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CAREGIVER TRAINING
A home care pulse COMPANY

A RISK MANAGEMENT MODULE:

ALL ABOUT CORPORATE COMPLIANCE

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A Risk Management Module:

ALL ABOUT CORPORATE COMPLIANCE

We hope you enjoy this inservice prepared by registered nurses especially for caregivers like you!

About this Course:

Corporate compliance training is an essential part of your risk management and regulatory requirements. This course provides an overview of corporate compliance that guides caregivers through the process of recognizing, avoiding, and reporting fraud, waste, and abuse.

Audience: Home Health Aide; Hospice Aide; Nurse Assistant - CNA; Personal Care Aide

Teaching Method: Classroom-based, instructor-led training.

For California, please indicate the teaching method used: ❒ Lecture

❒ Group Discussion ❒ Other (please specify) _____

CE Credit: 1 hour

Evaluation: The learner must achieve 80% or higher on the post-test to receive credit.

Disclosures: The authors, planners and reviewers of this educational activity declare no conflicts of interest with this activity. There are no commercial interests or sponsorships related to this educational activity.

Note to Instructors: Please see the Instructor's Guide for classroom activity suggestions, teambuilding activities, discussion questions, worksheets, quiz answer key, and a post-course survey for learners.

If you have comments and/or suggestions for improving this inservice, email In the Know at feedback@knowingmore.com.

THANK YOU!

COURSE OBJECTIVES

Define fraud, waste and abuse as it relates to a healthcare organization.

❖

Discuss the purpose of anti-fraud laws like the False Claims Act.

❖

Name at least three required parts of a Corporate Compliance Program.

❖

Explain what it means to be a whistleblower in relation to healthcare fraud, waste and abuse.

❖

List at least two ways that you could report any suspicions of financial fraud at your workplace.

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COURSE OUTLINE

A Risk Management Module:
All About Corporate Compliance

IT WAS JUST A FEW DOLLARS...

Brenda had worked as a caregiver for the same home health agency for five years. She enjoyed her job and her clients really seemed to love her. However, after going through a nasty divorce, Brenda was struggling financially. It grew harder and harder to make ends meet.

One day, her supervisor, Martha, approached her with an offer.

"Brenda," she said. *"I know times are tough for you and I'd like to help you out. But, you're going to have to do something for me in return. Don't worry...it's easy!"*

Martha went on to explain that she would pay Brenda an extra $300 every week if she documented that each of her clients had fallen down recently, was having trouble ambulating, and needed assistance with transferring out of bed.

"Let's face it," Martha said. *"That describes most elderly people at some point, so it's no big deal! You'll be helping your clients get therapy services now...so that they won't have mobility problems later!"*

Brenda thought it over. She made about 25 home visits every week, so $300 was *just a few dollars more for each visit.* And, Martha was right. Why not help *prevent* mobility problems from developing in her clients! In the end, Brenda decided that the extra money was too good to pass up. She followed Martha's instructions for how to document her home visits. Although she often wondered why the physical therapist never showed up to help her clients, Brenda was thrilled every week when Martha handed her an envelope containing $300 in cash. Within two years, Brenda had paid off all her debt, including the fees to her divorce lawyer. She figured that in another year or two, she would have enough money saved to buy a house.

But, Brenda's dreams came crashing down around her when the federal government brought a lawsuit against her employer for Medicare fraud. The organization had been caught billing for *thousands of physical therapy visits that never took place...and that the clients didn't need.* Martha, the physical therapist, and Brenda were all named in the lawsuit.

Keep reading to learn more about health care fraud and how having a **corporate compliance program** helps fight this serious problem.

UNDERSTANDING THE FALSE CLAIMS ACT

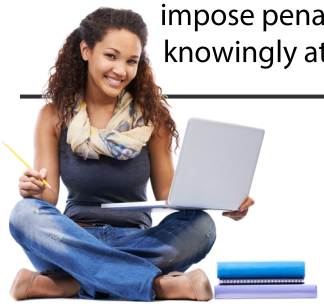
To fight fraud, the federal government instituted a law called the False Claims Act (or FCA, for short). Would it surprise you to learn that the False Claims Act was signed into law by President Abraham Lincoln? It's true. The FCA, nicknamed the "Lincoln Law," has been around since 1862, although major changes have been made to it over the years.

Some Facts about the False Claims Act

- The "Lincoln Act" was originally created to fight fraud committed by military contractors who would, for example, sell the government guns...but deliver boxes filled with sawdust (and take off with the government's money).
- False claims are a huge problem for health care. More than two-thirds of all the money collected by the government in false claim lawsuits comes from healthcare-related companies.
- Pharmaceutical and medical device companies are two of the main targets under the False Claims Act.
- In 2009, President Obama expanded false claims violations to include *retention of overpayments*. For example, a nursing home administrator realizes that, month after month, Medicare is sending duplicate payments for a number of residents...but the administrator keeps quiet about it. The facility (and the administrator) can be sued by the government for false claims.
- Since March, 2007, federal investigators have obtained more than 200 convictions, 500 indictments and recovered more than $2 billion *per year* from healthcare fraud cases.
- What are some examples of false claims? They include:
  - Billing twice for the same service.
  - Billing for unnecessary services.
  - Creating false medical records and/or fake treatment plans.
  - Failing to report and/or refund overpayments from the government.
  - Giving or receiving kickbacks for referring clients to certain providers.
- The penalties for making false claims are high—up to three times the amount of the claim PLUS fines up to $11,000 *per claim*. The court can also impose penalties, including jail time, against individuals who knowingly attempt to defraud the government.

SOME FALSE CLAIMS

- A Detroit oncologist was sentenced to 45 years in prison after being found guilty of billing Medicare for chemotherapy treatments he administered to 550 people *who didn't have cancer!*
- The owner of an x-ray company hired fake doctors to read x-rays and ultrasounds. As a result, several patients died. The scammer now faces life in prison.
- In just one year, a number of companies worked together to bill Medicare for $5.3 million in prosthetic legs. The real "kicker"? Most of the patients for whom false claims were filed had two good legs; they had not undergone an amputation.



WHAT'S NEW?

Grab your favorite highlighter!

*As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*

WHAT ABOUT WHISTLEBLOWERS?

- Some of the most important parts of the False Claims Act are what's called the "qui tam" provisions. "Qui tam" is the Latin abbreviation for "Who sues on behalf of the King as well as for himself."
- Basically, that means that private citizens can file lawsuits against an individual or an organization for committing fraud against the federal government. These lawsuits are known as "qui tam" actions...and the people who file them are called "whistleblowers."

"Whistleblower reward laws are the most powerful tool the American people have to protect the government from fraud."

~ U.S. Assistant Attorney General

- It takes courage to "blow the whistle" on a co-worker or an organization, but it is the bravery of whistleblowers that is responsible for 80% of healthcare fraud cases.
- At first, the whistleblower (also called a "relator") files the lawsuit as an individual (with the help of an attorney). Then, the government reviews the case and, if they decide to get involved and recover money from the guilty party, the whistleblower receives a incentive of 15-25% of that money (sometimes called the "bounty"). In some cases, that bounty can add up to millions of dollars!
- If the government decides not to get involved in the case, the whistleblower can still continue with the action on his/her own. If the court finds that there was fraud and money is recovered, the whistleblower is entitled to 25-30% of the bounty.
- If you witness fraud—and feel you have solid proof of the misconduct—you can report it to the Department of Health and Human Services at:

800-HHS-TIPS *or* **800-447-8477**

TRUE LIFE WHISTLEBLOWER

"The country needs more people like her. She deserves the money!"

~ A Louisiana attorney, speaking about the whistleblower in a major healthcare fraud case

In 2010, a home health nurse filed a lawsuit against her employer for violating the False Claims Act. She reported that the organization had "rigged" their computerized documentation system to make patients look sicker than they really were. As a result, the organization had improperly billed for additional services that were not necessary.

The case was settled and the government recovered $150 million. As her reward, the whistleblower received just over $15 million.

What if a whistleblower brings a frivolous false claims lawsuit?

Bringing a frivolous lawsuit can trigger plenty of negative consequences. For example, let's say that Steve was fired for performing poorly on the job. He's angry, so he decides to "get even" by accusing his former employer of healthcare fraud—even though it isn't true. If the court decides that Steve started the lawsuit simply to harass his old boss, he can end up having to pay ALL the attorney fees and expenses for his employer. Lawyers are expensive, so those costs could really add up!

IT TAKES ALL OF US!

It's important for everyone who works in health care to help fight fraud, waste, and abuse. Consider these facts:

- Every year, fraud and waste steals approximately $1000 per *each* member of the Medicare program.
- At least ten cents of every dollar spent by the Medicare program goes to thieves and scam artists—*not to help Medicare clients*. Some experts believe the problem is much greater, with at least thirty cents of each dollar being stolen!
- The amount of tax dollars lost every year to Medicare fraud and abuse is greater than the *entire budget* for the Department of Homeland Security!

WHAT'S HIPAA GOT TO DO WITH IT?

As you probably know, HIPAA is the law which outlines the privacy rules that protect the medical records and information of every client. But, what does HIPAA have to do with corporate compliance?

"Essentially, criminals have come to understand that using your medical credentials—your name, Social Security Number and health insurance numbers—to bill organizations like Medicare and Medicaid for false claims is more profitable than drugs, prostitution, and other crimes they may pursue."

~ Rick Kam,
President of ID Experts

Medical identity theft occurs when HIPAA laws are broken—and personal information gets into the wrong hands.

For example, by using stolen Medicare ID numbers, scam artists have stolen *billions of dollars* from the system. (See sidebar.)

To find out how rapidly criminals can get their hands on stolen information, a security firm called Bitglass conducted an experiment. First, they created 1,568 fakes names with fake Social Security numbers, addresses, and phone numbers. They put all the information into an Excel file that they could secretly track. Then, they posted the Excel file to a cyber-crime marketplace—a "store," located on the Dark Web, where criminals can purchase stolen personal information. **In less than two weeks, the fake file had traveled to 22 countries and had been accessed more than 1,100 times.** The activity rate was highest among two known cyber-crime syndicates, one operating in Nigeria and the other in Russia. Just imagine if that was YOUR personal information that was being misused around the globe!

Often, the victims of identity theft must fight to "clear" their names and get the fraudulent claims off of their records. And, the process of clearing their records can be expensive. A recent study found that it costs the average victim $13,500!

It can also cost people their good health. Imagine this: Your client needs hip replacement surgery, but when she tries to get it scheduled, her records say *she already had that hip replaced last year*. Your client is a victim of medical identity theft and false claims have been submitted in her name. Now, she must wait months—and deal with a lot of pain and stress—to get the false claims removed from her medical record.

So, remember, part of your job is to GUARD your clients' personal information by maintaining their confidentiality and following all HIPAA policies and procedures for your workplace.

And, if a client has questions about his healthcare bills or reports that the bills look "wrong," tell your supervisor and advise the client or a family member to contact their healthcare provider.

ANOTHER STATUTE: ANTI-KICKBACKS

- The federal Anti-Kickback Statute prohibits people from receiving anything of value in exchange for referring for services any patients who are insured by the government. This includes people on Medicare, Medicaid, Tricare, and about a dozen other federal healthcare programs.
- For example, a nursing home would be guilty of giving a kickback if, to get referrals, it pays a physician a big salary or fee to serve as a "consultant," but the doctor doesn't perform any useful work for the residents. Or, a drug company is violating the law if it pays kickbacks to pharmacies to get them to switch patients' prescriptions to the medications they manufacture.
- People who violate the Anti-Kickback Statute can be fined up to $25,000 and be sentenced to up to five years in prison for *each* kickback. So, for example, if Dr. B. pays a kickback to someone for referring 10 Medicare patients to his office, he may face 50 years behind bars!
- In addition to the federal Anti-Kickback Statute, most states have their own laws that make "commercial bribery" a crime. That means that people who give or take kickbacks can be dragged into both federal *and* state court.

CORPORATE COMPLIANCE IS KEY!

Because of anti-fraud laws, having a corporate compliance program is a requirement for any health care organization that serves Medicare and/or Medicaid clients. But your workplace corporate compliance program also provides a number of important benefits. ***For example, it:***

- Demonstrates your organization's commitment to integrity and honesty when it comes to federal and state-funded healthcare programs.
- Helps define acceptable standards of conduct for every employee of the organization.
- Protects the privacy of both clients and employees.
- Saves government money and resources.
- Helps organizations develop a plan for continually assessing and improving their procedures.
- Promotes high quality care and accurate billing for the care that is given.
- Provides guidance on how to identify and report financial misconduct.

THE DEFICIT REDUCTION ACT

Another law you may hear about as part of your organization's corporate compliance program is the Deficit Reduction Act.

- The 2005 Deficit Reduction Act created a Medicaid Integrity Program similar to one that already existed for the Medicare program.
- In 2006, the Deficit Reduction Act was signed into law by President G. W. Bush. The law requires states that participate in the Medicaid program to demand corporate compliance policies related to:
  - The False Claims Act
  - The Fraud Civil Remedies Act
  - Whistleblower protection
  - Any pertinent state law related to healthcare fraud, waste and abuse.

WHAT MAKES UP A CORPORATE COMPLIANCE PROGRAM?

There are SEVEN core requirements of a corporate compliance program. You don't need to *memorize* the components, but it's important to understand how they fit together to help fight healthcare fraud and abuse.

1. Each organization must have written policies and procedures relating to corporate compliance. This should include **standards of conduct**—spelling out the behavior expected from every employee.
2. There needs to be a "point person" in charge of each organization's corporate compliance program. Do you know who the **compliance officer** is at your workplace? You should! He or she is accountable for setting up and overseeing the corporate compliance program. Your organization may also have a **compliance committee**—a group of employees who assist the Compliance Officer to manage the program.
3. The regulations for fighting healthcare fraud include rules about **corporate compliance training**. Every employee who works for an organization that receives funds from Medicare and/or Medicaid must complete "corporate compliance" training—such as this course—within the first 90 days of employment. The goal of the training is to help employees like you prevent, detect, and report fraud, waste, and abuse.
4. Every corporate compliance program needs to have **effective lines of communication** that ensure confidentiality for whistleblowers who report suspected fraud or abuse. The program should spell out exactly how someone can make an anonymous report. Methods for reporting fraud at your workplace might include a telephone hotline, an internet site or a locked "mailbox."
5. What happens if an employee is discovered committing financial fraud or abuse? A corporate compliance program must include **disciplinary standards** that are well-publicized. You shouldn't have to guess what the consequences are for committing fraud or abuse. Instead, every employee should *know* the consequences for misconduct—and the organization must follow through with those disciplinary actions when someone knowingly breaks the law.

6. As part of a corporate compliance program, a healthcare organization must have an **effective system for routine monitoring, auditing and identification of compliance risks**.
7. What if an organization discovers fraud or abuse? The corporate compliance program must include **specific procedures for responding** promptly to any issues. The administration must take action quickly to correct the problem—and to ensure that it doesn't happen again.

Why Should You Care?

OK, so, there are laws against healthcare fraud and abuse. And, these laws require healthcare organizations to have a corporate compliance program. *Why should you care?* Here's why. Without a corporate compliance program helping to prevent fraud and abuse, harm can come to Medicare and Medicaid clients whose services are delayed or denied (because criminals have used their identities to make false claims). And, if we don't fight healthcare fraud and abuse, there will be less money for *everyone*. We will *all* suffer from higher insurance premiums and co-payments, fewer benefits, and less chance for a raise in salary (due to diminished profits for healthcare organizations). ***By understanding how a corporate compliance program works, you can help prevent fraud, waste, and abuse of taxpayer dollars. It's up to each of us to do our part.***

FRAUD, WASTE & ABUSE...OH MY!

When it comes to healthcare, financial misconduct can be defined like this:

Fraud = a deliberate deception or scheme that a person comes up with to gain a benefit for which that person is not entitled.

Examples of fraud include:

- Knowingly billing for medical appointments the patient did not keep.
- Documenting a false diagnosis for a patient so that expensive tests can be ordered.
- Knowingly billing for more complicated services than the services actually provided.
- Using unlicensed individuals to provide services (and then billing as if they were licensed professionals).

Waste = causing unnecessary costs to the healthcare system as a result of inefficient practices, systems or controls. Generally, waste is considered to stem from a misuse of resources—not from criminal actions.

Examples of waste may include:

- Spending money on high-cost services when less expensive alternatives give patients the same benefit.
- Failing to coordinate care, causing patients to have unnecessary hospital readmissions, avoidable complications, and/or declining health.
- Ordering unnecessary tests simply to guard against malpractice lawsuits.

Abuse = receiving payment for items or services when there is no legal entitlement to that payment—but the health care provider has not *knowingly* and/or *intentionally* lied to obtain payment.

Examples of abuse could be:

- Billing for unnecessary medical services.
- Charging too much for services or supplies.
- Misusing medical codes on a claim form.
- Billing for individual components of a service instead of "bundling" all the charges together.

- Fraud and abuse are illegal and could entail criminal and civil liability. If you suspect fraud, you can report it to the Medicare Fraud and Abuse Hotline at 1-800-447-8477 or TTY 1-877-486-2048. Hours Are 7 AM to 8 PM Mon-Fri, EST.

REAL LIFE EXAMPLES!

Since 1987, the federal government has recovered more than $53 BILLION from False Claims Act violations. Here are some examples:

In 2009, a hospice agreed to pay back the government nearly $25 million. The organization was accused of billing patients for hospice care when they were not terminally ill.

In 2016, a company that provided physical therapy to residents of skilled nursing facilities across the U.S. agreed to pay back $125 million in Medicare funds after being accused of submitting false claims for therapy services.

Before he was caught, the administrator of a Georgia nursing home raked in $32 million in fake Medicare and Medicaid claims...but spent none of the money on the residents in his facility. While he bought luxury cars and homes for himself, his residents were starving, surrounded by rodents, dirt, and rotting garbage.

EMPLOYEE CODE OF CONDUCT

As you've already learned, one of the required parts of a corporate compliance program is to develop Standards of Conduct that apply to every employee at the organization. You might also see this referred to as the Code of Conduct for employees.

In general, Standards of Conduct require all employees to behave in a professional and ethical manner. While the specific standards may be different at your workplace, this generally includes:

- Maintaining a positive, professional attitude at work.
- Coming to work on time and not leaving until the work day is over.
- Focusing on work and clients first. (Personal calls or business should never be a priority.)
- Putting your clients' health and safety above all else.
- Communicating in a polite manner, treating both clients and co-workers with respect at all times.
- Putting yourself in your clients' shoes and treating them the way you would want to be treated.
- Keeping all personal information confidential for both clients and co-workers.
- Following a no-tolerance policy for gossiping about, harassing or bullying your co-workers.
- Refusing to accept any gifts or money from clients.
- Acting fairly, honestly and ethically at all times.
- Identifying ways to do things better on your team or in your department—and take action to help with improvements.
- Reporting any suspected misconduct to your supervisor or to the Compliance Officer at your workplace.

Q: My manager just asked me to do something that I think might be considered fraud. What should I do?

A. If your manager has a "boss," let that person know the situation immediately. You can also go to your HR Department or your Compliance Officer with your concerns. If you still feel uncomfortable after talking about the issue, call the Medicare Fraud and Abuse hotline at 1-800-447-8477. (Note: This is what Martha *should* have done instead of accepting that extra $300/week!)

MOST WANTED BY the OIG

Did you know that the **Office of the Inspector General** (the OIG) has a "ten most wanted" list? They do!

Of course, they are chasing more than just 10 people. Currently, they are seeking ***more than 170 fugitives*** on charges related to healthcare fraud and abuse. If you're interested, you can see the people they are after by visiting this site:

https://oig.hhs.gov/fraud/fugitives/

Here's someone who was caught and convicted:

In 2014, a Florida certified nursing assistant was found guilty of conspiracy to commit healthcare fraud and of receiving illegal kickbacks. He had pocketed *hundreds of thousands of dollars* in kickbacks for referring Medicare patients to his employer—even though they didn't need home health care. The employer then billed Medicare for unnecessary services, stealing millions before being caught.

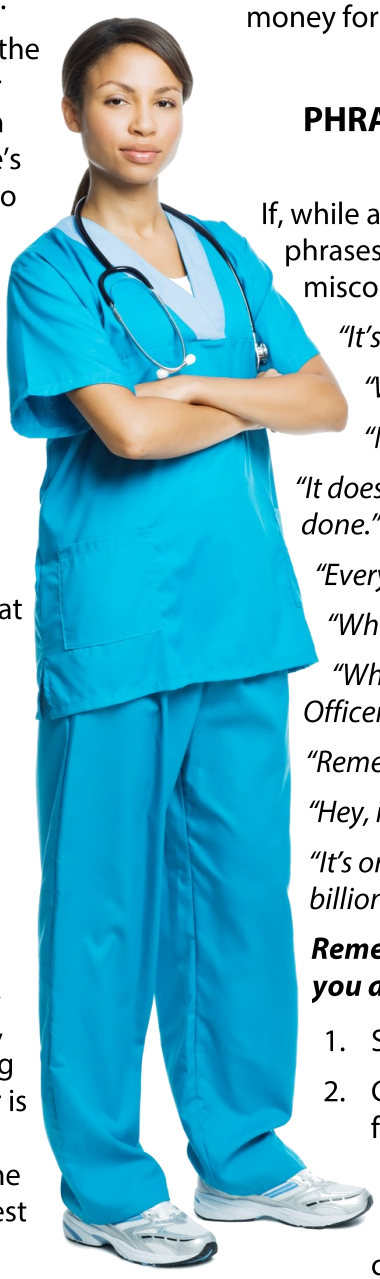
IDENTIFYING MISCONDUCT ON THE JOB

Are you wondering how on earth you are supposed to know if healthcare fraud is going on at your workplace? There are many different ways that fraud can be committed, but here are some examples of things you should watch out for:

Vickie works as a home health aide. Over a few months time, she uncovered these violations:

One of Vickie's clients told her that his weekly physical therapy treatment is showing up *twice* on each statement he receives from Medicaid.

Vickie heard a nurse bragging about the money she was making by giving her supervisor lists of senior citizens from her church. The lists included people's names and their Medicare numbers so that theses people could be "admitted" for home health care—even though they didn't need it.



Michael has been a CNA at a skilled nursing facility for several years. Recently, he discovered these violations:

One of his residents, Mr. McDonald, has a wheelchair that is in perfect working order. Michael found out that someone at his organization ordered *another* wheelchair from Medicare, claiming that Mr. McDonald's chair was broken beyond repair. That co-worker took the new wheelchair home, sold it, and pocketed the money.

Unfortunately, the facility where Michael works has seen better days. The furnace barely puts out any heat, residents get only two meals per day, and the doors to the Alzheimer's wing no longer lock. Yet, the administrator is submitting documentation to the government that makes it look like the care given to residents is of the highest quality.

Cherry works as a personal care aide. She uncovered these fraudulent activities:

She heard an administrator talking about billing Medicare for the services of an aide—*but those services were never provided.*

Cherry also heard the staff in the billing department laughing and talking about how dumb the government is. "They keep sending us money for five different hospice patients—even though all five of them passed away months ago. Oh well, it's more money for us!"

PHRASES THAT SHOULD CATCH YOUR IMMEDIATE ATTENTION:

If, while at work, you overhear or read any of the phrases below, there may be an issue of misconduct at your workplace:

"It's just between you and me…"

"Well, maybe just this once…"

"Nobody will ever know."

"It doesn't matter how it gets done as long as it gets done."

"Everyone does it!"

"What's in it for me?"

"Whatever you do, don't tell the Compliance Officer."

"Remember, we never had this conversation."

"Hey, if they don't ask, don't tell!"

"It's only a few dollars. The government has billions!"

Remember...as a trusted healthcare employee, you are required to:

1. Show honesty and respect for all.
2. Comply with state and federal laws...and focus on quality care.
3. Take responsibility for all of your actions.
4. Report any suspected ethical or compliance violations right away.

CORPORATE COMPLIANCE Q & A

Q: Is fraud really that big of a problem in health care?

A: Unfortunately, yes! For example, the federal government estimates that 10% of the bills they pay on behalf of Medicare recipients are fraudulent. That adds up to about $60 BILLION dollars every year. However, some experts on healthcare fraud believe that the number is much higher. They guess that the fraud rate could be as high as 20% or $120 billion annually.

Q: Is fraud widespread in private health insurance, too, or is it only government programs?

A: There's a big difference between private and government insurance programs. Private companies investigate claims *before* they pay them. The government is run as more of an "honor system," investigating most claims *after* they are paid. (Statistics show that only a small fraction of claims—3% or less—are actually reviewed before they are paid. The rest are reviewed later...or not at all.) Because of this, the government programs are more at risk for fraudulent claims.

Q: Do most of the fraud cases involve home health care?

A. No, healthcare fraud occurs in a variety of healthcare-related settings, including drug manufacturers. Pharmacies have the highest number of fraud cases, followed by medical equipment companies. Skilled nursing facilities are vulnerable to fraud because they are reimbursed by Medicare based on the level of care required for each resident. The more care that a facility claims they provide, the higher their reimbursement. This opens the door for dishonest people to try to defraud the system.

Q. What if I suspect healthcare fraud, but I'm worried that my boss will fire me if I report the issue? I really need my job!

A. The False Claims Act protects anyone who reports fraud, waste or abuse. A whistleblower *cannot* be fired, demoted, threatened, or harassed for doing what is right! This is known as a *non-retaliation policy*.

Q. If I report my suspicions of misconduct, my co-workers might get in big trouble. I feel guilty about that. What should I do?

A. Don't feel guilty! As long as your report is made in *good faith* (and not to get back at someone), you are required by law to file a report. Just remember that by doing the right thing, you are standing up for clients who might suffer because of the fraud. You are also helping your workplace improve its processes, prevent fraud from happening in the future, and are doing what's best for your entire healthcare team.

MORE REAL FRAUD!

For five years, a husband and wife in Washington, D.C. billed the D.C. Medicaid program millions for personal care aide services that were *not* provided to Medicaid beneficiaries. They created phony time sheets, phony patient files and even fake employment files for aides who didn't exist.

With their stolen money, they purchased a million dollar home and over $400,000 worth of new cars.

Now? The couple are both convicted criminals, serving prison time. The government seized their home and their bank accounts—but they still owe $80 million in fines.

FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. To fight fraud, the federal government instituted a number of laws, including the False Claims Act.
2. The amount of tax dollars lost every year to Medicare fraud and abuse is greater than the *entire budget* for the Department of Homeland Security!
3. Having a corporate compliance program is a requirement for any health care organization that serves Medicare and/or Medicaid clients.
4. Healthcare employees are required by law to report suspicions of healthcare fraud.
5. The False Claims Act protects anyone who reports healthcare fraud, waste or abuse. A whistleblower cannot be fired, demoted, threatened, or harassed for doing what is right!

REPORTING SUSPECTED FRAUD

So...let's say that in the course of your job, you become aware that one or more co-workers are breaking the rules by doing things like:

- Attempting to defraud the healthcare system.
- Lying to get money from the healthcare system.
- Using someone else's identity to make fraudulent medical claims.

What should you do?

Everyone who works for a company that serves members of a government program like Medicare or Medicaid is required to report suspected fraud, waste or abuse.

Follow the methods provided by your workplace for reporting your suspicions. This may include:

- Talking to your supervisor.
- Posting the issue to a secure website.
- Emailing your Compliance Officer.
- Putting a confidential note in a locked compliance "mailbox."
- Making an anonymous call to a "Compliance Hot Line."

If you are unsure how to make a report at your workplace, ask your supervisor today! Remember...it's against the rules for you to suffer any harassment or bullying just because you did the right thing. You will be protected!

WHAT ARE THE POSSIBLE CONSEQUENCES?

The Compliance Officer and/or Committee at your workplace have a number of options for disciplining people who are found guilty of fraud, waste or abuse activities. Depending on the seriousness of the misconduct, these disciplinary actions might include:

- Making the person repay any damages or fines.
- Demoting, suspending or firing the person.
- Turning the case over to law enforcement officials.

WHAT HAPPENS NEXT?

When fraud, waste or abuse activities are discovered at your workplace, compliance officials must ***analyze what went wrong*** with the system that allowed the misconduct to happen—and ***figure out what they can do*** to prevent it from ever happening again. This may mean changing policies and/or procedures, re-educating staff members, and conducting regular reviews of patient charts, billing documents, and reimbursement funds that are received from Medicare and Medicaid.

FINAL THOUGHTS!

- You may have heard that the government is having a hard time paying for healthcare programs like Medicare, especially with our elderly population getting bigger every day. (Across the U.S., about 10,000 people turn 65 every day!) Think how much easier it would be to afford the Medicare program if thieves weren't stealing billions of dollars from it every year!
- You play a vital role in protecting government programs, like Medicare and Medicaid, from unethical people who see them as a way to make a quick buck.
- Remember...every dollar wasted in healthcare spending is passed on to the consumer. And we are **ALL** healthcare consumers at some point. That's why it's up to each one of us to do our part to keep costs down. This includes being on the alert for financial fraud, waste and abuse at work.
- Your supervisor may require you to complete a training course on corporate compliance *every year*. Think of it as a good reminder, just like being reminded to wash your hands when you review standard infection control precautions once a year. Both topics help prevent serious issues from affecting your clients, your co-workers and your workplace!
- Don't be surprised if your workplace conducts periodic audits of your documentation. It may well be part of their fraud prevention plan. Regular audits help healthcare organizations uncover areas of risk *before* someone has the opportunity to commit any fraud or abuse.
- If you report suspected fraud activity to your supervisor or your Compliance Officer, but the activity seems to continue, consider contacting the Office of the Inspector General (OIG). You can do that by:
  - **Calling:** 1-800-HHS-TIPS (1-800-447-8477)
  - **Faxing a report** to: 1-800-223-8164
  - **Filling out a form online** at: https://oig.hhs.gov/fraud/report-fraud/index.asp
  - Or, by **mailing a letter** to:

  U.S. Department of Health & Human Services
  Office of Inspector General
  ATTN: OIG Hotline Operations
  P.O. Box 23489
  Washington, CD 20026

WHAT I KNOW NOW!

*Now that you've read this inservice, **All About Corporate Compliance**, jot down a couple of things you learned that you didn't know before.*

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inthe**know** A home care pulse COMPANY | CAREGIVER TRAINING

EMPLOYEE NAME
(Please print):

_____

DATE: _____

- ***I understand the information presented in this inservice.***
- ***I have completed this inservice and answered at least eight of the test questions correctly.***

EMPLOYEE SIGNATURE:

_____

SUPERVISOR SIGNATURE:

_____

1 Hour CE Credit

File completed test in employee's personnel file.

A Risk Management Module:

All About Corporate Compliance

Are you "In the Know" about corporate compliance? Circle the best choice or fill in your answer. Then check your answers with your supervisor!

1. **True or False**
   The False Claims Act is a new law that was created to help fight computer hacking of confidential patient files.

2. **True or False**
   Having a corporate compliance program is a requirement for any health care organization that serves Medicare and/or Medicaid clients.

3. **Corporate compliance is the responsibility of:**
   A. All administrators.
   B. Every employee at work.
   C. A Compliance Committee.
   D. A Compliance Officer.

4. **Examples of issues that can be reported to your Compliance Officer include:**
   A. Suspected fraud, waste and abuse.
   B. A HIPAA privacy violation.
   C. Unethical employee behavior.
   D. All of the above.

5. **Methods for reporting a compliance issue at your workplace may include:**
   A. Calling a telephone hotline.
   B. Making a report on your company's secure website.
   C. In-person reporting to your supervisor or the Compliance Officer.
   D. All of the above.

6. **A non-retaliation policy:**
   A. Allows supervisors to discipline employees who violate Standards of Conduct.
   B. Prohibits management from harassing employees who have committed fraud.
   C. Protects employees who make a good faith report about suspected fraud.
   D. Prevents fights between co-workers.

7. **True or False**
   Employees who commit fraud may be referred to law enforcement for possible prosecution.

8. **True or False**
   Training employees about corporate compliance is optional.

9. **True or False**
   Standards of Conduct spell out how to provide personal care to your clients.

10. **True or False**
    Conducting regular audits is a required part of a corporate compliance program.

WHAT YOU NEED TO KNOW BEFORE SUBMITTING A CLAIM

The OIG Hotline reviews and investigates thousands of complaints each year. Before you begin, make sure you understand exactly what information is needed to submit a claim.

What do you need to tell the OIG?

The more you tell the OIG, the better chance an investigation can be pursued. Before you begin, make sure you have the following information available:

- **Name and contact information of the individual or business related to your complaint.** This includes, if available, addresses, telephone numbers, e-mail addresses, etc.
- **A detailed explanation** of the nature, scope, time frame and how you came to learn about the activity in question.
- **The name and contact information of any individual who can help corroborate** the information you are reporting.
- **Supporting evidence** in electronic format that can be uploaded with your report. This may include e-mail communications, documents, billing records or photographs.

Do you have to disclose your identity?

If you want to disclose your identity or maintain your confidentiality when filing a complaint, there are a few options available. The options are:

1. **No Restrictions:** You provide the OIG your identifying information (name, address, etc.) when filing the online submission form. If the OIG determines that others need to know the information, they can disclose your identity to them.
2. **Confidential:** You provide the OIG your identifying information (name, address, etc.) but request that the office not share this information with individuals or entities outside the OIG.
3. **Anonymous:** You choose not to provide any identifying information. Choosing this option may hinder the OIG from thoroughly reviewing and/or resolving your complaint.

How do you contact the OIG?

Online: https://tips.oig.hhs.gov/

Phone: 1-800-HHS-TIPS (1-800-447-8477)

TTY: 1-800-377-4950

Mail: U.S. Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026

What to Expect After Submitting Your Complaint

An OIG analyst will review your complaint for relevance and completeness. Not all complaints result in an investigation. If you have identified yourself, a reviewing official may contact you for further information. However, if you are not contacted it does not mean your complaint is not being investigated.

IMPORTANT: The Hotline will not be able to confirm receipt of your complaint or respond to any inquiries about action taken on your complaint. We understand the natural inclination to follow up on a report but OIG does not provide the status of complaints.