Fraudulent Billing, CMS & other Troubles

Pharm 543

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"I may be too proud to beg, but I'm not too proud to bill."

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

Fraud

A deliberate deception

For unfair or unlawful gain

Washington State Case Findings

- Washington state has identified 9 elements of the cause of action for fraud. As the court in Pedersen v. Bibioff, 64 Wn. App. 710, 828 P.2d 1113 (1992) wrote at page 723,
- To sustain a finding of common law fraud, the trial court in most cases must make findings of fact as to each of the nine elements of fraud. Howell v. Kraft, 10 Wash. App. 266, 517 P.2d 203 (1973). Those elements generally are: (1) a representation of an existing fact, (2) its materiality, (3) its falsity, (4) the speaker's knowledge of its falsity or ignorance of its truth, (5) his intent that it should be acted on by the person to whom it is made, (6) ignorance of its falsity on the part of the person to whom it is made, (7) the latter's reliance on the truth of the representation, (8) his right to rely upon it, and (9) his consequent damage. *See* Turner v. Enders, 15 Wash .App. 875, 878, 552 P.2d 694 (1976).
- Example: Pharmacist tells a known Medicaid patient that they must pay “up front” for a covered product, perhaps causing a delay in receipt of the product with subsequent damage to the patient.

Federal Fraud Statute

- United States Code:

  TITLE 18 - CRIMES AND CRIMINAL PROCEDURE
  PART I - CRIMES
  CHAPTER 47 - FRAUD AND FALSE STATEMENTS

“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, IHS, foreign drugs, etc. and bill retail price)
- Fee splitting: (multiple refills instead of , one larger prescription)

“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

"Purposeful" Fraud

- Ghost patients: Pts not seen
- 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)

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

Purposeful Fraud
Kickbacks

- ***Overview:*** *On the books since 1972, the federal anti-kickback law's main purpose is to protect patients and the federal health care programs from fraud and abuse by curtailing the corrupting influence of money on health care decisions. Straightforward but broad, the law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony. Violations of the law are punishable by up to five years in prison, criminal fines up to $25,000, administrative civil money penalties up to $50,000, and exclusion from participation in federal health care programs.*
- Sec. 1128B. **[**42 U.S.C. 1320a–7b**]** (a) of the Social Security Act

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)

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

"Unwitting" Fraud

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

Medicare Part D

- Much larger exposure to fraud against the federal government:
  - Prescription Drug Plans (PDPs) required to monitor & report pharmacy:
    - Prescription reversals
    - MTM Oversight:
      - Patient eligibility
      - Fraud, waste and abuse
    - Generic dispensing
    - Grievances
    - Prior authorizations & formulary exceptions
    - Overpayments
    - Licensure

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

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?

False Claims Act and Qui Tam Actions

- The **False Claims Act** (31 U.S.C. § 3729 *et seq.*, also called the "**Lincoln Law**")
- 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"

1986 Amendment

- (False Claims Act Amendments of 1986, Pub.L. 99-562, 100 Stat. 3153, October 27, 1986)
- The elimination of the "government possession of information" bar against qui tam lawsuits;
- The establishment of defendant liability for "deliberate ignorance" and "reckless disregard" of the truth;
- Restoration of the "preponderance of the evidence" standard for all elements of the claim including damages;
- Imposition of treble damages and civil fines of $5,000 to $10,000 per false claim;
- Increased rewards for qui tam plaintiffs of between 15-30 percent of the funds recovered from the defendant;
- Defendant payment of the successful plaintiff's expenses and attorney's fees, and;
- Employment protection for whistleblowers including reinstatement with seniority status, special damages, and double back pay.

Findings: From 1993 June 2006, there were 840 qui tam cases relating to the US Medicare program.

- Aggregated settlements for all cases = $13,132,965,578 (Mean = $15,634,483; Median = $1,200,000).
- The minimum payment was $3,750; maximum = $875,000,000.
- Payments made to 242 whistleblowers = $904,906,953
- Billing violations accounted for 60% of fraud (type of fraud was identified in 48% of cases).
- **Fraudulent cost reports, billing violations, upcoding, kickbacks**

Fitzner, Karen A., Bennett, Charlie L., McKoy, June and Tigue, Cara,An Analysis of Fraudulent Actions Over Time in the United States(June 11,). iHEA 6th World Congress: Explorations in Economics Paper Available at SSRN: http://ssrn.com/abstract=992988

Case examples during 2007

- **Bristol-Myers Squibb to Pay $515 Million**
  Bristol-Myers Squibb has agreed to pay $515 million to settle allegations brought in seven *qui tam* cases (six in Boston and one in Florida) involved pricing and promotional activities (including kickbacks to doctors) for more than 50 drugs, including 13 drugs with a combined 2007 sales of $10.7 billion -- a total of 69 percent of Bristol-Myers' 2007 pharmaceutical revenue. Drugs included in this settlement include the blood thinner Plavix, antipsychotic Abilify, the cholesterol treatment Pravachol, the cancer therapy Taxol, and the antidepressant, Serzone. Of the $515 million, approximately $328 million will be paid under the Federal False Claims Act, with the state's getting a total of $187 million.

Case examples during 2007

- **Millionaire Doc Wanted More**
  Dr. Patrick Chan goes to court August 6th. The Little Rock, Arkansas doctor is accused of taking kickbacks for medical equipment paid for by Medicare and Medicaid. Dr. Chan, who say he is worth $10 million, made $200,000 a month while working as the only neurosurgeon at White County Medical Center.

Case examples during 2007

- **Texas Joins Three Pharma Cases**
  Texas Attorney General Greg Abbott has joined three False Claims Act case against Sandoz Inc. of New Jersey, Mylan Laboratories, and Teva Pharmaceuticals. All three cases involve "marketing the spread" by misstating the Average Wholesale Price of prescription medications. Abbott's office says it has recovered almost $190 million through civil and criminal Medicaid fraud prosecutions and settlements.

Case examples during 2007

- **TX Hospital to Pay $15.4 Mil.**
  Harris County's publicly-owned hospital district has agreed to pay $15.45 million to settle a False Claims Act lawsuit alleging the hospital routinely submitted claims to the state and federal governments without trying to first collect payment from private primary insurance companies, as required.

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

Damages

- **D**amages 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.

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.

Discovery

- Audits e.g. PBMs, Medicare Drug Integrity contractors (MEDICs)
- Board of Pharmacy inspections; complaints
- Wholesalers
- Manufacturer reps
- Consumers
- Providers
- Fellow employees

National Fraud Hotline (CMS)

- 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