• Patients as Victims of Fraud
  • Common fraud schemes
  • Case studies
  • Prevention and detection techniques

• Patients as Perpetrators of Fraud
  • Focus on beneficiary fraud
  • Common schemes

• Protecting Patients from Fraud
  • Initiatives
  • Resources
  • Reporting Fraud
Program Integrity Priority

Balance protecting beneficiary access to critical health care services with reducing administrative burden on providers and safeguarding taxpayer dollars from fraud, waste and abuse (FWA)

• FWA exposes beneficiaries to risk and harm from substandard care
• FWA restricts access to quality health care services
• FWA adds undue burden on legitimate providers and suppliers
• FWA results in significant losses to Trust Funds
Patients as Victims of Fraud
Medically Unnecessary Services

- Ordering same tests for all beneficiaries
- Billing supplies/services patient does not want, need or for which patient does not qualify
- Prescribing drugs without legitimate clinical need
Medically Unnecessary Services

- Ordering same tests for all beneficiaries
- Billing supplies/services patient does not want, need or for which patient does not qualify
- Prescribing drugs without legitimate clinical need

- Directed administration of unnecessary hematology and chemotherapy treatments and dangerously high doses of controlled substances to patients deliberately misdiagnosed to justify expensive treatments
- Kickback schemes for referrals to his own clinics and facilities
- Submitted $225M in false claims and was paid $91M

Case Study:
Farid Fata, MD

Sentenced to 45 years in prison and $17.6M forfeiture
Services Not Rendered

- Billing for lab or medical tests not performed
- Billing for services or products after patient’s date of death
- Billing for supplies, drugs or equipment beneficiary does not receive

Services Not Rendered (SNR)

Billing for products or services not supplied to the beneficiary
Services Not Rendered

- Billing for lab or medical tests not performed
- Billing for services or products after patient’s date of death
- Billing for supplies, drugs or equipment beneficiary does not receive

Case Study: Albert Ades, MD

- Sentenced to 37 months in prison and $280K forfeiture
- Fraudulently billed Medicare, Medicaid and private payers for office visits that did not happen
- Wrote prescriptions, authorized refills and altered medical charts to make it appear as if he had seen patients
- Resulted in loss of $280K from 2009-2013
Misrepresenting Products or Services

• Using higher-paying codes to define diagnosis
• Dispensing generic prescription and claiming brand name drug
• Billing separately for products or services grouped into a single rate

Falsifying nature of services or diagnosis to increase payment
Misrepresenting Products or Services

- Using higher-paying codes to define diagnosis
- Dispensing generic prescription and claiming brand name drug
- Billing separately for products or services grouped into a single rate

Case Study: Hung Viet Tran

Sentenced to 20 months in prison and $825K restitution

- Over 4 years, pharmacist billed for brand name prescriptions that were never dispensed
- Dispensed over the counter or cheaper generic drugs and billed Medicare and Medicaid for brand name
- Purchased 70,000 Costco brand fish oil capsules at 2.4 cents each and billed for expensive drug, Lovaza, reimbursed at $1.64 each
Durable Medical Equipment (DME): Common Schemes

- Billing for equipment not supplied to patient
- Pre-billing and/or automatically refilling medical supplies
- Billing for customized equipment and providing standard equipment

Billing for unnecessary equipment for beneficiaries who do not qualify and/or do not have legitimate medical need
Durable Medical Equipment (DME): Common Schemes

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- Pre-billing and/or automatically refilling medical supplies
- Billing for customized equipment and providing standard equipment

Common DME Schemes

Billing for unnecessary equipment for beneficiaries who do not qualify and/or do not have legitimate medical need

- Owner of Royal Medical Supply billed $4M between 1/2006 and 10/2009 for power wheelchairs, knee and back braces that were either unnecessary or not provided
- Falsified documentation to support fraudulent billing, including fake home assessments and delivery records for equipment

Case Study: Valery Bogomolny
Convicted and awaiting sentencing
Prevention and Detection of Common Fraud

- **Review MSNs/EOBs** to confirm validity and **verify receipt** of all listed products and services
- **Track dates** of office visits and procedures to compare to service dates on EOBS
- **Review documents** before signing and never sign blank forms
- **Use familiar providers** to order DME supplies and do not accept unneeded supplies
- **Be wary of free offers** that require beneficiary name, personal information or health insurance claim number (HICN)
Prevention and Detection of Common Fraud

• **Review MSNs/EOBs** to confirm validity and **verify receipt** of all listed products and services.

Hotline tips from members reporting discrepancies on their EOBs account for **60-70%** of one health plan’s criminal investigations.*

*BCBS of Michigan podcast, March 2016 ([linkis.com/com/q1Qyq](http://linkis.com/com/q1Qyq))
Telemarketing

Phone callers use phishing techniques to trick enrollees into providing identification numbers for fraudulent purposes

- **Misdialing number** similar to health plan’s number leads to identity theft
- Offers of **free items** by providing bank information to cover shipping costs
- **Free phones** to Medicare or Social Security beneficiaries
- **Impersonating** Medicare, Social Security or health plan to “verify” personal information
  - Special plans with **limited time offers** require Medicare identification and/or bank information to **act now**
Telemarketing

Phone callers use phishing techniques to trick enrollees into providing identification numbers for fraudulent purposes

**Recent Scams**

- **Misdialing number**: similar to health plan’s number leads to identity theft
- Offers of **free items** by providing bank information to cover shipping costs
- **Free phones** to Medicare or Social Security beneficiaries
- **Impersonating**: Medicare, Social Security or health plan to “verify” personal information
  - Special plans with **limited time offers** require Medicare identification and/or bank information to **act now**

**Prevention**

- Register personal phone numbers with **Do Not Call** registry ([https://donotcall.gov](https://donotcall.gov))
- **Never** provide HICN or personal information over the phone
- Do not submit to pressure from a caller to “act now!”
Marketing and Enrollment Fraud

- Cold calls from agents and brokers
  - Phone, email or door-to-door solicitation by persistent sales people
  - Cold calls and solicitation are prohibited by marketing guidelines

- Proposed plan may not be in beneficiary’s best interest
- Includes plan-switching for LIS beneficiaries for commissions
- Beneficiary should consider formularies, provider networks, plan costs, supplemental benefits

Steering into plan for agent incentives
Medical Identity Theft

Fraudulent use of beneficiary’s personal and medical identifier information for covered medical supplies, services or prescriptions

Submitting medical claims using unlawfully obtained medical identity

Perpetrated by friends, family, caregivers or criminal enterprises or as a result of health care data breach
Medical Identity Theft

Fraudulent use of beneficiary’s personal and medical identifier information for covered medical supplies, services or prescriptions

Submitting medical claims using unlawfully obtained medical identity

Perpetrated by friends, family, caregivers or criminal enterprises or as a result of health care data breach

- Financial loss and/or financial responsibility for fraudulent and false claims (e.g., copay, coinsurance)
- Compromised medical records
- Denial of future medical claims
- Loss of credit/downgrade of credit score
Medical Identity Theft: Statistics

Number of patients impacted by medical identity theft increased by 22% from 2014 to 2015¹

In 2015, **253 breaches** affecting >500 individuals combined for loss of >112 million health records²

Medical identity theft victims pay at least **$13,500** to resolve the crime and resultant issues³

Data breaches cost the health care industry about **$5.6 billion** annually⁴

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Medical Identity Theft: Prevention and Detection

Closely safeguard personal information

Provide information on a **need-to-know** basis

- Not on sign-in sheets
- Not over the phone to unknown people
- Not in exchange for free services or screenings
CPI issued Fraud Alerts to ZPICS and Part C plans to raise awareness of the schemes and a Fraud Awareness Flyer for Senior Medicare Patrol to understand the importance of warning beneficiaries of the scams.
Genetic Testing Fraud: Schemes

Lab representatives offer “free” health screenings at health fairs, taking swabs of beneficiaries’ cheeks for testing.

Ice cream socials at senior and Section 8 housing and assisted living facilities for “education of prescription medications”.

Beneficiaries give Medicare numbers and personal information for lab to bill Medicare and/or share results with their doctor.

Bill for high dollar, medically unnecessary genetic tests without specified medical condition or physician orders.
Medicare Coverage of Lab Testing Services

A lab test is covered by Medicare if it is:

☑ Medically necessary
☑ Ordered by the patient’s physician or qualified practitioner
☑ Accompanied by copy of signed consent form and medical record documentation

- Does not cover screening services
- Does not cover tests to assess risk for and/or a condition unless it directly affects management of patient care
- Does cover legislatively mandated preventive services to prevent, provide early detection and manage disease to avoid complications
Genetic Testing Fraud: Reminders

- Genetic testing is expensive and required only under very specific circumstances
- Be conscious of false claims about benefits
- Medicare-covered services must be ordered by treating physician for legitimate medical need
Genetic Testing Fraud: Case Study

Fraud Awareness

• Genetic testing is expensive and required only under very specific circumstances
• Be conscious of false claims about benefits
• Medicare-covered services must be ordered by treating physician for legitimate medical need

Case Study

Millennium Health

CMS revoked Medicare billing privileges of several labs for billing genetic testing services with no physician orders and with forged documentation

Billed medically unnecessary urine drug and genetic testing to federal health care programs
• Allegedly paid kickbacks to physicians for referrals for expensive lab testing
• Millennium Health agreed to pay $256 million to resolve alleged violations of the False Claims Act

Patients as Perpetrators of Fraud
Who and Why of Beneficiary Fraud

Who commits beneficiary fraud?

- Any Medicare beneficiary
- Disability beneficiaries under age 65*
- Low Income Subsidy recipients*

Why do beneficiaries commit fraud?

- Supplemental income
- Addiction
- Beneficiary abuse by caretakers

*OIG and GAO reports indicate beneficiary fraud is common among those under 65 and receiving LIS benefit - [http://1.usa.gov/1XChBuj](http://1.usa.gov/1XChBuj) and [http://go.cms.gov/1QO1gPx](http://go.cms.gov/1QO1gPx)
Focus on Beneficiary Fraud

• Law enforcement is more actively **pursuing, investigating and charging** beneficiaries with health care fraud
• Fraudsters’ **schemes** are becoming more **brazen and bold**
• Increased **collusion and coordination** is occurring among beneficiaries, providers and pharmacies
• Targeted **recruiting efforts** encourage beneficiaries to “get involved” in fraud
Beneficiary Fraud Schemes

Drug Seeking Behaviors
Doctor or pharmacy shopping, overutilization

Identity Theft
Potential issue of beneficiary harm

Complicit Relationships and Kickbacks
Financial relationships with providers or pharmacies

Recruiting and Buy-Back Schemes
High dollar drugs with high street value for big profit

Enrollment and Eligibility Fraud
Attempting to enroll or qualify for low income subsidy
Card Sharing

Uninsured individual uses a legitimate beneficiary’s Medicare identification to obtain medical care with beneficiary’s consent and knowledge.

Illegal Card Sharing

Favor to uninsured friend/family
For payment or other arrangement

Loss of future medical benefits based on stringent time limitations

Misdiagnosis, harmful drug interactions, unnecessary, inappropriate treatments
Uninsured individual uses a legitimate beneficiary’s Medicare identification to obtain medical care with beneficiary’s consent and knowledge.

- Favor to uninsured friend/family
  - For payment or other arrangement
- Loss of future medical benefits based on stringent time limitations
- Misdiagnosis, harmful drug interactions, unnecessary, inappropriate treatments

Industry estimates show that 26% of beneficiaries willfully share medical cards.
Recent Beneficiary Fraud Headlines

McMinn Co. woman facing murder charges after alleged sale of prescription drugs
...allegedly sold...some of her legally prescribed methadone pills...the married mother of one daughter died of a drug overdose from them.

Ten Individuals Indicted in Medicare Fraud Scheme
...for allegedly participating in a scheme to defraud Medicare by submitting false and fraudulent claims and the payment and receipt of kickbacks in connection with a federal health care program...

Medicare Recipient Pleads Guilty to Health Care Fraud
Defendant Used Forged Receipts to Collect More Than $71,000

Pharmacy owner in West Virginia charged with defrauding Medicare and Medicaid
December 24, 2014, Charleston, WV — U.S. Attorney Booth Goodwin announced a long-standing Kanawha City retail and compounding pharmacy, was charged by information with two counts of health care fraud and one count of misbranding drugs on Dec. 23.
...a Medicare beneficiary, is charged with submitting false claims...on her own behalf, seeking payment for drugs that were never dispensed to her.
Protecting Patients from Fraud
Revocations and Savings

New legislative authorities and tighter regulations strengthen CMS’ ability to combat FWA and improper payments in Parts C and D.

Deactivated **543,163 providers and suppliers** and revoked **34,888 providers and suppliers** since 2011.

About **$2.4 billion in payments** to revoked providers was/will be prevented since 2011.

Saved **>$25 billion** through recoveries and prepayment denials since 2011.
Prescriber Enrollment Requirement

As of February 1, 2017, Medicare will no longer cover Part D drugs prescribed by providers not enrolled in or validly opted-out of Medicare

• Promotes quality health care through verification of prescribers’ credentials
• Ensures only competent, licensed individuals enroll as Medicare providers
• Safeguards health and wellness of beneficiaries and protects the Medicare Trust Funds from fraudulent prescribers
Prescriber Enrollment Requirement: Impact on Beneficiaries

If a provider does not enroll in or validly opt-out:

- Part D will cover up to one 3-month provisional supply of prescription
- Provisional supply must be dispensed within 90 days, after which Part D will not cover other prescriptions or refills for the same drug from that provider
- Beneficiary will receive written notice that provider is not an approved Part D prescriber

If provider validly opts-out:

- Part D drugs will continue to be covered
- Neither Medicare nor the Part C plan will pay for office visits or other services from the provider

If provider is not an approved Part D prescriber, Part D plan will not cover prescriptions
Prescription Drug Abuse: A National Epidemic

Each day, almost 7,000 people receive treatment in emergency rooms for improper drug use*

44 people die everyday in the U.S. from overdose of prescription painkillers

Deaths from prescription painkillers have quadrupled since 1999, killing more than 16,000 in 2013**

*http://www.cdc.gov/drugoverdose/epidemic/index.html
**http://www.cdc.gov/drugoverdose/data/index.html
Overutilization Initiatives

CMS programs strengthen oversight of Part D to combat growing problem of prescription drug abuse

- New policies and system edits to monitor and track prescription drug use and potential overutilization
- Identify high risk beneficiaries for overutilization of opioids
- Curb the flow of diverted drugs and reduce drug overdoses

26% decrease in potential opioid overutilizers
47% decrease in first-time opioid overutilizers
Open Payments

- Publicly available information detailing **financial relationships** between physicians and pharmaceutical and medical device companies
- Enables beneficiaries to make **informed decisions** about providers
- May highlight **conflicts of interest** or **prescribing patterns** based on compensation by device or drug manufacturer

![Financial Information Table]

- Total US Dollar Value: $9.92 Billion
- Total Records Published: 15.67 Million

[https://www.cms.gov/openpayments/](https://www.cms.gov/openpayments/)
Senior Medicare Patrol (SMP): Empowering Seniors

54 SMP projects in 2014 had 5,249 active volunteers

Volunteers conducted 202,862 one-on-one counseling sessions

Volunteers held 14,692 group education sessions that reached 452,714 beneficiaries

Activities account for more than $17 million in savings from 2010 to 2014

For Senior Medicare Patrol program services in your state:
Call 800-562-6900 or visit http://insurance.wa.gov/your-insurance/medicare/report-medicare-fraud/
State Health Insurance Assistance Program (SHIP)

Educate, advocate, counsel and empower people to make informed health care benefit decisions

Statewide Health Insurance Benefits Advisors (SHIBA)

https://insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/
Online Resources

**Medicare.gov Resources**
- How to report fraud
- Tips to prevent fraud
- Links to educational videos

**CMS.gov Outreach and Education**
- Fraud prevention toolkit
- Frequently Asked Questions
- Fact sheet for beneficiaries

**CMS Outreach & Education MEDIC (Parts C & D)**
- Beneficiary outreach materials
- Online courses
- Quick reference cards and links

**CMS.gov Medicaid Integrity**
- Tips for beneficiaries
- Infographics
- Fact Sheets
Medicare Advantage and Part D Resources
Report Fraud to Proper Authorities

- For Medicare improper billing, contact 1-800-Medicare
- For Medicaid improper billing, contact State Medicaid Agency
- For identity theft, contact Federal Trade Commission or NBI MEDIC
- For criminal matters, contact OIG at 1-800-HHS-TIPS (1-800-447-8477)
Questions