

Medicare Part D Compliance Fraud, Waste & Abuse

**Training for Network Pharmacies
2011/2012**

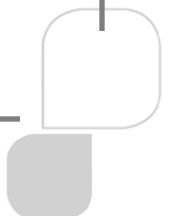


Table of Contents

Introduction.....	3
Section One: Medicare and the Medicare Part D Compliance Program.....	6
Medicare Part D.....	7
Section Two: Laws and Regulations.....	10
Knowledge Check.....	12
HIPAA Review.....	13
Section Three: Medicare Part D Vulnerabilities.....	15
Pharmacy Fraud, Waste and Abuse.....	16
Prescriber Fraud, Waste and Abuse.....	17
Medicare Part D Plan Member (Beneficiary) Fraud, Waste and Abuse.....	18
Medicare Part B vs. Part D Drug Coverage.....	21
Knowledge Check.....	23
Tips for Identifying FWA.....	24
Section Four: Network Pharmacy Responsibilities.....	25
Section Five: Reporting.....	27
Wrap-Up.....	29
Appendix A – Answer Key and Explanations.....	30

Introduction

Welcome

Welcome to the Medicare Part D Compliance / Fraud, Waste and Abuse (FWA) Training Program for Network Pharmacies.

As part of the Medicare Part D – Prescription Drug Benefit, Centers for Medicare and Medicaid Services (CMS) requires that all Plan Sponsors and their “downstream entities”, which include pharmacy staff, engaged directly or indirectly in the administration or delivery of the Medicare Part D prescription drug benefit, receive training to detect, correct and prevent fraud, waste and abuse.

Frequently Asked Questions

Question: *Why am I required to take this training?*

Answer: The Centers for Medicare and Medicaid Services (CMS) require all Part D Sponsors to provide FWA training to all entities they are partnering with that provide benefits or services in the Part D programs, not just to the direct employees within their organization. Because network pharmacies are considered a “downstream entity” to Part D Plan Sponsors, the training requirement applies. In order to meet the FWA training requirement for first tier, downstream, and related entities, PDP Sponsors may either conduct the training directly or provide appropriate training materials to these delegated and contracted entities. The Part D Sponsor is accountable for ensuring that materials have been provided to all entities.

Question: *What are the ways I can complete this training?*

Answer: These training materials can be utilized in training your pharmacy staff. Download the materials and provide them to your staff for review. Make sure to keep detail records on the date the training was provided and the staff who attended.

You may also have received training materials from other qualified Medicare Part D Plan Sponsors, or participated in a training program sponsored by industry organizations such as National Association of Chain Drug Stores (NACDS) or National HealthCare Anti-Fraud Association (NHCAA). If that is the case, then all you need to do is follow the instructions below on how to attest that FWA training has been completed in 2011/2012.

Question: *Can I provide my own training materials?*

Answer: No. Per CMS guidance, first tier, downstream, and related entities, including pharmacies, should not develop their own FWA training.

Continued on next page

Introduction, Continued

Frequently Asked Questions (Continued)

Question: *What if my pharmacy is DMEPOS Certified?*

Answer: If your pharmacy/organization has been officially accredited as a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) by a CMS-deemed accreditation organization (AO) and deemed to have met the training and education requirements for FWA per 423.504 (vi)(C)(3), all you need to do is follow the instructions below on how to complete the Attestation.

Question: *When does this training have to be completed?*

Answer: Training related to Medicare Part D Compliance, Fraud, Waste and Abuse must be completed when newly-contracted with a Network and annually thereafter. To meet the 2011 annual obligation, training must be conducted by 12/31/2011.

Question:

Answer: *How do I document that I completed the training?*

Pharmacies must complete the online Attestation found at:

http://2011.mhrx.com/compliance/fraud_waste_and_abuse.aspx

The Attestation allows you to confirm that all employees who have been identified as being involved directly or indirectly with the administration or delivery of the Medicare Part D Prescription Drug Benefit, including pharmacists and pharmacy technicians, have completed the 2011-2012 Annual Medicare Part D Compliance / Fraud, Waste & Abuse Training as mandated by CMS. In addition, the pharmacy should maintain attendance logs detailing the date and time the training was provided, and list those employees who were in attendance.

Question:

Answer: *Who do I contact with questions about the training/Attestation?*

Questions regarding the training materials and attestation process can be directed to Doug Finlinson, Delegation Oversight Director, at Doug.Finlinson@RxAmerica.com or (801-961-6246).

Continued on next page

Introduction, Continued

Objectives

The objective of this course is to help you understand the:

- Medicare Part D Compliance Program
- Medicare Part D Prescription Drug Benefit
- Key laws and regulations governing the benefit
- Areas that are at risk for FWA and your responsibility to report potential FWA

It will also highlight areas of potential compliance risk within the pharmacy environment, and how you can proactively minimize the risks associated with fraud, waste, and abuse.

At the conclusion of the training, your pharmacy will be required to attest that you have completed the annual Medicare Part D Compliance / FWA Training Program for network pharmacies.

Section One: Medicare and the Medicare Part D Compliance Program

Medicare

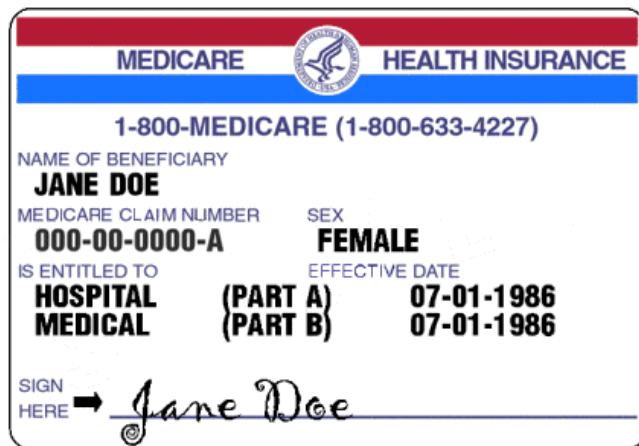
Medicare is the nation's largest health insurance program, which covers nearly 40 million Americans. It is a government health insurance program for people age 65 or older, some disabled people under age 65, and people of all ages with end-stage renal disease.

The federal government department that administers the Medicare program is the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS).

There are currently four parts to Medicare:

- **Part A** – Hospital Insurance (in-patient care)
 - CVS/pharmacy is not a supplier for Medicare Part A
- **Part B** – Medical Insurance
 - Pays for outpatient hospital services as well as other services
 - Helps pay for Durable Medical Equipment (DME), supplies, and select prescription drugs - such as immunosuppressive agents
- **Part C** - Medicare Advantage
 - Delivery of Part A and Part B health benefits through managed care organizations
- **Part D** – Prescription Drug Insurance
 - Helps pay for prescription drugs, certain vaccines and certain medical supplies (e.g. needles and syringes for insulin)

Sample Medicare Card



Medicare Part D

Overview Medicare Part D is a prescription drug program for Medicare eligible individuals. It helps beneficiaries pay for prescription drugs.

Medicare Part D Compliance/FWA Program The MemberHealth Medicare Part D Compliance/FWA Program is supported by CVS Caremark and is designed to:

- Detect, correct and prevent fraud, waste and abuse.
 - Promote a culture of ethical behavior.
 - Comply with all laws and regulations.
-

Fraud Acting in a dishonest manner with the intent to obtain a benefit for service that you know you are not entitled to.

Waste Behavior or conduct that results in the use of more resources than needed.

Abuse Inappropriately taking advantage of the Medicare Part D program for personal benefit

Medicare Part D, Continued

**Scope of
Fraud, Waste,
and Abuse**

The National Healthcare Anti-fraud Association (NHCAA) cites an average of 3 percent (at the low end) and 10 percent (at the high end) of healthcare spending is lost due to fraud. That's between \$67 Billion and \$230 Billion lost each year to fraud, waste, or abuse. That estimates to between \$184 million and \$630 million dollar loss per day, and this number is expected to increase every year as healthcare costs rise.*

Healthcare fraud is believed to be the second largest white-collar crime in the United States. It is often mistaken for a victimless crime, but it affects everyone. Fraud causes insurance premiums to rise, and victims may be put through unnecessary or unsafe procedures. Victims of identity theft may find their insurance information used to submit false claims. This is a staggering cost, and we at CVS Caremark are committed to battling these unnecessary expenditures every step of the way.

*The National Healthcare Anti-fraud Association (NHCAA). "Anti-Fraud Resource, Consumer Info & Action"; available at:

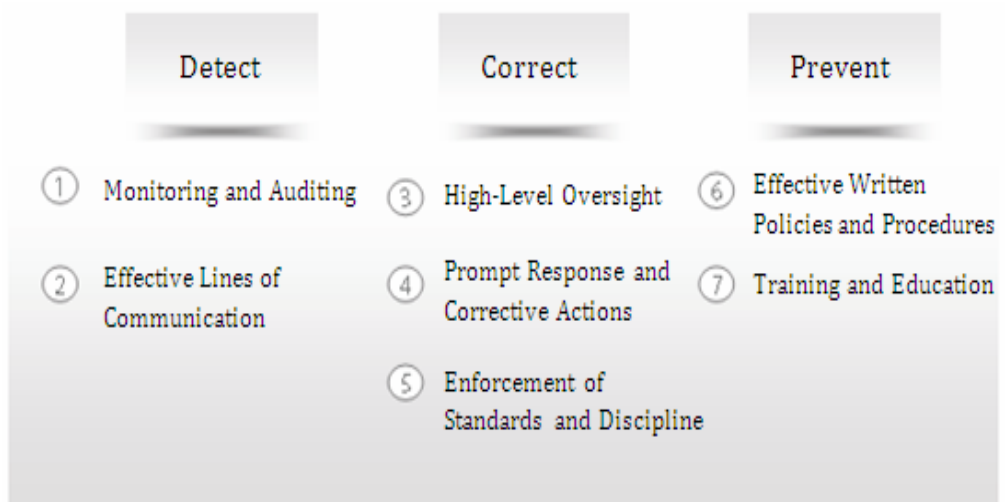
http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centra&wpscode=ConsumerAndActionInfo

Medicare Part D

Seven Key Elements

CMS requires that **seven key elements** are included in the Compliance / FWA program. Each of these helps to detect, correct and prevent issues which arise in the course of our business that could compromise the integrity of our organization and our ability to perform our Part D services in compliance with the requirements of the program.

These seven elements are as follows:



Many Medicare payment errors are simply mistakes. The vast majority of Medicare Part D Providers are committed to providing high quality care and/or services.

However, there are individuals intent on abusing or defrauding Medicare, thereby cheating the program out of millions of dollars annually.

Because fraud, waste and abuse could appear in each part of our daily operations, we must be watchful in our daily duties to help detect, correct, and prevent possible fraud, waste and abuse.

Section Two: Laws and Regulations

Overview

The success of the Medicare Part D prescription drug benefit depends on your compliance with federal and state rules related to the Medicare Part D program.

This section outlines some of the key federal compliance requirements that you need to follow as you perform your everyday duties.

The laws and regulations discussed in this training apply to pharmacies who administer the Medicare Part D prescription drug benefit. This section will:

- Discuss these key laws and regulations that manage the Medicare Part D benefit.
 - Discuss the risk of intermediate sanctions, which can occur if these laws are violated.
-

False Claims Act

This law makes it illegal for anyone to knowingly file, or make someone else file, a false claim for payment with the federal government. This includes submitting wrong or fraudulent claims for prescription drugs dispenses to beneficiaries in government program such as Medicare Part D.

When submitting claims data to Part D plans for payment, you should ensure that the data is true and accurate to the best of your knowledge. This Act also allows individuals to file actions against federal contractors claiming fraud against the government.

In addition, it makes it illegal for a person to make or use (or get someone else to make or use) fake records to get a false claim paid by any part of the federal government. Should you become aware of any information that may indicate the inaccuracy of these claims or records, you have a continuing obligation to report it.

Anti-Kickback Statute

This statute prohibits anyone from offering inducements to purchase or use health products or services if these products or services are reimbursable in whole or in part by the federal government. For purpose of this law, an “inducement” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Importantly, a violation of this statute by a health care provider can result in exclusion from participation in the Medicare and other federal healthcare programs. In addition, this statute carries both civil and criminal penalties for violation.

Continued on next page

Section Two: Laws and Regulations, **Continued**

**Beneficiary
Inducement
Statute**

This statute makes it illegal to offer remuneration that a person knows is likely to influence a beneficiary to select a particular provider or pharmacy.

For purposes of this statute, “remuneration” is defined to include, without limitation, waivers of co-payments and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value.

Because a prescription drug plan (“PDP”) is not considered a provider or supplier, inducements offered to beneficiaries to join a PDP are not covered by this law. However, incentives offered to Medicare beneficiaries to use a particular pharmacy are covered by this statute.

**Medicare
Modernization
Act**

These rules govern every aspect of a Medicare Part D Plan’s activities, including marketing to potential enrollees, grievance and appeals process but most importantly, forming pharmacy networks, developing formularies and reporting drug costs.

**Intermediate
Sanctions**

It is important that we understand these regulations since violations can result in civil and federal penalties.

CMS can impose intermediate sanctions on our Plan Sponsors for:

- Engaging in discriminatory practices
 - Providing false information to CMS
 - Imposing excessive premiums on members
 - Inappropriately disenrolling or refusing to re-enroll an individual
 - Failing to provide a beneficiary with medically necessary items or services that are required under law or contract
 - Employing or contracting with any health care provider that is excluded from participation in the Medicare program
-

Knowledge Check

Exercise 1

Based on what you have reviewed so far, read the following scenario, then choose the answer that best fits the example.

The Attorney General of Pennsylvania filed criminal charges against two pharmacists for billing insurance claims for nearly \$1 million worth of prescription drugs that were not prescribed by any doctors and were not dispensed to any customers. The pharmacists were also accused of creating drug prescriptions (Levitra, Marinol, Restoril and Pexeva) and submitting the claims to CMS for more than \$155,000 in reimbursements. They also submitted more than \$180,000 in claims by using the names of employees who worked for businesses near the pharmacy.

The law or statute that is violated in this example would be the:

- A. False Claims Act
 - B. Beneficiary Inducement Statute
 - C. Anti-Kickback Statute
-

Exercise 2

Based on what you have reviewed so far, read the following scenario, then choose the answer that best fits the example.

A large pharmaceutical company encouraged a nursing home pharmacy to increase the number of elderly patients taking medication for a diagnosis that required prescriptions relating to psychosis. To do so, these pharmacists persuaded physicians to prescribe drugs manufactured by this pharmaceutical company for their patients. As a result, these actions increased market share for the pharmaceutical company's antipsychotic drug against competing pharmaceutical companies.

In return for the nursing home pharmacy efforts, the drug maker paid the pharmacy tens of millions of dollars. The monies were based on the market share of some of the pharmaceutical company's drugs, as well as sponsorship of the nursing home pharmacy meetings, and grants. They also made payments for nursing home pharmacy data, like the prescribing habits of doctors, previously provided to the drug maker for free.

The law or statute that is violated in this example would be the:

- A. False Claims Act
 - B. Beneficiary Inducement Statute
 - C. Anti-Kickback Statute
-

HIPAA Review

Overview

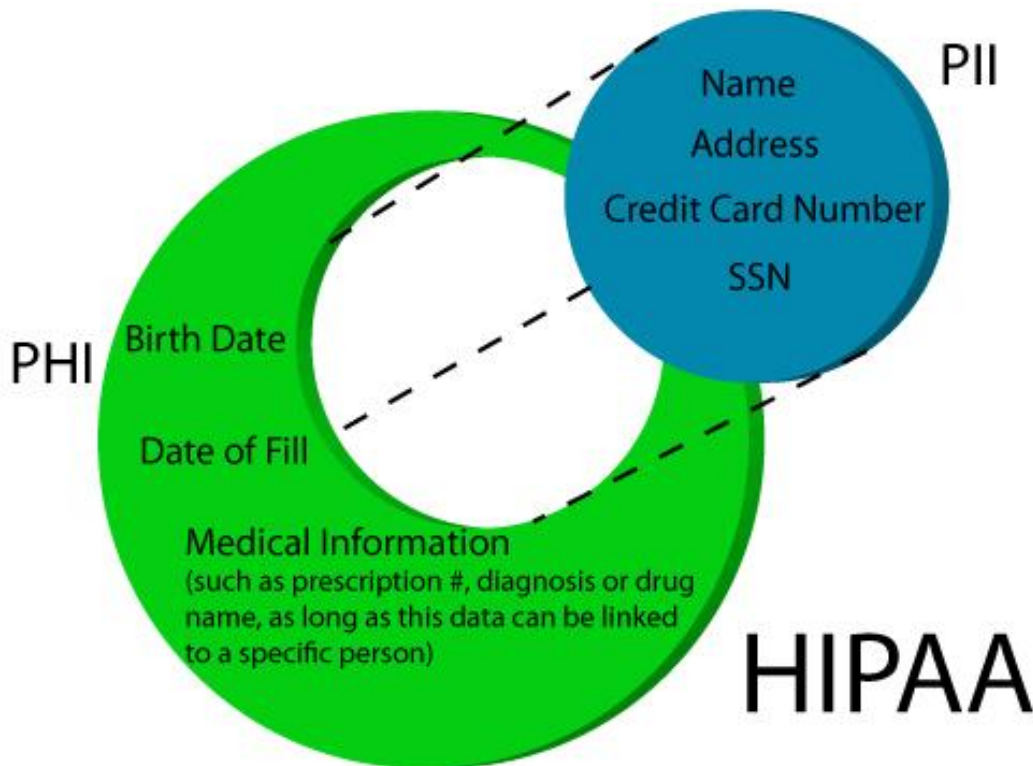
The Health Insurance Portability and Accountability Act (HIPAA) provides a set of rules that must be followed by health care organizations to ensure that they meet certain minimum standards with regard to protecting the privacy and security of information of patients and beneficiaries.

Protected Health Information (PHI)

PHI is personal health information that can be tied to a single person and that is obtained by or on behalf of a health plan or health care provider.

Personally Identifiable Information (PII)

PII is personal information that can be tied directly to a single person. PII is a subset of PHI.



HIPAA Review, Continued

HIPAA Privacy and Security Rules

The Privacy Rule specifies the purposes for which PHI may be used and disclosed, and requires that PHI in any form (paper, electronic, or oral) be kept secure. It also provides individuals with certain rights regarding their PHI, including to:

- Inspect, amend, and receive an accounting of certain disclosure of their PHI
- Request confidential communications for their PHI
- Receive proper notice regarding how their PHI may be used and disclosed

The Security Rule specifies certain administrative, technical, and physical requirements for keeping electronic PHI (ePHI) secure, and to protect it from unauthorized access, modification or destruction.

When accessing PHI of Part D beneficiaries, pharmacy staff must be aware of potential HIPAA violations, including:

- Employees sharing PHI with more individuals than required to complete their job duties.
- Failure to use approved encryption software when sharing PHI electronically with appropriate sources.

Employees with access to PHI may violate HIPAA regulations if they do not undertake appropriate beneficiary verification procedures before sharing PHI with the beneficiary.

Steps you can take to mitigate PHI risk:

- Ensure that beneficiary authentication procedures are undertaken any time that PHI is being shared with a beneficiary.
- Ensure employees complete mandatory HIPAA training.
- Use appropriate encryption methods and software to encrypt all PHI being transmitted externally, if appropriate.

Bottom Line

Safeguard all PHI that you use or access, and only access PHI to the extent necessary in order for you to perform your duties.

Section Three: Medicare Part D Vulnerabilities

Overview

This section describes potential schemes, risks, and vulnerabilities to the Medicare Part D benefit. This should be helpful for pharmacies in identifying potential risk areas present in the Medicare Part D benefit.

The schemes identified within each group are not necessarily unique to that particular group.



Pharmacy Fraud, Waste and Abuse

Overview

Without appropriate oversight and due diligence among the pharmacy staff, there are many risks for potential FWA. Below are just some examples you should watch out for and take steps to guard against.

Inappropriate Billing Practices

The following types of billing practices are not allowed and can result in varying levels of sanction, up to and including criminal charges:

Inappropriate Billing Practices (Pharmacy Level)	
<ul style="list-style-type: none"> Incorrectly billing for a secondary payer. 	<ul style="list-style-type: none"> Billing for non-existent prescriptions.
<ul style="list-style-type: none"> Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions. 	<ul style="list-style-type: none"> Billing for brand when generics are dispensed.
<ul style="list-style-type: none"> Billing for medications purchased from non-licensed wholesalers. 	<ul style="list-style-type: none"> Inappropriate use of dispense as written (“DAW”) codes.
<ul style="list-style-type: none"> Prescription splitting to receive additional dispensing fees. 	<ul style="list-style-type: none"> Billing for an item not dispensed.

Additional Schemes, Risks and Vulnerabilities

There are additional FWA risks at the pharmacy level that include the following:

Prescription drug shorting occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.

Bait and switch pricing occurs when a beneficiary is led to believe that a drug will cost one price, but at the point of sale, they are charged a higher amount. One example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy’s reimbursement.

Prescription forging or altering occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber’s authorization. Usually the medications are diverted after being billed to the Medicare Part D program.

Dispensing expired or adulterated prescription drugs occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.

Prescription refill errors occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.

Failure to offer negotiated prices occurs when a pharmacy charges a beneficiary the wrong amount.



Prescriber Fraud, Waste and Abuse

Overview Detecting potential FWA by the prescriber may be more difficult in the pharmacy. The following are types of prescriber FWA that you should be alert for and should report if you believe they have occurred.

Schemes, Risks and Vulnerabilities **Illegal Remuneration Schemes** occur when a prescriber is offered, paid, solicits, or receives compensation as an inducement or reward for writing prescriptions for drugs or products.

Prescription Drug Switching involves offers of cash payments or other benefits to a prescriber to induce him/her to prescribe certain medications rather than others.

Script Mills occurs when providers write prescriptions for drugs that are not medically necessary, often in large quantities, and often for patients that are not theirs. This may show up as a pattern of one prescriber writing a high number of prescriptions for a particular medication for a series of beneficiaries. These scripts are often for controlled drugs sold on the black market, and the situation may also involve improper payments to the provider.

Provision of False Information occurs when the prescriber may falsify information (not consistent with the medical record) and then submit this information through a prior authorization or other formulary oversight mechanism in order to obtain coverage. This information is false when it shows incorrect dates, descriptions of prescriptions or other services furnished, or falsifies the identity of the individual who furnished the services. This may be indicated when a prescription is contrary to a beneficiary's medication history or previous claims history.

Theft of Prescriber's DEA Number/or NPI Number or Prescription Pad Prescription pads and/or DEA numbers can be stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications often sold on the black market. In the context of e-prescribing, this includes the theft of the provider's authentication (log in) information. The pharmacy staff should look for questionably written scripts, such as:

- Mis-spelled drug names
- Quantities and dosing outside of normal patterns
- An extraordinary amount of people with unusually similar prescriptions arriving at the pharmacy within a short period of time, such that it would heighten your suspicion
- Submission of a prescription from a legitimate physician, but where the information on the pad appears to have been altered

Medicare Part D Plan Member (Beneficiary) Fraud, Waste and Abuse

Overview

It is important to mention that not all of the following examples are initiated by beneficiaries. There are some schemes conducted by individuals in which beneficiaries are unknowing victims of the scheme. The pharmacy staff should be on the lookout for the following examples.

Schemes, Risks and Vulnerabilities

Prescription Diversion and Inappropriate Use

Beneficiaries may get prescription drugs from a provider, possibly for a condition they do not have, and then give or sell this medication to someone else. This scheme may also include the inappropriate consumption or distribution of a beneficiary's medications by a caregiver or someone else.

Identity Theft

This is an example of fraud when an individual uses another person's Medicare card number to obtain prescriptions.

Misrepresentation of Status

A Medicare beneficiary misrepresents personal information, such as identity, eligibility, or a specific medical condition in order to illegally receive the drug benefit. Individuals who are no longer covered under a drug benefit plan may still attempt to use their identity card to obtain prescriptions.

Prescription Forging or Altering

This occurs when prescriptions are altered, by someone other than the prescriber or pharmacist without prescriber approval, in order to raise the quantity or number of refills.

Continued on next page

Medicare Part D Plan Member (Beneficiary) Fraud, Waste and Abuse, Continued

**Schemes,
Risks and
Vulnerabilities
(continued)**

Provider Shopping

This involves beneficiaries seeking out other physicians to receive prescriptions for the same types of drugs from multiple prescribers at the same time. There are a few situations to watch out for:

- A beneficiary having a history of prescriptions written by multiple providers within a short period of time. This may signal a potentially abusive situation, or a beneficiary attempting to get drugs outside of a proper drug review.
- Another example is a beneficiary that may consistently call to request early refills. The beneficiary may also claim to have lost or misplaced the original prescription fill in order to request an early refill override.
- A beneficiary calls on numerous occasions, trying to obtain details on what types of doctors can prescribe specific types of drugs (i.e. pain killers).

Provider shopping might be indicative of other underlying schemes, such as stockpiling or resale on the black market. These types of examples may need to be investigated further to prevent harm to the beneficiary or financial harm to the pharmacy, PBM or plan.

Pharmacy Shopping:

These are situations in which beneficiaries are receiving multiple prescriptions from multiple pharmacies for the same drug, often times simultaneously, in order to cover up the quantities and types of prescriptions received. Pharmacy shopping can occur in several ways. Here are a few things to watch out for:

- Beneficiary showing a history of getting his/her prescriptions from several different pharmacies within a short period of time.
- Prescriptions that are filled at a pharmacy that is a far distance from their home address.
- Prescriptions that are being filled for the same drugs (e.g. controlled substances / narcotics) at different pharmacies. This is potential fraud or abuse and may also signal a provider issue.

Continued on next page

Medicare Part D Plan Member (Beneficiary) Fraud, Waste and Abuse, Continued

**Schemes,
Risks and
Vulnerabilities
(continued)**

Resale of drugs on black market:

A beneficiary may falsely report the loss or theft of drugs or fake illness to obtain drugs for resale on the black market.

Prescription stockpiling:

Some beneficiaries attempt to “game” their drug coverage by obtaining and storing large quantities of drugs in order to:

- avoid out-of-pocket costs,
- protect against periods of non-coverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or
- resell on the black market.

Improper Coordination of Benefits:

This is another example of “gaming” the system where the beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies.

Medicare Part B vs. Part D Drug Coverage

Overview

Before the Medicare Modernization Act (MMA), Medicare beneficiaries received coverage for a limited number of drugs provided under Parts A and B.

Now, with the Medicare Part D prescription drug benefit, it is possible for inappropriate duplicate coverage between A, B, and D drugs. Crossover between Parts B and D is more likely because they contain specific drugs that may be covered under both programs, depending on the circumstances under which they are prescribed. Keep in mind that the Part D benefit does not change coverage or rules for drugs currently covered under Part B. If a drug is covered under Part B in a particular situation it is, by definition, not covered under Part D in that situation.

Some drugs will always be covered by Part B because of the service being provided. However, pharmacy staff should continue to be diligent in determining whether to bill Part B or Part D.

Potential Schemes

Here are some situations that could occur due to the crossover between Parts B and D.

Home Infusion

Home infusion pharmacies are often paid delivery and dispensing fees for certain self-injectable medications even if the beneficiary self-administers. Since they are part of both Part B and Part D networks, they may inappropriately submit the claim under wrong benefit.

Duplicate Billing

Claims could be submitted by a provider under both the medical benefit for Part B and the pharmacy benefit for Part D. Control mechanisms such as the prior authorization process identify by diagnosis and other qualifying factors if a drug is covered under Part B or Part D. This process helps to prevent the claim from being paid under the wrong benefit.

Continued on next page

Medicare Part B vs. Part D Drug Coverage, Continued

**Potential
Schemes
(continued)**

Crossover Drugs

Some of the medications that are crossover drugs are usually purchased and administered in the physician's office. These medications represent a potential revenue stream to the physician's office.

In some cases, the beneficiary may be able to purchase the drug under the Part D benefit at a community pharmacy and bring it to the physician's office for administration. In these circumstances, the physician may inappropriately bill for both the drug and the injection of the drug under Part B.

Differential Copays

Beneficiaries may have different cost sharing obligations if a crossover drug is paid under Part B versus Part D, or vice versa. They could improperly submit a claim to the inappropriate payer in an effort to lower their cost sharing obligations.

Knowledge Check

Exercise 3

The following scenario represents a situation where fraud, waste and abuse can take place. Read through the scenario then answer the question that follows.

A Medicare Part D plan member dropped off a prescription for Vicodin, enough for thirty days supply. You appropriately checked all their paperwork and identity and everything checked out correctly. You dispense the correct amount of Vicodin and the plan member was satisfied and off on their way.

Ten days later the same plan member returns to your pharmacy. They inform you that their dispensed prescription of Vicodin was stolen. The plan member also informed you that they had already reported their stolen prescription to the proper authorities, obtained another script from the same prescriber, but in the meantime they were still out of the medication. This is the third time in the past year that this situation happened with this plan member resulting in additional scripts being written.

This scenario could be an example of what type of potential FWA?

- A. Billing for non-existent prescriptions
 - B. Prescription Stockpiling
 - C. Identity Theft
 - D. Misrepresentation of Status
 - E. Provider shopping
-

Tips for Identifying FWA

**Be On the
Lookout for
Possible
Fraudulent
Activities:**

Review the prescription carefully to determine if it has been forged or altered.

If in doubt, verify. If the prescription or the situation doesn't seem right, take an additional step to call the doctor to verify the prescription. Use the prescriber's telephone number from the phone book or from pharmacy records prior to calling; do not call the number on the prescription. The telephone number on a forged prescription is typically changed so an accomplice can "verify" the forged prescription.

Confirm prescriptions called in to the pharmacy. Again, use the prescriber's telephone number from the phone book or from pharmacy records. The telephone number provided by the person calling in the prescription may be false.

Ask for identification. Don't be afraid to ask the beneficiary for party obtaining the prescriptions for identification and make a copy of it. This will help to identify the party picking up the prescription should it be fraudulent.

Ask for a signature. Don't be afraid to require a signature from the party obtaining the prescriptions, even when one is not required. Again, this will help to identify the party picking up the prescription.

Report it. Call the local police and the Special Investigations Unit (SIU) if you believe you have forged or altered a prescription.

Look for signs of drug diversion. Identify patterns of patients who may be doctor shopping or diverting drugs.

- Does the beneficiary get several rejects from the Part D plan for refills too soon?
- Does the beneficiary see a large number of doctors?
- Does the beneficiary present prescriptions written in names of other people?
- Could the drug interact with medication the beneficiary is currently prescribed or taking?

Section Four: Network Pharmacy Responsibilities

Overview

The “Pharmacy Audit” and the “Miscellaneous Pharmacy Provider Information - Medicare Part D Requirements” Sections of the Pharmacy Services Manual stipulate specific requirements that pharmacies and pharmacy staff must adhere to. Here is a short list reviewing some key responsibilities pertaining to Medicare Part D.

Key Responsibilities

Training

This training is a CMS requirement for pharmacy staff who are involved with the administration or delivery of the Medicare Part D prescription drug benefit. Pharmacy staff must complete this training on an annual basis.

Proof of your completion of this training must be made available to the Medicare Part D Compliance Department, upon request.

Audit Cooperation

It is the responsibility of pharmacy staff to cooperate with CVS Caremark, and any of its subsidiaries or affiliates as necessary, to support CVS Caremark in carrying out its monitoring responsibilities, including but not limited to, allowing CVS Caremark to inspect, evaluate and audit your pharmacy’s books and records.

Record Retention

The pharmacy must maintain its books and records relating to its services, for a period of at least ten (10) years, or longer as otherwise required by law [C.F.R. § 423.505(d)].

CMS-10147

The “Medicare Prescription Drug Coverage and Your Rights” notice is distributed to providers for use in instructing Part D beneficiaries about their appeal rights, and provides instructions to Medicare Part D beneficiaries on how to contact their Part D Plan. You must have this notice conspicuously posted at your location or available for beneficiary distribution.

OIG/GSA Exclusion List Process

Pharmacies must verify that they have researched and will continue to monitor the OIG exclusion list database to ensure none of its employees, vendors or contractors are OIG excluded. This check must be conducted at least yearly.

Continued on next page

, Continued

**Key
Responsibilities
(continued)**

Code of Conduct

CMS requires pharmacies have in place, or adopt a plan, which includes the adoption of a code of conduct, to detect, prevent, and correct fraud, waste and abuse in the delivery of its services.

Pharmacy staff, including pharmacists and pharmacy technicians, are required to read the CVS Caremark Code of Conduct and agree to abide by the standards specified in the Code, and/or adopt and follow a code of conduct, compliance program, and compliance policies particular to its own organization that reflects a commitment to detecting, preventing, and correcting non-compliance with Medicare requirements in the delivery of their Medicare services, including detecting, preventing, and correcting fraud, waste, and abuse.

Overview

MemberHealth is required to implement a process to identify Medicare Part D claims that were submitted for drugs that were prescribed by an excluded provider and to provide the pharmacy with notification to deny these claims.

This notification appears as “Provider is an OIG excluded provider” when the claim is submitted for processing. It is the pharmacy’s responsibility to deny these claims unless in your professional judgment as a pharmacist it is an emergency situation. You should then contact the CVS Contact Support Center Help Desk and follow their instructions.

Claims Adjudication Requirements

The pharmacy requirements for submitting claims to a Part D plan or its PBM are as follows:

- Pharmacies are required to submit Medicare Part D Claims within ninety (90) days of the original fill date.
 - Pharmacies should ensure that they are submitting valid physician prescriber IDs when submitting claims.
 - Medicare Part D Claims that are not processed though the on-line adjudication system are still eligible for processing for up to one (1) year from the original date of fill.
 - To determine if a claim is eligible for processing, you can call the appropriate Help Desk.
-

Section Five: Reporting

Reporting

You are required to report any suspected non-compliance and/or potential fraud, waste or abuse of any of CMS's rules and regulations as soon as you become aware of it.

When calling the CVS Caremark Ethics Line:

- You have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible.
- You have an obligation to disclose any action or situation that is, or may appear to be, a conflict of interest that would make it difficult for you to perform your work objectively or effectively.
- If you suspect issues of non-compliance or potential fraud, waste and abuse, you must report the issue to your supervisor or any other resources available to you, including the resources below.

Reminder: It is illegal for a provider to retaliate against an employee who reports suspected fraud, waste, or abuse.

Resources

MemberHealth Help Desk - The Help Desk is available by calling 1-866-684-5395 24 hours a day, 7 days a week. It is a resource available to support you as a pharmacy employee and your pharmacy by responding and providing requisite information regarding:

- beneficiary claims
- eligibility
- drug coverage
- program clarification

CVS Caremark Ethics Line (877-CVS-2040) - You can contact the CVS Caremark's Ethics Line by phone or email (Ethics.BusinessConduct@cvs.com).

Remember, you have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible.

Continued on next page

Section Five: Reporting, Continued

Resources (continued)

You can also contact any one of the **MED-D Compliance Resources** listed here.

Medicare Fraud Hotline

1-888-277-4149

Email: Medicare.fraud@caremarkrx.com

John Buckley

CVS Caremark Chief Compliance Officer

Email: JMBuckley@cvs.com

Todd Meek

Medicare Part D Compliance Officer

Email: todd.meek@caremark.com

Patrick Jeswald

Director, Compliance / Fraud, Waste & Abuse

Email: patrick.jeswald@caremark.com

Privacy Office

Email: privacy.officer@caremark.com

Ellen Hodge

Privacy Director

Email: ellen.hodge@caremark.com

Additional Resources

Below are some additional resources:

- <http://www.insurancefraud.org>
 - <http://www.stopmedicarefraud.gov>
 - <http://www.ssa.gov/oig/guidelin.htm>
 - <http://www.nhcaa.org/eweb/StartPage.aspx>
-

Wrap-Up

Course Review In this course, Medicare Part D Compliance / Fraud, Waste and Abuse (FWA) Training Program, we have:

- Defined the Medicare Part D prescription drug benefit.
 - Described the laws and regulations governing the benefit.
 - Identified the risk areas vulnerable to fraud, waste and abuse.
 - Outlined your responsibility to report potential FWA within the Program.
 - Listed contact information.
-

Appendix A – Answer Key and Explanations

Exercise 1

The law or statute that is violated in this example would be the:

- A. **False Claims Act (Correct)** – The pharmacists knowingly filed false claims to be reimbursed by the government. These claims were not prescribed by any doctor and were not dispensed to any customers.
 - B. **Beneficiary Inducement Statute (Incorrect)** – The pharmacists were not providing any type of incentives that would have influenced a beneficiary to select their pharmacy for their prescriptions. These prescriptions were written fraudulently therefore no beneficiaries were involved.
 - C. **Anti-Kickback Statute (Incorrect)** – The pharmacists were providing fraudulent prescriptions for their benefit to the government. There was no payment in return for their referral recommendations to anyone outside the government.
-

Exercise 2

The law or statute that is violated in this example would be the:

- A. **False Claims Act (Incorrect)** – The prescriptions that were filled were provided to actual residents of the nursing home; there were no fraudulent claims. No one was submitting a false claim payment to the federal government.
 - B. **Beneficiary Inducement Statute (Incorrect)** – Neither the pharmaceutical company nor the nursing home pharmacy were providing any incentives that may influence plan members to force them to select a particular provider or pharmacy for their prescriptions.
 - C. **Anti-Kickback Statute (Correct)** – The pharmaceutical company was providing monies to the nursing home pharmacies as a kickback to pharmacists to encourage prescribers to write a prescription of certain antipsychotic drugs. These antipsychotic drugs were only manufactured by this particular pharmaceutical company. The actions of the nursing home pharmacy resulted in the pharmaceutical company increasing its market share of its antipsychotic prescription drugs over their competitors.
-

Continued on next page

Appendix A – Answer Key and Explanations, Continued

Exercise 3

This scenario could be an example of what type of potential FWA?

- A. **Incorrect** – Though billing for non-existent prescriptions is an example of potential FWA, this scenario does not indicate that a valid prescription did not exist.
 - B. **Correct** – There is a potential this plan member is attempting to “game” their coverage by obtaining and storing prescriptions and stockpiling them. There is a potential that the plan member is attempting to sell the narcotic on the black market or avoid out-of-pocket costs. There has been a history of issues regarding this member’s ability to keep their prescription safe.
 - C. **Incorrect** – Though Identity Theft is an example of potential FWA, there is no instance of the plan member having additional scripts written without their knowledge. The plan member has been providing the correct paperwork before their medication has been dispensed to them.
 - D. **Incorrect** – Though Misrepresentation of Status is an example of potential FWA, the plan member is not providing incorrect personal information (identity, eligibility or a specific medical condition); their paperwork is correct. This member is still covered under this drug benefit plan and their identity card is valid.
 - E. **Incorrect** – Though Provider Shopping is an example of potential FWA, this plan member is submitting scripts from the same provider and not numerous prescriptions from different providers.
-