PerformCARE®
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Provider Notice

To:	**All Providers**
From:	**Dan Eisenhauer, Director of Operations**
Date:	**June 16, 2021**
Subject:	**AD 21 105 Fraud Waste and Abuse Notice**

As a Medicaid Managed Care Organization that participates in the Behavioral HealthChoices Program, PerformCare must actively monitor provider activities for fraud, waste, and abuse (FWA). PerformCare takes this obligation seriously and promotes provider practices that are compliant with all federal and state laws. PerformCare encourages its providers to read and be familiar with the federal and state guidelines as they pertain to this important issue.

Overview of Fraud, Waste, and Abuse

The Centers for Medicare & Medicaid Services (CMS) defines ***fraud*** as any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable state or federal law.

CMS defines ***abuse*** as provider practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medical Assistance program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards or contractual obligations. It also includes recipient practices that result in unnecessary cost to the Medical Assistance program.

Examples of FWA may include falsifying claims and/or Encounters, common examples include, but are not limited to:

- Billing for services not rendered
- Billing separately for services in lieu of an available combination code
- Misrepresentation of the service/supplies rendered (billing brand name for a generic drug, upcoding to more expensive service than was rendered, billing for more time or units of service than provided)
- Altering claims
- Submission of any false data on claims, such as date of service, provider or prescriber of service
- Duplicate billing for the same service
- Billing for services provided by unlicensed or unqualified persons
- Billing for used items as new

Other instances of FWA can be administrative or financial. These types of violations include, but are not limited to:

- Falsifying credentials
- Fraudulent enrollment practices
- Fraudulent third-party liability reporting
- Offering free services in exchange for a recipient's Medical Assistance identification number
- Providing unnecessary services/overutilization
- Kickbacks-accepting or making payments for referrals
- Concealing ownership of related companies

Potential consequences for providers convicted of committing FWA may include civil monetary penalties, criminal conviction and fines, civil prosecution, imprisonment, loss of provider license, and exclusion from federal health care programs.

If you suspect or detect fraud, you should report it immediately to the PerformCare Provider Line (1-888-700-7370). Reports may be made anonymously. Additional details on your duty to report and the ways in which reports can be made can be found in the PerformCare Provider Manual located on our website: (https://pa.performcare.org/assets/pdf/providers/resources-information/provider-manual.pdf)

This Provider Notice provides a high level summary of some of the key provisions relating to fraud, waste and abuse requirements and reporting for participating providers and does not constitute legal advice or counsel. This Provider Notice is intended to increase awareness of these laws, however, it is not a comprehensive list of laws pertinent to your responsibilities as a provider. It includes information relating to general compliance requirements for mental health and substance use providers serving Medicaid patients but is not meant to be considered all-inclusive as there are other applicable laws and regulations not cited. Providers are responsible for complying with all federal and state laws, regulations, and guidance pertaining to the Medicaid program and should always validate that the materials being referenced include the most up-to-date content.

Federal Laws Governing Fraud, Waste and, Abuse in Government Programs

Federal False Claims Act (FCA) – The FCA applies to fraud involving any federally funded contract or program. Any individual/entity that knowingly submits a false claim to the government is subject to civil penalties that may include treble damages.

Fraud Enforcement and Recovery Act (FERA) – This act increased the scope of liability of the FCA to include an individual/entity that knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval. This includes primary contractors being responsible for the accuracy of a subcontractor's invoices.

Deficit Reduction Act (DRA) – The DRA requires all entities receiving $5 Million or more in annual Medicaid payments to establish policies relating to: the FCA and administrative remedies for false claims, the prevention and detection of FWA, and detailed information on whistleblower protections.

Anti-Kickback Statute – This law prohibits someone from knowingly or willfully offering, paying, seeking, or receiving anything of value in return for referring an individual to a provider to receive services, or for recommending purchase of supplies or services that are reimbursable under a government health care program. Violations are punishable by criminal sanctions including imprisonment and civil monetary penalties.

Physician Self-Referral Statue (Stark Law) – This law prohibits physicians from referring Medicaid & Medicare patients for certain designated health services to an entity in which the physician (or immediate family) has a financial relationship. Violations are punishable by a civil penalty up to $15,000 per improper claim, denial of payment, and refunds for certain past claims.

Pennsylvania Specific Laws Relating to Fraud Waste, and Abuse in the Medicaid Program

55 PA Code § 1101.75 Provider prohibited acts

(a) An enrolled provider may not, either directly or indirectly, do any of the following acts:

(1) Knowingly or intentionally present for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA, knowingly present for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA, or knowingly submit 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.

(2) Knowingly submit false information to obtain authorization to furnish services or items under MA.

(3) Solicit, receive, offer or pay 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.

(4) Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.

(5) Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.

(6) Submit a claim for services or items which includes costs or charges which are not related to the cost of the services or items.

(7) Submit a claim or refer a recipient to another provider by referral, order or prescription, 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.

(8) Submit a claim 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.

(9) Submit a claim for a service or item at a fee that is greater than the provider's charge to the general public.

(10) Except in emergency situations, dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient.

(11) Except in emergency situations, dispense, render or provide 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.

(12) Enter 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.

(13) Make a false statement in the application for enrollment or reenrollment in the program.

(14) Commit a prohibited act specified in § 1102.81(a) (relating to prohibited acts of a shared health facility and providers practicing in the shared health facility).

(b) A provider or person who commits a prohibited act specified in subsection (a), except paragraph (11), is subject to the penalties specified in § § 1101.76, 1101.77 and 1101.83 (relating to criminal penalties; enforcement actions by the Department; and restitution and repayment).

55 PA Code § 1101.76 Criminal penalties

A person who is convicted of committing an offense listed in § 1101.75(a)(1)—(10) and (12)—(14) (relating to provider prohibited acts) will be subject to the following penalties:

(1) For the first conviction, the person is guilty of a felony of the third degree and is subject to a maximum penalty of a $15,000 fine and 7 years imprisonment for each violation.

(2) When a person has been previously convicted in a State or Federal court of conduct that would constitute a violation of § 1101.75(a)(1)—(10) and (12)—(14), a subsequent allegation, indictment or information under § 1101.75(a) shall be classified as a felony of the second degree with a maximum penalty of $25,000 and 10 years imprisonment.

(3) In addition to the penalties specified in subsections (a) and (b) and as ordered by the court, the convicted person shall repay the amount of excess benefits or payments received under the program, plus interest on the amount at the maximum legal rate. Interest will be calculated from the date payment was made by the Department to the date full repayment is made to the Commonwealth.

(4) As ordered by the Court, a convicted person shall pay to the Commonwealth an amount not to exceed threefold the amount of excess benefits or payments.

(5) The convicted person is ineligible to participate in the program for 5 years from the date of the conviction.

Medicaid Bulletins for Behavioral Health Providers

- MA Bulletin 29-02-03, 33-02-03, 41-0202 - Documentation and Medical Record-Keeping Requirements

- MA Bulletin 01-02-07, 29-02-04, 33-02-04, 41-02-03, 48-02-02, 49-02-04, 50-02-02 - Documentation Requirements for Prescribers

Thank you for your attention to this very important matter and for your continued partnership with PerformCare.

cc: Lisa Hanzel, PerformCare
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PerformCare Account Executives