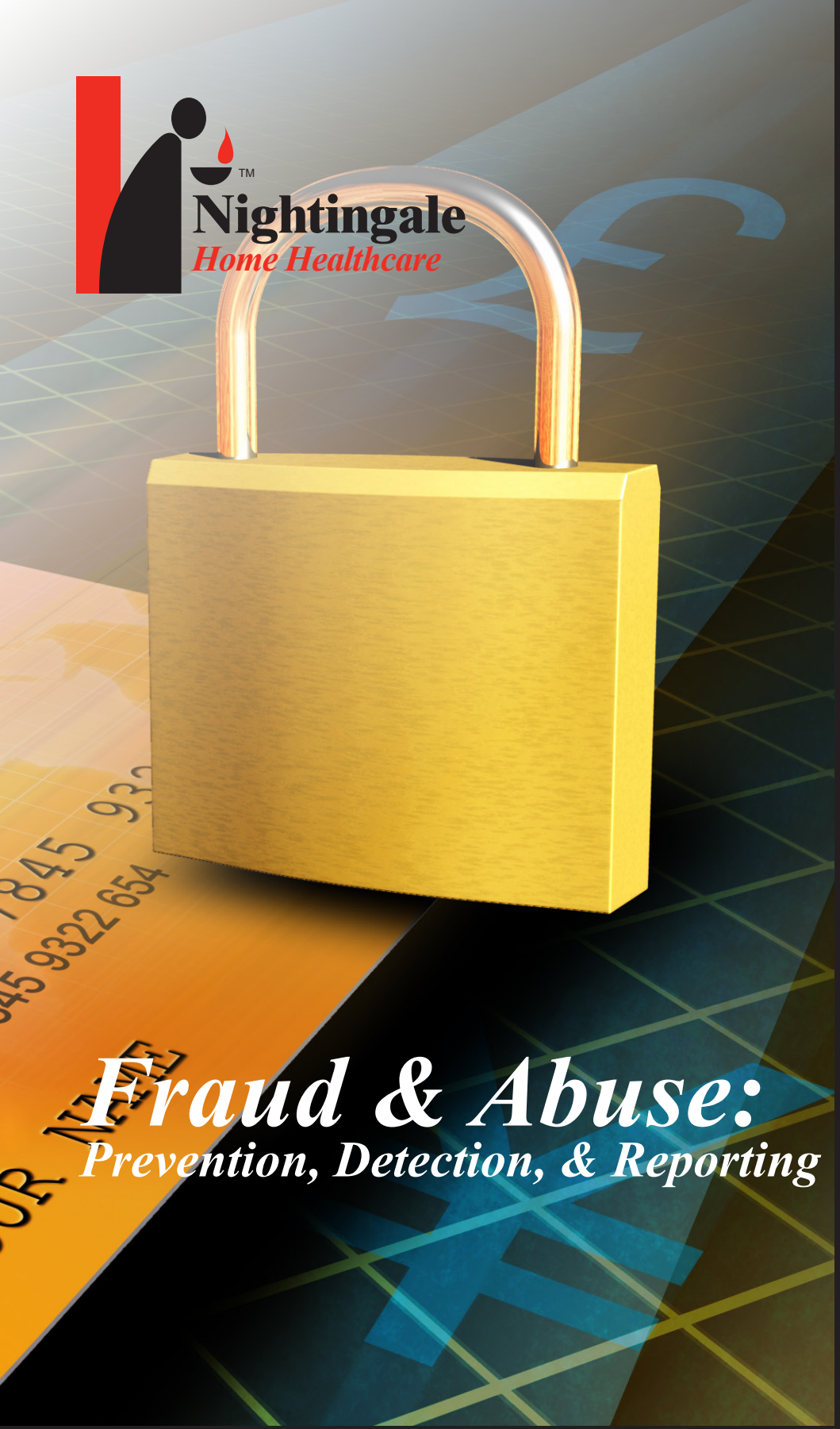
Nightingale™
Home Healthcare



Fraud & Abuse:
Prevention, Detection, & Reporting

Nightingale™
Home Healthcare

What Is Fraud?

Fraud is defined as making false statements or representations of facts to obtain benefit or payment for which none would otherwise exist. Fraud may be committed either for the person's own benefit or for the benefit of some other party. In other words, fraud applies to obtaining of something of value through misrepresentation or hiding facts.

Examples of fraud may include:

Knowingly billing for services that were not furnished and/or supplies not provided, including billing for home visits not provided; and knowingly altering claims and/or documents to receive a higher payment amount.

It is a crime to defraud the Federal Government and its programs. Punishment may involve imprisonment, high fines, or both. In some states, providers and health care organizations may lose their licenses. Convictions also may result in exclusion from program participation. Fraud may also result in civil fines.

What Is Abuse?

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to health programs. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

Examples of abuse may include:

Misusing codes on a claim, charging excessively for services or supplies, and/or billing for services that were not medically necessary.

Both fraud and abuse can expose providers to criminal and civil liability.

Fraud and Abuse Laws

The False Claims Act, Anti-Kickback Statute, Physician Self-Referral Law (Stark Law), Social

Nightingale
Home Healthcare

Security Act, and the U.S. Criminal Code are used to address fraud and abuse. Violations of these laws may result in nonpayment of claims, fines, exclusion from the federal health care programs, and criminal and civil liability, including jail time.

False Claims Act (FCA)

The FCA protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth.

An example may be an individual who submits documentation for visits he or she knows were not provided. Civil penalties for violating the FCA may include fines and up to 3 times the amount of damages sustained by the Government as a result of the false claims. Criminal penalties for submitting false claims may include fines, imprisonment, or both.

Anti-Kickback Statute

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any reward to get referrals for items or services reimbursable by a Federal health care program. If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute. Criminal penalties for violating the Anti- Kickback Statute may include fines, imprisonment, or both. For more information, visit http://oig.hhs. gov/compliance/safe-harbor-regulations.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (Stark Law) prohibits a physician from making a referral for health services to an entity in which the physician (or an immediate family member) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties for physicians who violate the Physician Self-Referral Law (Stark Law) include fines as well as exclusion from participation in all Federal health care programs. For more information, visit http://www.cms.gov/PhysicianSelfReferral.

Nightingale
Home Healthcare

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any reimbursement in connection with the delivery of health care. Proof of actual knowledge or intent to violate the law is not required. Penalties for violating the Statute may include fines, imprisonment, or both.

Exclusions

Under the Department of Health and Human Services (HHS) Office of Inspector General (OIG) is required to impose exclusions from participation in all Federal health care programs on health care providers who have been convicted of:

Medicare fraud; Patient abuse or neglect; Felony convictions for other health care related fraud, theft, or other financial misconduct; or Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Exclusion means that Federal health care programs will not pay the provider for services performed or for services ordered by the excluded party.

Civil Monetary Penalties (CMPs)

CMPs or fines may be imposed for a variety of conduct and in different amounts based on the type of violation. Penalties range from up to $10,000 to $50,000 per violation. CMPs can also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount paid or received.

Report Suspected Fraud & Abuse

Report suspected fraud or abuse concerns/complaints to your manager, compliance officer, or administrator. Online reporting is available through the Nightingale Intranet. Anonymous

reports can be sent via US Mail to 1036 South Rangeline Road, Carmel, IN 46032. Providers can report to:

OIG Hotline 1-800-HHS-TIPS
E-mail: HHSTips@oig.hhs.gov
Mail: Office of Inspector General
Department of Health and Human Services. Attn: Hotline
P.O. Box 23489. Washington, DC 20026
OR to your Medicaid State Agency (http://www.cms.gov/FraudAbuseforConsumers).

Code of Conduct Standard – False Claims

Federal and state laws prohibit submitting claims for services that were not provided. Individuals subject to the Agency Code of Conduct, who submit documentation for services they did not perform, or who are aware that documentation is fraudulent, but accept the documentation and submit documentation anyway, are submitting false claims and are violating the law. Similarly, submitting documentation for services that did occur, but for which the documentation has been modified to show longer or more services rendered or that are in some other way intentionally inaccurate is a violation of the law. Submitting false or altered documentation regarding service provided or the need for services is grounds will result in disciplinary action, up to and including termination.

Policies and Procedures

Both the federal and state False Claims Acts include "whistleblower" provisions. These provisions provide protection for employees who investigate or report an alleged false claim. They also protect employees who provide testimony or otherwise assist in a false claim prosecution. The protections afforded to whistleblowers includes prohibiting terminating, suspending, harassing or otherwise discriminating against an employee who cooperates with or participates in a false claims investigation. Employees who suffer such retaliation are entitled to reinstatement, back pay, two times back pay, and interest on back pay. Under False Claims Acts, an employee with independent knowledge of a false claim may file suit on behalf of the

Nightingale
Home Healthcare

government to enforce the state or federal act. The Agency maintains policies and procedures related to fraud and abuse. These policies and procedures address preventing, detecting, and eliminating waste, fraud, and abuse. If have questions or would like to review these policies and procedures, you may do so by contacting the Agency's Compliance Officer at (866) 334-7777.