

Fraud, waste and abuse awareness: Training for providers



Introduction

Annual requirement:

The Centers for Medicare & Medicaid Services (CMS) requires annual fraud, waste and abuse (FWA) training for organizations providing health care, prescription drug or administrative services to Medicare Advantage (MA) or Prescription Drug Plan (PDP) enrollees on behalf of the health plan.

As a MA and PDP Sponsor, we are committed to following all applicable laws, regulations and guidance that govern these programs.

Introduction, continued

Priority Health programs

Priority Health is committed to conducting business ethically and in compliance with all laws.

Our compliance program educates our board members, employees and contingent workforce about state and federal laws, regulations and ethics rules which apply to our business. We work to raise awareness of what constitutes questionable conduct, monitor compliance, and provide simple ways to report suspected violations.

Our written policies and procedures explain how to comply with business standards and federal and state laws. The company also employs a dedicated Compliance Officer and Compliance Committee to monitor suspected violations and, when appropriate, oversee corrective actions to prevent future violations.

Introduction, continued

We are a “plan sponsor”: Priority Health is under contract with the Centers for Medicare & Medicaid Services (CMS) to offer health and prescription drug coverage to eligible enrollees. Collectively, Priority Health is referred to as a Medicare Advantage (MA) Organization and Part D plan sponsor. We must follow applicable laws, regulations and guidance that govern all MA and Part D Plan sponsors.

You are a “related entity”: CMS requires entities associated with plan sponsors to attest that they are in compliance with legal and regulatory requirements.

As an entity that contracts with us to provide health, prescription and/or administrative services on behalf of our Medicare Advantage and/or Part D beneficiaries, your organization must meet new education and training requirements related to fraud, waste and abuse (FWA). The following slides provide learning objectives, revised regulations, definitions, education requirements, documentation requirements, relevant laws, examples of potential FWA, reporting and prevention mechanisms and resources.

Learning objectives

Objectives

At the conclusion of this presentation, you will have a better understanding of:

- New education and training regulations that govern Medicare Advantage and/or Part D plan sponsors
- Definitions used to help detect and prevent fraud, waste, and abuse
- Relevant laws and examples of potential fraud, waste and abuse
- Reporting and preventing potential fraud, waste and abuse and raise awareness about the issue
- Resources for further education on fraud, waste and abuse

Revised regulations

Revised regulations

On December 5, 2007, the Centers for Medicare & Medicaid Services (CMS) issued final rules in the Federal Register for 42 CFR Parts 422 and 423 of the Medicare Advantage Program and Prescription Drug Benefit Program, respectively.

Priority Health must:

- Maintain appropriate oversight and attest it will implement a compliance plan that includes effective training and education between the compliance officer, organization employees, contractors, agents and directors.
- Establish training and communication requirements for first tier, downstream and related entities with which Priority Health has a contractual relationship.

Definitions

Definitions

First tier entity

Any party that enters into a written arrangement with an MA (Medicare Advantage) and/or Part D organization or contract applicant to provide administrative services or health care services for a Medicare-eligible individual.

Example: Pharmacy Benefit Managers, hospitals, physicians.

Downstream entity

Any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a Sponsor (health plan) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and/or administrative services.

Examples: Mail order pharmacies, firms providing agent/broker services, agents, brokers, marketing firms, and call center firms.

Definitions, continued

Related entity

Any entity that is related to the MA organization by common ownership or control and:

1. Performs some of the MA organization's management functions under contract or delegation;
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the MA organization at a cost of more than \$2,500 during a contract period.

Definitions, continued

Plan sponsor

An entity that has a contract with CMS to offer one or more of the following Medicare products:

- Medicare Advantage (MA) Plan
- Medicare Advantage Prescription Drug Plan (MAPD)
- Prescription Drug Plan (PDP).

Definitions, continued

Fraud

An intentional deception, misrepresentation, false statement(s) or false representation of material facts with the knowledge that the deception could result in unauthorized benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. This includes any act that constitutes fraud under applicable Federal or State law.

Examples of fraud:

- Billing for services not furnished
- Soliciting, offering or receiving a kickback, bribe or rebate
- Violations of the physician self-referral (“Stark”) prohibition

Definitions, continued

Abuse

Practices inconsistent with sound fiscal, business or medical practices, result and result in an unnecessary cost to Priority Health or in reimbursement for services that are not medically necessary, violation of an agreement or certificate of coverage, or that fail to meet professionally recognized standards for health care. It includes member, employer group, agent or provider practices that result in unnecessary cost to us.

Examples:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards

Definitions, continued

Waste

Waste is generally defined as activities that unjustly enrich a person through the receipt of benefit payments but where the intent to deceive is not present; or is an attempt by an individual to obtain a benefit payment he or she does not deserve.

Medicare drug integrity contractor (MEDIC)

An organization that CMS has contracted with to perform specific program integrity functions for Part D under the Medicare Integrity Program. The MEDIC is CMS' designee to manage CMS' audit, oversight, and anti-fraud and abuse efforts in the Part D benefit.

Definitions, continued

Pharmacy Benefit Manager (PBM)

An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies.

Argus is Priority Health's Pharmacy Benefit Manager.

Education requirements

Education requirements

According to federal regulations, Priority Health is ultimately responsible for oversight and monitoring of education and training of first tier, downstream and related entities. Training is required to be completed annually and this material has been provided to assist you with your obligation to take annual fraud and abuse training. Your organization must maintain internal training logs to demonstrate that you have completed fraud and abuse training. This material may be included and tracked as part of your organizations compliance program.

How can you comply with the FWA education and training requirements?

1. Complete this training provided by Priority Health, OR
2. Take training from another MA and/or Part D Plan Sponsor, or other organization that meets the CMS requirements.

Education requirements, continued

Priority Health FWA training

Training is divided into three sections:

- Relevant laws
- Examples of potential fraud, waste and abuse
- Reporting and preventing fraud, waste and abuse

Relevant laws

False Claims Act

The False Claims Act prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. When submitting claims data to CMS for payment, Priority Health and our subcontractors must certify that claims data is true and accurate to the best of their knowledge and belief.

The False Claims Act is enforced against any individual/entity that knowingly submits (or causes another individual/entity to submit) a false claim for payment to the Federal government.

Note: It is not necessary to prove that the government was in fact defrauded, so long as it is established that the person acted “with intent to defraud.”

Anti-kickback statute

Individuals are prohibited from knowingly or willfully offering, paying, soliciting or receiving remuneration (the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind) in order to induce and reward business payable (or reimbursable) under the Medicare or other federal health care programs.

There are three objectives behind the federal anti-kickback law.

- 1) To prevent over-utilization of health care programs
- 2) To limit patient steering
- 3) To promote market competition

Penalties

A criminal sanction may place those in violation of the law in jail for up to 5 years, assess a \$25,000 fine and impose mandatory exclusion from participation in any government funded health care programs. On the civil side, the monetary penalty of \$50,000 per violation and treble damages (damages that equal three times the dollar amount the government is defrauded) may apply.

The Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against any person who makes, or causes to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services.

The Program Fraud Civil Remedies Act:

- Addresses lower-dollar fraud
- Generally applies to claims of \$150,000 or less

Stark law

The Stark law pertains to physician referrals under both Medicare and Medicaid. It states that:

- A physician cannot refer patients to an entity for the purpose of furnishing certain designated health services if the physician or an immediate family member has a financial relationship with that entity.
- The entity cannot bill for improperly referred services unless an exception or safe harbor applies.

The Stark law has no state-of-mind requirement. The intention and motives of the parties involved are irrelevant. If statutory requirements are met, there is a violation, unless an exception or safe harbor applies.

The Stark law targets over-utilization and improper patient steering, and is intended to increase market competition.

Penalties

Sanctions and fines are civil (criminal penalties do not apply). The billing entity must refund the payments for improperly referred services. There is also a civil monetary penalty of up to \$15,000 for any person who presents or causes a claim for improperly referred designated health services as long as they know that the claim is improper.

Why focus on FWA?

- Scams alone cost the health care industry more than \$100 billion annually.
- Fraud, waste and abuse programs save Medicare dollars. This benefits taxpayers, government, health plans and beneficiaries.
- Detecting, correcting and preventing fraud, waste and abuse requires collaboration between:
 - You
 - Providers of services such as physicians, pharmacies, beneficiaries, etc.
 - State and Federal agencies

Examples of potential FWA

Potential FWA committed by ...

MA and/or Part D Plan sponsors

Unlawful marketing schemes:

- Offering beneficiaries a cash payment as an inducement to enroll in Part D
- Unsolicited door-to-door marketing
- Enrollment of beneficiaries without their knowledge or consent
- Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS
- Misrepresenting the product being marketed as an approved Part D Plan when it actually is a Medigap policy or non-Medicare drug plan
- Requiring beneficiaries to pay up front premiums

Potential FWA committed by ...

Pharmacy Benefit Managers (PBM)

Unlawful remuneration:

- PBM receives unlawful remuneration in order to steer a beneficiary toward a certain plan or drug, or for formulary placement. Includes unlawful remuneration from vendors beyond switching fees.

Failure to offer negotiated prices:

- Occurs when a PBM does not offer a beneficiary the negotiated price of a Part D drug

Potential FWA committed by ...

Retail pharmacies

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 drug shorting:

- A 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.

Prescription forging or altering:

- Where existing prescriptions are altered by an individual without the prescriber's permission to increase quantity or number of refills.

Potential FWA committed by ...

Providers

Illegal remuneration schemes:

- Provider is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs, products or services

Script mills:

- Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not their own. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.

Theft of provider's DEA number or prescription pad:

- Prescription pads and/or DEA numbers can be stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications often sold on the black market.

Potential FWA committed by ...

Pharmaceutical manufacturers

Illegal off-label promotion:

- Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotion campaigns

Illegal usage of free samples:

- Providing free samples to physicians knowing and expecting those physicians to bill the federal health care programs for the sample

Potential FWA committed by ...

Beneficiaries

Misrepresentation of status:

- A Medicare beneficiary misrepresents personal information such as identity, eligibility, or medical condition in order to illegally receive the drug benefit. Enrollees who are no longer covered under a drug benefit plan may still attempt to use their identity card to obtain prescriptions.

Identify theft:

- A person uses a beneficiary's Medicare card to obtain prescriptions

Resale of drugs on Black Market:

- Beneficiary falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market

Doctor shopping:

- Beneficiary or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might indicate an underlying scheme, such as stockpiling or resale on the black market.

Reporting and Preventing FWA

Reporting potential FWA

Contact Priority Health immediately if your organization, or another downstream entity that you contract with on behalf of Priority Health Medicare beneficiaries, identifies potential fraud, waste and abuse.

You may remain anonymous.

Reporting methods:

- Priority Health Compliance Helpline: 800 560-7013
- Customer Service: 800 446-5674
- Write to: Priority Health Fraud and Abuse Program
Cost Recovery Department MS-2305
1231 East Beltline NE
Grand Rapids, MI 49525
- E-mail : kathy.kilduff@priorityhealth.com or
brenda.gross@priorityhealth.com
- Website: www.priorityhealth.com/contact/fraudabuseprgm/reporting

Reporting, continued

Suspected cases of Medicare fraud may also be reported to the Office of Inspector General at: 800 447-8477

Office of Inspector General HHS Tips Hotline
PO Box 23489
Washington, DC 20026

Examples of information that will assist with an investigation:

- Contact information (e.g., name of individual making the allegation, address, telephone number). You may share your name and telephone number with Priority Health and request that your name not be used. Your name will be left out of the report, but we will be able to call you with any questions we may have.
- Summary of the complaint, including a description of the service, date of incident, and documentation such as a bill or EOB if appropriate.

As situations warrant, Priority Health may make referrals to law enforcement agencies and/or the MEDIC.

Preventing potential FWA

CMS follows four parallel strategies to prevent fraud and abuse:

- Preventing fraud through effective enrollment and through education of physicians, providers, suppliers and beneficiaries.
- Early detection through Medical Review (MR) and data analysis.
- Close coordination with partners, including contractors, the MEDIC and law enforcement agencies.
- Applying fair and firm enforcement policies

Resources

Resources

Visit these federal government websites for more information on fraud, waste and abuse education, detection, correction and prevention.

Department of Health and Human Services Office of Inspector General

<http://oig.hhs.gov/fraud/hotline/>

Centers for Medicare & Medicaid Services

<http://www.oig.hhs.gov/fraud.asp>

http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage

Department of Health and Human Services

<http://www.stopmedicarefraud.gov/>

Social Security Administration

<http://www.ssa.gov/oig/guidelin.htm>

CMS Information about the Physician Self Referral Law

www.cms.hhs.gov/PhysicianSelfReferral

Priority Health

<http://www.priorityhealth.com/contact/fraudabuseprgm>

Examples of fraud, waste & abuse

General

- Billing for items or services not rendered or not provided as claimed
- Submitting claims for equipment or supplies and services that are not reasonable and necessary
- Double billing resulting in duplicate payment
- Billing for non-covered services as if covered
- Knowing misuse of provider ID numbers, resulting in improper billing
- Unbundling (billing for each component of a service instead of billing or using all-inclusive code)
- Failure to properly code using modifiers
- Altering medical records
- Improper telemarketing practices
- Compensation programs that offer incentives for items or services ordered and revenue generated
- Inappropriate use of place of service codes
- Routine waivers of deductibles or coinsurance
- Upcoding the level of service provided

Examples, continued

Skilled nursing facilities (“SNF”)

- Upcoding resident RUGs assignments to gain higher reimbursement;
- Improperly using therapy services to inflate the severity of the RUG classification to obtain additional reimbursement
- DME or supplies offered by DME provider that are covered by the Medicare Part A benefit in the SNF’s payment

Hospitals

- Failure to follow the same-day rule
- Abuse of partial hospitalization payments
- Same day discharges and readmissions
- Improper billing for observation services
- Improper reporting of pass through costs
- Billing on an outpatient basis for “inpatient only” procedures
- Submitting claims for medically unnecessary services
- Incorrect diagnosis coding to inflate the DRG resulting in higher reimbursement

Examples, continued

Physicians and others

- Chiropractor intentionally billing Medicare for physical therapy and chiropractic treatments that were never actually rendered
- Psychiatrist billing for psychiatric services provided by his nurse rather than himself
- Physician certifies on a claim form that he performed laser surgery on a Medicare beneficiary when he knew that the surgery was not actually performed on the patient
- Physician instructing employees to tell investigators that the physician personally performs all treatments when technicians do the majority of the treatment and the physician is rarely present in the office
- Physician under investigation altering records to cover up improprieties
- Neurologist knowingly submits electronic claims to the Medicare carrier for tests that were not reasonable and necessary and intentionally upcoding office visits and electromyograms
- Podiatrist knowingly submits claims for non-routine surgical procedures when routine, non-covered services such as the cutting and trimming of toenails and the removal of corns and calluses were performed

Examples, continued

Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

- Billing for items or services not provided to the beneficiary
- Continued billing for rental items after they are no longer medically necessary
- Resubmission of denied claims with different information in an attempt to be improperly reimbursed
- Providing and/or billing for substantially excessive amounts of DME items or supplies
- Upcoding a DME item by selecting an inappropriate code
- Providing a wheelchair and billing for the individual parts (unbundling)
- Delivering or billing for certain items or supplies prior to receiving a physician's order and/or appropriate certificate of necessity
- Completing portions of the certificate of necessity that are reserved for completion by the treating physician only
- Cover letters to encourage physicians to order medically unnecessary items or services

Examples, continued

Home health providers

- Furnishing more visits than as medically necessary
- Duplicate billing for the same service
- Submitting claims for home health aide services to beneficiaries that did not require any skilled qualifying service
- Providing personal care services by aides in assisted living facilities when such is required by the facility's State license
- Providing services at no charge to an assisted living center

Ambulances

- Providing free transportation to beneficiaries to influence their selection of a particular provider, practitioner or supplier

Hospices

- Providing nursing services for non-hospice patients

Examples, continued

Pharmacies

- Short-filling prescriptions
- Working around edits and pre-authorization guidelines to avoid using generic medications or step therapy protocols
- Billing a brand-name medication and delivering the generic medication
- Altering prescriptions
- Billing for medications not received by the beneficiary
- Billing for medications that were returned to stock
- Long-term care facilities/pharmacy issues – Destroying medications when the patient is no longer a resident versus returning medication to stock

CONGRATULATIONS!

You've completed the fraud and abuse compliance training.

Please report back to your organization that you have completed this training. Your organization is required to keep a log of who completed the training and to ensure that the training is completed annually.