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

2023

Physicians Health Plan

September 7, 2023

Important Notice

This training module will assist PHP Medicare (PHPM) Parts C and D in satisfying the fraud, waste, and abuse (FWA) training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
- 42 CFR Section 423.504(b)(4)(vi)(C)
- CMS-4182-F, Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs
- Section 50.3.2 of the Compliance Program Guidelines (Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual)

Training Agenda

1. Introduction
2. What is FWA?
3. Your Role in the Fight Against FWA
4. Resources
5. Knowledge Test

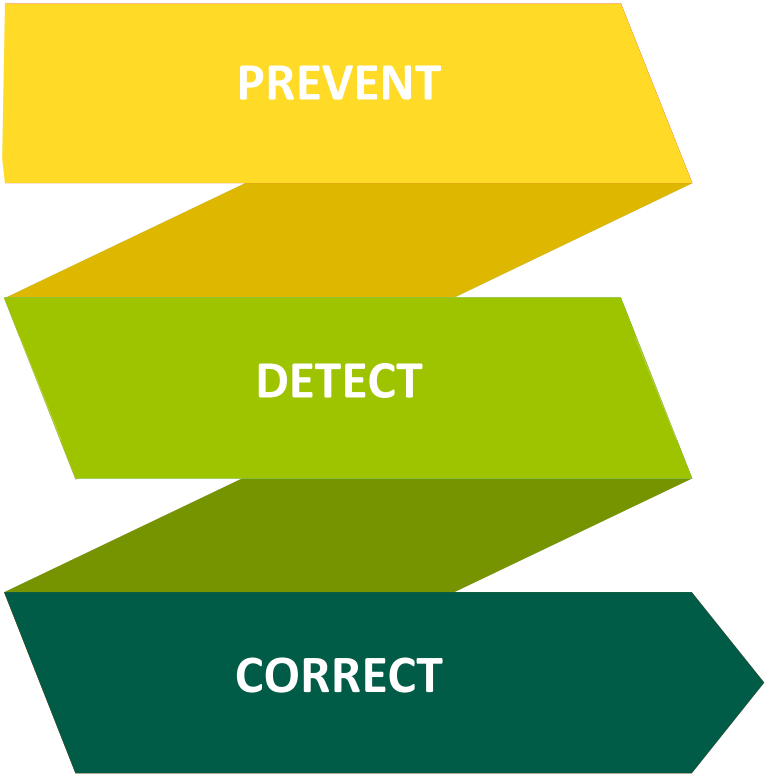
Introduction
Fraud, Waste, & Abuse (FWA)

Physicians Health Plan

Why Do I Need Training?

Medicare FWA Compliance is **everyone's** responsibility!

Every year billions of dollars are improperly spent because of FWA. It affects everyone – including you. This training will help detect, correct, and prevent FWA. You are part of the solution.



Training Objectives

- Recognize FWA in the Medicare Program
- Identify the significant laws and regulations pertaining to FWA
- Recognize potential consequences and penalties associated with violations
- Identify methods of preventing FWA
- Identify how to report FWA
- Recognize how to correct FWA

What is FWA?

Physicians Health Plan

Fraud, Waste, & Abuse

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

Waste

includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources

Abuse

includes actions that may, directly or indirectly, result in unnecessary Medicare program costs. Abuse involves paying for items or services when there is no legal entitlement to the payment or the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of Medicare Fraud

1. Knowingly billing for services not furnished
2. Billing for nonexistent prescriptions
3. Knowingly altering claims forms, medical records, etc. for higher payment

Examples of Medicare Waste

1. Providing medically unnecessary services
2. Charging in excess for services or supplies
3. Ordering excessive lab tests

Examples of Medicare Abuse

1. Unknowingly billing for unnecessary medical services
2. Unknowingly excessively charging for services or supplies
3. Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Difference Among Fraud, Waste, & Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve receiving improper payments or creating unnecessary costs to the Medicare program but do not require the same intent and knowledge.

To Detect FWA, You Need to Know the Law

1. Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud
2. Anti-Kickback Statute
3. Stark Statute (Physician Self-Referral Law
4. Exclusion from all Federal health care programs
5. Health Insurance Portability and Accountability Act (HIPAA)

Civil False Claims Act (FCA)

The civil provisions of the FCA makes a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty

Health Care Fraud Statute

- The Health Care Fraud Statute states, “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both.”
- Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law.
- For more information, refer to 18 USC Sections 1346–1347.

Criminal Health Care Fraud

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000
- Imprisonment for up to 20 years

If the violations resulted in death, the individual might be imprisoned for any term of years or for life.

For more information, refer to 18 USC Section 1347.

Anti-Kickback Statue

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including the Medicare Program).

For more information, refer to 42 USC Section 1320a-7b(b).

- Violations are punishable by:
- A fine up to $25,000
- Imprisonment up to 5 years

Stark Statute

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest or
- A compensation arrangement

Exceptions may apply. For more information, refer to 42 USC Section 1395nn.

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around **$24,250** can be imposed for each service provided. There may also be around a **$161,000** fine for entering into an unlawful arrangement or scheme.

Civil Money Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:

- Arranging for services or items from an excluded individual or entity
- Providing services or items while excluded
- Failing to grant OIG timely access to records
- Knowing of and failing to report and return an overpayment
- Making false claims
- Paying to influence referrals

The penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three times the amount:

- Claimed for each service or item or
- Of remuneration offered, paid, solicited, or received

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 OIG. The OIG has the authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).
- The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.
- When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same.

Exclusion

EXAMPLE

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the U.S. Food and Drug Administration concerning oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. At the time the unconvicted executive was excluded, there was evidence he was involved in misconduct leading to the company's conviction

PHP is required to screen all employees and contracted entities associated with its Medicare Plan to verify they are not excluded from federal contracting. Screening must be performed before hire/contract and every month after that.

Health Insurance Portability & Accountability Act (HIPAA)

HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards deter unauthorized access to protected health care information.

As an individual with access to protected health care information, you must complete education and comply with HIPAA.

Damages and Penalties

HIPPA Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

Your Role in the Fight Against FWA

Physicians Health Plan

Where Do I Fit In?

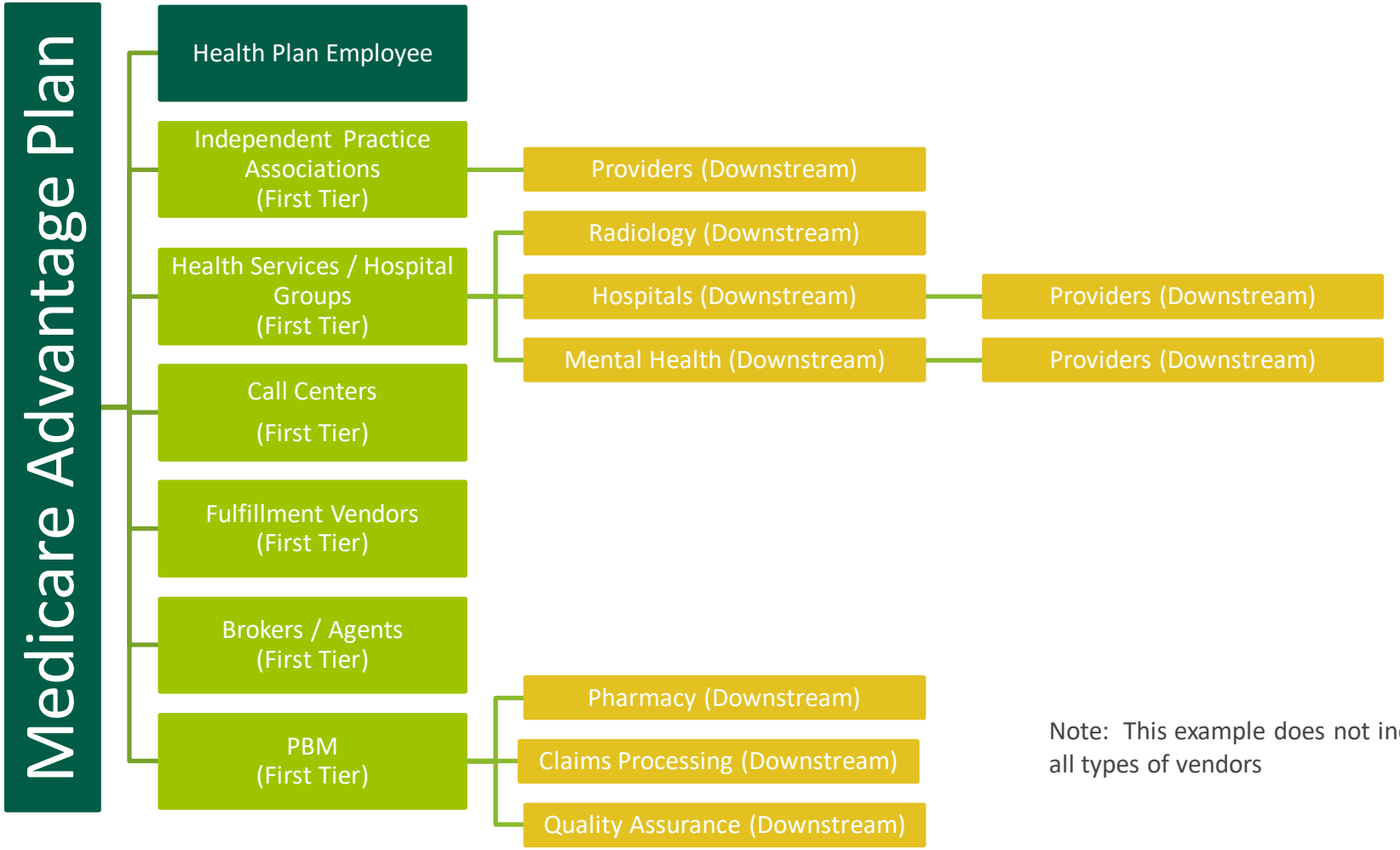
Medicare Advantage Prescription Drug (MAPD) Plan: Also known as a Sponsor (Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP]) – PHP Medicare is a MAPD plan

First-tier entity: Examples of First- tier entity: agents & brokers directly contracted with; firms providing agent/broker services, hospital or health care facility; provider group; doctor's office; clinical laboratory; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents

Downstream entity: Examples of Downstream Entity: brokers & agents contracted by sales firms, pharmacies, doctor's offices, firms providing agent/broker services, marketing firms, and call centers

Related entity: Examples of Related entity: Entity with common ownership or control of a Sponsor, health promotion provider

Where Do I Fit in the Medicare Program



Note: This example does not include all types of vendors

What Are Your Responsibilities?

- Comply with all applicable laws
- Report any noncompliance
- Follow PHP's Code of Conduct

How Do You Prevent Medicare FWA?

1. Understand fraud, waste, and abuse, look for and report any suspicious activity
2. Conduct yourself in an ethical manner
3. Ensure accurate and timely data and billing
4. Ensure coordination with other payer types
5. Verify all received information

Stay Informed About Policies & Procedures

Know PHP Medicare's policies and procedures.

We must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.

Our Code of Conduct describes our expectations:

- All employees conduct themselves in an ethical manner
- Appropriate mechanisms are in place for anyone to report noncompliance and potential FWA
- Reported issues will be addressed and corrected

The Code of Conduct communicates to employees, and FDRs compliance is everyone's responsibility, from the organization's top to the bottom.

Report Medicare FWA

Talk with your Manager or Supervisor

Call the Compliance Hotline

Report directly to PHP Medicare Compliance

How to Report FWA Concerns

Verbal: Contact your Supervisor, Medicare Compliance Officer (MCO) (Michelle Coberly), the Chief Compliance Officer (CCO) (Nick D'Isa), or designee in person, by telephone, or via e-mail

Written correspondence to Physicians Health Plan (PHP) Compliance Department at:

- PO Box 30377 Lansing MI 48909-7877
- E-mail phpcompliance@phpmm.org

Call the Compliance Hotline to report concerns and violations confidentially and anonymously, 24 hours a day, 7 days a week, 866.747.2667

I'm Afraid to Report FWA or Noncompliance

- There can be **NO** retaliation against you for reporting suspected FWA and noncompliance in good faith
- All employees are required to report issues of FWA and noncompliance
- PHPM prohibits any retaliatory action for good faith reporting of suspected violations of law, regulation, or PHPM policy
- Managers are to promote/support employees reporting FWA and noncompliance issues

Correction

Once fraud, waste, or abuse is detected, we will promptly correct it. Correcting the problem saves the government money and ensures our compliance with CMS requirements.

In collaboration with the business department, the Medicare compliance department will develop a plan to correct the issue. The actual plan is going to vary, depending on the specific circumstances. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future noncompliance.
- Tailor the corrective action to address the identified FWA, problem, or deficiency. Include timeframes for specific actions.
- Document corrective actions addressing noncompliance or FWA committed by our employee or FDR's employee, and include consequences for failure to complete the corrective action satisfactorily.
- Monitor corrective actions continuously to ensure effectiveness.

Corrective actions may include:

- Adopting new prepayment edits or document review requirements
- Conducting mandated training
- Providing educational materials
- Revising policies or procedures
- Sending warning letters
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment
- Terminating an employee or provider

Indicators of Potential FWA

Now that you know your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.

Key Indicator: Potential Beneficiary Issues

- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- Have numerous identical prescriptions for this beneficiary been filled, possibly from different doctors?
- Is the person receiving the medical service the beneficiary (identify theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

Key Indicator: Potential Provider Issues

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Does the provider bill PHP Medicare for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Does the provider's prescription have an active and valid NPI on it?

Key Indicator: Potential Pharmacy Issues

- Are drugs being diverted, being sent elsewhere?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires dispensing brand drugs?
- Are PBMs billed for unfilled or never picked up prescriptions?
- Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or dispense as written)?

Key Indicator: Potential Health Plan Issues

- Does PHP Medicare encourage or support inappropriate risk adjustment submissions?
- Does PHP Medicare lead the beneficiary to believe the cost of benefits is one price when the actual cost is higher?
- Does PHP Medicare offer beneficiaries cash inducements to join the plan?
- Does PHP Medicare use unlicensed agents?

Recent OIG Reviews and Findings

- Between October 2022 to March 2023, the OIG office, with partners DOJ; Medicaid Fraud Control Units (MFCUs); and other Federal, State, and local law enforcement agencies, led to $892.3 million in expected investigation recoveries and resulted in 345 criminal actions.
- From October 2022 to March 2023, OIG completed 62 audit reports with identified $200.1 million in expected recoveries.
  - These audits resulted in 213 new audit and evaluation changes to policies and procedures within the HHS programs.
- Investigation Examples:
  - February 2023, OIG identified three DME suppliers involved in one of the largest health care fraud investigations with over $1.2 billion in losses related to telemarketing whereby DME services are ordered through unsolicited telephone calls.
  - In May 2023, OIG identified 553 Prescribers with a total of $86.2 million in fentanyl prescriptions that were dispensed outside of the Medically Accepted Indication (MAI).

Summary

As a person providing health or administrative services to a Medicare Part C or D enrollee, you play a vital role in preventing FWA. Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.

Report potential FWA. Every Medicare Advantage plan must have a mechanism for reporting potential FWA. We must accept anonymous reports and cannot retaliate against you for reporting.

We will promptly correct identified FWA with an effective corrective action plan.

Everyone plays a role in preventing , detecting, and correcting FWA

Resources

Physicians Health Plan

Additional Compliance Resources

Job Aids: Applicable Laws for Reference

- Anti-Kickback Statute 42 USC Section 1320a-7b(b)
- Civil False Claims Act 31 USC Sections 3729–3733
- Civil Monetary Penalties Law 42 USC Section 1320a-7a
- Criminal False Claims Act 18 USC Section 287
- Exclusion 42 USC Section 1320a-7
- Criminal Health Care Fraud Statute 18 USC Section 1347
- Physician Self-Referral Law 42 USC Section 1395nn
- Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training
- OIG's Provider Self-Disclosure Protocol
- Physician Self-Referral
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians
- Safe Harbor Regulations