Medicare Parts C & D Fraud, Waste, and Abuse Training and General Compliance Training

Developed by the Centers for Medicare & Medicaid Services

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Why Do I Need Training?

Every year *millions* of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

Including <u>YOU</u>.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

<u>YOU</u> are part of the solution.

Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse
- Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
- Provide information on how to report fraud, waste, and abuse
- Provide information on laws pertaining to fraud, waste, and abuse

Requirements

The Social Security Act and CMS regulations and guidance govern the Medicare program, including parts C and D.

- Part C and Part D sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
- Sponsors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Helpful Definitions

- **CMS** – Centers for Medicare & Medicaid Services
- **FDR** – First Tier, Downstream, Related Entities, entities contracted or subcontracted with RMHP. Contracted physician groups and hospitals, as well as Express Scripts, Inc. (our PBM) are examples of RMHP's First Tier entities.
- **MA-PD** – Medicare Advantage & Prescription Drug plan
- **PBM** – Pharmacy Benefit Manager, administrator for processing prescription claims
- **Part C** – Medicare Advantage Plans (combine Parts A & B), RMHP is a Sponsor
- **Part D** – Medicare Prescription Drug Plan, RMHP is a Sponser
- **PDP** – Prescription Drug Plan

Where Do I Fit In?

As a person who provides health or administrative services to a Part C or Part D enrollee you are either:

- Part C or D Sponsor Employee
- First Tier Entity
  - Examples: PBM, a Claims Processing Company, contracted Sales Agent
- Downstream Entity
  - Example: Pharmacy
- Related Entity
  - Example: Entity that has a common ownership or control of a Part C/D Sponsor

What are my responsibilities?

You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Part C or Part D requirements, including adopting and implementing an effective compliance program.
- **SECOND** you have a duty to the Medicare Program to report any violations of laws that you may be aware of.
- **THIRD** you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

An Effective Compliance Program

- Is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste and abuse.

- Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Prevention

How Do I Prevent Fraud, Waste, and Abuse?

- Make sure you are up to date with laws, regulations, policies.
- Ensure you coordinate with other payers.
- Ensure data/billing is both accurate and timely.
- Verify information provided to you.
- Be on the lookout for suspicious activity.

Policies and Procedures

Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Make sure you are familiar with your entity's policies and procedures.

Detection

Understanding Fraud, Waste and Abuse

In order to detect fraud, waste, and abuse

you need to know the **Law**

Criminal FRAUD

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 United States Code §1347

What Does That Mean?

Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse

Waste: 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. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Differences Between Fraud, Waste, and Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

Report Fraud, Waste, and Abuse

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your compliance department or your sponsor's compliance department. Your sponsor's compliance department area will investigate and make the proper determination.

Indicators of Potential Fraud, Waste, and Abuse

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

Indicators of Potential Fraud, Waste, and Abuse

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your role as a sponsor, pharmacy, or other entity involved in the Part C and/or Part D programs.

Key Indicators: Potential Beneficiary Issues

- Does the prescription look altered or possibly forged?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the service/picking up the prescription the actual beneficiary(identity theft)?
- Is the prescription appropriate based on beneficiary's other prescriptions?
- Does the beneficiary's medical history support the services being requested?

Key Indicators: Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?

Key Indicators: Potential Provider Issues

- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill the sponsor for services not provided?

Key Indicators: Potential Pharmacy Issues

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Are generics provided when the prescription requires that brand be dispensed?

Key Indicators: Potential Pharmacy Issues

- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?

Key Indicators: Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?

Key Indicators: Potential Manufacturer Issues

- Does the manufacturer promote off label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a federal health care program?

Key Indicators: Potential Sponsor Issues

- Does the sponsor offer cash inducements for beneficiaries to join the plan?
- Does the sponsor lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?
- Does the sponsor use unlicensed agents?
- Does the sponsor encourage/support inappropriate risk adjustment submissions?

How Do I Report Fraud, Waste, or Abuse?

Reporting Fraud, Waste, and Abuse

Everyone is required to report suspected instances of fraud, waste, and abuse. Your sponsor's Code of Conduct and Ethics should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.

*See, RMHP Reporting Mechanisms, slide **62.**

Reporting Fraud, Waste, and Abuse

Every MA-PD and PDP sponsor is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities. Each sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting. Review your sponsor's materials for the ways to report fraud, waste, and abuse.

When in doubt, call the MA-PD or PDP fraud, waste, and abuse Hotline or the Compliance Department.

Correction

Correction

Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government money and ensures you are in compliance with CMS' requirements.

How Do I Correct Issues?

Once issues have been identified, a plan to correct the issue needs to be developed. Consult your compliance officer or your sponsor's compliance officer to find out the process for the corrective action plan development.

The actual plan is going to vary, depending on the specific circumstances.

Laws You Need to Know About

Laws

The following slides provide very high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

Civil Fraud
Civil False Claims Act

Prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring 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.

31 United States Code § 3729-3733

Civil False Claims Act Damages and Penalties

The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

Criminal Fraud Penalties

If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code §1347

Anti-Kickback Statute

Prohibits:

Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

42 United States Code §1320a-7b(b)

Anti-Kickback Statute Penalties

Fine of up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment.

Stark Statute
(Physician Self-Referral Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn

Stark Statute Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with Stark are not payable. Up to a **$15,000** fine for each service provided. Up to **a $100,000** fine for entering into an arrangement or scheme.

Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

HIPAA

Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

Consequences

Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs

Scenario #1

A person comes to your pharmacy to drop off a prescription for a beneficiary who is a "regular" customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

What is your next step?

Scenario #1

A. Fill the prescription for 160
B. Fill the prescription for 60
C. Call the prescriber to verify quantity
D. Call the sponsor's compliance department
E. Call law enforcement

Scenario #1 Answer

Answer: C

Call the prescriber to verify

If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the sponsor's compliance hotline. The sponsor will provide next steps.

Scenario #2

Your job is to submit risk diagnosis to CMS for purposes of payment. As part of this job you are to verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the sponsor's process and to adjust/add risk diagnosis codes for certain individuals.

What do you do?

Scenario #2

A. Do what is asked of your immediate supervisor
B. Report the incident to the compliance department (via compliance hotline or other mechanism)
C. Discuss concerns with immediate supervisor
D. Contact law enforcement

Scenario #2 Answer

Answer: B

Report the incident to the compliance department (via compliance hotline or other mechanism)

The compliance department is responsible for investigating and taking appropriate action. Your sponsor/supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.

Scenario #3

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider ("Doe Diagnostics") has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics' claims far exceed any other provider that you reviewed.

What do you do?

Scenario #3

A. Call Doe Diagnostics and request additional information for the claims
B. Consult with your immediate supervisor for next steps
C. Contact the compliance department
D. Reject the claims
E. Pay the claims

Scenario # 3 Answer

Answers B or C

Consult with your immediate supervisor for next steps

or

Contact the compliance department

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance department have occurred, including whether additional documentation is necessary.

Scenario #4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

Scenario #4

A. Call the local law enforcement
B. Perform another review
C. Contact your compliance department
D. Discuss your concerns with your supervisor
E. Follow your pharmacies procedures

Scenario #4 Answer

Answer E

Follow your pharmacies procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.

Additional Resources

- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
  - Title XVIII of the Social Security Act
  - Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
  - Civil False Claims Act (31 U.S.C. §§ 3729-3733)
  - Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
  - Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
  - Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)
  - Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)
  - OIG Compliance Program Guidance for the Healthcare Industry: http://oig.hhs.gov/compliance/compliance-guidance/index.asp

Reporting Mechanisms-FWA

- Call the RMHP (Rocky Mountain Health Plans) Compliance/Fraud Hotline (You can remain anonymous via this method.) 888-237-1179 or 970-248-5101.

- Notify the Internal Audit Manager (write, email or call directly):

  Rocky Mountain Health Plans

  PO Box 10600

  Grand Junction CO 81502-5600

  ATTN: Internal Audit Manager

- Email: **FRAUDAUDITOR@rmhp.org**