

Fraudulent Billing

Pharm 543
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Goals and Objectives

- Goals
 - Provide billing information to insure compensation for services
 - Assist understanding of illegal billing practices
- Objectives: After this program students should be able to:
 - Identify billing practices that are fraudulent
 - Prevent themselves and others from involvement in fraudulent billing practices

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Fraud

A deliberate deception
For unfair or unlawful gain

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["Purposeful" Fraud]

- Dispense generic Rx - bill for brand Rx
- Dispense nothing - bill for drug
- Dispense one strength - bill for another
- Acquire drug samples - bill for them
- Acquire non-retail drugs (e.g. VA,, foreign drugs, etc. and bill for them)
- Fee splitting

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["Purposeful" Fraud]

- Misrepresentations on applications
 - Professional degrees (e.g. not state-licensed)
 - practice status (e.g. license suspended)
 - shareholder histories (e.g. hx of crime)
 - medical directors (e.g. lack of permission)
 - previous actions, etc

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["Purposeful" Fraud]

- Ghost patients
- Unnecessary services, false referrals
- Participating provider-patient payments
- Services provided by non-pharmacists
- Antitrust activities
 - "Price fixing", collusion (secret agreements or cooperation for deceitful purpose)

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Purposeful Fraud Kickbacks]

- One party offers money or some other form of inducement to another party in return for increased (Medicare or Medicaid) business
- Corrupts provider's decision-making process and encourages actions not in the patient's best interest

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Purposeful Fraud Upcoding

- Provision of one service but charging for another, more profitable (or permissible) one
- Pharmacists may be more susceptible to this when providing pharmaceutical care services (e.g. MTM)

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Purposeful Fraud Unbundling

- The whole is sometimes worth less than the sum of its parts
- Example: bill for lipid panel by billing separately for TC, HDL, LDL, TRGs, etc
- Flu Vaccinations billed to Medicaid by billing vaccine and for syringe

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“Unwitting” Fraud

- Prescriptions billed but not picked up
- Medicare patients paying for services*
- Price database and algorithm errors
- Wrong billing code assigned to service
- Incorrect provider numbers
- Dates of service changed
- Undocumented services

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Medicare Part D

- Much larger exposure to fraud against the federal government:
 - PDP's required to monitor & report pharmacy:
 - Prescription reversals
 - MTM patient eligibility
 - Generic dispensing
 - Grievances
 - Prior authorizations & formulary exceptions
 - Overpayments
 - Licensure

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Medicare/Medicaid Provider Participation

- Accepting assignment
 - Illegal patient payments:
i.e. Immunizations, covered DME
- OBRA-90 mandate(federal) for Medicaid participation (state)
 - Prospective DUR: screen Rxs, counsel patients, document relevant information

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Rules for Participation

- Licensed to practice in the state in which you are applying?
- Ever been excluded from Medicare?
- Have civil or monetary penalties ever been levied against you by the Medicare or Medicaid programs?
- Do you have ownership in other organizations that bill M'care/M'caid?

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False Claims Act and Qui Tam Actions

- False claims act 1863, amended 1986
 - Qui tam pro domino rege quam pro si ipso in hac parte sequitor *"he who brings the action as well for the king as for himself"*

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False Claims Act and Qui Tam Actions

- Expanded enforcement activities
 - Increased penalties, relator role increased
 - 32 qui tam cases in '87, over 500 '97 w/ over \$600mil. recovered;
 - Total through 2004: \$9 billion
 - \$6 billion from healthcare alone

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Penalties

- Criminal, civil and administrative
- Civil: \$5,500-11,000 per false claim & treble damages under false claims act
- HIPAA*: criminal fines &/or imprisonment of up to 10 years
- M'care/M'caid anti-kickback statute: imprisonment up to 5 yrs, fines up to \$25,000
- Debarment, exclusion, licensure
- Loss of pharmacy's public trust & respect

*Healthcare Insurance Portability and Accountability Act

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Damages

- Damages under the False Claims Act are severe. A person who violates the act must repay three times the amount of damages suffered by the government plus a mandatory civil penalty of at least \$5,500 and no more than \$11,000 per claim, for all claims made after September 29, 1999.

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Damages

- This means that, for example, a person who submits fifty false prescription claims to Medicaid or Medicare for fifty dollars each is liable for between:
 - \$282,500 [(\$2,500 x 3) + (50 x \$5,500)] &
 - \$557,500 [(\$2,500 x 3) + (50 x \$11,000)]in damages under the False Claims Act.

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Whistleblowers

- WAC 246-15-001 (9)
"Whistleblower" means a consumer, employee, or health care professional who in good faith reports alleged quality of care concerns to the [WA State] department of health.

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Chapter 246-15 WAC

WHISTLEBLOWER COMPLAINTS IN HEALTH CARE SETTINGS

- **WAC SECTIONS**
- 246-15-001 Purpose and scope.
- 246-15-010 Definitions.
- 246-15-020 Rights and responsibilities -- Whistleblower and department.
- 246-15-030 Procedures for filing, investigation, and resolution of whistleblower complaints.

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Whistleblower rights and responsibilities:

- Immune from civil liability
- Entitled to recover costs
- Human rights commission protections
- Whistleblowers revealed only:
 - To DOH staff/disciplinary authority member
 - By court order
 - If the complaint in no in good faith

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Discovery

- Audits (e.g. PBMs)
- Board of Pharmacy inspections; complaints
- Wholesalers
- Manufacturer reps
- Consumers
- Providers
- Fellow employees

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National Fraud Hotline (Medicare/Medicaid)

- 1-800-HHS-tips
 - Recipient's name
 - Recipient's Medicaid/Medicare number
 - Provider's name
 - Date of service
 - Amount approved by Medicaid/Medicare
 - Description of fraudulent or abusive act



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