FRAUD, WASTE AND ABUSE

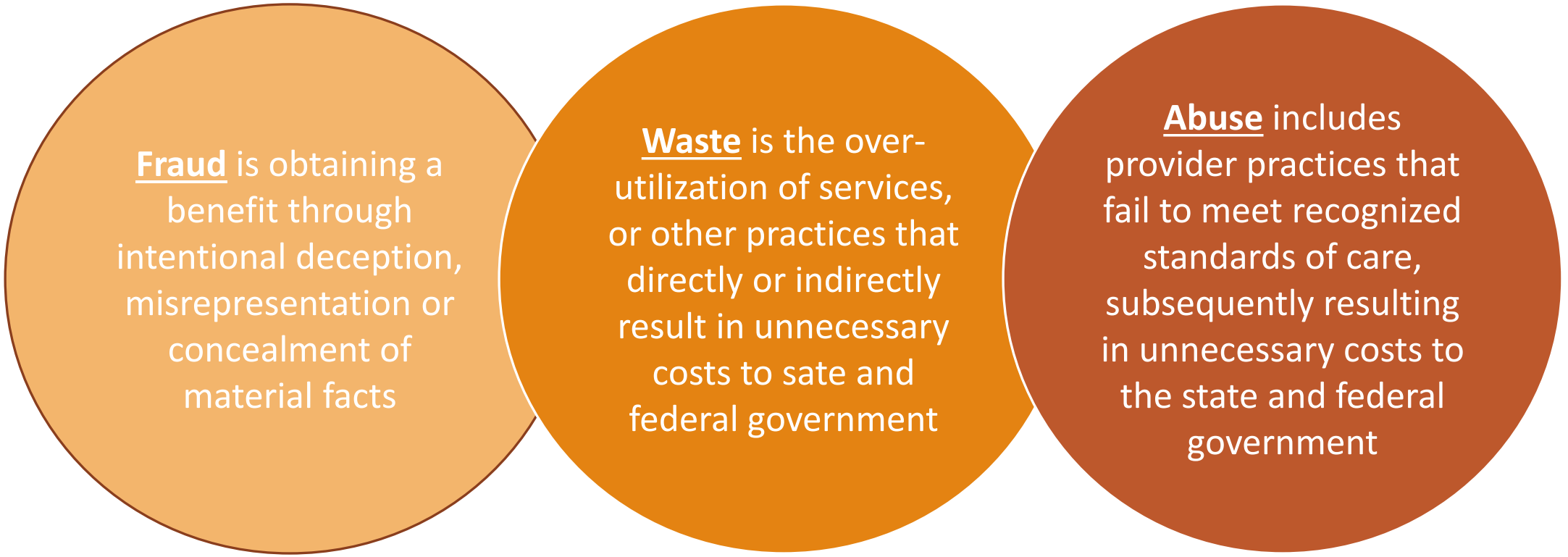
Public Awareness Program Training

What is compliance?

- Compliance is a commitment to promote a work environment that fosters compliance with ethical, legal and regulatory requirement.

- Preventing Healthcare Fraud, Waste and Abuse, is a core element of our Compliance program and thus a high priority at VillageCare

"Our goal is to set the gold standard when it comes to Compliance" – Cathy Engelbert


Fraud is obtaining a benefit through intentional deception, misrepresentation or concealment of material facts
Waste is the over-utilization of services, or other practices that directly or indirectly result in unnecessary costs to sate and federal government
Abuse includes provider practices that fail to meet recognized standards of care, subsequently resulting in unnecessary costs to the state and federal government

Examples of Fraud, Waste, Abuse and Compliance Issues

- Billing for services not provided
- Identity Theft
- Providing services or products not medically necessary
- Unprofessional Conduct
- Authorizing or receiving payment for hours not worked
- Overusing medical services and products
- Authorizing or receiving payments for goods not received or services not performed
- Providing services inconsistent with professional standards
- Vendor Kickbacks
- Coding Issues
- Misrepresenting the identity of the provider, date of service, or description of service provided
- Accepting gifts from vendor/members/patients or family

CONSEQUENCES

Depending on the nature of the violation, consequences for violating these laws include:

- Criminal Prosecution/Fines
- Imprisonment
- Civil Action
- Civil Money Penalties
- Loss of Provider License/Sanctions
- Exclusion from Federal and State Health Care programs

Overpayments and Self Disclosure

Any un-entitled funds that an individual or organization receives or retains under the Medicaid or Medicare program.

Providers who have a compliance program should be utilizing routine internal audits to review compliance with Medicaid requirements and identify any Medicaid fund overpayments that may have been received.

Providers are required to report, return and explain any overpayments they have received to the New York State Office of the Medicaid Inspector General (OMIG) Self Disclosure program within sixty (60) days of identification, or by the date of corresponding cost report due, whichever is later.

- Social Services Law (SOS) § 363-d(6)

Reporting Fraud, Waste and Abuse

- Everyone is required to report suspected instances of FWA.
- VillageCare will not retaliate against anyone for making a good faith effort in reporting suspected FWA.
  - Email: compliance@villagecare.org
  - Hotline 844-348-2664 or www.villagecare.ethicspoint.com

Referral to OMIG

- Email: bmfa@omig.ny.gov
- Electronically: File an Allegation | Office of the Medicaid Inspector General (ny.gov)
- Hotline: 1 (877) 873-7283