

# Medicare Advantage- Prescription Drug Fraud, Waste, and Abuse Training

Providence Health Plans  
2009-2010

# Why Do I Have to Participate in Fraud, Waste and Abuse Training?

# The CMS Mandate

- The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage Prescription Drug health plans to ensure that their participating providers complete Fraud, Waste, and Abuse training no later than December 31, 2009 and annually thereafter.
- Providence Health Plans is offering this presentation to help providers fulfill the training requirement.

Providence Health Plans (PHP) provides access to the training materials on this website for the convenience of their participating providers. PHP had made every attempt to create this presentation to comply with CMS's requirements as we understand them to date.

# The Cost of Healthcare Fraud

- The U.S. spent \$2.2 trillion on health care in 2007
- Estimates suggest that 3% - 10% of health care dollars are lost to fraud<sup>1</sup>
- Prescription drugs constitute approximately 10% of all health care spending<sup>2</sup>
  - <sup>1</sup>[http://www.fbi.gov/publications/financial/fcs\\_report2007/financial\\_crime\\_2007.htm#health](http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health)
  - <sup>2</sup>[http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=56280](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=56280)

# Risk to Individuals

- Unnecessary procedures may cause injury or death
- Falsely billed procedures create an erroneous record of the patient's medical history
- Diluted or substituted drugs may render treatment ineffective or expose the patient to harmful side effects or drug interactions
- Prescription narcotics on the black market contribute to drug abuse and addiction

# FWA Training Requirement

- FWA training is required for all Part C and D first tier, downstream, related and delegated entities, including Medicare Advantage providers who administer the Part D drug benefit or provide health care services to Medicare Advantage enrollees.
- Pharmacy Benefit Managers(PBMs)
- Pharmacies and pharmacists
- Subcontractors such as claims processing firms
- Hospitals
- Primary care providers
- Specialists
- Ancillary
- Note: The lists in this presentation are not all-inclusive.

# How does CMS combat Fraud

1. Close coordination with contractors, providers, and law enforcement agencies
2. Developing Medicare Program compliance requirements that protect stakeholders
3. Applying fair and firm enforcement policies
4. Early detection through Medical Review and data analysis
5. **Effective education of physicians, providers, suppliers, and beneficiaries**
  - Among other things, the fifth strategy led to the development of *this* FWA training requirement.

# Learning Objectives

- Describe the Medicare Advantage- Prescription Drug Fraud, Waste, and Abuse (FWA) training requirements
- Recognize examples of health care FWA
- Describe steps taken to prevent and combat FWA
- Describe how you can prevent health care FWA
- Report suspected health care FWA

# Key Terms and Definitions

- Part C Medicare Advantage Plans (MA)
  - Provides all of a person's Part A and Part B coverage
  - Most MA plans are offered by private entities and many include Part D prescription drug coverage
- Part D Plans
  - Optional drug coverage available to everyone with Medicare
  - Most Part D plans are either stand-alone prescription drug plans (PDPs) or Medicare Advantage plans offering prescription drug coverage (MA-PD)

# Key Terms and Definitions, Cont.

- Medicare Advantage Organizations
  - A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements
- Part D Sponsors
  - Refers to a PDP Sponsor, MA organization offering a MA-PD plan, a PACE\* organization offering a PACE plan including qualified prescription drug coverage, and a Cost Plan offering qualified prescription drug coverage. This includes employer- and union sponsored plans
- \* PACE is the Program of All-Inclusive Care for the Elderly.

# What are the Fraud, Waste, and Abuse Requirements?

# Health Plan Requirements

- CMS stipulates that Medicare Advantage Organizations and Part D Plan Sponsors are ultimately responsible for training entities and providers who render service to Medicare health plan members to meet CMS' contractual requirements.

# Provider Responsibility

- By 12/31/09 and annually thereafter all affected providers and entities must:
  - Complete training as defined in 42 CFR 422.503 (“Medicare Advantage Programs”) and 42 CFR 423.504 (“Voluntary Medicare Prescription Drug Benefit”)
  - Retain an attestation of completion to be provided upon request to each of the health plans with which you are contracted to provide services for Medicare Advantage and/or Part D beneficiaries

# What is Fraud, Waste and Abuse?

# Fraud

- ***Health Care Fraud:*** Intentionally, or knowingly and willfully attempting to execute a scheme to falsely obtain money from any health care benefit program
- ***Medicare Fraud:*** Purposely billing Medicare for services that were never provided or received

# Abuse

- ***Abuse:*** Improper behaviors or billing practices that create unnecessary costs
- Fraud is distinguished from abuse in that, in the case of fraudulent acts, there is clear evidence that the acts were committed knowingly, willfully, and intentionally or with reckless disregard.

# Waste

- **Waste:** Health care spending that can be eliminated without reducing the quality of care
  - Quality Waste: Overuse, underuse, and ineffective use
  - Inefficiency Waste: Redundancy, delays, and unnecessary process complexity

# What are Some Examples of Fraud, Waste, and Abuse?

# Potential Risks-MA Organizations and Part D Sponsors

- Failure to provide medically necessary services
- Marketing schemes such as offering beneficiaries a cash payment as an inducement to enroll in Part D
- Selecting or denying beneficiaries based on their illness profile or other discriminating factors
- Inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness

# Potential Risks - Providers: Prescription Drug FWA

- Illegal remuneration schemes, such as selling prescriptions
- Prescription drug switching
- Script mills
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing log-in information
- Falsifying information in order to justify coverage

# Other Potential Risks - Providers

- Unnecessary treatments
- “Rent-A-Patient” scheme
- Billing for services not rendered and/or supplies not provided
- Double billing
- Eligibility fraud
- Misrepresenting the date services were rendered or the individual who received the services
- Misrepresentation of services
- Misrepresenting who rendered the service
- Billing non-covered services as covered items

# Other Potential Risks - Providers, continued

- Unbundling
  - Using separate billing codes for services that have an aggregate billing code, a practice known as “exploding” the charge
- Upcoding
  - Choosing a level of service higher than supported by documentation

# Other Potential Risks - Providers, continued

- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services
- Soliciting, offering, or receiving a kickback, bribe, or rebate

# Potential Risks—Pharmacies

- Inappropriate billing practices such as:
  - Billing for brand when generics are dispensed
  - Billing for non-covered prescriptions as covered items
  - Billing for prescriptions that are never picked up
  - Prescription splitting
  - Prescription drug shorting
  - Bait and switch pricing
  - Prescription forging or altering
  - Dispensing expired or adulterated prescription drugs
  - True Out-of-Pocket (TrOOP) manipulation

# Potential Risks - Pharmacy Benefit Managers (PBMs)

- Prescription drug switching
- Unlawful remuneration, such as remuneration for steering a beneficiary toward a certain plan or drug, or for formulary placement
- Inappropriate formulary decisions
- Prescription drug splitting or shorting
- Failure to offer negotiated prices

# Potential Risks - Medicare Beneficiaries

- Beneficiary ID card sharing
- Misrepresentation of status
- Doctor shopping
- Prescription forging and altering
- Resale of drugs on the black market
- Looping (i.e., arranging for a continuation of services under another beneficiary's ID)
- Identity theft

# Who is at risk for Fraud, Waste, and Abuse?

- Stakeholders include:
  - MA Organizations and Part D Sponsors
  - Providers
  - Pharmacies
  - Pharmacy Benefit Managers
  - Beneficiaries
- Schemes:
  - Vary in degree of severity
  - Are not necessarily unique to a single stakeholder
  - May involve multiple types of fraud, waste, or abuse

# What are the Laws Relevant to Healthcare Fraud, Waste and Abuse?

# False Claims Act

- The ***False Claims Act*** prohibits any false or fraudulent claim for government money or property, whether or not the claim is presented to a government official, and whether or not the defendant specifically intended to defraud the government. Liability attaches to government funds dispersed through intermediaries including state agencies, and may apply to subcontractors as well as funds received from Medicare Advantage Plans and Medicaid HMOs.

***American Recovery and Reinvestment Act of 2009  
(ARRA)***

# Anti-Kickback Statute

- The ***Anti-Kickback Statute*** makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.
- **Remuneration** includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

# How is Fraud, Waste and Abuse Combated and Prevented?

# Combating Fraud is a Collaborative Effort

- Department of Justice (DOJ), including the Federal Bureau of Investigation (FBI)
- Office of Inspector General (OIG) of the Department of Health and Human Services (HHS)
- Quality Improvement Organizations (QIOs)



## Department of Justice

FOR IMMEDIATE RELEASE  
Thursday, December 18, 2008  
[WWW.USDOJ.GOV](http://WWW.USDOJ.GOV)

CRM  
(202) 514-2007  
TDD (202) 514-1888

### Physician's Assistant Sentenced to 14 Years in Prison for His Role in \$119 Million Medicare Fraud

WASHINGTON – A Miami physician's assistant was sentenced today to 14 years in prison in connection with his role in a \$119 million HIV-infusion Medicare fraud scheme, Acting Assistant Attorney General Matthew Friedrich of the Criminal Division

# Remediation

- The government has several possible outcomes to a FWA investigation they may:
  - Educate the provider or entity
  - Use Administrative sanctions
  - Use Civil litigation and settlements
  - Use Criminal prosecution including;
    - Automatic debarment
    - Prison time

# What Can I Do?

# Best Practices for Preventing Fraud, Waste, and Abuse

- Develop a compliance program
- Monitor claims for accuracy - ensure coding reflects services provided
- Monitor medical records – ensure documentation supports services rendered
- Perform regular internal audits

# Best Practices

- Maintain open lines of communication with colleagues and staff members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem

***Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.***

# Exclusion List

- Check the OIG and General Services Administration (GSA) exclusion lists for all new employees and at least once a year thereafter to ensure that employees and other entities that assist in the administration or delivery of services to Medicare beneficiaries are not included on such lists
  - OIG List of Excluded Individuals/Entities (LEIE):  
<http://exclusions.oig.hhs.gov/search.html>
  - General Services Administration (GSA) database of excluded individuals/entities:  
<http://epls.arnet.gov/>

# Whistleblower Protections

- ***Whistleblower:*** An employee, former employee, or member of an organization who reports misconduct to people or entities that have the power to take corrective action
- A provision in the False Claims Act allows individuals to:
  - Report fraud anonymously
  - Sue an organization on behalf of the government and collect a portion of any settlement that results
  - Employers cannot threaten or retaliate against whistleblowers

# How Do I Report Suspected Fraud, Waste, or Abuse?

# Confidential Methods for Reporting to Medicare/Medicaid



- Office of the Inspector General
  - By Phone: **1-800-HHS-TIPS (1-800-447-8477)**
  - By TTY: **1-800-377-4950**
  - By E-mail: **HHSTips@oig.hhs.gov**
- Centers for Medicare & Medicaid Services (CMS)
  - By Phone: **1-800-MEDICARE (1-800-633-4227)**
  - By TTY: **1-877-486-2048**

Callers are encouraged to provide information on how they can be contacted for additional information, but they may remain anonymous if they choose.

# To Report Suspected Fraud, Waste and Abuse to PHP



- For cases involving our members call us:
  - Contact Providence Health Plan’s Special Investigations Unit at (503)574- 8505 or the toll free number is 1-888-233-4101
- Or mail your letter to:
  - Special Investigations Unit
  - PO Box 3150
  - Portland, OR 97208-3150

# Thank You!

- Please click on the link below to complete your attestation.
- Save this attestation in your files to provide in the case of CMS, PHP or other insurer audit.
- PHP cannot be responsible for preservation, storage, or production of attestation certificates.
- Link – [Click HERE for Attestation](#)
- Credits: This training program was developed using material contributed by HCAS member health plans.

# Resources

# General Contact Information

- **Providence Health Plans Customer Service**
- *503-574-7500* Commercial Products
- Toll free: 1-800-878-4445
- *503-574-8000* Medicare Products
- Toll free: 1-800-603-2340
  
- **General Correspondence:**  
Providence Health Plans  
PO Box 4327  
Portland OR 97208-4327

# Online Resources

- Chapter 9 Fraud Waste and Abuse Manual
  - [http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual\\_Chapter9\\_FWA.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf)
- CMS' Prescription Drug Benefit Manual
  - [http://www.cms.hhs.gov/PrescriptionDrugCovContra/12\\_PartDManuals.asp](http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp)
- Code of the Federal Register (see CFR 422.503 and CFR 423.504)
  - <http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms4124fc.pdf>
- Office of the Inspector General
  - <http://www.oig.hhs.gov/fraud.asp>
- Medicare Learning Network (MLN) Fraud & Abuse Job Aid
  - [http://www.cms.hhs.gov/MLNProducts/downloads/081606\\_Medicare\\_Fraud\\_and\\_Abuse\\_brochure.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/081606_Medicare_Fraud_and_Abuse_brochure.pdf)