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
“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

“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
- 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

- 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)

- 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 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:
  - PDP’s required to monitor & report pharmacy:
    - Prescription reversals
    - MTM patient eligibility
    - 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

- 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”

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
**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**

- 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.

**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 \[\{(2,500 \times 3) + (50 \times 5,500)\}\] &
  - $557,500 \[\{(2,500 \times 3) + (50 \times 11,000)\}\]

  in damages under the False Claims Act.

**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.
## 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.

## 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

## Discovery

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

## 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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*Note: The text is presented in a structured format with appropriate headings and bullet points to enhance readability.*