



# Medicare Fraud, Waste, and Abuse Training for Entities that Support Medicare Activities

2010 - 2011

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# Medicare Requirements

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Plans to have a comprehensive plan to detect, prevent, and correct fraud, waste, and abuse (FWA) in the Medicare program. An element of the plan includes fraud, waste, and abuse training and education.

Medicare contracted providers and their employees must participate in fraud, waste, and abuse training upon new hire and annually thereafter.

# 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.
- A compliance plan, that includes measures to detect, correct, and prevent fraud, waste, and abuse.

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

The National Healthcare Anti-fraud Association (NHCAA) cites an average of 3 percent (at the low end) and 10 percent (at the high end) of healthcare spending is lost due to fraud. That's between \$67 Billion and \$230 Billion lost each year to fraud, waste or abuse. That estimates to between \$184 million and \$630 million dollar loss per day, and this number is expected to increase every year as healthcare costs rise.\* Healthcare fraud is believed to be the second largest white-collar crime in the United States. It is often mistaken for a victimless crime, but it affects everyone. Fraud causes insurance premiums to rise, and victims may be put through unnecessary or unsafe procedures. Victims of identity theft may find their insurance information used to submit false claims. This is a staggering cost, and we are committed to battling these unnecessary expenditures every step of the way.

\*The National Healthcare Anti-fraud Association (NHCAA). "Anti-Fraud Resource, Consumer Info & Action"; available at: [http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti\\_fraud\\_resource\\_cent&wpscode=ConsumerAndActionInfo](http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_cent&wpscode=ConsumerAndActionInfo)

## Defining Fraud, Waste and Abuse

***Fraud:*** The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that deception could result in some unauthorized benefit.

***Waste:*** Acting with gross negligence or reckless disregard for the truth in a manner that results in any unnecessary cost or any unnecessary consumption of a healthcare resource.

***Abuse:*** Those incidents that are inconsistent with accepted medical or business practices, improper or excessive.

## Fraud Can Be Committed By:

- Beneficiaries
- Pharmacies
- Physicians
- Third Parties
- or any combination of the above



## Examples of Fraud, Waste and Abuse 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

## Examples of Fraud, Waste and Abuse Committed by **Physicians**:

- *Illegal Remuneration Schemes*: A prescriber is offered, paid, solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or services
- *Prescription Drug Switching*: Offering cash or other benefits to induce the prescriber to prescribe certain medications rather than others
- *Script Mills*: Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled substances for sale on the black market and may include improper payments to the provider
- *Up-coding*: Providers billing for a higher level of service than was actually administered
- *Medically Unnecessary Services*: Physicians providing services to beneficiaries, even though those services were not needed
- *Services Not Rendered*: A provider billing for a service that was never performed
- *False Diagnosis*: A provider falsifying a patient diagnosis condition in order to inflate Risk Adjusted Premium (RAPs) remuneration

## Examples of Fraud, Waste and Abuse Committed by **Sales Agents/Brokers:**

- When a sales agent/broker claims to work or contract with either Social Security or The Centers for Medicare and Medicaid Services (CMS), when in fact they do not, the agent has made a false statement and this can be considered fraud
- 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 or change their insurance
- Publishing or stating untrue, deceptive or misleading information to induce enrollment. An example would be making a false statement about the financial condition or stability of another company, with the goal of convincing the member they should switch health plans
- Agents sponsoring luncheons and then taking information, including the signature, from the sign-in sheets or attendance logs to produce enrollment forms. The forms are then submitted and the beneficiary who attended the event ends up enrolled into a plan without their knowledge or consent

## Examples of Fraud, Waste and Abuse Committed by **Sales Agents/Brokers:**

- 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.

## Examples of Fraud, Waste and Abuse Committed by **Sales Agents/Brokers:**

- Requiring applicants to pay their premiums, or provide financial information (banking or credit card information) up front, or offering to take and “pass on” the member’s monthly premium payments to the insurance company
- Sales agents/brokers ‘recycling’ previously utilized enrollment forms. In this scheme, agents retain copies of previous years enrollment forms, and simply change dates and resubmit without the member’s knowledge, resulting in the member being moved to another plan
- Sales agents/brokers selling beneficiary information. There have been noted increases of agents utilizing their client lists to sell beneficiary data on the black market. This information is then also used in identity theft and false claims schemes



## Examples of Fraud, Waste, and Abuse Committed by **Pharmacies:**

- *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
  - 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)

## Examples of Fraud, Waste, and Abuse Committed by Pharmacies: (Cont'd)

- **Inappropriate Billing Practices (Cont'd)**
  - 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 Fraud, Waste, and Abuse Committed by **Pharmacies:** *(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 Fraud, Waste, and Abuse Committed by **Pharmacies:(Cont'd)**

- *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.
- *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.

## 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: 1-866-684-0595

Email: [Fraud@UniversalAmerican.com](mailto:Fraud@UniversalAmerican.com)

### In Writing:

Universal American SIU  
29100 Aurora Road  
Solon, Ohio 44139

or

Universal American SIU  
4888 Loop Central Drive Ste 700  
Houston, TX 77081



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.**

## False Claim 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 knowingly:
  - Submitting 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 or to an ‘obligation’ to pay money to the government.
  - Engaging in a conspiracy to defraud by the improper submission of a false claim.
  - Concealing, improperly avoiding or decreasing an ‘obligation’ to pay money to the government.
- Penalties
  - Civil fines range from \$5,000 to \$11,000 per claim, plus 3 times the amount of damages
- Qui Tam or ‘Whistleblower’ Protection
  - In accordance with the False Claims Act, 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: <http://www.taf.org/federalfca.htm>, or <http://www.law.cornell.edu/uscode/html/uscode31/usc sec 31 00003729----000-.html>

## The Anti-Kickback Act

- 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 the Medicare or other Federal health care programs.
- In compliance with the Anti-Kickback Act 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.

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

[http://www.ssa.gov/OP\\_Home/ssact/title11/1128B.htm](http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm)

# 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.

## Additional Medicare Requirements

- **OIG Exclusion List:** CMS requires pharmacies to review the Office of Inspector General (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
- **Notice of Medicare rights:** Pharmacies are required to visibly post the Notice of Medicare Rights for beneficiaries who disagree with the information provided by the pharmacy
- **Record Retention:** Pharmacies are required to maintain books, records, and documents related to the Part D Program for a minimum of 10 years



## Additional Resources

- <http://www.cms.hhs.gov/pharmacy/>
- Chapter 9 Part D Program to Control Fraud, Waste, and Abuse:  
<http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManualChapter9FWA.pdf>  
<http://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManualChapter9FWA.pdf>
- <http://www.insurancefraud.org>
- <http://www.stopmedicarefraud.gov>
- <http://www.ssa.gov/oig/guidelin.htm>
- <http://www.nhcaa.org/eweb/StartPage.aspx>