EPIC MANAGEMENT, L.P.

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

IMPORTANT NOTE

All persons who provide health or administrative services to Medicare enrollees must satisfy FWA training requirements. This module *may* be used to satisfy this requirement.

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Why Do I Need Training?

Every year *millions* of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

Including YOU.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

YOU are part of the solution.

Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse
- Explain obligation of 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

Requirements

The Social Security Act and CMS regulations and guidance govern the Medicare program, including parts C and D.

- Part C and Part D sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare fraud, waste, and abuse.
- Sponsors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Key Terms and Acronyms

Original Medicare

- Medicare Part A – Hospital Insurance: pays for inpatient care, skilled nursing facility care, hospice, and home health services
- Medicare Part B – Medical Insurance: pays for doctor's services and outpatient care such as lab tests, medical equipment, supplies, some preventive care and some prescription drugs

Medicare Advantage Organizations (MAO)

- Medicare Part C – is also known as Medicare Managed care or Senior Health Plans, where coverage is through an MAO for coverage that would otherwise be through original Medicare under Part A and Part B

Medicare Prescription Drug Sponsors

- Medicare Part D – prescription drug coverage which helps pay for prescription drugs, certain vaccines and certain medical supplies (e.g. needles and syringes for insulin)
  - Part D coverage can be through an MAO that adds Part D benefits, which is called a Medicare Advantage Prescription Drug Plan (MAPD), OR
  - Part D coverage may be through a Prescription Drug Plan Sponsor (PDP)

Where Do I Fit In?

As a person who provides health or administrative services to a Part C or Part D enrollee you are either:

- Part C or D Sponsor (MAO or PDP) Employee
- First Tier Entity
  - Examples: Medical Groups, IPAs, Management Services Organizations (MSO), Pharmacy Benefit Managers (PBM), hospitals, a Claims Processing Company, contracted Sales Agent
- Downstream Entity
  - Example: Subcontractors of an IPA / MSO / hospital / PBM such as physicians, claims processing firms, ancillary providers, pharmacy
- Related Entity
  - Example: Entity that has a common ownership or control of a Part C/D Sponsor and performs some of the MAO or PDP management functions under contract or delegation

What are my responsibilities?

You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Part C or Part 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 that 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 non-compliance as well as fraud, waste and abuse.

- Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Prevention

How Do I Prevent Fraud, Waste, and Abuse?

- Make sure you are up to date with laws, regulations, 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

Understanding Fraud, Waste and Abuse

In order to detect fraud, waste, and abuse

you need to know the **Law**

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

18 United States Code §1347

What Does That Mean?

Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse

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

Abuse: includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment and 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 does not require the same intent and knowledge.

Report Fraud, Waste, and Abuse

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your compliance department. Your compliance department 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 present issues that may be potential FWA. Each slide provides areas to keep an eye on.

Key Indicators: Potential Beneficiary Issues

- Does the beneficiary's medical history support the services being requested?
- Did the beneficiary fail to disclose that he/she has a supplemental or other insurance plan?
- Identity Theft – using a different member's I.D. card to obtain doctor visits and/or hospital stays, prescriptions, ancillary services, equipment

Key Indicators: Potential Provider Issues

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider performing unnecessary services for the member?
- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill the sponsor for services not provided?

Key Indicators: Potential Purchasing Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Does the manufacturer promote off label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a federal health care program?

How Do I Report Fraud, Waste, or Abuse?

Reporting Fraud, Waste, and Abuse

Everyone is required to report suspected instances of fraud, waste, and abuse. Your employer's Code of Conduct and Ethics should clearly state this obligation. Employers may not retaliate against you for making a good faith effort in reporting.

Reporting Fraud, Waste, and Abuse

EPIC Management has a Compliance Hotline, **909-335-4153**, in place in which potential fraud, waste, or abuse may be reported.

EPIC Management accepts anonymous reports and cannot retaliate against you for reporting in good faith.

Review your Code of Conduct for the ways to report fraud, waste, and abuse.

Correction

Correction

Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government money and ensures you are in compliance with CMS' requirements.

How to Correct Issues?

Once issues have been identified, the compliance officer will develop a corrective action plan with management in accordance to Policy and Procedure.

The actual plan is going to 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 the 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;
- 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 Penalty 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

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 (which includes the Medicare program).

42 United States Code §1320a-7b(b)

Anti-Kickback Statute Penalties

Fine of 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

Additional Resources

- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
  - Title XVIII of the Social Security Act
  - Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
  - Civil False Claims Act (31 U.S.C. §§ 3729-3733)
  - Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
  - Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
  - Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)
  - Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)
  - OIG Compliance Program Guidance for the Healthcare Industry: http://oig.hhs.gov/compliance/compliance-guidance/index.asp