2024

Provider Fraud, Waste and Abuse Training

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

Learning Objectives

1. Provide an overview of Fraud, Waste and Abuse (“FWA”).
2. Review FWA laws and regulations.
3. Identify provider responsibilities as they relate to FWA.
4. Identify the various types of FWA investigations.
5. Discuss outcomes for non-compliance with State, Federal and contractual obligations.
6. Review FWA case study to understand process.

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Disclaimer

The information provided in this presentation outlines the requirements for claims billing audits completed by Highmark Health Options Financial Investigations and Provider Review ("FIPR") Team.

Providers may also be required to complete other audits by Highmark Health Options or State and Federal oversight agencies as a requirement of their participation in Federal and State healthcare programs.

Please consult your provider manual and the appropriate Federal and State regulatory agency websites for further information.

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Agenda

- Overview of FWA
- Laws and Regulations
- Provider Responsibilities
- Types of Investigations
- Outcomes for Noncompliance
- Reporting FWA

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Overview of FWA

- Definitions of FWA
- Examples of FWA
- Differences Between FWA
- FIPR Mission
- FIPR Team Functional Areas
- FIPR Functions
- Red Flags

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Definitions of FWA

Fraud

- Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or 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 healthcare benefit program.
- Fraud is intentional or actions that result in deliberate overpayments.

Abuse

- Actions that may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program.
- Abuse involves paying for items or services when there is no legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Waste

- Practices that, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program, such as overusing services.
- Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

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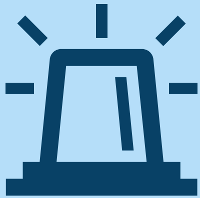
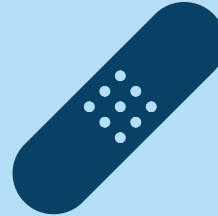
Examples of FWA



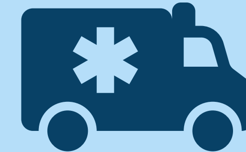
Fraud

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep.
- Billing for nonexistent prescriptions.
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.



Waste

- Conducting excessive office visits or writing excessive prescriptions.
- Prescribing more medications or supplies than necessary for treating a specific condition.
- Ordering excessive laboratory.



Abuse

- Unknowingly billing for unnecessary medical services.
- Unknowingly billing for brand name drugs when generics are dispensed.
- Unknowingly excessively charging for services or supplies.
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes.

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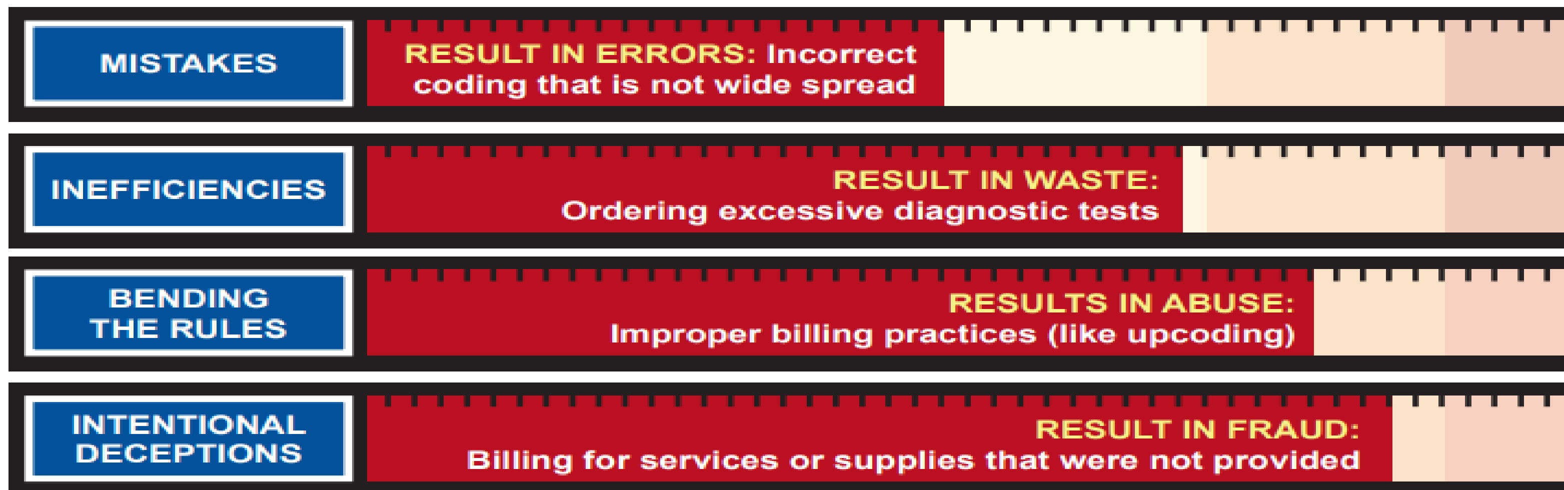
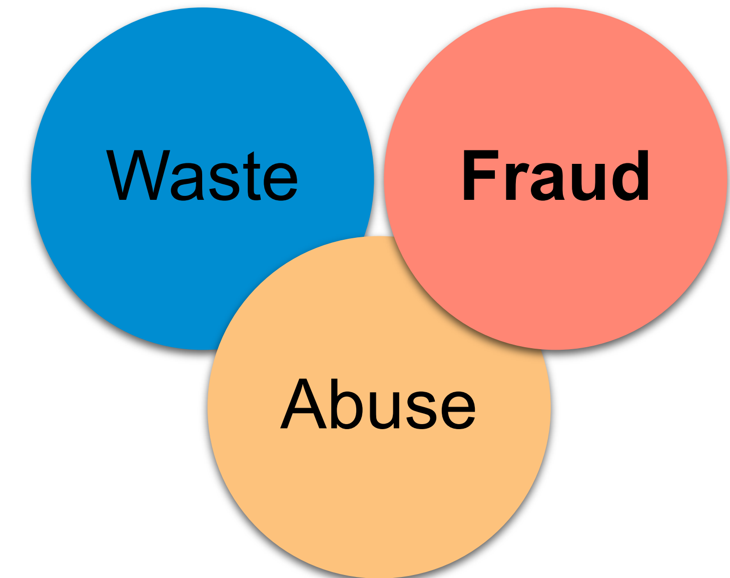
Differences Between FWA

“There are differences among fraud, waste and abuse. One of the primary differences is intent and knowledge.

- ***Fraud requires intent to obtain payment and the knowledge the actions are wrong.***
- *Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.”*





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Source: *Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training Course*, January 2019.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf

FIPR Mission and Strategy

- Highmark Health Options ("HHO") **Financial Investigation and Provider Review ("FIPR")** supports HHO by investigating fraud, waste and abuse ("FWA") and recovering overpayments for our customers.
- HHO FIPR reviews and investigates potentially fraudulent and/or inappropriate billings submitted by providers and/or participants, using industry-leading data analytics and national vendor partners.
- HHO FIPR also works with local, state and federal law enforcement agencies to identify and remove unscrupulous providers from our network.

Highmark Health Options Mission:
Medicaid that goes beyond care.

FIPR Mission:
To protect our customers and lower the cost of healthcare by deploying comprehensive solutions that combat FWA.

FIPR Strategy:
Utilize data analysis techniques to identify aberrant claims, perform claim coding reviews and conduct a variety of audits using investigative methods to assess the appropriateness of provider payments and pursue overpayment recoveries.

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FIPR Team and Functional Areas

A multi-faceted team that is responsible for detecting and investigating FWA.

Special Investigations

- The Special Investigations Unit ("SIU") is responsible to prevent, detect and investigate FWA.
- The SIU is comprised of AHFIs, CFEs and Investigators.
- The SIU is charged with:
  - Auditing and investigating providers
  - Communicating audit results and coordinating recoveries
  - Collaborating with law enforcement and government agencies

Opportunities & Coding

- The Intake, Triage, and Opportunities ("ITO") is responsible for receiving, assessing, and progressing FWA referrals.
- The ITO is comprised of Medical Coders and Investigators.
- The ITO is charged with:
  - Triaging FWA calls and emails
  - Data-mining potential FWA leads
  - Reviewing medical records

FWA Solutions

- The FWA Solutions Unit is responsible for auditing and monitoring of improper payments.
- FWA Solutions is comprised of delegated payment integrity vendors, Financial Investigators and Collections Specialists.
- FWA Solutions is charged with:
  - Managing vendors
  - Conducting pre-payment reviews
  - Conducting post-payment reviews
  - Collecting provider balances

Compliance & Reporting

- The FIPR Team is responsible for ensuring compliance standards and accurate financial reporting.
- The FIPR Team is comprised of a medical ethicist, CHCs, AHFIs, CFEs, Medical Coders, Financial Investigators, Consultants and Investigators.
- The FIPR Team is charged with:
  - Reporting financial data
  - Implementing an effective FWA program

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FIPR Functions

What we DO and why

- ✓ Prevent, detect and investigate alleged FWA referrals
- ✓ Identify and recoup inappropriate payments
- ✓ Responsibility to educate providers on what is required.
- ✓ Work with Federal, State and Local law enforcement agencies
- ✓ Believe in maintaining the integrity of services provided to Highmark Health Options members
- ✓ To ensure services are sustainable in the future

What we DON'T do

- X Criminal investigations (Local, State, Federal law enforcement)
- X Complaints or grievances
- X Approve documentation templates
- X Investigate provider related HIPAA concerns
- X Licensing
- X Investigate quality of care concerns
- X Review medical necessity

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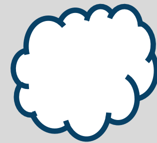
Red Flags

Red flags are patterns, practices, or aberrant activities that indicate the possibility of fraud. Through identifying and reporting these activities, **YOU** can help combat FWA.



Examples of Red Flags:

- Billing for services that haven't been rendered
- Unusual/inconsistent billing practices
- Unusually high volume or percentage of the same services
- High-dollar member reimbursement claims
- Altering receipts or claims
- Pressure to pay claims quickly
- Submitting multiple billings for the same service

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Laws and Regulations

- False Claims Act
- Anti-Kickback Statute
- Stark Law
- Balanced Budget Act
- Deficit Reduction Act
- Patient Protections and Affordable Care Act
- Civil Monetary Penalties Law
- Other Regulations

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Laws and Regulations: False Claims Act

Federal law that imposes liability on persons and companies who defraud government programs.

Under the FCA, it is illegal to submit false or fraudulent claims for payment to Medicare or Medicaid. A person is liable to pay damages to the government if he or she knowingly:

- Presents a false claim for payment or approval
- Uses a false record or statement to support a false claim
- Conspires to commit any violation of the FCA
- Uses a false record to avoid or decrease an obligation to pay the government
- Carries out other acts to obtain property from the government by misrepresentation

The FCA penalties and sanctions can include:

- Fines between $5,000 - $10,000 per claim
- Additional monetary penalties up to 3x the amount of damages
- Federal and state exclusions

The FCA includes a *qui tam* provision that allows individuals who are not affiliated with the government to file actions on behalf of the government in exchange for a percentage of any recovery.

EXAMPLE

On March 11, 2024, Dr. Nishi Patel was ordered to pay $95k to resolve allegations that he ordered medically unnecessary genetic testing for Medicare beneficiaries. Dr. Patel had no medical relationship with these patients, never examined them and the referrals were based on brief telehealth consultants and in some cases, no consultation at all. https://www.justice.gov/usao-edpa/pr/physician-pays-95000-resolve-allegations-genetic-testing-fraud

For more information, refer to 31 United States Code (USC) Sections 3729–3733

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Laws and Regulations: Anti-Kickback Statute

Federal law that prohibits financial payments or incentives for referring patients or generating federal healthcare business.

Under the Anti-Kickback Statute, it is illegal to knowingly and willfully solicit, receive, offer or pay any kickback, bride, or rebate for referrals for services that are paid under a federal healthcare program like Medicaid or Medicare.

- The statute covers both those that offer kickbacks and those that receive kickbacks.
- The illegal kickbacks covered include anything of value and is not limited to just cash.

Violation of the Anti-Kickback Statute is a felony and upon conviction, individuals can be fined up to $100,000 or imprisoned up to 10 years, or both.

EXAMPLE

On March 29, 2023, Covenant Healthcare System paid $69M to resolve allegations that Covenant provided multiple physicians medical directorship roles, employment, rent payments, and lease agreements in exchange for referrals. The *qui tam* suit was brought up by Dr. Stacy Goldsholl.
March 29, 2023 - Constantine Cannon

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See 42 United States Code § 1320a-7b for further information

Laws and Regulations: Stark Law

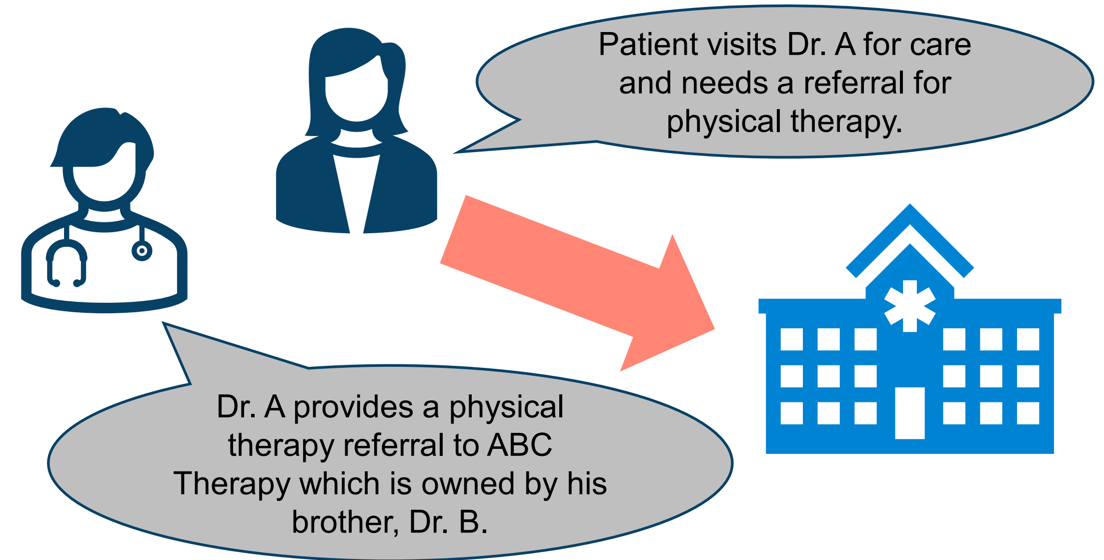
Law that prohibits physicians from referring patients to receive designated health services payable by Medicare or Medicaid from entities with which the physician (or a member of his or her family) has a financial relationship.

Under the Stark Law, financial relationships can include both ownership/investment interests and compensation arrangements. However, exceptions may apply.

- Claims that do not comply with the Stark Law are **not payable.**

Violations of Stark Law can include the following penalties:

- Refund of monies received by physicians and facilities for amounts collected
- Up to $15,000 penalty payment for each service provided
- Exclusion from the Medicare and Medicaid programs
- Up to $100,000 penalty payment for each attempted scheme



EXAMPLE

On December 21, 2023, Community Health Network paid $345M to settle charges of violations of the Stark Law by billing Medicare for certain services referred by physicians with whom the hospital system had financial relationships. The *qui tam* suit was brought up by Community Health's former Chief Financial and Chief Operating Officer, Thomas Fischer. Community Health Network Pays $345 Million to Settle Stark Law Case - Constantine Cannon

See 42 United States Code § 1395nn for further information

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Laws and Regulations

Deficit Reduction Act ("DRA")

The DRA established the Medicaid Integrity Program, the first comprehensive Federal strategy to reduce FWA in the Medicaid Program.

The DRA established anti-fraud provisions, such as:

- Strengthening the ability of State Medicaid agencies to pursue third party liability;
- Establishing a national expansion of the Medicare-Medicaid data match program; and
- Including incentives for states to enact their own False Claims Act statutes.

See Public Law 109-171 *for further information*

Balanced Budget Act ("BBA")

The BBA expanded the OIG's sanction authorities and established a toll-free FWA hotline for individuals who suspect that FWA has occurred in Federal Healthcare Programs.

The BBA required health plans to implement the following measures:

- Document policies and procedures
- Articulate a commitment to comply with State and Federal regulations
- Designate a Compliance Officer and Compliance Committee
- Develop a solid detection and reporting processes
- Provide education to employees, providers, and members

See Public Law 105-33 *for further information*

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Laws and Regulations: Affordable Care Act

Referred to as the Patient Access and Affordable Care Act (“ACA”), this Act’s primary goal was to establish affordable health insurance available to more people and expand the Medicaid Program.

The ACA enacted provisions targeted toward the prevention of FWA, including the following notable components:

- Establishment of screening requirements for providers and suppliers;
- Expansion of the role of Recovery Audit Contractors to Medicaid and Medicare Parts C and D;
- Requirement of providers to develop a Compliance Plan; and
- Revisions to the False Claims Act and Stark Law

ACA Penalties:

- Harsher civil and monetary penalties
- Increasing Federal sentencing guidelines for healthcare fraud offenses
- New fines and penalties for providers who fail to return overpayments from Medicare and Medicaid within 60 days

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See Public Law 111-148 for further information.

Laws and Regulations: Civil Monetary Penalties

Law that allows Office of Inspector General (“OIG”) ability to seek civil monetary penalties for a wide variety of abusive conduct

Reasons the OIG may impose civil penalties includes, but is not limited to:

- Submitting claims for items or services not provided as claimed or services not furnished or supervised by a licensed physician
- Making false claims
- Arranging for services or items from an excluded individual or entity
- Presenting claim patterns for medically unnecessary services or items
- Providing services or items while excluded
- Failing to grant OIG timely access to records
- Paying to influence referrals
- Knowing of and failing to report and return an overpayment

Penalties can range from $5,000 to $100,000 depending on the specific violation

EXAMPLE

On January 31, 2024, Advocates, Inc. agreed to pay $22,517.54 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Advocates, Inc. employed an individual that it knew or should have known was excluded from participation in Federal Healthcare Programs. Advocates Agreed to Pay $22,000 for Allegedly Violating the Civil Monetary Penalties Law by Employing an Excluded Individual | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services (hhs.gov)

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For more information, refer to 42 USC 1320a-7a and the Act, Section 1128A(a).

Other Laws and Regulations

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act ("HIPAA") is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.
See Public Law 104-191 for further information.

Fraud Enforcement and Recovery Act of 2009

The Fraud Enforcement and Recovery Act of 2009 ("FERA") restates part of the False Claims Act to reflect the original intent of the law, including, but not limited to, broadening the range of conduct that can be subject to false claims prosecution, as well as updates to FCA filing procedures.
See Public Law 111-21 for further information.

21st Century Cures Act

The 21st Century Cures Act enacted changes to strengthen fraud and abuse measures in the Medicaid program; including requiring states to screen and enroll providers with the State Medicaid Agency and establishing a timeline for states to adopt electronic verification systems.
See Public Law 114-255 for further information.

Criminal Health Care Fraud: Penalties

Persons who knowingly make a false claim may be subject to criminal fines up to $250,000 and imprisonment for up to 20 years.
If the violations resulted in death, the individual may be imprisoned for any term of years up to life.
For more information, refer to 18 United States Code §1347.

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Beware of Scams

As Providers, it is your due diligence to report anything suspicious. This means being on the look out for scams and **REPORT** anything that could be potential FWA.

This can include, but is not limited to:

- Member eligibility issues
- Relationships with healthcare agents and brokers
- Providing personal or financial information to someone claiming to work for Medicaid or Medicare and becoming threatening when information is not promptly provided
- Scam websites
- Use of artificial intelligence

If you suspect FWA, call us at 1-844-718-6400 so we may investigate your concerns.

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Provider Responsibilities

- Compliance Plan
- Provider Screenings
- Provider Self-Audit
- Medical Necessity
- Standards of Practice
- Corrective Action Plans
- Medical Record Requests

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Provider Compliance Plan

Providers are required to establish a compliance program that prevents and detects FWA as a condition of enrollment in the Medicare and Medicaid programs.

- All providers are required to have a compliance plan, no matter the size of your practice.

OIG Recommendations for Effective Compliance Program

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards
3. Designate a Compliance Officer
4. Conduct appropriate training and education
5. Respond to detected offenses and develop corrective actions
6. Develop open lines of communication with employees
7. Enforce disciplinary standards through well-publicized guidelines
8. Compliance programs **MUST** be effective

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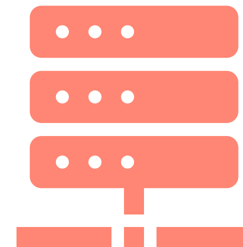
Provider Screenings: WV Medicaid Requirements

WV Department of Health and Human Resources, Bureau of Medical Service (“BMS”) is required under the Affordable Care Act (“ACA”) and related regulations at 42 CFR 455 to follow specific provider enrollment and screening practices for WV Medicaid. BMS follows the policies outlined in Chapter 300, Provider Participation Requirements. Providers may enroll as inpatient or outpatient facilities, agencies, pharmacies, suppliers, individual practitioners or groups. All group practices must comply with WV law applicable to group and corporate practice.

- **Providers are responsible to screen all individuals, employees, contractors, owners, board of directors, etc. to assure that no entity or individual meets the federal or state criteria for exclusion.**

Below are links to the exclusion databases:

- **Federal Department of Health and Human Services, Office of Inspector General – List of Excluded Individuals and Entities:**
    - https://exclusions.oig.hhs.gov/
- **Federal General Services Administration, System for Award Management:**
    - https://sam.gov/content/home
- **West Virginia Medicaid Management Information System:**
    - https://www.wvmmis.com/default.aspx



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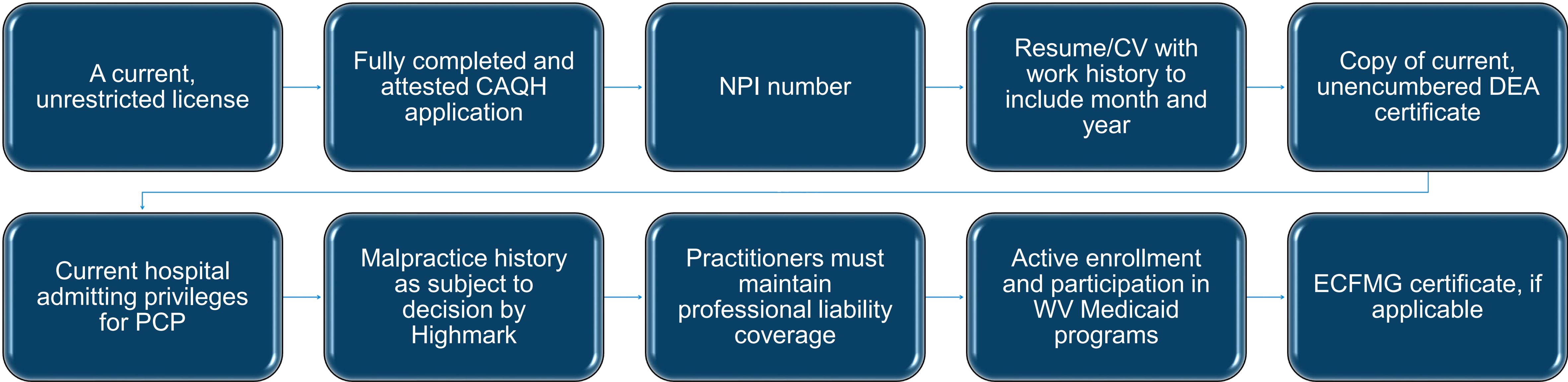
Provider Screenings

Per provider contracts, Highmark Health Options requires providers to conduct employee sanction checks, complete all credentialing requirements, review exclusions and conduct criminal background checks of all practitioners and clinicians.

- Additionally, Highmark Health Options requires the following verifications:



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Provider Self-Audits

- Providers can submit overpayments to Highmark Health Options ("HHO") by using the Provider Self-Audit Overpayment form found on our website.
- HHO relies on the Office of Inspector General ("OIG) self-disclosure requirements including sample sizes, reporting requirements and timeframes.
- Federal and state laws and regulations require overpayments to be returned within 60 days of identification.

Resources for Provider Self-Audits:
OIG Guidance

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Provider Self Audits and Overpayments Form

Instructions for Providers: Highmark Health Options (HHO) cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit this form for any self-identified overpayments to the HHO Payment Integrity Department.* Required fields are outlined in Red*

I. Self-Audit / Overpayment Information

A. Reason for Refund: Select Option

If your reason is not listed in the dropdown OR relates to a Credit Balance OR if you are unable to identify the Member, do NOT use this form.

II. *Type of Refund:* (please check one)

Retraction Requested (Claims more than 3 years old)

Check Provided (Claims more than 3 years old)

RETRACTION

II. Provider Information

Date: Practice Name: Provider Number:
Practitioner Name: Phone Number:
Tax Identification Number: NPI Number:
Contact Person at Provider's Office:
Contact Phone Number: Contact E-mail Address:

III. Member/Claim Information: (Please use a separate sheet for additional Member/Claim Information)

Member Name	Member ID	Date of Service	Claim Number	Refund Amount

Other Information:
Period of Claims (based on dates of service):

Detailed Description of Overpayment:

IV. Other Required Information (as necessary for Provider Self Audits)

Extrapolation Used? Yes

Extrapolation Method & Calculation:

*If a listing of claims is not provided, Highmark Health Options cannot guarantee that the claims will not be included in separate audits, for the same reason.

Email this form to: ProviderSelfAudits@highmark.com

Mail checks and copy of this form to:

Highmark Health Options
HHOFRAUD
120 Fifth Avenue
Pittsburgh, PA 15222

Note: It is the responsibility of the Provider to ensure the Member's Protected Health Information (PHI) is sent to Highmark Health Options in a secure manner. If secure email or fax is not an option, mail the completed form to the address provided. Highmark Health Options is not responsible for any compromised PHI that is sent in an unsecure manner.

If you have problems completing this form, call the Fraud, Waste, and Abuse department at 1-844-325-6256.

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WV Medicaid: Medically Necessary

BMS Mission Statement

- *The Bureau for Medical Services is committed to administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that* ***assures access to appropriate, medically necessary and quality health care services for all members****; provide these services in a user friendly manner to providers and members alike; and focus on the future by providing preventive care programs.*

Member Liability

- *Medicaid patients MUST PAY for:*
    - After Medicaid benefit is exhausted
    - **Not medically necessary**
    - Not approved by the Managed Care provider (except for medical emergency)
    - Convenience items not related to the medical care
    - Services provided when a patient is not eligible
    - Services from a provider who tells a patient that he/she will not bill Medicaid before the services is provided
    - Services provided when the patient refuses to use other private insurance
    - Services provided when the patient does not follow the plan provisions of their primary insurance
- *Medicaid members must not be billed, or otherwise held responsible for claims denied for provider error.*

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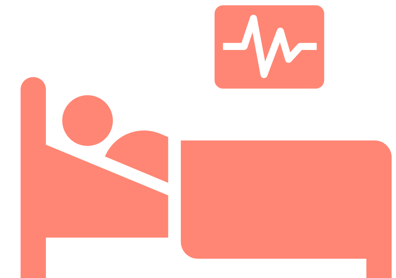
Medical Necessity: CMS Guidance

- The CMS definition of medically necessary specifically states that a service must be medically necessary to be covered, which means that it must be reasonable and necessary for the purpose of diagnosing or treating illness or injury to improve the functioning of a malformed body member.

- Medically necessary refers to services or supplies that:
  - Are proper and needed for the diagnosis or treatment of the member's medical condition;
  - Are used for the diagnosis, direct care, and treatment of the member's medical condition;
  - Meet the standards of good medical practice in the local community; and
  - Are not mainly for the convenience of the member or the doctor.

- These requirements are also included in the Highmark Health Options Provider Manual.



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Standards of Care: Record Requirements

Payment will not be made when the review of a practitioner's medical records reveals instances where these standards have not been met.

Record Requirements

- Providers must maintain records in accordance with Federal regulations for a period of five years, or three years after audits, with any and all exceptions having been declared resolved by BMS or the U.S. DHHS. Minimum documentations standards include:
    - Conformance to federal and West Virginia Medicaid rules and regulations.
    - Medical necessity and appropriateness.
    - Payment to an enrolled and qualified provider on behalf of an enrolled member.
    - Units and services billed match units and services documented in the providers' records.

Additional Record Requirements

- W. Va. Code R. § 69-9-15 - MEDICAL RECORDS AND RETENTION outlines the following minimum standards for patient records:
    - A medical record must be maintained for every individual evaluated or treated in the facility.
    - Medical records must be accurately written, promptly completed, properly filed and retained.
    - All patient medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with policies and procedures of the center.
    - The clinical or medical record must contain minimum clinical information as outlined in 15.8.
    - Medical records shall be maintained, handled and stored in a confidential manner to comply with all state and federal laws.
    - Access to the medical record is limited to the patient, parents, legal representative, attorney, employees, or others as permitted by state and federal law.

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Corrective Action Plans (“CAPs”)

HHO FIPR may recommend corrective action plans for providers.

- An investigation of a provider for aberrant behavior that results in overpayments may require a CAP. There may be other circumstances in which a CAP is needed, such as actions that may cause potential harm to patients, quality of care issues and inappropriate behaviors.
- The Investigator will consult with Highmark FIPR Management to determine if a CAP is needed. Other internal departments may be requested to provide feedback on corrective actions for a provider or member if additional opinions are needed to bring resolution to a case.

CAP Elements	
	1. Date
	2. Findings
	3. Timeframe of CAP
	4. Type of Actions
	5. Duration of CAP

If at any time the provider fails to fulfill the requirements of their CAP, the Investigator will discuss next steps with Highmark FIPR Management.

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Medical Record Requests

Highmark Health Options FIPR Team will conduct retrospective reviews of claims and medical records to ensure claims accuracy and documentation standards.

Provider must provide requested records at no cost to HHO. - This includes notifying any third-party vendor who may maintain medical records of this stipulation.

All requested documentation must be submitted at the time of the medical record request within 30 days from the letter date.

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Types of Investigations

- Overview
- Routine Investigations
- Routine Audits
- Other SIU Activities
- FWA Solutions

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Types of FWA Activities

- Highmark Health Options FIPR Team works to ensure that claims are paid correctly by both monitoring and auditing methods and in accordance with recipient benefits and provider contracts.

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Routine Investigations

Investigation of a reported allegation related to organizational activities for potential fraud, waste and abuse.

- Conduct Data Analysis
- Review Contract/ Provider Credentialing
- Review Internal Policy for Coding
- Review State/Federal Guidelines
- Member and Provider Interviews

- Coordinate with Other Departments
- Overpayment Notification
- Recoupment of Overpaid Dollars
- Submit State and CMS Referrals
- Local, State, and Federal Collaboration

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Routine Audits

- Highmark Health Options Special Investigations Unit ("SIU") performs provider profile and outlier analyses and conducts routine audits based on the progressive audit protocol.
- The **progressive audit protocol** is a comprehensive audit that includes discovery reviews, full sample reviews and provider CAPs.
- The SIU plans to make referrals of credible allegations of fraud in accordance with contractual and regulatory requirements.

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Other SIU Activities

Recurring Overpayment Projects

- SIU conducts data analysis to monitor claims billing on a reoccurring basis (monthly, quarterly, or yearly) in order to identify aberrant claim payments made. Overpayments can occur from the inability to systematically correct an issue, claim adjudication error and provider submission errors.
- Examples include:
  - Surgical Unbundling
  - Member and Provider eligibility

Requests for Information ("RFIs")

- Requests for Information are incoming requests sent by regulatory or law enforcement agencies to Managed Care Organizations ("MCOs") like Highmark Health Options. These requests require MCOs to pull specific information including, but not limited to, claims data, contracts etc.
- Sources include:
  - DHS and BPI
  - CMS
  - I-MEDIC
  - OIG HHS
  - AG/MFCU
  - FBI

Provider Education and Training

- Highmark Health Options FIPR Team assures that its beneficiary and provider populations are also educated on healthcare FWA issues. Methods of educating include:
  - Fraud and Abuse webpage
  - Provider and member newsletters
  - Audit finding notifications, including CAPs
  - Explanation of benefits statements
  - Provider and member forums
  - Provider and member manuals

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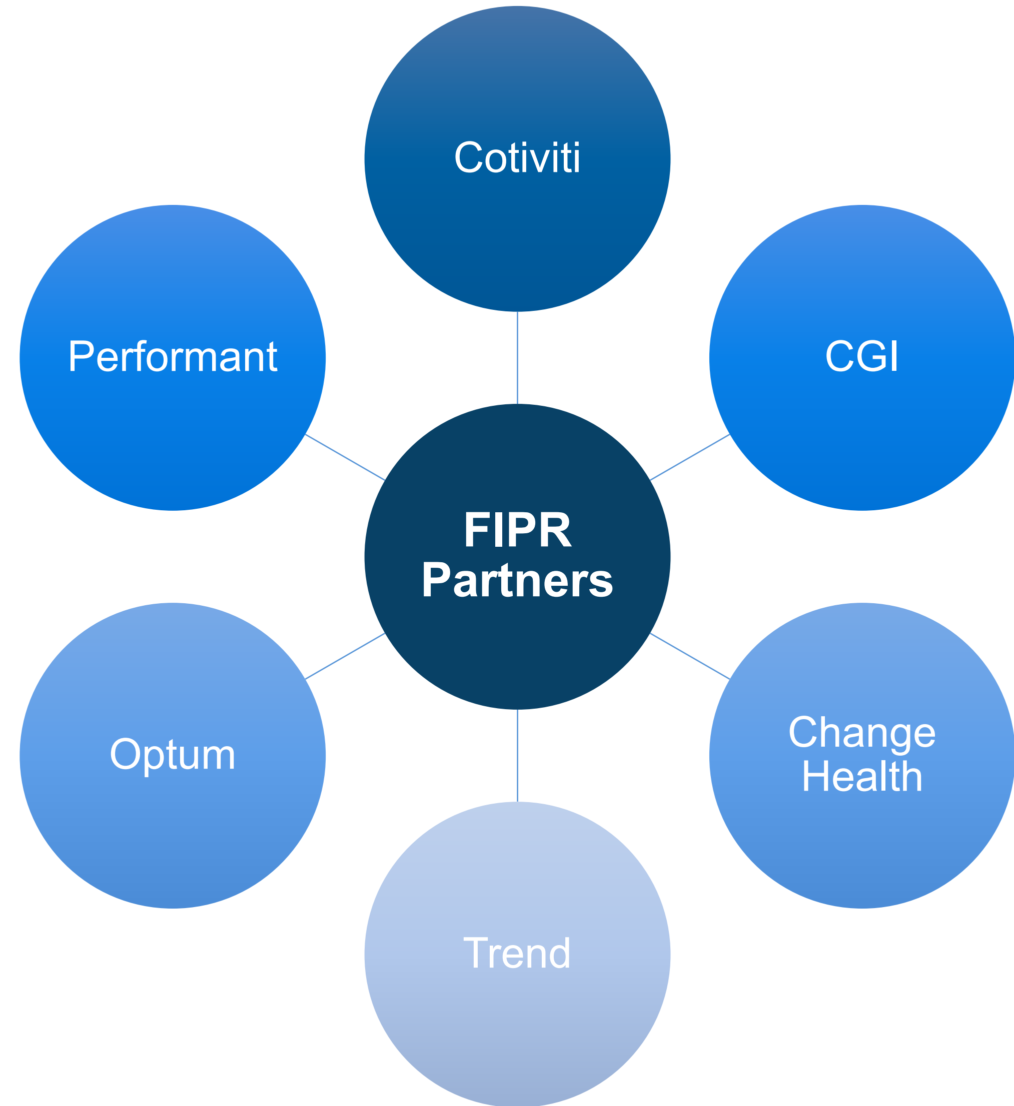
FWA Solutions: Vendor Partnerships

- Pre-payment Edits and Reviews
  - FIPR contracts with Vendors to monitor claims prior to payment to ensure claims accuracy. FIPR has the capability to suspend claims to conduct pre-payment reviews prior to releasing payment to flagged Providers.
- Post-payment Audits
  - FIPR contracts with Vendors to audit claims through retrospective reviews.
- Other contracted vendors of Highmark Health Options specialize in the following oversight activities that may include:
  - Ensuring payment accuracy
  - Inpatient/Outpatient Chart Reviews
  - Clinical Validation
  - Complex system edit set-ups
  - Data mining trending healthcare patterns
  - Contract Compliance



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Outcomes of Noncompliance

- Overpayments
- Disciplinary Actions
- Provider Sanctions and Penalties

Recovery of Overpayments

- If any FWA efforts identify overpayments, the following activities will occur:

Identify overpaid claims

Refunds must be processed within 60 days

Refunds by claims adjustments or provider checks

Credible allegations of fraud referrals, BMS/MFCU

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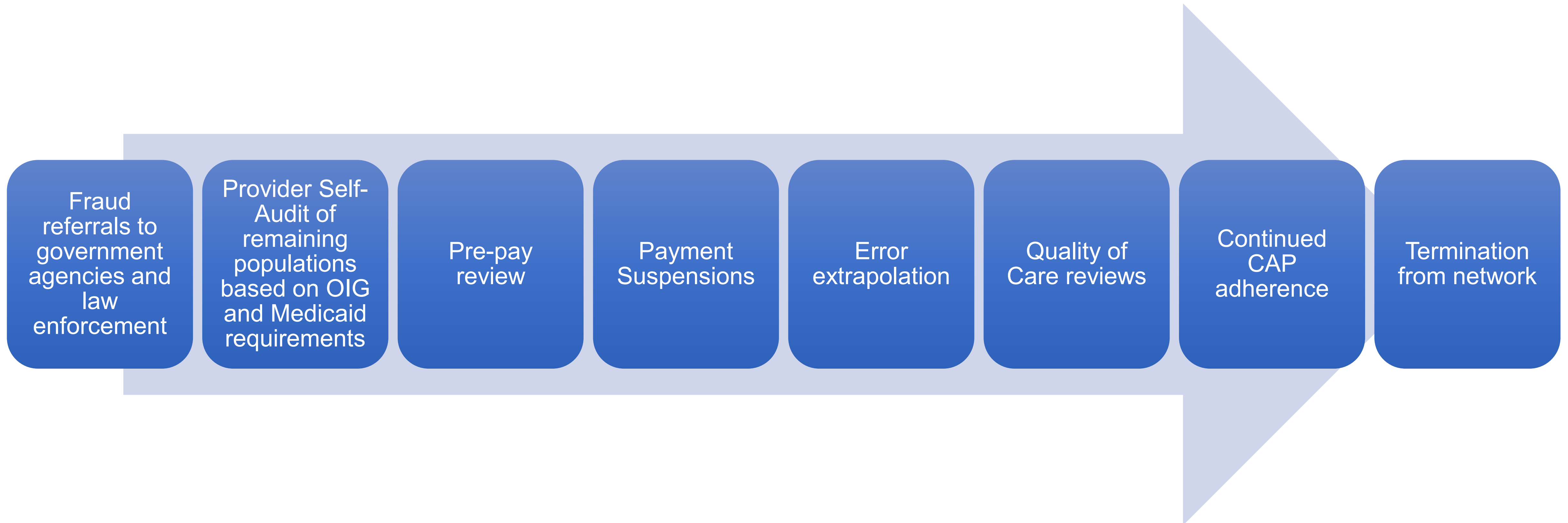
FWA Review Outcomes

Disciplinary Actions



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Consequences of Committing FWA

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

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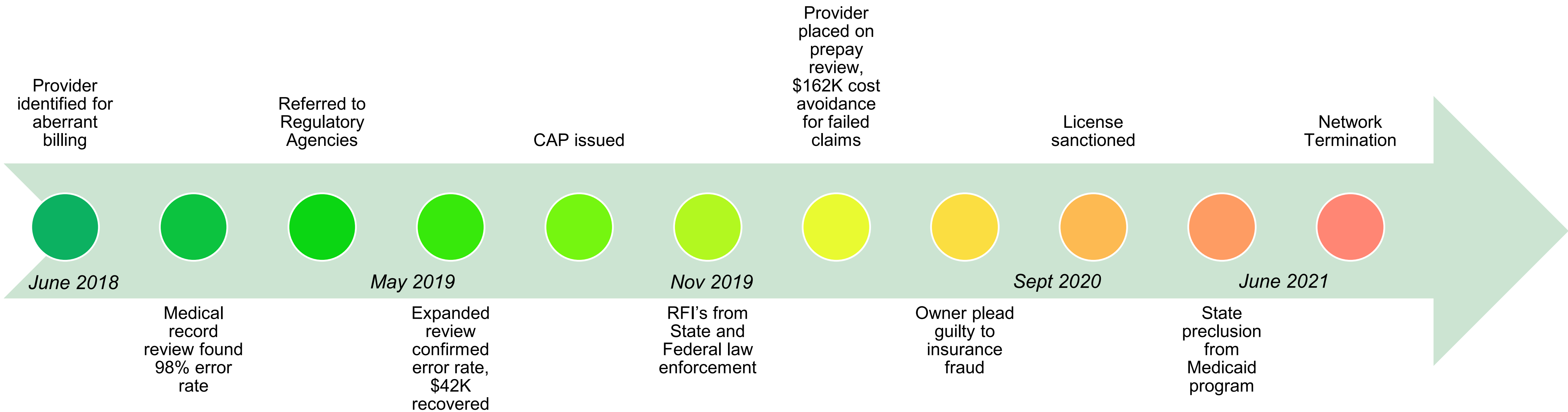
Case Study: Physical Therapy Provider



Legal outcomes:

- 6 months – 2 years jailtime
- $340K+ in fines and restitution

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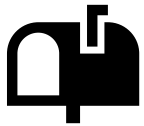
Reporting FWA

Reporting FWA

If you suspect, FWA there are several options to report anonymous:



Send letter to:
Highmark Health Options
Delivery Code: FIPR
120 Fifth Avenue
Pittsburgh, PA 15222

Submit email to:
SIU_HHO@highmark.com

Call FWA hotline at:
844-718-6400

In your report, please provide a detailed description of the activity, including specifics, such as, subject name, provider or member number, claim number(s), date(s) of activity and any information that will be helpful for the investigation.

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Thank you!