Medicare Fraud, Waste, and Abuse Training for Healthcare Professionals

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.

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 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 Fraud, Waste, and Abuse

- **Services Not Rendered:** Billing for services and/or supplies that were never performed or provided. Examples include billing insurance companies for office visits even though the patient did not show up for a scheduled appointment, billing for an MRI with contrast even though there were no contrast materials injected, and pharmacies billing for non-existent prescriptions.

- **Up-coding:** Billing for a higher-level treatment than was actually provided. This is most commonly found to occur in the various Evaluation and Management codes. An example would be a provider billing a CPT 99215, when only a 99212 was justified by the service provided. It is highly encouraged that physicians and billers review their billing information prior to claim submission. Physicians are responsible for the actions of their billing personnel.
Examples of Fraud, Waste, and Abuse (Cont’d)

- **Unbundling**: Billing separately for services that are already included in the primary procedure. A common example is a physician billing a separate office visit for a follow up that was included in the global surgical code. By appending a modifier 25, the physician is indicating that the service was separate and distinct. Audits often reveal that the follow up visit was indeed a simple check up related directly to the surgery, and was ‘unbundled’ from the primary procedure.

- **Under-utilization**: Physicians not providing enough care or delaying needed care. This is most commonly found to occur with capitation contracts, when Primary Care Physicians (PCPs) and Independent Physician Associations (IPAs) are attempting to delay a beneficiary’s visit to a specialist in order to maximize their service funds.
Examples of Fraud, Waste, and Abuse *(Cont’d)*

- **Services Not Medically Necessary:** Billing for services or procedures that are not needed. The most common example includes adding unrelated history and/or review of systems to office visits to drive the key components required to bill higher level E & M codes. Medicare has strict guidance related to medical necessity and we encourage physicians and billers to continually monitor these guidelines. This has also become more prevalent with the increasing usage of Electronic Medical Records (EMR) by physicians offices. Many of these systems are configured to automatically add bullet statements to the medical record, regardless of if performed or not.

- **ICD-9 Up-coding:** Utilizing false or inflated diagnosis codes for encounter information to increase premiums. An example is listing Dx 250.0, indicating diabetes, however the patient has never had this disease. This results in a higher risk adjusted premium (RAPs) being paid by the Medicare Trust Fund to care for the beneficiary. CMS has placed great emphasis on eliminating inappropriate costs and undue remuneration in this area.
Examples of Fraud, Waste, and Abuse (Cont’d)

• **Formulary versus Brand:** Writing scripts for brand name pharmaceuticals even though the generic is stated in the plan formulary. Brand name drugs can often carry costs five times as high as the generics, results and effectiveness are the same, the outcome is a higher co-pay for the member and wastes spending from the Medicare Trust Fund.

• **Medical Identity Theft and Theft of Services:** Use of medical benefits by an unauthorized individual. This can be the result of outright theft or collusion between parties. It is critical that physicians and their staff verify identity of their patients, preferably with a government issued photo ID.
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.
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.
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 or pharmacy manipulates True Out of Pocket cost (“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
Examples of FWA Committed by Agents/brokers

• If a sales agent/broker intentionally misrepresents a product being marketed, with the goal of getting the beneficiary to enroll, this is considered fraud. An example would be omitting information about a comparative Medicare product to induce a beneficiary to purchase their insurance.

• Sales agents/brokers enrolling beneficiaries solely interested in a Part D Plan into a Medicare Advantage Plan without their knowledge and/or understanding

• If a sales agent/broker offers a beneficiary a kickback as an inducement to enroll

• Forging a beneficiary signature or knowingly accepting a forged signature on an enrollment form

• Utilizing beneficiary data to facilitate any enrollment without the beneficiaries knowledge, regardless of if a commission was paid or not

• Sales agents/brokers engaging in unsolicited door to door marketing activities

• Misuse of Scope of Appointment form or knowingly circumnavigating the rules concerning Scope of Appointment.
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.
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
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.
Health Insurance Portability and Accountability Act (HIPAA)

- The law known as “HIPAA” stands for the Health Insurance Portability and Accountability Act of 1996 which 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.
Office of Inspector General ("OIG") Exclusion Listing

No Federal funded health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. 42 U.S.C. §1395(e)(1) 42 C.F.R. §1001.1901

OIG’s List of Excluded Individuals/Entities ("LEIE") provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE. **

The OIG Exclusion list is available at: http://oig.hhs.gov/exclusions/index.asp

**http://oig.hhs.gov/faqs/exclusions-faq.asp
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 others 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 Resources

- 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_Chapter9_FWA.pdf
When the right thing to do isn’t clear….

Focus on integrity

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