Introduction

- 2008: United States spent $2.3 trillion on health care.

- Federal fiscal year 2010: Medicare expected to cover an estimated 46.6 million beneficiaries at a total cost of $528 billion to the Federal government.
An overwhelming majority of health care providers and suppliers are honest. Unfortunately, even a small percentage of dishonest activity can result in billions of precious health care dollars lost or wasted.
Impact of Fraud, Waste, and Abuse

- The National Health Care Anti-Fraud Association conservatively estimates that 3% of all health care spending, about $68 billion a year, is lost to health care fraud.

- Other estimates by law enforcement agencies run as high as 10%, approximately $230 billion lost to health care fraud annually.

- Health care fraud has resulted in physical harm to some and increased costs to all. Preventing health care fraud requires active participation from providers and insurers, the government and the public.
CMS Training Expectations

Medicare Advantage organizations:

- Training for employees, governing body members, and first tier and downstream entities (contractors and subcontractors).

- Required training must include prevention and detection of fraud, waste, and abuse.
Description of Training

This training course includes:

1. Examples of fraud, waste, and abuse to help you detect possible occurrences

2. Descriptions of pertinent laws related to fraud and abuse

3. Information on **when and where** to report potential fraud, waste, and abuse
Fraud and Abuse Defined

- **Health care fraud**: the intent to deceive or misrepresent for financial gain.

- **Health care abuse**: conduct that goes against or is inconsistent with acceptable business and/or medical practices resulting in greater reimbursement.
  - Can include inefficient methods and practices that result in unnecessary or increased health care costs. Intent is usually not present in cases of abuse.
Examples of Fraud and Abuse by Medicare Advantage Plans and Medicare Part D Sponsors

- Reporting incorrect or inaccurate information to CMS to inflate plan performance or increase reimbursement
- Requiring or pressuring Medicare beneficiaries to provide contact or personal information at marketing sales events
- Providing inaccurate or misleading information about the plan
Examples of Fraud and Abuse by Medicare Advantage Plans and Medicare Part D Sponsors

- Discouraging a segment or certain types of Medicare beneficiaries from enrolling in the plan to improve the plan’s financial performance by reducing health care benefit payments

- Providing information about plan premiums and benefits at Educational Events (events that are advertised to beneficiaries as “educational” as opposed to “sales and marketing”)

- Accepting enrollment applications at Educational Events
Examples of Fraud and Abuse by Healthcare Providers and Suppliers

- Billing for services, procedures, or supplies that were not furnished.
  Example – A physician files a claim for a Medicare beneficiary that they did not see or treat

- Billing for services, procedures, or supplies that are not medically necessary.
  Example – A Durable Medical Equipment supplier bills Medicare for a power wheelchair when the beneficiary does not meet Medicare’s qualifications for receiving the equipment.

- Upcoding, reporting inaccurate diagnosis codes, procedure codes, or other information on a claim to increase reimbursement.
  Example – A hospital reports a diagnosis code that does not accurately reflect the patient’s condition on an inpatient claim to increase reimbursement.

- Physician billing for services performed by an assistant.
  Example – A patient is treated by a nurse practitioner without supervision by a physician. However, the services are billed under the physician’s provider number to increase reimbursement.
Examples of Pharmacy Fraud, Waste, and Abuse

Inappropriate billing practices:

1. Billing for non-existent prescriptions
2. Billing for brand drugs when generic drugs are dispensed
3. Billing for non-covered prescriptions as covered items
4. Billing for prescriptions that are never picked up (by not reversing claims when prescriptions are not picked up)
5. Inappropriate use of dispense as written (DAW) codes
6. Prescription splitting to receive additional dispensing fees
7. Billing multiple payers for the same prescription (except as required for coordination of benefit transactions)
Examples of Pharmacy Fraud, Waste, and Abuse

- **Prescription drug shorting**: A pharmacist provides less than the prescribed quantity of drugs without informing the patient and bills for the fully prescribed quantity.

- **Prescription forging or altering**: Existing prescriptions are altered by an individual without the prescriber’s permission to increase the quantity or number of refills.

- **Dispensing expired or adulterated prescription drugs**: Dispensing drugs that are expired or have not been stored or handled in accordance with manufacturer and FDA requirements.

- **Bait and switch pricing**: The beneficiary is led to believe that a drug will cost one price, but is charged a higher price at the point of sale.
Prescriber Fraud, Waste, and Abuse

- **Prescription drug switching**: Cash payments or other benefits are offered to a prescriber to induce the prescriber to prescribe certain medications rather than others.

- **Theft of prescriber’s DEA number or prescription pad**: A stolen DEA number or prescription pad is used to write prescriptions for controlled substances or other medications that are often sold on the black market.

- **Script mills**: Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. The scripts are often written for controlled drugs for sale on the black market, and may include improper payments to the provider.
Beneficiary Fraud, Waste, and Abuse

- **Identity fraud**: Perpetrator uses another person’s Medicare card to obtain Medicare-covered services or prescriptions.

- **Prescription diversion and inappropriate use**: Beneficiaries obtain prescription drugs and gives or sells these medications to someone else. Diversion also includes the inappropriate consumption or distribution of a beneficiary’s medication by a caregiver.

- **Doctor shopping**: Beneficiary consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs.
**False Claims Act**

- **Purpose:** to discourage fraud against the government by establishing liability against persons and organizations who knowingly present (or cause to be presented) to the government a false or fraudulent claim for payment or approval. Violations of the False Claims Act may result in **civil monetary penalties**.

- The False Claims Act also prohibits knowingly making or using (or causing to be made or used) a **false record or statement** to get a false or fraudulent claim paid or approved by the federal government or its agents, like a carrier, other claims processor, or state Medicaid program.

- The False Claims Act also includes a qui tam or “whistleblower” provision. Under this provision, an individual with actual knowledge of allegedly false claims to the government can **file a lawsuit** on behalf of the government. The Act provides for the individual’s protection from retaliation resulting from filing an action under the False Claims Act, investigating a claim, or providing testimony to assist in a False Claims Act action.
Violations of the False Claims Act can result in civil penalties ranging from $5,500 to $11,000 per claim and up to triple the amount of damages sustained by the government.

The Fraud Enforcement and Recovery Act (FERA), a new law signed on May 20, 2009, expands the reach of the False Claims Act and strengthens the government’s ability to combat health care fraud. Health plans may face severe penalties for the retention of government overpayments even if the health plan did not make a false or improper claim for payment.
Anti-Kickback Statute

- Provides **criminal penalties** for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under Medicare or other Federal health care programs. In addition to applicable criminal sanctions, an individual or entity may be **excluded** from participation in Medicare or other Federal health care programs and subject to **civil monetary penalties**.

- For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

- Violations of the Anti-Kickback statute may result in fines of up to $25,000, **imprisonment** for up to 5 years, and **exclusion** from federal health care programs.
The Health Insurance Portability and Accountability Act (HIPAA)

- HIPAA established standards and requirements for the electronic transmission of certain health information. These standards and requirements are aimed at improving the **efficiency** and **effectiveness** of health information systems.

- Various regulations have been promulgated, including those establishing standards for certain electronic transactions, minimum security requirements, and minimum privacy protections for individually identifiable health information (i.e., protected health information) that is held by covered entities. Covered entities include health plans, health care clearing houses and certain health care providers. Additional rules have or will establish national identifiers for providers, health plans, and employers.

- Privacy regulations are enforced by the Office for Civil Rights. The Centers for Medicare and Medicaid Services (CMS) is responsible for enforcing other HIPAA regulations.
The American Recovery and Reinvestment Act of 2009 (ARRA)


- Title XIII of ARRA, the Health Information Technology for Economic and Clinical Health Act (HITECH Act):
  1. Establishes breach notification requirements for HIPAA covered entities and their business associates.
  2. Limits certain uses and disclosures of protected health information (PHI).
  3. Increases individuals’ rights with respect to PHI.
  4. Increases penalties for violations of privacy and security of PHI.
Fraud Enforcement and Recovery Act (FERA)

- Signed into law on May 20, 2009, FERA introduced major changes to the False Claims Act and increased funding for law enforcement activities related to health care fraud.

- Under FERA, a health plan may face penalties for the knowing retention of government overpayments – even if the overpayments did not result from false or improper claims for payment.

- FERA expanded the definition of “claim” subject to the False Claims Act to include claims filed by healthcare providers to Medicare managed care plans.
Exclusion from Federal Healthcare Programs

- The Department of Health and Human Services Office of the Inspector General (OIG) and the General Services Administration (GSA) maintain lists of individuals and entities excluded from participation in federal health care programs.

- Excluded individuals and entities should not be involved in the administration or delivery of Medicare Advantage, Medicare cost plan, or Part D benefits.

- The OIG List of Excluded Individuals and Entities is available at http://www.oig.hhs.gov

- The GSA Excluded Parties List System is available at http://www.epls.gov

- Federal regulations at 42 CFR 1003.102(a)(2) authorize the imposition of civil money penalties (CMP) against health care providers and entities that employ or enter into contracts with excluded individuals or entities to provide items or services to Federal healthcare program beneficiaries.
Exclusion from Federal Healthcare Programs

- The following are examples of services that violate an OIG or GSA exclusion when furnished by an excluded individual:

1. Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filing prescriptions for drugs reimbursed, directly or indirectly, by a Federal health care program.

2. Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly by a Federal health care program.
Exclusion from Federal Healthcare Programs

- Medicare Advantage Organizations and Part D sponsors like HMSA, hospitals, physicians, other providers, pharmacy benefit managers, and pharmacies should:

  1. Check the OIG and GSA exclusion status of individuals at the time of hire and at least annually thereafter.

  2. Remove any excluded employee or contractor from work on Medicare programs.
Medicare Drug Integrity Contractors (MEDICs)

- CMS contracts with private organizations, called MEDICs, to assist in the management of audit, oversight, and anti-fraud and abuse efforts for the Medicare Part D benefit.

- MEDIC functions include:
  - Identifying and investigating potential Part D fraud and abuse
  - Accepting potential fraud case referrals from Part D sponsors
  - Developing Part D fraud and abuse cases for referral to law enforcement
  - Acting as a liaison to law enforcement
  - Auditing Part D sponsor and subcontractor operations
Medicare Drug Integrity Contractors (MEDICs)

- CMS currently contracts with two regional MEDICs
  - North region – SafeGuard Services LLC (SGS)
  - South region – Health Integrity LLC
HMSA’s Benefits Integrity Department

- HMSA’s Benefits Integrity department spearheads our efforts to detect, investigate, and prevent fraud and abuse.

- Benefits Integrity combats health care fraud by investigating complaints, conducting proactive data analysis and case development, raising fraud and abuse awareness through training and education, and strengthening provider and vendor contract language.
Reporting Fraud, Waste, and Abuse

- HMSA encourages the reporting of potential or actual fraud, waste and abuse (FWA).

- HMSA has established hotline numbers to receive, record, and respond to potential FWA identified by any individual or entity, including beneficiaries, employees, and subcontractors. Calls to the hotlines may be made anonymously. No retaliation against individuals who report actual or suspected violations in good faith will be tolerated.
Reporting Fraud, Waste, and Abuse

- If you are aware that someone is involved or potentially involved in FWA activities or violating or potentially violating any Medicare law or regulation you should do one of the following:
  - Contact HMSA’s Benefits Integrity department or Compliance and Ethics Office
  - Call HMSA’s Compliance & Ethics Hotline at 1-800-749-4672
  - Call HMSA’s Fraud Hotline at 1-808-948-5166 on Oahu or 1-888-398-6445 toll-free
Policies and Procedures

- CMS expects Medicare Advantage Plans, Part D sponsors, pharmacy benefit managers, first tier and downstream entities, providers, and pharmacies to have policies and procedures that address the prevention, detection, and reporting of fraud, waste, and abuse.

- Policies and procedures should clearly articulate the organization’s commitment to comply with all applicable Federal and state laws, regulations, and program guidance related to the Medicare program. CMS lists examples of policies and procedures in Chapter 9, section 50.2.1.2 of the Prescription Drug Benefit Manual.
Thank you for completing our Medicare Advantage and Part D Fraud, Waste, and Abuse training course.