criminal investigation. Additionally, if there is a credible allegation of fraud, payment to a provider may be suspended immediately.

Abuse refers to acts that are not criminal in nature but do not comply with MA regulations or other requirements, such as:

- Submitting claims for services that are not medically necessary.

- Submitting claims for services that are not appropriate to recipients' health needs.

- Providing services outside of customary standards of practice.

- Failure to document services of maintain records that fully disclose the nature and extent of services rendered.

Recognizing Potential Fraud

There are generally two types of provider-related fraud:

1. Fraudulent acts committed by the individual or agency enrolled as the provider, or
2. Fraudulent acts committed by a person employed by the individual or agency enrolled as the provider.

The first type of fraud has much more serious consequences for the provider than the second; provider fraud will result in recovery of funds paid to the provider relating to the fraudulent act(s), termination from the MA program, termination from Medicaid participation in other states, and preclusion from participation in any state or federal government program. Also, if a provider is also Medicare-certified (e.g. a home health agency), termination from MA Program will also result in termination from the Medicare Program.

Fraudulent acts committed by an employee *do* result in recovery of funds paid to the provider relating to the fraudulent act(s), but do not necessarily result in termination from the MA program, termination from Medicaid participation in other states, and preclusion from participation in any state or federal government program. **However**, BPI will carefully analyze employee fraud to ensure that there was no collusion or knowledge of the act(s) by the provider. Additionally, although fraud by an employee may not necessarily result in termination of the provider, it will be criminally investigated and, if proven, will involve criminal prosecution of the employee and result in preclusion of the employee from participation in any federally funded health care program including Medicaid. There are several indicators of potential fraud that providers should be aware of and closely monitor:

Indicators of Services Not Rendered (SNR)

SNR generally refers to billing when no service was rendered, but can also include billing for more units of service than were actually provided (e.g. billing for one hour of service when only 45 minutes were provided). Indicators of SNR include:

- An employee who submits time sheets consistently for the same number of units/sessions per week.
- An employee works with multiple consumers, and a comparison of the employee's hours submitted for billing with consumers' records reveals overlapping times and/or an excessive amount of hours claimed in one day.
- The type, scope, amount, duration and frequency of services ordered or identified in a treatment plan(s) does not correlate with services or hours claimed by an employee.
- The dates, types, or lengths of appointments listed on internal schedules or appointment books do not correlate with billing slips submitted by the employee.
- Consumers or their formal supports report that they are asked to sign blank billing or encounter forms.
- An employee does not maintain progress notes for one or more consumers.

- Signatures on encounter forms appear copied or differ from the clients' signatures in the record.

Indicators of Forged, Fabricated, or Altered Documentation

Effective recordkeeping and maintenance of documentation is not only a good practice when rendering services, it is also a regulatory requirement (for example, see 55 Pa. Code § 1101.51(d)-(e)). It is very important to understand that creating documentation after a service was rendered is a very serious violation, as is submission of documentation of services rendered when no services were actually provided. Indicators of forged, fabricated, or altered documentation include:

- Progress notes exist, but do not "flow" from one date to another. Examples include exact copies of notes documenting each date of service, using the wrong pronoun when describing a consumer (i.e. writing "she" when the consumer is male), or describing conditions that are inconsistent with a consumer's diagnosis or condition. A similar example is computer-generated documentation where documentation has obviously been "cut and pasted" from other records.

- Handwriting or signatures differ from other documentation in the record, or client signatures on encounter forms appears copied, or is in various handwriting attributed to the client or parent, or contains signatures that differ from the client's signature in the record.

- Documentation is in the same color of ink, same type of writing implement, and no deviation in handwriting at all.

- Dates have been altered, or the record shows signs of alterations (such as use of correction fluid or sections that have been erased and written over).

Note that indicators of SNR and forged, fabricated, or altered records are similar – if one is happening, the other probably is, too.

Other Indicators of Fraud

The following indicators do not "prove" fraud, and do not trigger an automatic "red flag." After all, these indicators are not prohibited. However, these are situations where it is easy for fraud to occur:

- Numerous complaints are received regarding services or staff.

- Employees are paid on a fee-for-service basis, or by the number of billable hours they generate.

- Employees work for more than one agency at the same time.

- Employees are offered bonuses for generating referrals or for delivering the prescribed number of hours.

- Direct supervision is not available for offsite services

Preventing Abuse

There are many proactive initiatives that providers can take to identify and prevent abuse.

General Tips

- Do not offer bonuses for service delivery.
- Require and review documentation with billing forms before claims are submitted for payment.
- Take complaints seriously! Ask pertinent questions and take appropriate follow-up actions.
- Routine monitoring of employees and caregivers providing services.
- If you suspect that there is abusive activity, hold related billing until a self-audit is completed (see below).

Compliance Programs, Self-Audits, and Voluntary Disclosure

A Compliance Program is an ongoing, good faith effort by a provider to:

- Prevent and detect violations of law or regulations.
- Identify under and over payments.
- Report findings to the applicable sources for resolution.

BPI strongly encourages providers to adopt a Compliance Program. The benefits of a Compliance Program include:

- Prevention of violations and their recurrence.
- Avoidance of penalties by identifying violations or overpayments and voluntarily disclosing them to BPI.
- Prevention and management of errors and system failures.
- Overall improvement of operations and quality service provision.

Compliance programs also include self-audits. Self-audits include auditing service delivery and billing practices, comparing recipient records with what was billed to MA, and a review of regulations and other requirements to ensure that services were rendered and billed correctly. The benefits of a self-audit process include:

- Identification of inappropriately billed services, overpayments and underpayments, and improperly implemented services.
- The provider, not BPI, conducts the review.
- BPI will not seek double damages for self-reported inappropriate payments.

BPI recommends that any self-audit process include the following, at a minimum:

- Validation of employees' credentials, including criminal background checks.
- Validation of employees' professional license status through the Department of State at http://www.licensepa.state.pa.us/
- Checking precluded and excluded status of prospective employees using the state's Medicheck list and the Department of Health and Human Services *Excluded Individuals and Entities* (LEIE) list. Lists can be found at http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicheckprecludedproviderslist/S_001152

If a self-audit finds evidence of overpayments or regulatory noncompliance, providers have an ethical and legal duty to voluntarily return inappropriate payments and/or correct deficiencies. Additionally, there are significant benefits to voluntary disclosure, which include:

- Penalty-free acceptance of inappropriate payments.
- Facilitating a resolution of matters that a provider believes potentially violate MA regulations or involve overpayments that don't suggest violations of law.
- Strengthening partnerships between BPI and providers.
- Promoting our common interest to protect the financial integrity of the MA Program.

To self-disclose a finding or request guidance about possible issues for self-audits, please contact BPI by phone at 717-772-4606. Self-audits may be submitted to:

Department of Public Welfare
Office of Administration
Bureau of Program Integrity
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

For more information about the self-audit process, please visit http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicalassistanceproviderselfauditprotocol/

Reporting Suspected Fraud or Abuse

Most providers have reporting requirements as a regulatory or programmatic requirement. This section is not meant to address such requirements, but rather to provide a source to report suspected MA fraud or abuse. To report fraud and abuse, you may contact BPI by phone, email, internet, fax, or traditional mail.

By Phone:
The MA Provider Compliance Hotline at **1-866-DPW-TIPS** (1-866-379-8477).

The Hotline was established by and is located in BPI. It is designed to provide easy access for anyone to report suspected fraudulent or noncompliant MA billing, service delivery, or substandard care practices by providers or individuals in the MA Program. The Hotline is staffed from 8:30 AM to 3:30 PM Monday through Friday; voice messaging is available outside these hours. Callers are not required to identify themselves.**Interpreter services are available for** Non-English-speaking callers, and TTY services are available for persons with hearing impairments.

By Email:
omaptips@state.pa.us

By Internet Submission:
http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm

By Fax: (717) 772-4655 - Attention: MA Provider Compliance Hotline

By Mail:
Department of Public Welfare
Office of Administration
Bureau of Program Integrity
MA Provider Compliance Hotline
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

PATIENT NEGLECT

As the elderly or disabled become more and more dependent on others for their care, it becomes increasingly important for individuals who accept the position of trust as caretakers of these vulnerable people to be held accountable for neglecting those in their care. Failure to provide the care and treatment necessary to maintain the welfare of those who depend on that care is every bit as dangerous and harmful as intentional assaultive behavior.

Criminal neglect of a care dependent person occurs when a caregiver knowingly, intentionally or recklessly fails to provide treatment, care, goods, or service that is necessary to maintain the health or safety of the care dependent person. The failure must then result in bodily injury to the care dependent person.

INDICATORS OF PATIENT NEGLECT

- Care dependent persons who are malnourished, dehydrated, or have untreated bedsores.
- Staff failing to follow doctors' orders with regard to treatment of a care dependent person.
- Failure to seek needed medical treatment for a care dependent person in a timely manner or not at all.
- Care dependent persons who appear unkempt, unclean, or disheveled.

If you suspect that Medicaid Fraud is being committed by a provider, or a care dependent person you know is suffering from patient neglect, write or call:

Office of Attorney General
Medicaid Fraud Control Unit
1600 Strawberry Square
Harrisburg, PA 17120
717-783-1481

Office of Attorney General
Medicaid Fraud Control Unit
10950 Route 30
North Huntingdon, PA 15642
724-861-3670

Office of Attorney General
Medicaid Fraud Control Unit
106 Lowther Street
Lemoyne, PA 17043
717-712-1220

Office of Attorney General
Medicaid Fraud Control Unit
1000 Madison Avenue
Norristown, PA 19403
610-631-5920

www.attorneygeneral.gov

Commonwealth of Pennsylvania
Office of Attorney General

PENNSYLVANIA ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT

In 1978, the Pennsylvania Office of Attorney General created a Medicaid Fraud Control Unit whose purpose was to investigate and prosecute fraud committed by medical providers enrolled in the Medicaid program, as well as to investigate patient abuse and neglect in Medicaid funded health care facilities pursuant to the Medicare-Medicaid Anti-Fraud and Abuse Amendment of 1977.

The unit is a part of the Office of Attorney General's Criminal Law Division and is comprised of prosecutors, agents and auditors housed in three regional offices across the Commonwealth. The Medicaid Fraud Control Unit has the authority to file felony and misdemeanor charges against those who defraud the Medicaid program or commit patient neglect.

MEDICAID FRAUD

The Medicaid Fraud Control Unit investigates PROVIDER FRAUD. A provider is any business or individual that supplies health care goods and services to Medicaid recipients. Providers can be medical doctors, dentists, hospitals, nursing homes, pharmacies, durable medical equipment sellers, ambulance companies, or anyone else who bills the Medicaid Program for health care goods and services provided to a Medicaid recipient. A provider commits fraud by giving false information regarding services rendered to Medicaid recipients. The result is an increase in the cost of the Medicaid program, which eventually will be passed along to the taxpayers.

EXAMPLES OF MEDICAID FRAUD

- Billing for medical services not actually performed.
- Billing for a more expensive service than was actually rendered.
- Billing for separate services that should be combined into one billing.
- Billing twice for the same medical service.
- Dispensing generic drugs and billing for brand-name drugs.
- Giving or accepting something of value in return for providing medical services, i.e. kickbacks.
- Providing medically unnecessary services.
- Falsifying cost reports.
- Billing for ambulance runs to doctor appointments.

In many areas of the Commonwealth, Health Maintenance Organizations (HMO's) have contracted with the Department of Public Welfare to administer the Medicaid funded medical services.

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

Although HMO's can be defrauded by providers in ways similar to the fraud committed in the traditional fee-for-service setting, HMO's present unique fraud issues. Whereas in standard health care reimbursement situations the fraud is characterized by overbilling, an HMO environment creates an incentive to deny care to patients/consumers. This means that while a fee has been paid by the HMO to the provider for covered services, the services are denied or cut back for other than sound medical reasons. This not only defrauds the insurance company, but also compromises patient health.