

# Medicare Prescription Drug Part D Compliance Conference



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## Session 102 – Fraud, Waste & Abuse: Medicare Drug Integrity Contractor (MEDIC) Reporting

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## Agenda

- Role of Medicare Drug Integrity Contractors (MEDIC)
- Regional MEDIC Structure
- Responding to MEDIC Requests
- MEDIC Referrals
- Recommended Best Practices
- Open Discussion/Questions

## Introduction – Role of MEDICs

- MEDIC authority is derived from Chapter 9 of the prescription drug benefit manual and are contracted by CMS.
- MEDICs are acting on behalf of CMS and have the same level of authority with respect to reviewing and investigating potential fraud, waste and abuse.
- The MEDIC responsibilities include the following activities:
  - Conducting complaint investigations
  - Performing data analysis proactively and efficiently
  - Developing and referring cases to law enforcement (LE)
  - Supporting ongoing LE investigations
  - Conducting audits
  - Reviewing Prescription Drug Plan (PDP) and Medicare Advantage Part D (MA-PD) fraud and abuse compliance programs beginning in September, 2008

## Chapter 9 Guidance – MEDICs

- Prevention Activities
  - Review of bids
  - Review Fraud, Waste and Abuse (FWA) component of compliance plan
  - Proactively evaluate data
  - Facilitate intermediate sanctions as appropriate
  - Educate entities about fraud, waste and abuse
- Detection Activities
  - Conduct reviews and complaint investigations
  - Conduct preliminary investigations
  - Review and investigate aberrant behavior
  - Identify potential overpayments

## Chapter 9 Guidance

- Section 50.2.6.4
  - MEDICs do not need to sign a confidentiality agreement as they are acting on behalf of the government
  - Plan sponsors are required to cooperate with the MEDICs relating to any request for information or complaint investigation
- Section 50.2.8.2
  - Recommendation to notify the MEDIC of potential FWA; the MEDIC will refer to law enforcement as necessary
  - For plan sponsors without an Special Investigation Unit (SIU) or resources, plan sponsors are encouraged to report issues to the MEDIC within two weeks from when the potentially fraudulent activity is discovered
  - If the plan sponsor determines through an investigation that FWA has occurred, they should refer to the MEDIC within 60 days
- 42 CFR 423.322(b) states that “employees and contractors of DHHS, such as the MEDICs, may use the information disclosed or obtained in accordance with the regulation only for the purposes of, and to the extent necessary in, carrying out the regulation including, but not limited to, determination of payments and payment-related oversight and program integrity activities”

## Regional MEDICs

- North Region
  - SafeGuard Services (SGS)
  - Contact Person: Shannon Mease
    - 1-717-975-4445 (direct) or 1-877-772-3379
  - Mailing Address:  
SGS  
MEDIC North  
225 Grandview Avenue  
Mailstop F10  
Camp Hill, PA 17011

## Regional MEDICs

- South Region
  - Health Integrity
  - Contact Person: Patricia Serio
    - 1-410-763-6223 (direct) or 1-877-772-3379
  - Mailing Address:  
Health Integrity  
Attention: MEDIC  
9240 Centreville Road  
Easton, MD 21601

## Responding to MEDIC Requests

- Types of Requests
  - Pharmacy Claims Data
  - Beneficiary Claims Data
  - Enrollment Verification
  - Complaint Investigation
- Requests for Information (RFI) Process
- Evidence of Closure Memo

## Types of MEDIC Requests

- Pharmacy Claims Data
  - Generally pharmacy specific although some requests have focused on multiple pharmacies
  - Time period generally goes back to the start of the benefit to the present
  - Includes approximately 30+ data fields such as NDC, fill date, days' supply, prescription number, beneficiary ID number, etc. (standard data layout utilized)
- Beneficiary Claims Data
  - Focus may be a beneficiary who is provider or pharmacy shopping
  - Can be related to a specific complaint from a beneficiary or an individual who knows the beneficiary
  - Outcome from a proactive claims analysis by the MEDIC as part of the MEDIC's routine oversight process

## Enrollment Verification

- Generally based on a beneficiary complaint
- Seeks to identify how the beneficiary was enrolled and if adequate documentation exists to support the type of enrollment
- Primary objectives are to:
  - Ensure that the enrollment was authorized by the beneficiary
  - If enrolled through a third-party marketing broker/sales agent, that the enrollment was processed in accordance with the CMS Marketing Guidelines
  - If enrolled by an authorized representative, that the proper Authorization of Representative (AOR) form has been received

## Complaint Investigation

- These types of requests are more involved and generally require significantly more research depending upon the nature of the complaint
- Typical types of complaints in this category include, but are not limited to the following:
  - Inability or difficulty with obtaining medications from a pharmacy or the beneficiary is out of medications
  - Pharmacy/Pharmacist was unprofessional
  - Allegations of other individuals utilizing their Part D benefit to obtain medications
  - Customer Service

## Requests for Information (RFI) Process

- Standardized process for all RFIs is utilized
  - Investigator contacts plan sponsor contact by phone
    - Describes nature of request
    - Provides general background information
    - Addresses potential questions or clarifications from plan sponsor needed to initiate the request or research
  - Verbal request confirmed in writing via certified mail and/or fax
    - Provides confirmation of the initial request by phone
    - Outlines the description of the problem and the specific documentation or courses of action needed from the plan sponsor
    - Confirms the expected due date for the request, which is currently 30 days from receipt
  - Provision of documentation or resolution of issue to the MEDIC via the Evidence of Closure process
  - Confirmation of documentation receipt and case closure

## Evidence of Closure Memo

- Document that accompanies the documentation to support the RFI initially received from the MEDIC
- Depends on the nature of the RFI
  - If the RFI is a standard data request, the letter acknowledges the initial request, what data is being provided and that it is being sent via an encrypted file (Note: password is always provided separately)
  - If the RFI is related to a complaint or more detailed issue, the memo will include the following:
    - Acknowledgement of the initial issue
    - Confirmation of the facts and details per discussions with the MEDIC
    - Description of the analysis and research related to the complaint
    - The outcome of the complaint
    - Recommended next steps, if necessary

## MEDIC Referral Process

- Preparing a MEDIC referral
  - Review of all facts and circumstances surrounding the potential fraud, waste or abuse
  - Compilation of all data needed to support the referral
  - Review of data for completeness
  - Develop formal case referral package
  - Submit the case referral package for review by the SIU/Fraud, Waste and Abuse Committee and the Compliance Committee

### **MEDIC Referrals – Section 50.2.8.3 (Data)**

- Once the plan sponsor determines that a MEDIC referral is appropriate, the sponsor should provide the following information:
  - Name, Address, Billing ID Number of provider
  - Provider type and description of service
  - Nature and time frame of allegation
  - Description of the steps taken by the plan sponsor to investigate the issue
  - Date and place of service
  - Beneficiary information
  - Name and contact number of individual who received the complaint
  - Contact information
  - All supporting documentation

### **Recommended Best Practices**

- Based on experience to date, there are emerging best practices that can be utilized to ensure the plan sponsor has an efficient process in place to receive, respond and retain all MEDIC requests:
  - Require that all verbal requests be submitted in writing for documentation purposes; this ensures that the correct data is provided for the correct beneficiary
  - Always acknowledge receipt of the request with the benefit integrity analyst; part of this acknowledgement process is to address any additional information from the MEDIC that may be needed to properly respond to the request
  - Develop internal policies and procedures for responding to all requests and communicate those policies to those individuals who will be managing the process or may be involved in assisting with the request
  - Reach out to the MEDICs to provide them with a single point-of-contact for all casework; it will greatly help the process

## Recommended Best Practices

- Based on experience to date, best practices also include:
  - Develop procedures for voluntarily referring cases to the MEDICs
    - Review and approval by the Part D Compliance Officer, Legal, SIU, etc.
    - Standardized reporting when possible
    - Development of case summary to accompany all data provided
    - Respond to all subsequent requests for information once case has been referred
  - Data should always be sent using appropriate encryption software to protect beneficiary Personal Health Information (PHI)
  - All case work and related documentation should be maintained in accordance with CMS record retention requirements, preferably in a network database
  - Notify the MEDIC immediately if unable to meet the 30-day required turnaround time

## Closing Comments

- MEDIC requests will continue to ramp up as the benefit becomes increasingly more complex and more beneficiaries enter the program
- The MEDICs have the same end goal as the Part D plan sponsor – the prevention of fraud, waste and abuse, beneficiary protection, and ensure the integrity of the Medicare Trust Fund
- Work with your PBM or subcontracted entity as soon as you receive a MEDIC request to ensure you meet the required 30-day time frame for responding