

Medicare Compliance: Detecting, Correcting and Preventing Fraud, Waste and Abuse

The Various Parts of Medicare

- Part A – the hospital insurance portion of Medicare. Part A covers inpatient care in hospitals and skilled nursing facilities as well as hospice and home health care.
- Part B – the medical insurance portion of Medicare. Part B covers medically necessary outpatient health care, including physician's services and preventive care.
- Part C – also called Medicare Advantage, is a combination of Parts A and B managed by private insurance companies.
 - Asuris TruAdvantage products.
- Part D – the Medicare prescription drug benefit. Part D is run by private companies and can either be in stand-alone form ("PDPs") or combined with a Medicare Advantage plan ("MAPDs")
 - Asuris TruAdvantage+Rx and Medicare Script products.

Doing Business With Asuris

The Asuris Code of Business Conduct outlines Asuris' business standards and the expectations for people working for, or on behalf of, Asuris. See <http://www.regence.com/docs/legal/codeOfConduct.pdf>

The Asuris Fraud & Abuse Web site answers commonly asked questions about fraud & abuse and gives details on how to report suspected fraud or abuse to Asuris. See <http://www.asuris.com/fraud/>

Impact of Health Care Fraud and Abuse

- Health Care Fraud and Abuse Hurts Everyone
- It is estimated that between 3 to 10 percent of health care programs' (both public and private) total expenditures result from fraudulent billings.
- The Centers for Medicare & Medicaid Services (CMS) estimates that fraud costs the Medicare program \$60 billion per year.

Why is Fraud & Abuse Training Necessary?

- All organizations and individuals that contract directly or indirectly with the Federal government, including through Asuris' TruAdvantage and Medicare Script products, are subject to the fraud and abuse laws.
- Penalties for violation of fraud and abuse laws can be severe:
 - Suspension of payments from Federal health care programs
 - Exclusion from Federal health care programs
 - Monetary penalties (both civil and criminal)
 - Imprisonment

Fraud & Abuse Compliance Training Requirement

External entities responsible for the administration or delivery of Asuris' Medicare product benefits must complete fraud and abuse compliance training by December 31, 2009 and annually thereafter.

Examples of responsible external entities include:

- Individual health care providers and health care facility staff
- Individual pharmacists and pharmacy staff
- Providers of durable medical equipment
- Home health providers

External entities must maintain records of the attendance and completion of a compliance training course. Asuris does not maintain these records.

Overview of Fraud & Abuse

Definition of Health Care Fraud (18 U.S.C. §1347)

Knowingly or **willfully** executing a scheme or artifice to defraud any health benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises any of the money or property owned by, or under the control or custody of, any health care benefit program.

Definition of Abuse

Abuse describes practices that do not rise to the level of fraud but that result in unnecessary costs to, or improper payment from, a health care program. Abuse can occur where an intent to defraud cannot be shown.

Risks for Fraud & Abuse

All entities and persons involved in the administration of Medicare benefits are capable of engaging in fraudulent or abusive activities. This section will give examples of high risk areas for each group.

Provider Risks for Fraud & Abuse

- Billing for services/supplies that were not provided
- Incorrectly reporting diagnoses or procedures to maximize payment
- Billing for services/supplies or writing prescriptions for drugs that are not medically necessary
- Remuneration schemes that unlawfully induce or reward the provider to bill for services/supplies or write prescriptions
- Provision of false information (e.g. falsifying info on a prior authorization request, misrepresenting dates of service, etc.)
- Unbundling charges
- Violating the assignment agreement, Fee Schedule, or Maximum Allowable Actual Charge Limits

Pharmacy Risks for Fraud & Abuse

- Inappropriate billing practices (e.g. billing for non-existent prescriptions, billing multiple payers, billing for brand when dispensing generics, billing for prescriptions that are never picked up)
- Remuneration schemes that unlawfully induce or reward the pharmacy to steer patients to certain drugs or plans
- Prescription drug shorting
- Prescription forging or altering
- Dispensing expired or adulterated drugs
- True Out-of-Pocket (“TrOOP”) Costs manipulation
- Failing to offer negotiated prices

Pharmaceutical Manufacturer Risks for Fraud & Abuse

- Inappropriate relationships with physicians including “switching” arrangements, offering unlawful incentives, and consulting and advisory payments
- Illegal off-label promotion
- Illegal usage of free samples

Beneficiary Risks for Fraud & Abuse

- Misrepresentation of coverage status
- Identity theft (using another person’s Medicare card to obtain prescriptions, services, supplies, etc.)
- Prescription forging or altering
- Prescription diversion and inappropriate use
- Resale of prescription drugs

Laws Pertinent to Medicare Fraud & Abuse

- The False Claims Act (31 U.S.C. §§3729-3733)
- The Anti-Kickback Statute (42 U.S.C. §1320a-7b(b))
- Physician Self-Referral (“Stark”) Statute (42 U.S.C. §1395nn)
- Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)

The False Claims Act

Prohibits knowingly presenting, or causing to be presented, to the federal government a false or fraudulent claim for payment or approval. Also prohibits 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.

Penalties for Violation

- Fine of \$5,000-\$10,000 per false claim
- Up to 3x the amount of damages sustained by the Government

The Anti-Kickback Statute

Prohibits knowingly or willfully soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) in order to induce or reward business that is payable under a Federal health care program.

Penalties for Violation

- Criminal penalty of fines of up to \$25,000; and/or imprisonment of up to 5 years
- Civil penalty of up to \$50,000 per act plus 3x the amount of remuneration
- Exclusion from Federal health care programs

Physician Self-Referral (“Stark”) Statute

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

Penalties for Violation

- Up to \$15,000 for each claim submitted in violation of the law
- Up to \$100,000 for each “scheme” that violates the law
- Penalties of up to 3x the amount claimed
- Exclusion from Federal health care programs

HIPAA

Established the national Health Care Fraud and Abuse Control Program (“HCFAC”) that coordinates Federal, state, and local law enforcement activities with respect to health care fraud and abuse. Created the offense of “health care fraud” and established criminal penalties for violation.

- Fines
- Imprisonment of up to 10 years
- Violations resulting in physical injury can be punished by imprisonment of up to 20 years
- Violations resulting in death be punished in imprisonment for life

Reporting Suspected Fraud or Abuse

Reporting to Asuris

- Call the 24-hour confidential toll-free hotline
 - Relating to Medicare Part D: 1 (877) 479-8477
 - Oregon (non-Medicare Part D): 1 (888) 207-4211
 - Washington (non-Medicare Part D): 1 (800) 434-2277
 - Idaho (non-Medicare Part D): 1 (800) 323-1693
 - Utah (non-Medicare Part D): 1 (866) 686-8555
- Use the confidential & anonymous online form:
<https://www.regence.com/asuris/forms/reportFraud.html>

Reporting to the Office of the Inspector General (OIG) Hotline

- Phone: 1 (800) HHS-TIPS (800-447-8477)
- Fax: 1 (800) 223-8164
- Email: HHTips@oig.hhs.gov
- Mail: Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE
PO Box 23489
Washington, DC 20026

Where to Get Additional Information

- Office of the Inspector General (OIG) Web site: <http://www.oig.hhs.gov/>
 - Health Care Fraud and Abuse Control Program Report
 - Audit and Evaluation/Inspections Reports
 - Compliance Program Guidance
- The Centers for Medicare & Medicaid Services (CMS) Web site:
<http://www.cms.hhs.gov/>

Congratulations!

You have completed the Medicare Compliance: Detecting, Correcting and Preventing Fraud, Waste and Abuse training

Complete and sign the certification page as documentation that you have completed the required training.

**Certificate of Completion Medicare Compliance: Detecting,
Correcting and Preventing Fraud, Waste and Abuse**

Name: _____

Employer: _____

Location: _____

Signature: _____

Date: _____