Medicare Parts C & D
Fraud, Waste, & Abuse Training
Requirement

The Centers for Medicare and Medicaid Services (CMS) requires that Network Health must provide fraud, waste, and abuse training within 90 days of contract hire and annually thereafter to all first tier, downstream, and related entities who supply administrative services to Network Health’s Medicare Advantage plans.

(42 CFR §422.503 and 42 CFR §422.504)

Contents of the training document have been taken from the Centers for Medicare and Medicaid Services (CMS) training document available at: http://www.cms.gov/MLNProducts
Objectives

• Meet the regulatory requirements for training and education
• Provide information on the scope of fraud, waste and abuse
• Explain the obligation for everyone to detect, prevent and correct fraud, waste and abuse
• Provide information on how to report fraud, waste, and abuse
• Provide information on laws pertaining to fraud, waste, and abuse (FWA).
Where Do You Fit In?

- As an individual or entity who provides health or administrative services to a Part C or Part D enrollee, you are either:
  - A Part C or D sponsor employee or organization
  - A First tier entity
    - Examples: PBM, Claims processor, or contracted sales agent
  - A Downstream Entity
    - Example: Pharmacy
  - A Related Entity
    - Example: Entity that has a common ownership or control of a Part C/D Sponsor
What Are Your Responsibilities?

If you provide health or administrative services, you are a vital part of the effort to prevent, detect, and correct FWA and non-compliance.

- **FIRST**, you are required to comply with all applicable statutory, regulatory, and other Part C/D requirements, including adopting and implementing an effective compliance program.

- **SECOND**, you have a duty to the Medicare Program to report any violations of laws that you may be aware of.

- **THIRD**, you have a duty to follow your organization’s Code of Conduct, which articulates your and your organization’s commitment to standards of conduct and ethical rules of behavior.
An Effective Compliance Program

• Is essential to prevent, detect, and correct Medicare fraud, waste, and abuse and Medicare non-compliance.

• Must at a minimum include the seven core compliance program elements. (42 CFR §422.503 and 42 CFR §422.504)
PREVENTION

STOP!
This means YOU.

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NetworkHealthMedicare.com
How Can You Prevent FWA?

- Make sure you are familiar with current laws, regulations, and policies
- Ensure you coordinate with other payers
- Ensure data/billing is both accurate and timely
- Verify information provided to you
- Be on the lookout for suspicious activity
Policies and Procedures

Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Make sure you are familiar with your entity’s policies and procedures.
Detection
What is “Fraud, Waste, and Abuse”?

In order to detect fraud, waste and abuse you need to become familiar with and know the laws surrounding FWA.
Criminal Fraud

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, representation, or promises, any of the money or property owned by, or under the custody or control of any health care benefit program.

18 United State Code 1347
What Does This Mean?

Intentionally submitting false information to the government or a government program in order to get money or a benefit constitutes criminal fraud.
Waste and Abuse

Waste and abuse are requesting payment for items or services when there is no legal entitlement to payment.

Unlike fraud, the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.
Differences Between Fraud, Waste, and Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but do not require the same intent and knowledge.
Report Fraud, Waste, and Abuse

Do not be concerned about whether a situation constitutes fraud, waste, or abuse. Just report any concerns to your compliance department or your sponsor’s compliance department. Your sponsor’s compliance department area will investigate and make the proper determination.
Indicators of Potential Fraud, Waste, and Abuse

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

The following slides are examples of potential fraud, waste, and abuse.
Potential Beneficiary Fraud Indicators

- Does the prescription look altered or possibly forged?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the service/picking up the prescription the actual beneficiary (identity theft)?
- Is the prescription appropriate based on the beneficiary’s other prescriptions?
- Does the beneficiary’s medical history support the services being requested?
Potential Provider Fraud Indicators

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider’s prescriptions appropriate for the member’s health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?
- Is the provider’s diagnosis for the member supported in the medical records?
- Does the provider bill the sponsor for services not provided?
Potential Pharmacy Fraud Indicators

• Are the dispensed drugs expired, fake, diluted, or illegal?
• Do you see prescriptions being altered (quantity changes or dispense as written)?
• Are proper provisions made if the entire prescription cannot be filled (no additional fees for split prescriptions)?
• Are generics provided when the prescription requires that brand be dispensed?
• Are PBMs being billed for prescriptions that are not filled or picked up?
• Drug diversion: Are drugs meant for nursing homes, hospice, etc being sent elsewhere?
Potential Wholesaler Fraud

• The wholesaler is distributing fake, diluted, expired, or illegally imported drugs
• The wholesaler is diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies
Potential Manufacturer Fraud

• The manufacturer promotes off label drug usage
• The manufacturer provides samples knowing that the samples will be billed to a federal health care program
Potential Sponsor Fraud

- The sponsor offers cash inducements for beneficiaries to join the plan
- The sponsor leads the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher
- The sponsor uses unlicensed agents
- The sponsor encourages/supports inappropriate risk adjustment submissions
How Do I Report Fraud, Waste, or Abuse?
Reporting Fraud, Waste, and Abuse

- Everyone is required to report suspected instances of fraud, waste, or abuse. Your sponsor’s Code of Conduct and Ethics should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.
Reporting Fraud, Waste, and Abuse

As a contracted Medicare Advantage plan, Network Health is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities. Network Health must be able to accept anonymous reports and cannot retaliate against you for reporting. Review your facility’s or Network Health’s materials for ways for the ways to report fraud, waste, or abuse.

Call Network Health’s Corporate Integrity Hotline at 1-800-886-2566 or email us at MedicareSIU@networkhealth.com
Correction
Correction

• Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government and Network Health money and ensures we all are in compliance with CMS requirements.
How Do I Correct Issues?

Once issues have been identified, a plan to correct the issue needs to be developed. Consult your compliance officers or your facility’s compliance officer to find out the process for the corrective action plan development.

The actual plan will vary depending on the specific circumstances.
Laws You Need To Know About
Laws

The following slides provide very high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning law.
Civil Fraud - Civil False Claims Act

Prohibits:

• Presenting a false claim for payment or approval;
• Making or using a false record or statement in support of a false claim;
• Conspiring 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

31 United States Code § 3729-3733
Civil False Claims Act Damages and Penalties

The damages may be tripled. Civil Money Penalties are between $5,000 and $10,000 for each claim.
Criminal Fraud Penalties

If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code §1347
Anti-Kickback Statute

Knowingly and willfully soliciting, receiving, offering, or paying remunerations (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program)

42 United States Code §1320a-7(b)
Anti-Kickback Statute Penalties

Fines up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment
Stark Statute  
(Physician Self-Referral Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn
Stark Statute Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with Stark are not payable. Up to a $15,000 fine for each service provided. Up to a $100,000 fine for entering into an arrangement or scheme.
Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

42 U.S.C. §1395(e)(1)
42 C.F.R. §1001.1901
HIPAA

Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

• Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry

• Safeguards to prevent unauthorized access to protected health care information.

• As a individual who has access to protected health care information, you are responsible for adhering to HIPAA
Consequences
Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs
Knowledge Check
Scenario 1

A person comes to your pharmacy to drop off a prescription for a beneficiary who is a “regular” customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

What is your next step?
Scenario 1

A. Fill the prescription for 160
B. Fill the prescription for 60
C. Call the prescriber to verify quantity
D. Call the sponsor’s compliance department
E. Call law enforcement
Scenario 1 Answer

Answer: C

Call the prescriber to verify

If the prescriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the sponsor’s compliance hotline. The sponsor will provide next steps.
Scenario 2

Your job is to submit risk diagnosis to CMS for purposes of payment. As part of this job you are to verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the sponsor’s process and to adjust/add risk diagnosis codes for certain individuals.

What do you do?
Scenario 2

A. Do what is asked of your immediate supervisor
B. Report the incident to the compliance department (via compliance hotline or other mechanism)
C. Discuss concerns with the immediate supervisor
D. Contact law enforcement
Scenario 2 Answer

Answer: B

Report the incident to the compliance department (via compliance hotline or other mechanism)

The compliance department is responsible for investigating and taking appropriate action. Your sponsor/supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.
Scenario 3

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider ("Doe Diagnostics") has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics’ claims far exceed any other provider that you reviewed.

What do you do?
Scenario 3

A. Call Doe diagnostics and request additional information for the claims
B. Consult with your immediate supervisor for next steps
C. Contact the compliance department
D. Reject the claims
E. Pay the claims
Scenario 3 Answer

Answers: B or C

Consult with your immediate supervisor for next steps or Contact the compliance department

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance department have occurred, including whether additional documentation is necessary.
Scenario 4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?
Scenario 4

A. Call the local law enforcement
B. Perform another review
C. Contact your compliance department
D. Discuss your concerns with your supervisor
E. Follow your pharmacy’s procedures
Scenario 4 Answer

Answer: E

Follow your pharmacy’s procedures

Since this a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacy’s procedures to determine the next steps.
Congratulations!

You have completed the Network Health Insurance Corporation’s Part C and D Fraud, Waste and Abuse Training

Please complete the attestation and return it to:
Network Health Insurance Corporation
Attn: Medicare SIU