



Fraud, Waste and Abuse Prevention Training Guide

Designed for First-tier, Downstream and Related Entities

CarePlus is providing this *Fraud, Waste and Abuse Prevention Training Guide* as a resource for meeting a Centers for Medicare & Medicaid Services (CMS) requirement that contracted entities provide fraud, waste and abuse prevention training to their employees who administer or deliver Medicare benefits or services. This training guide is designed for use by first-tier, downstream and related entities that provide services or benefits in the Medicare Part C and Part D programs. For additional information, CMS issued the Medicare fraud, waste and abuse guidance that may be found at:

http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf

As a first-tier, downstream or related entity that provides services or benefits in the Medicare Part C and Part D programs, you are responsible for recognizing behavior that may be considered fraud, waste or abuse. When such behavior is detected, it should not only be reported, but measures should also be put in place to confirm that such behavior does not occur in the future.

Introduction

The detection and prevention of insurance fraud, waste and abuse is essential to maintaining a health care system that is affordable for everyone. Both state and federal law enforcement agencies are increasingly focused on investigating health care fraud, waste and abuse. Following are definitions:

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Some examples of fraud include, but are not limited to:

- Double billing
- Billing for more expensive services or procedures than were actually provided
- Doctor shopping for prescription drugs
- Eligibility fraud
- Short-filling prescriptions
- Prescription forging or altering

False claims are the leading type of Medicaid and Medicare fraud and abuse.

An example of double billing is a pharmacist who deliberately charges both the patient and Medicare for the full cost of the same prescription and keeps the extra money.

Waste – To use health care benefits or spend health care dollars without real need. An example:

- Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed

Abuse – Provider practices that are inconsistent with sound fiscal, business or medical practices that result in unnecessary costs to the health care system, such as:

- Reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the health care system.

Victims of fraud, waste and abuse include and may not be limited to the health plan, government agencies, contracted entities and consumers. Potential fraud, waste and abuse are risks associated with the business of providing health care insurance and the prescription Part D benefit to consumers. Potential risk areas include:

- Consumers
- Health plans
- Insurance agents and brokers
- Pharmacies
- Pharmacy benefit managers
- Providers (including prescribers, wholesalers and pharmaceutical manufacturers)

An agent who enrolls a group of individuals to form a nonexistent company commits fraud.

Contracted health care professionals, entities and vendors are responsible for developing their own policies and procedures for detecting, correcting and preventing fraud, waste and abuse.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable.

CarePlus Health Plans, Inc. (CarePlus) is committed to complying with applicable state and federal rules, laws, regulations and other requirements as it pertains to providing services to its members.

Fraudulent Activities

Definitions and examples of fraudulent activities are cited below.

Health Plan Fraud

Fraud committed by the health plan is defined as acts committed through deception, misrepresentation or concealment by the health plan's employees as directed by leadership of the health plan. Such acts can include:

- Failure to provide medically necessary services
- Marketing schemes
- Improper bid submissions
- Payments for excluded drugs
- Multiple billing
- Inappropriate formulary decisions
- Inappropriate enrollment/disenrollment
- False information
- Inaccurate data submission

Fraud by Agents/Brokers

Fraud committed by agents/brokers is defined as deception, misrepresentation or concealment by a licensed representative in order to obtain something of value for which he/she would not otherwise be entitled. Some examples of agent/broker fraud can include:

- Helping individuals fill out their enrollment information so they will be eligible for insurance
- Enrolling a group of individuals to form a nonexistent company
- Falsifying location of a group to gain insurance or obtain lower premium rates
- Adding false individuals to the group to avoid being medically underwritten
- False advertising

Fraud Due to Misrepresentation of Enrollment Information

Fraud due to misrepresentation of enrollment information is defined as commission of an act of deception, misrepresentation or concealment, or allowing it to be done by someone else to obtain coverage for which one would not otherwise be entitled. Examples of eligibility fraud can include:

- Individuals joining to form a nonexistent group for insurance purposes
- Members not meeting the eligibility requirements (e.g., not working the required number of hours, not receiving a wage)
- Dependents not meeting the definition of a dependent (e.g., a girlfriend, grandchildren or a child who is not a full-time student)
- Not disclosing medical conditions on an application

Claims Fraud

CarePlus associates are trained in fraud prevention and how to recognize typical fraud techniques such as:

- Provider is not in the insured's geographic region
- Member is in a different state than the company and no group affiliations exist for that state
- Large bills incurred just prior to term date or immediately after effective date
- Inconsistencies in company information versus medical records

Provider Fraud

Provider fraud is defined as “the devising of any scheme by any provider of health care or services to defraud for the purpose of personal or financial gain by means of false or fraudulent pretenses, representations, or promises.” Examples of provider fraud can include:

- Billing for services not rendered
- Providing “free” services and billing the insurance company
- Nonqualified practitioners billing as qualified practitioners
- Providers being rewarded for writing prescriptions for drugs or products
- Billing for noncovered services using an incorrect code (American Medical Association (AMA) Current Procedural Terminology (CPT[®]), Healthcare Common Procedure Coding System (HCPCS) and/or diagnosis codes) in order to have the services covered

Dental Fraud

Examples of dental fraud can include:

- Billing for dental services not rendered
- Providing excessive dental work that is not needed by the patient
- Falsifying the date of service to correspond with the member's coverage period
- Billing for noncovered services using an incorrect code (Current Dental Terminology (CDT) and/or diagnosis codes) in order to have the services covered

Suspected fraudulent activity committed by physicians, dental providers or other medical providers is to be reported to the local health plan medical directors, State Fraud Bureau, the Federal Bureau of Investigation (FBI) or other agencies at the discretion of the Special Investigations Unit (SIU) manager and/or supervisor.

Pharmacy Fraud

Examples of pharmacy fraud can include:

- Filling less than the prescribed quantity of a drug
- Billing for brand when generic drugs are dispensed
- Billing multiple payors for the same prescriptions
- Dispensing expired or adulterated prescription drugs
- Forging or altering prescriptions
- Refilling prescriptions in error

Examples of pharmacy benefit management fraud can include:

- Prescription drug switching
- Unlawful remuneration
- Prescription drug shorting
- Failure to offer negotiated prices

Examples of wholesale fraud can include:

- Inappropriate documentation of pricing information
- Speculative buying
- Counterfeit and adulterated drugs through black market purchases

Examples of pharmaceutical manufacturer fraud can include:

- Lack of integrity of data to establish payment and/or determine reimbursement
- Kickbacks, inducements and other illegal remuneration
- Inappropriate relationships with physicians
- Illegal usage of free samples

Suspected fraudulent activity involving the Part D prescription drug program should be reported to the appropriate Medicare Drug Integrity Contractor (MEDIC).

Member Fraud

Member fraud is defined as the commission of acts of deception, misrepresentation or concealment by any policyholder or group of policyholders to obtain something of value to which they would not otherwise be entitled. Examples of member fraud can include:

- Alteration of bills
- Submission of false claims
- Applying for insurance when you know you are not eligible
- Reselling drugs on the black market
- Doctor shopping
- Identity theft
- Forging or altering prescriptions
- Prescription stockpiling
- Improper coordination of benefits
- Failure to disclose information on applications, accident inquiries, continuation of benefits (COB) and full-time student information requests, etc.

Special Investigations Unit (SIU)

CarePlus' parent company, Humana's special investigations unit is responsible for detection, prevention and recommendation of process improvement for health insurance and prescription Part D fraud, waste and abuse. In an effort to confirm proper business practices and preserve

reasonable premium rates, the SIU staff investigates and works with appropriate law enforcement agencies when dealing with insurance fraud, waste and abuse by providers, insureds, agents, employer groups, company associates and other individuals. Our health care insurance products and lines of business include medical, dental, pharmacy, commercial, Medicaid, Medicare Parts A, B, C, and D-prescription drug plan). Life and disability insurance fraud are also investigated by the SIU.

All information received or discovered by the SIU will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, corporate law department, market medical directors or CarePlus/Humana senior management). Individuals providing information to or receiving information from the SIU may be instructed to refrain from discussing facts, suspicions and allegations with anyone outside the SIU, unless directed to do so by the SIU, or as required pursuant to government action or court order.

SIU utilizes a software tool for data mining that aids in the detection and prevention of claims fraud and assists in the investigation process. This tool is the Fraud and Abuse Management System (FAMS). In addition, the tool helps detect and investigate prescription fraud. FAMS has the capability to pull all data, and to include encounter data.

Humana, CarePlus' parent company, is actively involved with anti-fraud organizations, such as Midwest Anti-Fraud Insurance Association (MAIA), Special Investigations Unit Anti-Fraud Coalition (SIUAC) and the National Health Care Anti-Fraud Association (NHCAA) of which Humana is a corporate member. CarePlus, along with Humana, cooperates with federal, state and local authorities in the investigation of potential fraud, waste and abuse when indicated. The SIU supports law enforcement agencies, Centers for Medicare and Medicaid Services (CMS) and the Medicare Drug Integrity Contractor (MEDIC) in the execution of any resulting corrective action plan that is taken as a result of the fraud, waste and abuse investigation.

Some of the actions taken by CarePlus' parent company SIU Department are to:

- Sustain an anti-fraud program
- Train associates in detecting, preventing and reporting suspected fraudulent activities
- Conduct investigations
- Recommend to terminate contracts with agent/brokers engaged in fraudulent or abusive practices
- Recommend potential termination of company associates and/or members
- Recommend potential termination of business entities
- Refer cases for criminal or civil litigation
- Deny potential fraudulent claims submissions
- Report suspected fraudulent acts to the appropriate state, federal or government agency, if required
- Report cases of suspected Part D prescription drug fraud, waste and abuse to the MEDIC
- Cooperate with state or federal officials in criminal matters as a witness for CarePlus and/or attest to the validity of information provided by CarePlus.

Reporting of Fraud-Related Data to the Insurance Commissioner

SIU reports cases of suspected fraudulent insurance activity to a state's Department of Insurance (DOI) as required, or other appropriate state, federal or regulatory agency. SIU reports such activity to the state at the time that it has been determined or reasonably suspected that a fraudulent insurance act has been committed. SIU conducts an in-depth review of the suspect(s), which involves various means of investigation, including telephone interviews, claims and medical records review, review of various reports, working with other departments, insurance companies, and law enforcement agencies, along with many other techniques, to reach the determination of suspected fraud, waste or abuse.

SIU complies with any time frame set by the state for reporting fraudulent activity. SIU reports to the state's DOI through the Special Investigation Resource and Intelligence System (SIRIS), the National Association of Insurance Commissioners (NAIC) or through the state's DOI Web site.

Special requests for data are forwarded to the SIU and given priority handling upon receipt of a specific written request for information. Data is compiled and submitted to the appropriate law enforcement agency.

Referrals of Fraud Cases to Law Enforcement Authorities

CarePlus, along with our parent company, is committed to aggressive investigation and referrals for possible prosecution of health care insurance fraud by members, providers, agents, business entities, employer groups, company employees and other individuals. The SIU is responsible for the coordination of referrals to law enforcement and government authorities, and appropriate follow-up of these referrals. SIU works with the appropriate departments within the company to provide the maximum possible assistance to law enforcement and government agencies, including CMS and MEDIC officials, in compliance with state and federal laws.

Referrals may be made to state fraud bureaus, the U.S. Postal Inspectors, FBI, U.S. Department of Health and Human Services, MEDIC, state medical licensing and disciplinary boards, state insurance commissioners, federal, state and county attorneys, local police departments, Immigration and Naturalization Service, Internal Revenue Service or any other appropriate authority. The SIU reports fraud, waste and abuse for all products and lines of business, including medical, dental, life, pharmacy, commercial, Medicare and Medicaid.

Suspected fraud, waste and abuse for Medicare (Parts A, B and C) is reported to CMS through the Department of Health and Human Services (HHS) Office of Inspector General (OIG). Suspected Medicaid fraud, waste and abuse is reported to the Medicaid Program Integrity (MPI) administrator, Agency for Health Care Administration (AHCA), analyst with the Bureau of Managed Health Care, Medicaid Fraud Control Unit (MFCU) or appropriate Medicaid agency.

Laws Against Health Care Fraud

There are a number of laws that address health care fraud. These laws define fraud and establish the framework for the prosecution of criminal acts and the initiation of civil suits by injured parties. Listed below are a few of the laws that address health care fraud:

Federal False Claims Act (FCA) – 31 U.S.C. Title 1347

The False Claims Act addresses any person or entity who does any of the following:

- Knowingly presents, or causes to be presented, to an employee of the United States government a false or fraudulent claim for payment or approval
- Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid

- Knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money to the government
- Has actual knowledge of the information
- Acts in deliberate ignorance of the truth or falsity of the information
- Acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required

The False Claims Act imposes two sorts of liability:

- The submitter of the false claim or statement is liable for a civil penalty, regardless of whether the submission of a claim actually causes the government any damages and even if the claim is rejected
- The submitter of the claim is liable for damages that the government sustains because of the submission of the false claim

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment by the government are liable for three times the government's damages plus civil penalties of \$5,000 to \$10,000 per false claim.

Note: The federal government does not consider an innocent mistake as a legitimate defense for submitting a false claim and the violation could result in a multitude of penalties.

The False Claims Act is the primary federal law used to fight fraud in Medicaid and Medicare and has become one of the most widely enforced statutes to fight health care fraud.

Whistleblower (Qui Tam) Protection – 31 United States Code Service (USC) 3730 (h)

The whistleblower provision protects employees who assist the federal government in investigation and prosecution of violations of the False Claims Act. Whistleblower protections apply only to actions taken in furtherance of a viable False Claims Act case, which has been, or is about to be, filed. The provision prevents retaliation against employees such as firing them for assisting in the investigation and prosecution. If any retaliation does occur, the employee has a right to obtain legal counsel to defend the actions taken.

Note: A whistleblower (Qui Tam) is someone such as an employee who reports suspected misconduct that would be considered an action against company policy or federal laws or regulations. In 1994 alone, false claims act litigation resulted in payment to people/plaintiffs of \$379 million.

Physician Self-Referral Prohibition Statute commonly referred to as the “Stark Law” 1877 of the Social Security Act (42 USC 1395)

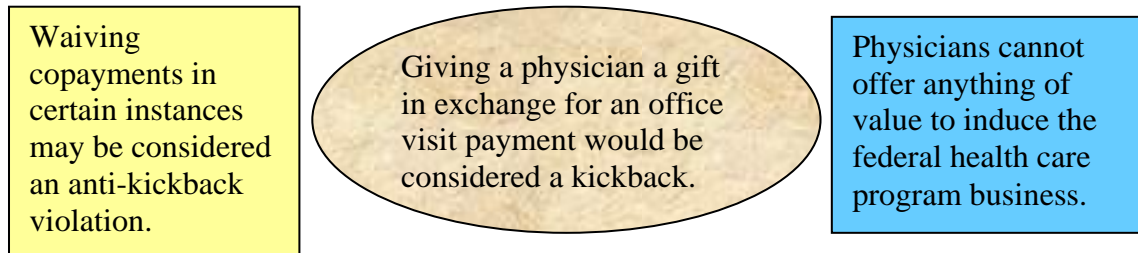
This statute prohibits physicians from referring Medicare patients for certain designated health services (DHS) to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a DHS furnished as a result of a prohibited referral. For more information, see <http://www.cms.hhs.gov/PhysicianSelfReferral> on the CMS Web site.

Anti-Kickback Statute Section 1128(b) of the Social Security Act (42 USC 1320a-7b (b))

The federal anti-kickback laws that apply to Medicare and Medicaid prohibit health care professionals, entities and vendors from knowingly offering, paying, soliciting or receiving remuneration of any kind to induce the referral of business under a federal program. In addition, most states have laws that prohibit kickbacks and rebates. Remuneration under the federal anti-

kickback statute includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Violators are subject to criminal sanctions such as imprisonment, as well as high fines, exclusion from Medicare and Medicaid, very costly civil penalties and possible prosecution under many similar state laws.



The anti-kickback law is extremely broad and covers a wider range of activities than just traditional kickbacks. Federal regulations include safe harbors that protect certain technically prohibited activities from prosecution. If you are unsure whether an activity violates the anti-kickback law, you should seek the advice of a legal professional.

Antitrust Laws

State and federal antitrust laws prohibit monopolistic conduct and agreements that restrain trade. CarePlus is committed to competition and consumer choice in the marketplace. All health care professionals, entities and vendors must adhere to the antitrust laws and must avoid any agreements or understandings with competitors on price, customers, markets or other terms of dealing and avoid trade practices that unfairly or unreasonably restrain competition in dealings with providers or customers.

Examples of illegal practices are price-fixing conspiracies, corporate mergers likely to reduce the competitive vigor of particular markets and predatory acts designed to achieve or maintain monopolistic power.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA was enacted to improve the efficiency and effectiveness of health information systems by establishing standards and requirements for the electronic transmission of certain health information. Regulations established standards for certain electronic transactions, along with minimum privacy and security requirements for individually identifiable health information that is held by covered entities. The protection of individual information may decrease chances of misuse of the information involving fraudulent activities. In addition, these measures may decrease the risk of identify theft.

CarePlus does not knowingly tolerate fraudulent activity by any of its contracted providers, associates, members, vendors, contractors and/or other business entities, and will investigate and report any such known activity to the appropriate regulatory, federal and state agencies for further action and investigation.

Reporting of Violations by Health Care Professionals, Entities or Vendors

If you become aware of a possible violation of any federal or state rule, law, regulation or policy, or of any violation of the *Principles of Business Ethics: Compliance and Fraud Prevention Guide*, immediately report it by calling the Ethics Help Line at **1-877-5THE KEY** (1-877-584-3539).

CarePlus strictly prohibits retaliation against any health care professional, entity or vendor who, in good faith, reports an actual or possible violation of any federal or state law or regulation, policy or ethical standard. Your call to the Ethics Help Line may be made anonymously. You are expected to cooperate fully in any investigation of an alleged violation.

You may also contact the following:

Humana Special Investigations Unit

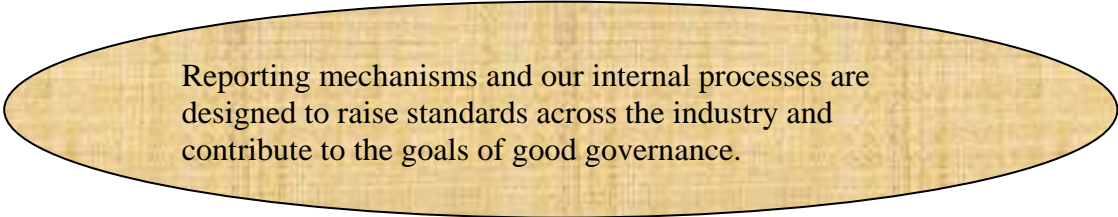
1100 Employers Blvd.
Green Bay, WI 54344
Phone number: 1-800-558-4444, ext. 8187 or 920-337-8187
Fax number: 920-339-3613

U.S. Department of Health and Human Services (HHS)

Office of Inspector General (OIG)
OIG's National Hotline: 1-800-447-8477
Fax: 1-800-223-8164
E-mail: HHSTips@oig.hhs.gov

Centers for Medicare & Medicaid Services (CMS)

1-800-633-4227
Web site: <http://www.cms.hhs.gov>



Reporting mechanisms and our internal processes are designed to raise standards across the industry and contribute to the goals of good governance.