

**Fraud, Waste, and
Abuse Training
2012**

CMS Final Rules

➤ On December 5, 2007, 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.

The Plan Sponsor must:

- Maintain appropriate oversight and develop a compliance plan that includes measures to detect, prevent and correct fraud, waste and abuse.
 - Establish fraud, waste and abuse training and effective lines of communication between the MA or Part D plan and its first tier, downstream and related entities.
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Training and Documentation Requirements

➤ Most delegated entities will need to fulfill their contract requirements which now includes that they participate in a Fraud, Waste and Abuse (FWA) training program. Failure to take the CMS mandated FWA training is a contract violation.

- The training must comply with the requirements of 42 CFR Parts 422.503(b)(4)(vi)(C) or 423.504(b)(4)(vi)(C).
 - CMS clarified in April of 2010 that medical providers enrolled in the fee-for-service Medicare Program do not need to complete the FWA training. In addition, entities enrolled into the Medicare Program as DMEPOS suppliers are also deemed to have met the training requirements. However, all other delegated entities MUST take FWA training.
 - FWA training must be done at a minimum within 90 days of initial hire and annually thereafter.
 - Organizations must maintain internal training logs and submit copies of the training logs along with required attestations demonstrating that employees received FWA training.
 - If your organization has contracted with other entities to provide health and/or administrative services for MA and Part D enrollees, you will need to obtain attestations from those entities that they have completed FWA training.
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What is a Compliance Plan?

- A compliance plan is a series of internal controls and measures to ensure the plan sponsor follows applicable laws and regulations that govern Federal programs, like Medicare.
 - The adoption and implementation of a compliance program significantly reduces the risk of fraud, waste and abuse in the health care setting, while providing quality of services and care to patients.
 - Organizations contracting directly or indirectly with the federal government are obligated to:
 - Report fraud, waste and abuse;
 - Demonstrate their commitment to eliminating fraud, waste and abuse; and
 - Implement internal policies and procedures to identify and combat health care fraud.
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What is a Compliance Plan? (cont'd)

➤ *An effective Compliance Plan includes 7 core elements:*

1. **Written Standards of Conduct:** Development and distribution of written Standards of Conduct and Policies and Procedures that promote our Plan Sponsors' commitment to compliance and that address specific areas of potential fraud, waste and abuse.
 2. **Designation of a Compliance Officer:** Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
 3. **Effective Compliance Training:** Development and implementation of regular, effective education and training, such as this training.
 4. **Internal Monitoring and Auditing:** Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem areas.
 5. **Disciplinary Mechanisms:** Policies to consistently enforce standards and address dealing with individuals or entities that are excluded from participating in CMS programs.
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What is a Compliance Plan? (cont'd)

6. **Effective Lines of Communication:** Between the compliance officer and the organization's employees, managers and directors and members of the compliance committee, as well as first tier, downstream and related entities.
 - Includes a system to receive, record and respond to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality
 - First tier, downstream, and related entities must report compliance concerns and suspected or actual misconduct involving the MA or Part D programs to their immediate upline
 7. **Procedures for Responding to Detected Offenses and Corrective Action:** Policies to respond to and initiate corrective action to prevent similar offenses including a timely, reasonable inquiry.
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What are Sponsors and Entities?

- Plan Sponsor: An entity that has a contract with CMS to offer one or more of the following Medicare Products:
 - Medicare Advantage Plans
 - Medicare Prescription Drug Plans
 - 1876 Cost Plans

 - First Tier Entity: A party that enters into a written arrangement, acceptable to CMS, with a Plan Sponsor to provide administrative services or health care services for a Medicare eligible individual under the MA or Part D programs.

Examples include:

 - Provider Organizations
 - Pharmacy Benefits Manager (PBM)
 - Hospitals
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What are Sponsors and Entities?

➤ Downstream Entity: A party that enters into a written arrangement, acceptable to CMS, with persons or entities involved in the MA or Part D benefit, below the level of the arrangement between a Plan Sponsor and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Examples include:

- Management Services Organizations (MSO)
- Disease Management Organizations
- Claims Processing Organizations

➤ Related Entity: An entity that is related to the Plan Sponsor by common ownership or control and performs some of the Plan Sponsor's management functions under contract or delegation; furnishes services to Medicare enrollees under an oral or written agreement; or leases real property or sells materials to the Plan Sponsor at a cost of more than \$2,500 during a contract period.

Conflict of Interest

➤ A conflict of interest occurs when an individual's private interest interferes in any way — or even appears to interfere — with the interests of the Company as a whole. The Company expects all employees, officers and directors to exercise good judgment and the highest ethical standards in their activities on behalf of the Company as well as in their private activities outside the Company. Merely an appearance of a conflict can reflect negatively on the Company and its reputation, even if there is no actual conflict present. The Company's employees and officers are expected to devote their full time and attention to company business during regular working hours and for any additional hours that are required to complete their day to day operations.

Definitions

➤ Fraud: Fraud is the intentional misrepresentation of data for financial gain. Fraud occurs when an individual knows or should know that something is false and makes a knowing deception that could result in some unauthorized benefit to themselves or another person.¹

*Examples of Fraud:*²

- Billing for services not furnished
- Billing for services at a higher rate than is actually justified
- Soliciting, offering or receiving a kickback, bribe or rebate
- Deliberately misrepresenting services, resulting in unnecessary cost, improper payments or overpayment
- Violations of the physician self-referral (“Stark”) prohibition

Source:

1. CMS Glossary; CMS Medicare Learning Network (MLN)

2. Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals, Tenth Edition (October 2008)

Definitions

➤ Abuse: Abuse involves payment for items or services where there was no intent to deceive or misrepresent but the outcome of poor insufficient methods results in unnecessary costs to the Medicare program.¹

*Examples of Abuse:*²

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards
- Billing Medicare based on a higher fee schedule than is used for patients not on Medicare

➤ Waste: Waste is the extravagant, careless or needless expenditure of healthcare benefits or services that results from deficient practices or decisions.¹

Examples of Waste:

- Over-utilization of services
- Misuse of resources

Source:

1. CMS Glossary; CMS Medicare Learning Network (MLN)
2. CMS Medicare Fraud and Abuse Web-based Training (April 2007)

FWA Laws: False Claims Act

- The False Claims Act, in part, prohibits any person from:
 - Knowingly presenting, or causing to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval
 - Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government
 - Conspiring to defraud the Government by getting a false or fraudulent claim allowed or paid
 - A violator may be liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person.
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FWA Laws: Anti-Kickback Statute

- The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully solicit, receive, offer or pay remuneration (including any kickback, bribe or rebate) in return for:
 - Referrals for the furnishing or arranging of any items or service reimbursable by a Federal health care program
 - Purchasing, leasing, ordering or arranging for the purchasing or leasing of an item or service reimbursable by a Federal health care program
 - Remuneration is defined as the transfer of anything of value, directly or indirectly, overtly or covertly in cash or in kind. When this happens, both parties are held in criminal liability of the impermissible “kickback” transaction.
 - Penalties include up to \$25,000 or imprisonment of up to five years or both.
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FWA Laws: Physician Self-Referral Prohibition Statute (**Stark Law**)

➤ The Physician Self-Referral Prohibition Statute, commonly referred to as the “Stark Law,” prohibits:

- A physician from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician’s immediate family has a financial relationship -unless an exception applies.
 - An entity from presenting or causing to be presented a bill or claim to anyone for a designated health service furnished as a result of a prohibited referral.
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Health Insurance Portability and Accountability Act (HIPAA)

- Among other things, HIPAA, was enacted to improve the efficiency and effectiveness of health information systems through the establishment of standards and requirements for the electronic transmission of certain health information.
 - Regulations include standards for certain electronic transactions, minimum security requirements, and minimum privacy protections for individually identifiable health information covered entities (i.e., protected health information).
 - HIPAA includes a provision that established the Medicare Integrity Program (MIP)
 - The goal of the MIP is to pay it right -pay the right amount, to the right provider or supplier, for the right service, to the right beneficiary.
 - The CMS staff, Fiscal Intermediaries, and carriers work within a wide range of Medicare programs to improve payment accuracy.
 - These programs include cost report auditing, the Medicare Secondary Payment (MSP) provisions, Medical Review (MR), and anti-fraud activities to improve payment accuracy.
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Legal Actions

- A provider, supplier or health care organization that has been convicted of fraud may receive a significant fine, prison sentence or be temporarily or permanently excluded from the Medicare program or other Federal health care programs, and in some states, lose their license. Failure to comply with fraud and abuse laws may result in:
 - Investigations referred to the Office of Inspector General (OIG)
 - Civil monetary penalties that can result in up to \$10,000 per violation and exclusion from the Medicare program
 - Denial or revocation of a Medicare Provider Number
 - Suspension of payment
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Why Focus on FWA?

- The United States spends more than \$2 trillion on health care every year.*
- The National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent —or more than \$60billion each year —is lost to fraud.*

* Statement by Daniel R. Levinson, Inspector General, Office of the Inspector General, U.S. Department of Health and Human Services; before the Senate Special Committee on Aging, United States Senate, on combating Fraud, Waste, and Abuse in Medicare and Medicaid (May 06, 2009).

Examples of Potential FWA:

Billing

➤ Inappropriate Billing Practices:

- Billing for services not furnished and/or supplies not provided; this includes billing Medicare for appointments that the patient failed to keep.
 - Billing that appears to be a deliberate application for duplicate payment for the same services or supplies, billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice.
 - Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount.
 - Unbundling (billing for each component of the service instead of billing or using all inclusive code)
 - Billing based on "gang visits" such as a physician visiting a nursing home and billing for 20 nursing home visits without furnishing any specific service to individual patients.
 - Misrepresentations of dates and descriptions of services furnished or the identity of the beneficiary or the individual who furnished the services.
 - Billing Medicare based on a higher fee schedule than is used for patients not on Medicare.
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Examples of Potential FWA:

Beneficiary

- Identify Theft
 - Using a member's I.D. card that does not belong to that person to obtain prescriptions, services, equipment, supplies, doctor visits, and/or hospital stays.
 - Doctor Shopping
 - Visiting a number of doctors to obtain multiple prescriptions for painkillers or other drugs. Might point to an underlying scheme (stockpiling or black market resale).
 - Resale of Drugs or Black Market
 - Falsely reporting loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.
 - Improper Coordination of Benefits
 - Beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies to "game" the system.
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Examples of Potential FWA:

Prescriber

➤ Illegal Payment Schemes

- Prescriber is offered, paid, solicits or receives unlawful payment to induce or reward the prescriber to write prescriptions for drugs or products.

➤ Script Mills

- Prescribers write 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 drugs for sale on the black market, and might include improper payments to the prescriber.

➤ Theft of Prescriber's Drug Enforcement Agency (DEA) Number or Prescription Pad

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

Retail Pharmacy

- Inappropriate Billing Practices
 - Billing for non-existent prescriptions
 - Billing for brand when generics are dispensed
 - Billing for non-covered prescriptions as covered items

 - Prescription Drug Shorting
 - Providing less than the prescribed quantity but billing for the fully-prescribed amount.

 - Dispensing Expired or Adulterated Drugs
 - Dispensing drugs that are expired, or have not been stored or handled in accordance with manufacturer and FDA requirements.

 - 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.

 - Forging or Altering
 - Where existing prescriptions are altered, by an individual without the prescriber's permission to increase quantity or number of refills.
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Examples of Potential FWA: *Pharmaceutical Manufacturer*

➤ Illegal Off-label Promotion

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

➤ Illegal Usage of Free Samples

- Providing free samples to prescribers knowing and expecting prescriber to bill Medicare for the sample.

➤ Kickbacks, Inducements, Other Illegal Payments

- Inappropriate marketing or promotion of products reimbursable by federal health care programs.
 - Inappropriate discounts or educational grants.
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Examples of Potential FWA:

Wholesaler

- Counterfeit, Impure Drugs through Black Market
 - Black market includes fake, diluted, expired, illegally imported drugs.
 - Diverters
 - Individuals who illegally gain control of discounted medicines and mark up the prices and move them to small wholesalers.
 - Inappropriate Documentation of Pricing Information
 - Submitting false or inaccurate pricing or rebate information.
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Examples of Potential FWA: *Pharmacy Benefits Manager (PBM)*

- Prescription Drug Switching
 - PBM receives a payment to switch a beneficiary from one drug to another or influence prescriber to switch patient to a different drug.

 - Prescription Drug Splitting or Shorting
 - PBM mail order pharmacy intentionally provides less than the prescribed quantity, does not inform the patient or make arrangements to provide the balance and bills for the fully-prescribed amount.
 - Splits prescription to receive additional dispensing fees.

 - Inappropriate Formulary Decisions
 - PBMs or their P&T committees make formulary decisions where cost takes precedence over clinical efficacy and appropriateness of formulary drugs.

 - Failure to Offer Negotiated Prices
 - Occurs when a PBM does not offer a beneficiary the negotiated price of a Part D drug.
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Examples of Potential FWA: *Plan Sponsor*

- Failure to Provide Medically Necessary Services
 - Fails to provide medically necessary items or services that the organization is required to provide (under law or under the contract) to a Part D plan enrollee, and that failure adversely affects (or is substantially likely to affect) the enrollee.

 - Inappropriate Enrollment/Disenrollment
 - Improperly reporting enrollment and disenrollment data to CMS to inflate prospective payments. For example, Sponsor fails to effect timely disenrollment of beneficiary from CMS systems upon beneficiary's request.

 - Marketing Schemes
 - Offering beneficiaries a cash payment as an encouragement to enroll in a Medicare Plan.
 - Unsolicited door-to-door marketing.
 - Use of unlicensed agents.
 - Enrollment of individual in a Medicare Plan without such individual's knowledge or consent.
 - Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS.
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Partnership for FWA Prevention

- Prevention and detection of fraud, waste and abuse requires the involvement and collaboration between:
 - Centers for Medicare & Medicaid Services
 - Medicare beneficiaries
 - Medicare contractors
 - Physicians, suppliers, and other providers
 - Quality Improvement Organizations (QIOs)
 - State and federal law enforcement agencies such as:
 - Office of Inspector General (OIG) of the Department of Health and Human Services (HHS)
 - Federal Bureau of Investigation (FBI)
 - Department of Justice (DOJ)
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Preventing Potential FWA

- How can you prevent potential fraud, waste and abuse?
 - Understand your organization's FWA policies and procedures, including standards of conduct and reporting potential FWA
 - Identify your organization's compliance officer and compliance hotline
 - Conduct effective training and education
 - Enforce standards of conduct
 - Develop effective lines of communication between compliance officer, employees and downstream entities
 - Conduct internal monitoring and auditing, including detection through medical review and data analysis
 - Maintain confidentiality of protected health information (PHI)
 - Implement a comprehensive fraud, waste, and abuse program
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Reporting Suspected FWA

- Everyone has the right and responsibility to report suspected fraud, waste or abuse. You may report anonymously and retaliation is prohibited when you report a concern in good faith.

 - To report suspected fraud, waste, or abuse please contact any of the following:
 - The compliance officer in your office or your supervisor
 - Phone: 1-877-392-3375 (1-877-FWA-DESK)
 - Fax: 1-877-329-3922 (1-877-FAX-FWA2)
 - Visit www.recovery.gov/contact/reportfraud/
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FWA Resources

Resource	Link
Centers for Medicare and Medicaid Services (CMS)	www.cms.hhs.gov
Chapter 6 – Protecting the Medicare Trust Fund	www.cms.hhs.gov/MLNProducts/downloads/Chapter6.pdf
Fraud & Abuse General Information	www.com.hhs.gov/MDFraudAbuseGeninfo
Federal Register	www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms4124fc.pdf
Federal Bureau of Investigation	http://www.fbi.gov/
Health Insurance Portability and Accountability Act (HIPAA)	http://www.cms.hhs.gov/EducationMaterials/02_HIPAAMaterials.asp#TopofPage
Medicare Fraud and Abuse Brochure	www.cms.hhs.gov/MLNProducts/downloads/081606 Medicare Fraud and Abuse brochure.pdf
Medicare Learning Network (MLN)	www.cms.hhs.gov/MLNGenInfo/

FWA Resources

Resource	Link
Medicare Managed Care Manual	www.cms.hhs.gov/Manuals/IOM/
Office of Inspector General Department of Health and Human Services	http://oig.hhs.gov/
National Health Care Anti-Fraud Association	http://www.nhcaa.org
Part D Prescription Drug Benefit Manual	www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage
Physician Self Referral Law	www.cms.hhs.gov/PhysicianSelfReferral
Social Security Administration	www.ssa.gov/oig/guidelin.htm
Social Security Laws	www.ssa.gov/OP_Home/ssact/comp-ssa.htm

**Fraud, Waste and Abuse
Attestation Form**

I, _____, attest that as a non-agent employee of a UnitedHealthcare agent it is my responsibility to read and understand this Fraud, Waste and Abuse training, and I will, to the best of my ability, agree to adhere to the teachings found herein.

Printed Name: _____

Signed By: _____ Date: _____

Employer Name: _____ Agent ID: _____