



# Medicare Fraud, Waste, and Abuse Training for Healthcare Professionals

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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.

## 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 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 were '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 beneficiaries 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.

## Tips for Identifying Fraud, Waste, and Abuse

- **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?

## 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 Resources

- <http://www.cms.gov/>
- <http://www.hhs.oig.gov/fraud/exclusions.asp>
- <http://www.insurancefraud.org>
- <http://www.stopmedicarefraud.gov>
- <http://www.stophealthcarefraud.com/>
- <http://www.taf.org/federalfca.htm>
- <http://www.nhcaa.org/eweb/StartPage.aspx>
- <http://www.naag.org/>
- <http://www.justice.gov/opa/pr/2010/July/10-ag-821.html>
- 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>