Fraud Schemes & Genetic Testing

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Center for Program Integrity

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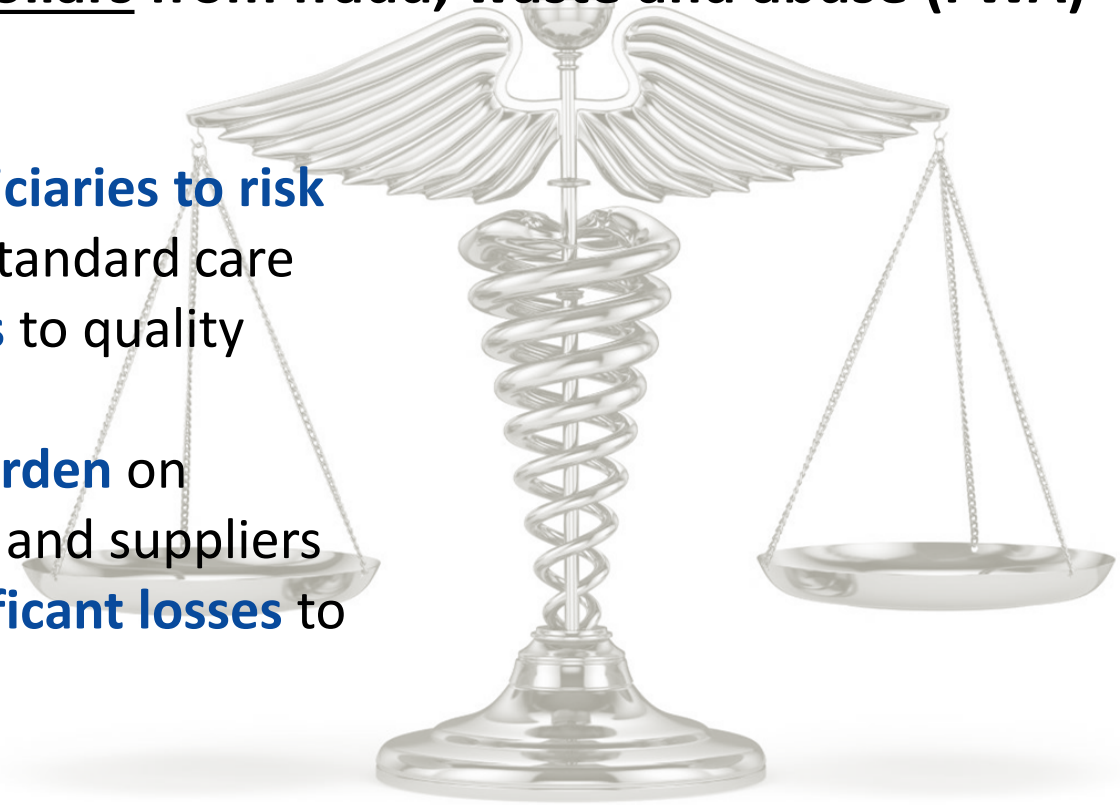
Agenda

- 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

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Medically Unnecessary Services

Medically Unnecessary Services

Billing services unrelated or unnecessary to treat a patient's medical need

- **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**

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- 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

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Services Not Rendered (SNR)

Billing for products or services not supplied to the beneficiary

Case Study: Albert Ades, MD

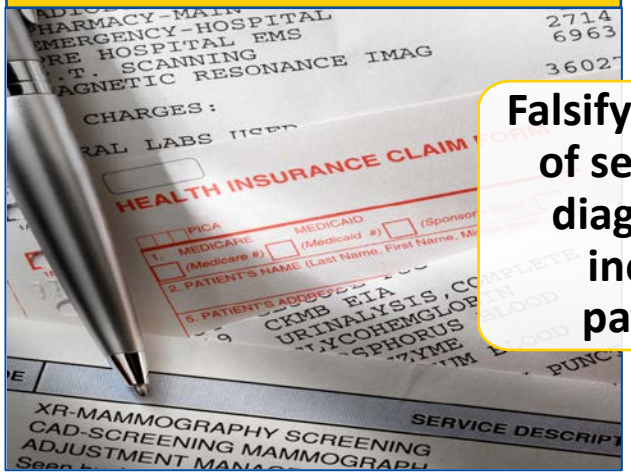
Sentenced to 37 months in prison and $280K forfeiture

- 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

Misrepresenting Products or Services



Falsifying nature of services or diagnosis to increase payment

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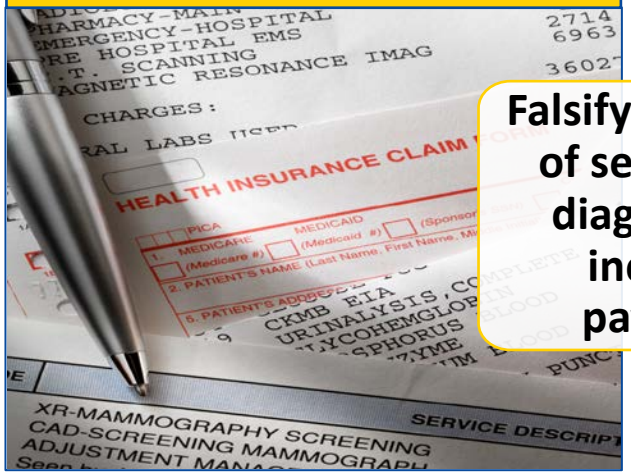

Falsifying nature of services or diagnosis to increase payment

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

Common DME Schemes

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

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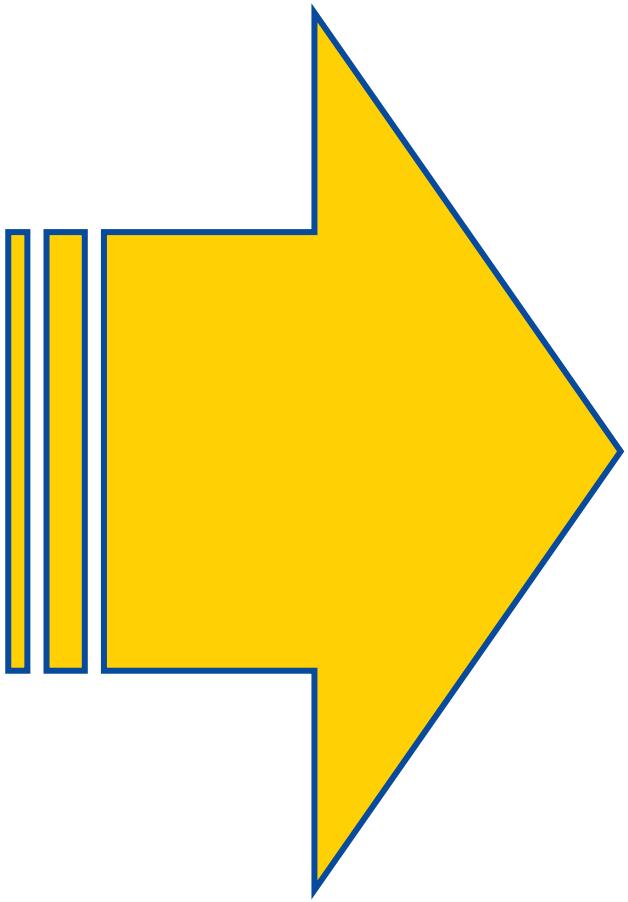
Case Study: Valery Bogomolny

Convicted and awaiting sentencing

- 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

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 (http://linkis.com/com/q1Qyq)

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**

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Prevention

Register personal phone numbers with **Do Not Call** registry (https://donotcall.gov)

Never provide HICN or personal information over the phone

Do not submit to pressure from a caller to "act now!"

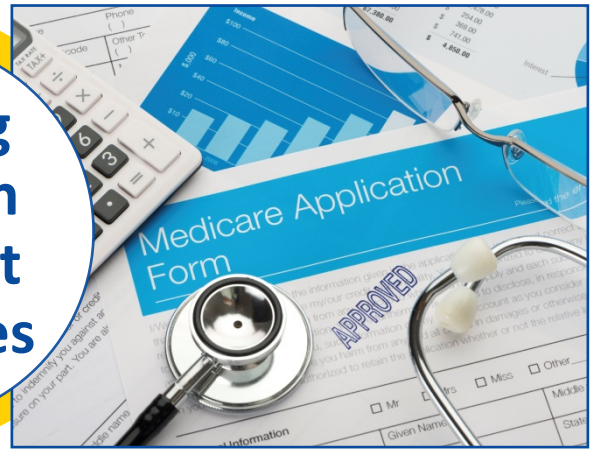
Marketing and Enrollment Fraud

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

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- **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 2015[1]

In 2015, **253 breaches** affecting >500 individuals combined for loss of **>112 million health records**[2]

Medical identity theft victims pay at least **$13,500** to resolve the crime and resultant issues[3]

Data breaches cost the health care industry about **$5.6 billion** annually[4]

[1] http://www.healthcareitnews.com/news/medical-identity-theft-sees-sharp-uptick
[2] http://www.forbes.com/sites/danmunro/2015/12/31/data-breaches-in-healthcare-total-over-112-million-records-in-2015/#4ec957537fd5
[3] http://www.healthcareitnews.com/news/medical-identity-theft-hits-all-time-high
[4] http://www.forbes.com/sites/danmunro/2015/12/31/data-breaches-in-healthcare-total-over-112-million-records-in-2015/#4ec957537fd5

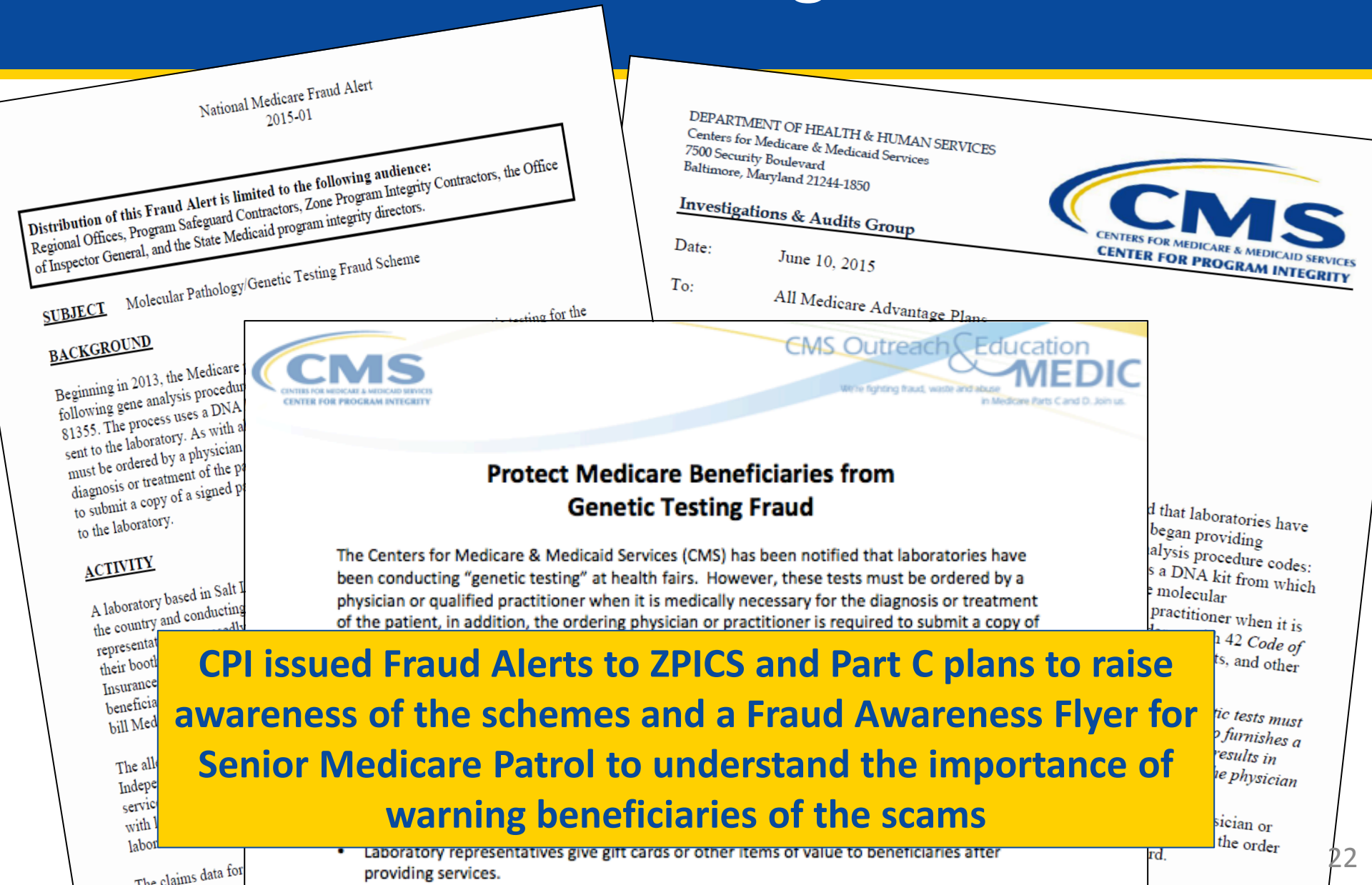
Medical Identity Theft: Prevention and Detection

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

Genetic Testing Fraud


National Medicare Fraud Alert
2015-01

Distribution of this Fraud Alert is limited to the following audience:
Regional Offices, Program Safeguard Contractors, Zone Program Integrity Contractors, the Office of Inspector General, and the State Medicaid program integrity directors.

SUBJECT Molecular Pathology/Genetic Testing Fraud

BACKGROUND

ACTIVITY

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Investigations & Audits Group

Date: June 10, 2015

To: All Medicare Advantage Plans

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR PROGRAM INTEGRITY

CMS Outreach & Education MEDIC

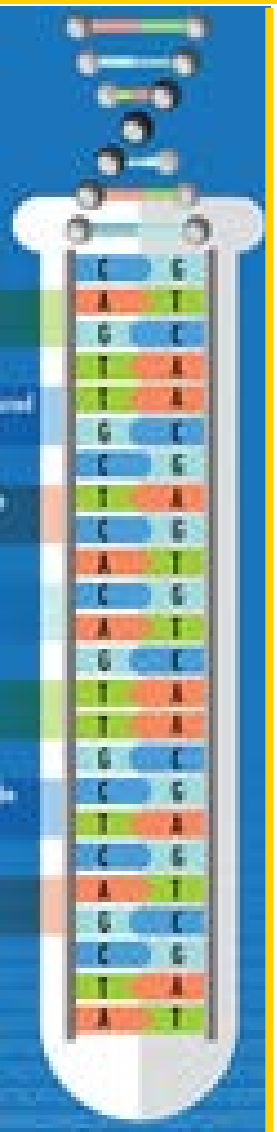
Protect Medicare Beneficiaries from Genetic Testing Fraud

The Centers for Medicare & Medicaid Services (CMS) has been notified that laboratories have been conducting "genetic testing" at health fairs. However, these tests must be ordered by a physician or qualified practitioner when it is medically necessary for the diagnosis or treatment of the patient, in addition, the ordering physician or practitioner is required to submit a copy of

- Laboratory representatives give gift cards or other items of value to beneficiaries after providing services.

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



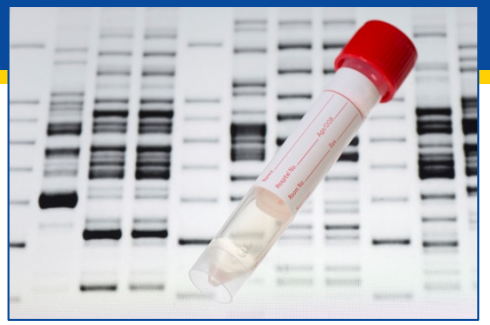
Lab representatives offer "free" health screenings at health fairs, taking swabs of beneficiaries' cheeks for testing

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

Fraud Awareness

Genetic Testing Fraud: Case Study

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- Be conscious of false claims about benefits
- Medicare-covered services must be ordered by treating physician for legitimate medical need

Fraud Awareness

- 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

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

https://www.justice.gov/usao-ma/pr/millennium-laboratories-pay-256-million-resolve-false-billing-and-kickback-claims

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 and http://go.cms.gov/1QOIgPx

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

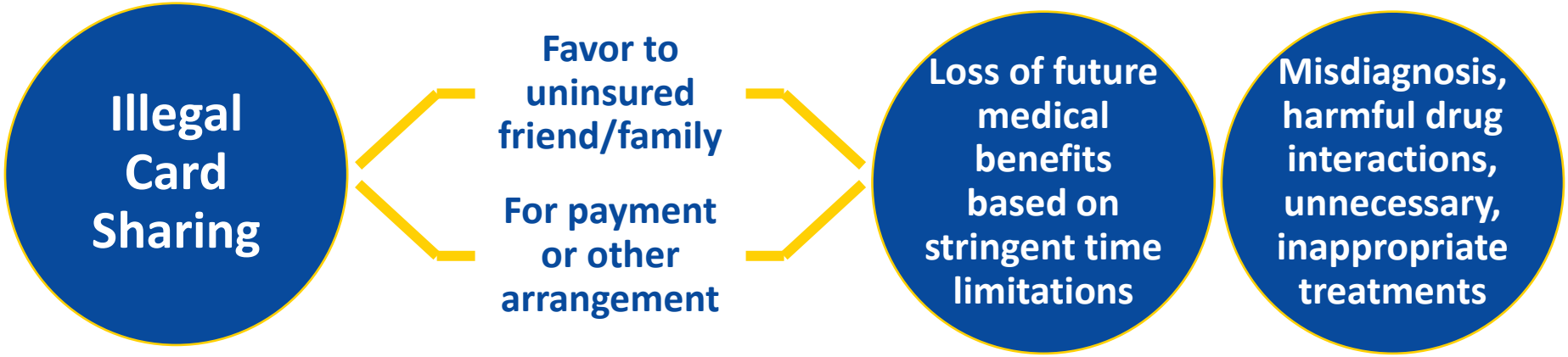
Complicit Relationships and Kickbacks
Financial relationships with providers or pharmacies

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



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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**

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.

By WDEF Staff | Posted: Wed 6:32 PM, Jan 13, 2016

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…

Cops: DNA evidence traces suspect to shotgun, fake prescription

DNA evidence linked [redacted] to the incident and Shelt…
shotgun, criminal…
police in pursuit.

using fraud and deceit to obtain a controlled substance, forgery

…stance, forgery and engaging

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 [redacted] 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:

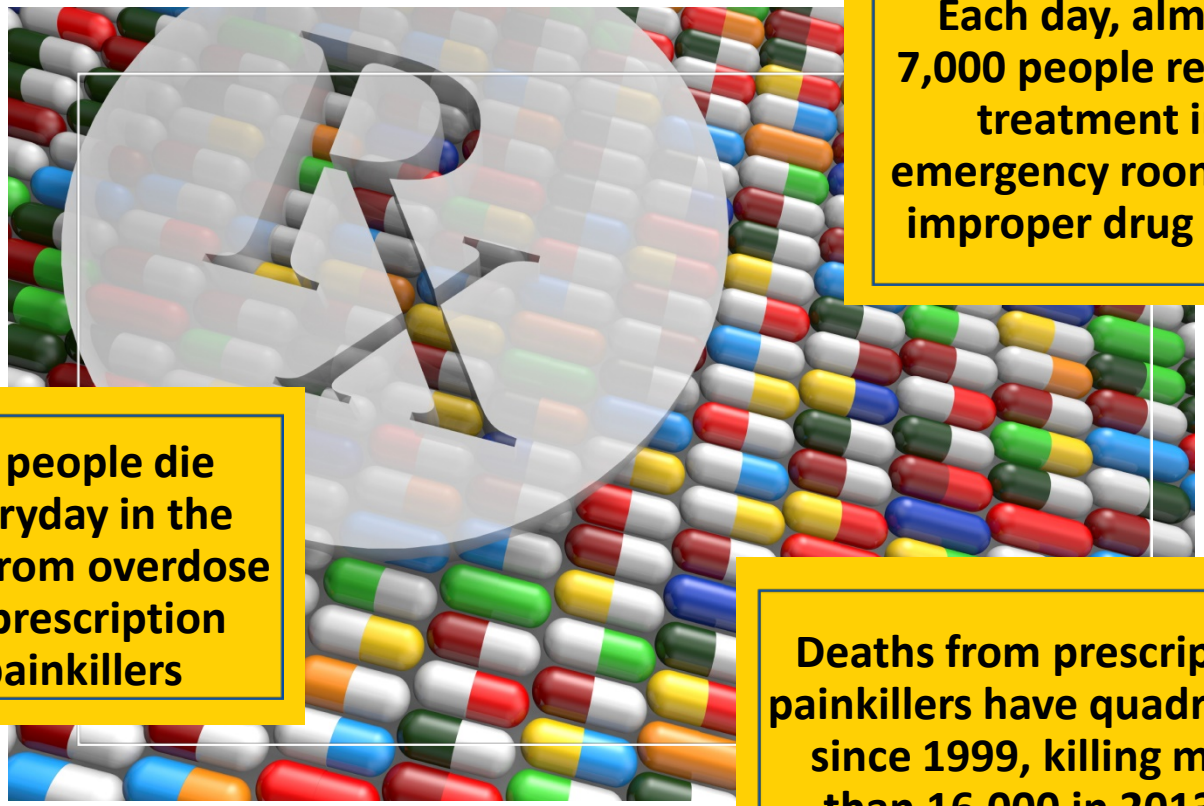
- Part D will cover up to one 3-month provisional supply of prescription
- Provisional supply must be dispensed within 90 days, after which Part D will not cover other prescriptions or refills for the same drug from that provider
- Beneficiary will receive written notice that provider is not an approved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

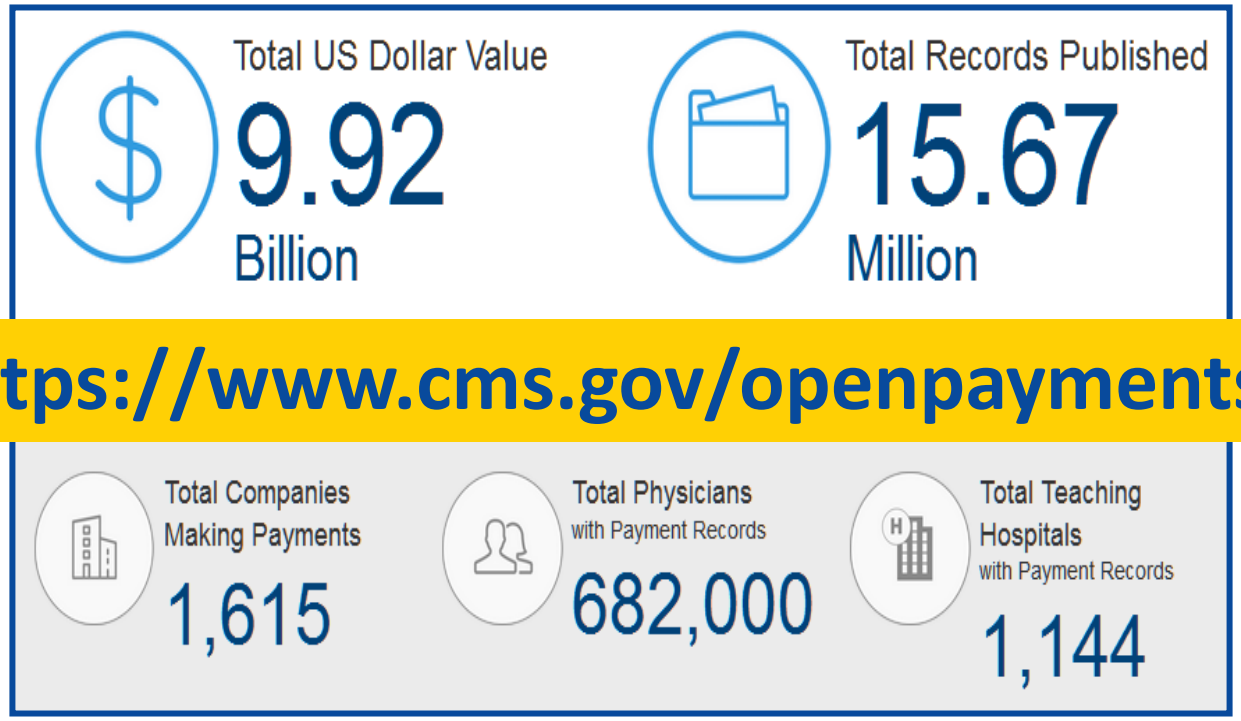
CMS programs strengthen oversight of Part D to combat growing problem of prescription drug abuse

- 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



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

Medicaid 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