



Medicare Fraud, Waste, and Abuse Training for Pharmacies and Their Staff

2013/2014

Medicare Requirements

The Centers for Medicare and Medicaid Services (“CMS”) requires Medicare Advantage Organizations (“MAO”) and Medicare Prescription Drug Plans (“PDP”) collectively known as “Parts C & D” have a comprehensive plan to detect, prevent, and correct fraud, waste, and abuse (“FWA”). Each sponsor must implement an effective compliance program that meets the regulatory requirements. Included in the effective compliance program is a program to effectively train and educate its governing body members, employees and First Tier , Downstream or Related Entity (“FDR”).

The training and education must occur at least annually and be made part of the orientation for new employees within 90 days of initial hiring, including the chief executive and senior administrators or managers, governing body members and FDRs

Learning Objectives

- Understanding what is fraud, waste, and abuse
- Detecting fraudulent schemes
- Preventing, and reporting incidents of fraud, waste, and abuse.
- Understanding your protections

Compliance Plan Elements

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
- The designation of a compliance officer and compliance committee that are accountable to senior management.
- Effective training and education between the compliance officer and the MA organization's employees, managers and directors, and the MA organization's first tier, downstream, and related entities.
- Effective lines of communication between the compliance officer, members of the compliance committee, the MA organization's employees, Managers and directors, and the MA organization's first tier, downstream, and related entities.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Procedures for internal monitoring and auditing.
- Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to the organization's MA contract.

The Scope of Fraud, Waste, and Abuse in our Healthcare System

In 2007, the United States spent over \$2.24 trillion on health care and more than 4 billion health insurance claims were processed and an undisputed reality that some of these health insurance claims are fraudulent. The National Health Care Anti-Fraud Association (“NHCAA”) estimates that tens of billions of dollars are lost to health care fraud each year. This loss directly impacts patients, taxpayers and government through higher health care costs, insurance premiums and taxes. Be careful. Scam artists use fraudulent schemes to obtain your patient identification and insurance information to commit health insurance fraud. Between \$67 billion and \$224 billion is stolen every year by use of fraudulent schemes designed to cheat Medicare and insurance companies with fraudulent and illegal medical charges.** The most common fraudulent acts include, but are not limited to

- Billing for services, procedures and/or supplies that were never provided or performed.
- Billing for more expensive services or procedures than were actually provided or performed, commonly known as “upcoding”.
- Performing medically unnecessary services solely for the purpose of generating insurance payments.
- Falsifying a patient’s diagnosis to justify tests, surgeries or other procedures that aren’t medically necessary.
- Accepting kickbacks for patient referrals.

**The National Healthcare Anti-fraud Association (NHCAA). “Fighting Health Care Fraud: an Integral Part of Health Care Reform; available at: http://www.nhcaa.org/media/5997/fighting_health_care_fraud_nhcaajune2009.pdf

Defining Fraud, Waste and Abuse

- ***Criminal Fraud:*** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.
- ***Waste:*** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- ***Abuse:*** includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Differences Between Criminal Fraud, Waste and Abuse

Differences exist between fraud, waste and abuse. The primary difference is fraud requires intent and knowledge. The intent to obtain payment with the knowledge the action is wrong. Both waste and abuse may involve receiving an improper payment, but do not include the person having the same intent and knowledge.

Who Commits Fraud, Waste and Abuse?

- Anyone with a motive, means, and opportunity can commit fraud, waste, and abuse.
- Fraud, waste, and abuse can be committed by:
 - Beneficiaries
 - Pharmacies
 - Physicians
 - Sales Agents/Brokers
 - Anyone
 - or any combination of the above

Examples of Pharmacy Fraud, Waste, and Abuse

Inappropriate Billing Practices: Inappropriate billing practices at the pharmacy level occur when pharmacies engage in the following types of billing practices. These practices may be subject to the false claims act.

- Incorrectly billing for secondary payer to receive increased reimbursement;
- Billing for non-existent prescriptions;
- Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions;
- Billing for brand when generics are dispensed;

Examples of Pharmacy Fraud, Waste, and Abuse

Inappropriate Billing Practices (Cont'd)

- Billing for non-covered prescriptions as covered items
- Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up)
- Billing based on “gang visits,” e.g., a pharmacist visits a nursing home and bills for numerous pharmaceutical prescriptions without furnishing any specific service to individual patients
- Inappropriate use of dispense as written (“DAW”) codes
- Prescription splitting to receive additional dispensing fees
- Drug Diversion

Examples of Pharmacy Fraud, Waste, and Abuse

Inappropriate Billing Practices (Cont'd)

- Prescription Drug Shorting: Pharmacist provides less than the prescribed quantity and intentionally does not inform the patient or make arrangements to provide the balance but bills for the fully-prescribed amount.
- Bait and Switch Pricing: Bait and switch pricing occurs when a beneficiary is led to believe that a drug will cost one price, but at the point of sale the beneficiary is charged a higher amount.
- Prescription Forging or Altering: Where existing prescriptions are altered by an individual without the prescriber's permission.

Examples of Pharmacy Fraud, Waste, and Abuse

- **Dispensing Expired or Adulterated Prescription Drugs:** Pharmacies dispense drugs that are expired, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- **Prescription Refill Errors:** A pharmacist provides the incorrect number or refills prescribed by the provider
- **Illegal Remuneration Schemes:** Pharmacy is offered, paid, solicits, or receives unlawful remuneration to induce or reward the pharmacy to switch patients to different drugs, influence prescribers to prescribe different drugs, or steer patients to plans.

Examples of Pharmacy Fraud, Waste and Abuse

- **True Out-of-Pocket (“TrOOP”) Manipulation:** When a pharmacy manipulates TrOOP to either push the beneficiary through the coverage gap, so the beneficiary can reach catastrophic coverage before they are eligible, or manipulates TrOOP to keep a beneficiary in the coverage gap so that catastrophic is never realized.
- ***Failure to Offer Negotiated Prices:*** Occurs when a pharmacy does not offer a beneficiary the negotiated price of a Part D drug.

Tips for Identifying Fraud, Waste, and Abuse

Be on the lookout for possible fraudulent activities:

- **Review the prescription carefully to determine if it has been forged or altered.** Refer to the checklist on the back for tips for spotting forgeries.
- **If in doubt, verify.** If the prescription or the situation doesn't seem right, take an additional step to call the doctor to verify the prescription.
 - Use the prescriber's telephone number from the phone book or from pharmacy records prior to calling; do not call the number on the prescription. The telephone number on a forged prescription is typically changed so an accomplice can "verify" the forged prescription.
- **Confirm prescriptions called in to the pharmacy.** Again, use the prescriber's telephone number from the phone book or from pharmacy records. The telephone number provided by the person calling in the prescription may be false.

Tips for Identifying Fraud, Waste, and Abuse

- **Ask for identification.** Don't be afraid to ask the patient or party obtaining the prescriptions for identification and make a copy of it. This will help to identify the party picking up the prescription should it be fraudulent.
- **Ask for a signature.** Don't be afraid to require a signature from the party obtaining the prescriptions, even when one is not required. Again, this will help to identify the party picking up the prescription.
- **Report it.** Call the local police and the Plan if you believe you have a forged or altered prescription.
- **Look for signs of drug diversion.** Identify patterns of patients who may be doctor shopping or diverting drugs.
 - Does the patient get several rejects from the Part D Plan for refills too soon?
 - Does the patient see a large number of doctors?
 - Does the patient present prescriptions written in names of other people?
 - Could the drug interact with medication the patient is currently prescribed or taking?

Medical Identity Theft

As consumers we are aware identity theft can have devastating effects on your financial health-jeopardizing bank accounts, credit ratings and the ability to borrow. But are you as familiar with the risks posed by medical theft?

When a person's name or other identifying information is used without that person's knowledge or consent to obtain medical services or goods, or to submit false insurance claims for payment, that's medical identity theft. Medical identity theft frequently results in erroneous information being added to a person's medical record, or even the creation of an entirely fictitious medical record in the victim's name.

Victims of medical identity theft may receive the wrong medical treatment, find that their health insurance benefits have been exhausted, and could become uninsurable for both life and health insurance coverage.

A medical identity theft victim may unexpectedly fail a physical exam for employment because a disease or condition for which he's never been diagnosed or received treatment has been unknowingly documented in his health record.

Tips in Battling Identity Theft

- ***Ask for identification:*** Don't be afraid to ask the patient or party obtaining the prescriptions or receiving the medical service for identification and make a copy for your records.
- ***Ask for a signature:*** Don't be afraid to require a signature from the party obtaining the prescriptions or the medical service, even when one is not required.
- ***Report it:*** Call the local police and the impacted insurance company if you believe you have encountered a case of medical identity theft.
- ***Inform the Beneficiary:*** If you know who the true beneficiary is, immediately alert that individual so they can take steps to protect against further activity.

Examples of FWA Committed by Beneficiaries

- Misrepresentation of Status: A Medicare beneficiary misrepresenting personal information, such as identity, eligibility, or medical condition in order to receive a benefit
- Misrepresentation of Current Coverage: When a beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies to take advantage of the benefits
- Soliciting or Receiving a Kickback: A Medicare beneficiary soliciting a kickback or fee from a sales agent as a condition of enrollment. This includes any payment up-front or any payment after the enrollment is completed
- TrOOP Manipulation: A beneficiary manipulates TrOOP to push through the coverage gap so they can reach the catastrophic phase before they are eligible
- Prescription Forging or Altering: Beneficiary alters a prescription to increase quantity or number of refills
- Drug Diversion and Inappropriate Use: A beneficiary obtains a prescription then gives or sells the medication to someone else
- Resale of Drugs on the Black Market: Beneficiary falsely reports loss or theft of drugs or fake an illness to obtain drugs to resell on black market
- Theft of Services: Beneficiaries loaning their Medicare ID Cards and member identification cards to family members

Report Fraud, Waste and Abuse

If you suspect fraud, waste, or abuse report it to the Universal American Special Investigation (SIU) at:

Fraud, Waste, and Abuse Hotline: **1 (800) 388 - 1563**

Email: Fraud@UniversalAmerican.com

In Writing: **Universal American SIU
PO Box 27869
Houston, TX 77227**

Please provide the details of the allegation in your report to include:

- Subject of investigation
- Applicable member information (ID number, name, phone number)
- Date of incident
- Has the incident been reported to any other agency. If yes, who?

All reports are confidential and may be anonymous

It is illegal for a provider to retaliate against an employee who reports suspected fraud, waste, or abuse.

Stark Statute (Physician Self-Referral Law)

The Stark Statute, also referred to as the Physician Self-Referral Law, prohibits a physician from making a referral to an entity for certain designated health care related procedures that the physician has partial ownership or an investment interest in a manner the physician can receive compensation in return for services from the entity. Some exceptions do apply.

42 United States Code §1395nn

Medicare claims in violation of the Stark Statute are not payable and violators may be fined up to \$15,000 for each service provided and up to \$100,000 for entering into an fraudulent arrangement or scheme.

Civil False Claims Act and the Fraud Enforcement and Recovery Act (FERA)

- The enactment of the Fraud Enforcement and Recovery Act (FERA) in May 2009, amended the False Claims Act. With these amendments the False Claims Act now prohibits:
 - Presenting a claim known to be false or fraudulent for payment or reimbursement;
 - Making or using a false record or statement material to a false or fraudulent claim;
 - Engaging in a conspiracy to violate the False Claims Act;
 - Falsely certifying the type/amount of property to be used by the Government;
 - Certifying receipt of property without knowing if it's true;
 - Buying property from an unauthorized Government officer; and
 - Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the government.
- Penalties
 - Civil fines range from \$5,000 to \$10,000 per claim, plus 3 times the damages
- Qui Tam or 'Whistleblower' Protection
 - Individuals who come forward as 'whistleblowers' are afforded certain rights, and may not be retaliated against.

For more information on the False Claims Act please visit: or http://www.law.cornell.edu/uscode/html/uscode31/usc_sec_31_00003729----000-.html

Whistleblower Protection

In accordance with Section 3730 of the False Claims Act, If an individual is discharged, demoted, suspended, discriminated against or otherwise mistreated by his/her employer in retaliation for filing a Qui Tam (pronounced kway taem), the person is entitled to reinstatement at the same level, two times the amount of back pay plus interest and compensation for any special damages that were incurred as a result of the retaliation.

The Anti-Kickback Statute

- The Anti-Kickback Statute makes it illegal for individuals or entities to knowingly or 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 compliance with the Anti-Kickback Statute pharmacies cannot direct, urge or attempt to persuade a Medicare beneficiary to enroll in a particular plan or to insure with a particular company based on the financial or any interest of the pharmacy.
- In addition, pharmacies cannot inappropriately offer, pay, solicit or receive unlawful remuneration to switch patients to different drugs or influence prescribers to prescribe different drugs.
- Violations of the are punishable by up to five (5) years in prison, criminal fines up to \$25,000, administrative civil money penalties up to \$50,000, and exclusion from participation in federal health care programs.

For more information on the Anti-Kickback statute please visit:

<http://oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm>

Health Insurance Portability and Accountability Act (“HIPAA”) of 1996

HIPAA created Privacy and Security requirements for the personal health information of individuals.

- Privacy Requirements: The privacy requirements govern disclosure of patient protected health information (“PHI”), while protecting patient rights.
- Security Requirements: The security regulation adopts administrative, technical, and physical safeguards required to prevent unauthorized access to protected health care information.
- HIPAA created regulatory expectations for protecting the privacy and security of PHI. Failure to properly protect and secure beneficiary information can result in fines and penalties, both civil and criminal.
- Covered entities, like pharmacies, are bound by HIPAA regulations and the proper implementation of the protections it provides.

Other Important Compliance Tips

HIPAA

- Protect member information by complying with HIPAA rules and regulations
- Log off and lock your computer before you leave your workstation
- Put away, turn over, or lock up any member information before you leave your workstation
- Immediately retrieve print-outs or faxes that contain member information from common equipment
- Do not permit other access to work areas. Everyone must swipe their own badge.
- Do not store member information on any portable device
- IMMEDIATELY report any stolen equipment like a laptop, hard drive, or Blackberry to the IT Helpdesk 1-866-333-1444.
- Compliance & Ethics Hotline and Email
 - 1-800-388-1563
 - Compliance@UniversalAmerican.com

Fraud Waste & Abuse

- What Does Medicare Fraud or Abuse Look Like? Here are some examples:
 - A beneficiary loans his or her Medicare ID and Medicare Identification cards to a family member. (This is called "Theft of Service")
 - Someone alters a prescription to increase the quantity or refills of drugs. ("Prescription forging or Altering")
 - A provider bills for a service that was not performed. ("Services Not Rendered")
 - A sales agent or broker forges a beneficiary's signature in order to get him or her to enroll. ("Forgery")
 - A provider relations employee enriches a contract with a provider and receives something in value in return. ("Kickback")
- If you suspect fraud, waste or abuse, report it immediately! The company will not tolerate any retaliatory actions against you. Retaliation is not only wrong – it's against the law. Don't be afraid to do the right thing!
- FWA Hotline and Email
 - 1-800-388-1563
 - Fraud@UniversalAmerican.com

Additional Medicare Requirements

- **Office of Inspector General (“OIG”) Exclusion List:** OIG has the authority to exclude individuals and entities from federally funded health care programs pursuant to sections 1128 & 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (“LEIE”). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (“CMP”). CMS requires pharmacies to review the OIG exclusion list annually to confirm its employees are in good standing and have not been excluded from participating in the Medicare and Medicaid programs
- **Record Retention:** Pharmacies are required to maintain books, records, and documents related to the Part D Program for a minimum of 10 years

Notice of Medicare Rights

You **have the right to get a written explanation** from your Medicare drug plan if:

- Your doctor or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed by your doctor.
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

The Medicare drug plan's written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan's decision.

- You also have the right to ask your Medicare drug plan for an exception if: You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;" or
- You believe you should get a drug you need at a lower cost-sharing amount.

Additional Resources

- <http://oig.hhs.gov/compliance/compliance-guidance/index.asp>
- <http://exclusions.oig.hhs.gov/>
- <http://www.insurancefraud.org>
- <http://www.stopmedicarefraud.gov>
- <http://www.taf.org>
- <http://www.nhcaa.org/>
- <http://www.naag.org/>

- Chapter 9 Part D Program to Control Fraud, Waste, and Abuse:
http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/PDBManual_Chapt

When the right thing to do isn't clear....

Focus on integrity

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