



Fraud, Waste and Abuse Training for Medicare and Medicaid Providers

Contents and Agenda

- Define Fraud, Waste, and Abuse (FWA)
- Identify Who Can Commit FWA
- Review Applicable FWA Laws and Examples
- Review the Whistleblower Protection Act
- How to Report Suspected FWA
- What Can You Do
 - Implement a Compliance Program
- Review More Examples of FWA
- Additional FWA Resources
- Compliance Attestation Statement

Learning Objectives

- By the end of the training you will be able to:
 - Recognize general health care FWA
 - Identify various types of health care FWA
 - Identify who can commit FWA
 - Identify who is responsible for combating FWA
 - Understand how to report suspected health care FWA
 - Understand protections available to you when reporting suspected FWA
 - Recognize pertinent laws related to FWA

Defining Fraud, Waste & Abuse



What is Fraud?

- **Fraud** is the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).
- For example:
 - To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.
 - Misrepresenting who provided the services, altering claim forms, electronic claim records or medical documentation.
- Source: CMS Glossary:
<http://www.cms.gov/apps/glossary/default.asp?Letter=A&Language=English>
- Fraud involves making false statements or misrepresentation of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. The acts may be committed for the person's own benefit or for the benefit of another party. In order to be considered fraud, the act must be performed knowingly, willfully and intentionally.

What is Waste?

- **Waste** means over-utilization of services, or practices that result in unnecessary costs.
- Waste also refers to useless consumption or expenditure without adequate return, or an act or instance of wasting.
- For example:
 - Providing services that are not medically necessary.

What is Abuse?

- **Abuse** describes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in:
 - An unnecessary cost to the Medicaid and Medicare program;
 - Reimbursement for services that are not medically necessary; or
 - Services that fail to meet professionally recognized standards for health care.
- It also includes recipient practices that result in unnecessary cost to the Medicaid and Medicare program.
- Abuse is similar to fraud except that there is no requirement to prove or demonstrate that abusive acts were committed knowingly, willfully and intentionally.
- For example: Abuse includes but is not limited to a range of the following improper behaviors or billing practices:
 - Billing for a non-covered service;
 - Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or
 - Inappropriately allocating costs on a cost report.
- Source: CMS Glossary:

<http://www.cms.gov/apps/glossary/default.asp?Letter=A&Language=English>

Who can be Involved in FWA?

- Members/Patients
- Employees
- Health Plans
- Providers/Prescribers
- Manufacturers
- Pharmacies
- Pharmacy Benefit Managers (PBMs)

Federal and State Oversight Authorities

- The Office of Inspector General (OIG), U.S. Department of Health and Human Services
- Department of Justice
- Centers for Medicare & Medicaid Services (CMS)
- Office of the State Attorney General
- State Medicaid Agencies
- Medicaid Fraud Control Units
- The Office of the State OIG and Medicaid OIG

Applicable Laws and Regulations



Laws and Regulations Related to Fraud, Waste and Abuse

- Federal False Claims Act
- Anti-Kickback Statute
- Beneficiary Inducement Law
- Exclusion Statute
- Whistleblower Protection Act
- Other Relevant Federal FWA Laws
 - Physician Self-Referral Prohibition (Stark Law)
 - Civil Monetary Penalties Law (CMPL)
 - Health Insurance Portability and Accountability Act (HIPAA)
 - Deficit Reduction Act of 2005

Federal False Claims Act (FCA)

The federal False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare (as well as Medicare Advantage [MA]) and Medicaid programs. The FCA applies to all federal funded programs.

- Under the FCA, any individual or organization that knowingly submits a claim he or she knows (or should know) is false and knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid or approved under any federally funded health care program, is subject to civil penalties. It also includes those cases in which any individual or organization obtains money to which they may not be entitled, and then uses false records or statements to retain the money, and instances where a provider retains overpayments.
- Under the federal FCA, a person, provider, or entity is liable for up to triple damages and penalties between \$5,500 and \$11,000 for each false claim it knowingly submits or causes to be submitted to a federal program.
- In addition to civil penalties, individuals and entities also can be excluded from participating in any federal health care program for non-compliance.
- States also have false claims laws that are similar to the federal FCA.

Examples of Violations of the False Claims Act

- A provider who submits a bill to Medicare or Medicaid for services that were not rendered
- A government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements
- A provider who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program
- Submission of false information about services performed or charges for services performed

Examples of Violations of the False Claims Act (cont.)

- Inserting a diagnosis code not obtained from a physician or other authorized individual
- Misrepresenting the services performed (for example, up-coding to increase reimbursement)
- Violation of another law - For example, a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (e.g., a physician received kickbacks for referrals)
- Submission of claims for services ordered by a provider who has been excluded from participating in Medicare, Medicaid and other federally funded health care programs

Anti-Kickback Statute

- The Anti-Kickback Statute (42 U.S.C. §§ 1320a-7b) is a federal law that prohibits persons from directly or indirectly offering, providing or receiving kickbacks or bribes in exchange for goods or services covered by Medicare, Medicaid and other federally funded health care programs. These laws prohibit someone from knowingly or willfully offering, paying, seeking or receiving anything of value (“remuneration”) in return for referring an individual to a provider to receive services, or for recommending purchase of supplies or services that are reimbursable under a government health care program.
 - For purposes of the Anti-Kickback Statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- Violations of the law are punishable by criminal sanctions including imprisonment and civil monetary penalties. The individual or entity also may be excluded from participation in Medicare or other federal health care programs for violating the Anti-Kickback Statute.

Anti-Kickback Statute (cont.)

- An arrangement will be deemed to not violate the Anti-Kickback Statute if it fully complies with the terms of a safe harbor issued by the Office of the Inspector General (OIG). Arrangements that do not fit within a safe harbor and thus do not qualify for automatic protection may or may not violate the Anti-Kickback Statute, depending on the facts.
- Some states have enacted similar laws that apply to goods or services covered by the state health care programs and in some cases even private insurance.



Examples of Violations of the Anti-Kickback Statute

- The following are examples of acts that may be considered a violation of the Anti-Kickback Statute:
 - A provider who has a general policy and practice of routinely waiving member copayments and deductibles to induce Medicare and/or Medicaid beneficiaries to receive services from the provider
 - Payments to a Medicare provider by a supplier to induce the purchase of Part B products from that supplier
 - Other incentives to a provider or contractor, such as a pharmacy that induces Medicare beneficiaries to enroll in a particular Medicare Advantage or Part D plan

Beneficiary Inducement Law

- The Beneficiary Inducement Law:
 - Prohibits offering a remuneration that a person knows or should know is likely to influence a beneficiary/member to select a particular provider, practitioner or supplier; and
 - Creates civil liabilities with monetary penalties of up to \$10,000 for each wrongful act.

Examples of Violations of the Beneficiary Inducement Law

- The following are examples of acts that may be considered a violation of the Beneficiary Inducement Law:
 - A provider who has a general policy and practice of routinely waiving member copayments and deductibles to induce Medicare and/or Medicaid beneficiaries to receive services from the provider
 - Providers who give Medicaid & Medicare beneficiaries “gifts” to influence the beneficiaries’ decision to select the provider

Exclusion & Debarment Statute

- The federal Exclusion Statute excludes individuals or entities from participating in the Medicare or Medicaid program for a minimum of 3 to 5 years, depending on the offense, to possible lifetime exclusion.
- Individuals or entities that participate in or bill a federal health care program may not employ or contract with an excluded or debarred individual or entity.
 - Being excluded means no payment will be made by any federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity.
 - No excluded individual or entity may provide goods or services reimbursed by a federal health care program (e.g., Medicare and Medicaid).
- Several states also have exclusion lists with the names of individual and entities that are excluded from participating in any state-funded program.

Exclusion Lists

- The U.S. Department of Health and Human Services (HHS), through the Office of Inspector General (HHS-OIG), can exclude individuals and entities from participating in federally funded health care programs. The HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE) online at <http://exclusions.oig.hhs.gov/>. According to the HHS-OIG, the “basis for exclusion” includes:
 - Convictions for program-related fraud and patient abuse;
 - Licensing board actions; and
 - Default on Health Education Assistance Loans.
- In addition, the U.S. General Services Administration’s (GSA) web-based Excluded Parties List System (EPLS) at <https://www.epls.gov/> is used to identify individuals and entities excluded from receiving federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits.

Exclusion List Screening

- According to the Centers for Medicare and Medicaid Services (CMS), to further protect against payments for items and services furnished or ordered by excluded parties, **providers that participate in federally-funded health care programs must take the following steps to determine whether their employees and contractors are excluded individuals or entities:**
 - Providers have an obligation to screen all employees and contractors to determine whether any of them have been excluded.
 - Providers are required to comply with this obligation as a condition of enrollment.
 - Providers can search the HHS-OIG LEIE website by the names of any individual or entity at <http://www.oig.hhs.gov/>.
 - Providers are required to search the HHS-OIG LEIE website monthly to capture exclusions and reinstatements that have occurred since the last search.
 - Providers must immediately report to the respective state Medicaid agency any exclusion information discovered.

Exclusion List Screening (cont.)

- In addition, to comply with Magellan's fraud, waste and abuse programs, your responsibility is to:
 - Check each month to ensure that you, your employees, directors, officers, partners or owners with a 5 percent or more controlling interest and subcontractors are not debarred, suspended or otherwise excluded under the HHS-OIG LEIE at <http://www.oig.hhs.gov/>, the EPLS at <http://www.epls.gov/> or any applicable state exclusion list where the services are rendered or delivered; and
 - Immediately notify Magellan in writing of the debarment, suspension or exclusion of yourself, your employees, subcontractors, directors, officers, partners or owners with a 5 percent or more controlling interest.

Whistleblower Protection Act

- To encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a “qui tam” or whistleblower provision. This provision essentially allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government.
- Under federal law, the whistleblower may be awarded a portion of the funds recovered by the government, typically between 15 and 30 percent. The whistleblower also may be entitled to reasonable expenses, including attorney’s fees and costs for bringing the lawsuit.
- In addition to a financial award, the False Claims Act entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from employer retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim, providing testimony, or assisting in a False Claims Act action.

Whistleblower Protection Act (cont.)

- The False Claims Act includes specific provisions to protect whistleblowers from retaliation by their employers. Any employee who initiates or assists with an FCA case is protected from discharge, demotion, suspension, threats, harassment and discrimination in the terms and conditions of his or her employment.
- A person who brings a qui tam action that a court later finds was frivolous may be liable for fines, attorney fees and other expenses.

Other Relevant Federal FWA Laws

- **Self-Referral Prohibition Statute (Stark Law)**
 - This law prohibits physicians from referring Medicaid & Medicare patients for certain designated health services (DHS) to an entity in which the physician or the physician's immediate family has a financial relationship unless an exception applies. Violations of the law are punishable by a civil penalty up to \$15,000 per improper claim, denial of payment, and refunds for certain past claims.
- **Civil Monetary Penalties Law**
 - The federal Civil Monetary Penalties Law covers an array of fraudulent and abusive activities and is similar to the False Claims Act. Violations of the law may result in penalties between \$10,000 and \$50,000 and up to three times the amount unlawfully claimed.
- **Health Insurance Portability and Accountability Act (HIPAA)**
 - This act authorized the establishment of the Health Care Fraud and Abuse Control Program (HCFAC) under the U.S. Attorney General and the Office of the Inspector General (OIG). The goal is to coordinate federal, state and local efforts in combating FWA.

The Deficit Reduction Act of 2005

- The Deficit Reduction Act of 2005 (DRA), effective January 1, 2007, requires all entities that receive \$5 million or more in annual Medicaid payments to establish written policies that provide detailed information about the federal False Claims Act, the administrative remedies for false claims and statements, applicable state laws that provide civil or criminal penalties for making false claims and statements, the whistleblower protections afforded under such laws and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.
- Deficit Reduction Act FAQs:
<http://www.cms.gov/smdl/smd/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1197237&intNumPerPage=10>

Record Retention Requirements

- Providers must maintain service, prescription, claim and billing records for 10 years.
- Records are subject to CMS or contractor audit.

Reporting Suspected FWA and Implementing a Compliance Plan



Reporting Suspected Cases of FWA

- Magellan does not retaliate against an employee for reporting or bringing a civil suit for a possible False Claims Act violation. It also is against our policy for Magellan to discriminate against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a False Claims Act action. Magellan does not retaliate against any of its agents and contractors for reporting suspected cases of fraud, waste, or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits Magellan from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a False Claims Act action.
- **How to report suspected cases of fraud, waste and abuse:**
 - Magellan **will not retaliate against you** if you inform us, the federal government, state government, or any other regulatory agency with oversight authority of any suspected cases of fraud, waste and abuse.
 - Reports may be made to Magellan using one of the following methods:
 - Special Investigations Unit hotline: 1-800-755-0850
 - Special Investigations Unit email: SIU@MagellanHealth.com
 - Corporate Compliance hotline: 1-800-915-2108
 - Compliance Unit email: Compliance@MagellanHealth.com
 - **Reporting to the Magellan Corporate Compliance hotline may be made 24 hours a day/seven days a week and is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.**

What You Can Do

- We encourage all of our providers to implement a comprehensive **compliance plan** to detect, prevent, monitor, and report suspected cases of fraud, waste and abuse.
- The U. S. Department of Health and Human Services' Office of the Inspector General has developed compliance plan guidance for a number of different health care provider types. These guidelines can be accessed at:
<http://oig.hhs.gov/fraud/complianceguidance.asp>.
- In general, **each compliance plan should contain the following elements:**
 1. Written policies and procedures
 2. Designation of a compliance officer and a compliance committee
 3. Conducting effective training and education
 4. Developing effective lines of communication
 5. Auditing and monitoring
 6. Enforcement through publicized disciplinary guidelines and policies dealing with ineligible persons
 7. Responding to detected offenses, developing corrective action initiatives and reporting to government authorities
 8. Whistleblower protection and non-retaliation policy
- Some states require providers to implement an effective mandatory compliance plan under the state's Medical Assistance program.

More Examples of Fraud, Waste & Abuse



Examples of FWA by Members/Patients

- **Misrepresentation of eligibility status**
- **Identity theft:** An individual uses another person's insurance card to obtain health care services or prescriptions.
- **Prescription forging or altering:** Prescriptions are altered, by someone other than the prescriber or pharmacist without prescriber approval, to increase quantity or number of refills (e.g., the prescription is written in different inks, looks like it is photocopied, or the quantity is more than usual amount dispensed).

Examples of FWA by Members/Patients

- **Prescription diversion/inappropriate use:** A member obtains prescription drugs and gives or sells them to someone else.
- **Resale of drugs on the black market:** A member falsely reports loss of drugs to obtain drugs for resale.
- **Doctor shopping:** A member or other individual consults several doctors, inappropriately obtaining multiple prescriptions for narcotics painkillers or other drugs.
- **Prescription stockpiling:** A member obtains and stores large quantities of drugs to avoid out-of-pocket costs.

Examples of Health Plan FWA

- **Failure to provide authorization for medically necessary services**
- **Marketing schemes:**
 - Unsolicited door-to-door marketing
 - Misrepresentation of the Medicare Advantage (MA) or prescription drug plan being marketed
 - Requirement for members to pay up-front premiums
- **Payment for services excluded under the Medicaid or MA plan**
- **Kickbacks, inducements or other illegal payments**

Examples of *Medicare Advantage* Health Plan FWA

- **Inappropriate handling of the appeals process:** A member is denied the right to appeal or is denied a timely appeal.
- **Incorrect calculation of True Out of Pocket (TrOOP) expense:** Falsifying TrOOP to keep members in a coverage gap.
- **Enrolling members without their knowledge or consent.**

Examples of Provider FWA

- **Illegal Remuneration Schemes:** A prescriber is offered, paid, solicits or receives unlawful payment to induce or reward the prescriber to write prescriptions for specific drugs or products.
- **Script mills:** Prescribers write prescriptions for drugs that are not medically necessary—usually multiple scripts and often for patients who have not seen the prescriber. These scripts are usually written for drugs for sale on the black market and the prescriber is usually inappropriately paid.

Examples of Provider FWA

- **Payments for excluded items:** Receiving payment for services that are excluded by the plan or federal program
- **Billing for services that were never provided**
- **Billing for a higher level of service than what was actually delivered**
- **Billing for non-covered services or prescriptions as covered items**

Examples of Prescriber FWA

- **Script mills:** A provider prescribes drugs that are not medically necessary.
- **Dispensing expired or altered prescription drugs**
- **Provision of false information:**
 - A prescriber falsifies or misrepresents information on a prescription.
 - A prescriber falsifies information submitted through prior authorization.
- **Theft of a Drug Enforcement Administration (DEA) number or prescription pad:** A DEA number or prescription pad is stolen and used to illegally write prescriptions for controlled substances.

Examples of FWA by a Pharmacy Benefit Manager (PBM)

- **Prescription drug switching:** A PBM receives payment to switch a member from one drug to another.
- **Failure to offer negotiated prices:** A PBM does not offer a beneficiary the negotiated price of a drug.
- **Inappropriate formulary decisions:** Costs take priority over criteria such as clinical efficacy.
- **Unlawful payments/remuneration:** A PBM receives unlawful payment(s) to steer a member toward a certain plan or drug.
- **Submission of falsified data to CMS**

Examples of Manufacturer FWA

- **Inappropriate relationships with physicians:**
 - Offering the prescriber money to switch prescriptions
 - Offering incentives to physicians to prescribe medically unnecessary drugs
 - Improper entertainment or incentives offered by sales agents
- **Illegal off-label promotion**

Examples of Manufacturer FWA

- **Kickbacks or inducements:**
 - Inappropriate marketing of products
 - Inducements offered if the products purchased are reimbursed by the federal health care programs
- **Illegal usage of free samples:** Free samples are provided to physicians knowing that they will bill the drugs to the federal health care programs.

Examples of Pharmacy FWA

- **Inappropriate billing practices include:**
 - Incorrectly billing for secondary payers to receive increased reimbursement
 - Billing for nonexistent prescriptions
 - Billing for brand drugs when generics have been dispensed
 - Billing for non-covered prescriptions as covered items
 - Billing for prescriptions that were never picked up
- **Failure to offer negotiated prices:** A pharmacy does not offer a member the negotiated price of a Part D drug.

Examples of Pharmacy FWA

- **Inappropriate billing practices include:**
 - Inappropriate use of dispense-as-written codes
 - Drug diversion
 - Prescription splitting (dividing a single prescription into two or more separately billed orders) to receive additional dispensing fees
- **Prescription drug shorting:** A pharmacist dispenses less than what was prescribed, but bills for the full dispensed amount.
- **Dispensing expired or altered prescription drugs**

Examples of Pharmacy FWA

- **Bait-and-switch pricing:** A member is led to believe that a drug will cost one price, but at the point of sale, he or she is charged a higher amount.
- **Prescription forging or altering:** Existing prescriptions are altered to increase the quantity or number of refills.
- **Prescription refill errors:** A pharmacist provides the incorrect number of refills prescribed by the provider.

Examples of Pharmacy FWA

- **Illegal remuneration schemes:** A pharmacy is offered, solicits or receives unlawful remuneration to induce or reward it to:
 - Switch patients to different drugs;
 - Influence prescribers to prescribe different drugs; or
 - Steer patients to prescription drug plans.
- **TrOOP manipulation:** A pharmacy manipulates true out-of-pocket (TrOOP) expense to push a member through the coverage gap so he or she reaches the catastrophic coverage before being eligible.

Additional Information

- **CMS:** <http://www.cms.hhs.gov/>
- **HHS/OIG:** <http://oig.hhs.gov>
- **CMS Prescription Drug Benefit Manual:**
https://www.cms.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf
- **CMS Medicaid Integrity:**
<http://www.cms.gov/MedicaidIntegrityProgram/>
- **DEA Drug Diversion:** <http://www.deadiversion.usdoj.gov/>

Next Step: Compliance Certification



Congratulations!

- You have completed your annual CMS training requirement.

- **Final Step:**

Complete the Magellan Compliance Certification form and send it to the address or fax number listed on the form.