



Geisinger Health Plan Compliance Program

Geisinger Health Plan's Compliance Program is designed to oversee the development, implementation and maintenance of a compliance and privacy program that meets or exceeds federal and state laws and regulations, as well as contractual and accreditation obligations.

Geisinger Health Plan is committed to ethical and legal conduct that is compliant with all relevant laws and regulations, and to correcting wrongdoing whenever it may occur in the administration of any of our plans.

This commitment encompasses our organization and any of the parties that we contract with to provide services related to the administration of our plans.

For more detail on our compliance standards, please refer to our Code of Conduct (insert link to Code of Conduct).

Who do you contact with compliance questions?

You can contact our Compliance Department at (570)271-7389.

What do you do if you suspect Fraud, Waste, and/or Abuse?

It is very important for individuals who participate with our plans to report all cases of suspected fraud, waste and/or abuse.

Geisinger Health Plan has made available several methods for reporting the information.

- You can call Geisinger Health Plan's Fraud and Abuse Hotline at 1-800-292-1627. (Calls to the hotline may be made anonymously)
- You can contact our Chief Compliance Officer at (570)271-7389.

Defining Fraud, Waste, and Abuse

- Fraud – A deception or misrepresentation made by a person or entity that knows or should know the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entity(ies).
- Waste – Waste occurs when an act of carelessness in performance and/or lack of training result in otherwise unnecessary repetition of services.
- Abuse – A deception or misrepresentation made by a person or entity that is unaware the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entity(ies).

Examples of Risks for Fraud, Waste and Abuse

Prescriber Fraud, Waste and Abuse

- *Illegal remuneration schemes*: Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.
- *Prescription drug switching*: Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.
- *Script mills*: Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.
- *Provision of false information*: Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism in order to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnished the services.
- *Theft of prescriber's DEA 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, includes the theft of the provider's authentication (log in) information.

Medicare Beneficiary Fraud, Waste and Abuse Risks

- *Misrepresentation of status*: A Medicare beneficiary misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive the drug benefit. Enrollees who are no longer covered under a drug benefit plan may still attempt to use their identity card to obtain prescriptions.
- *Identity theft*: Perpetrator uses another person's Medicare card to obtain prescriptions.
- *Prescription forging or altering*: Where prescriptions are altered, by someone other than the prescriber or pharmacist with prescriber approval, to increase quantity or number of refills.
- *Prescription diversion and inappropriate use*: Beneficiaries obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. Also can include the inappropriate consumption or distribution of a beneficiary's medications by a caregiver or anyone else.
- *Resale of drugs on black market*: Beneficiary falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.
- *Prescription stockpiling*: Beneficiary attempts to "game" their drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against periods of non-coverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market.

- *Doctor shopping*: Beneficiary or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.
- *Improper Coordination of Benefits*: Improper coordination of benefits where beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies to “game” the system.
- *Marketing Schemes*: A beneficiary may be victimized by a marketing scheme where a Sponsor, or its agents or brokers, violates the Medicare Marketing Guidelines, or other applicable Federal or state laws, rules, and regulations to improperly enroll the beneficiary in a Part D Plan.

Pharmacy Fraud, Waste and Abuse

- *Inappropriate billing practices*: Inappropriate billing practices at the pharmacy level occur when pharmacies engage in the following types of billing practices:
 - Incorrectly billing for secondary payers to receive increased reimbursement
 - Billing for non-existent prescriptions
 - Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions
 - Billing for brand when generics are dispensed
 - Billing for non-covered prescriptions as covered items
 - Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up)
 - Billing based on “gang visits,” e.g., a pharmacist visits a nursing home and bills for numerous pharmaceutical prescriptions without furnishing any specific service to individual patients
 - Inappropriate use of dispense as written (“DAW”) codes
 - Prescription splitting to receive additional dispensing fees
 - Drug diversion
- *Prescription drug shorting*: Pharmacist provides less than the prescribed quantity and intentionally does not inform the patient or make arrangements to provide the balance but bills for the fully-prescribed amount.
- *Bait and switch pricing*: Bait and switch pricing occurs when a beneficiary is led to believe that drug will cost one price, but at the point of sale the beneficiary is charged a higher amount.
- *Prescription forging or altering*: Where existing prescriptions are altered, by an individual without the prescriber’s permission to increase quantity or number of refills.
- *Dispensing expired or adulterated prescription drugs*: Pharmacies dispense drugs that are expired, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- *Prescription refill errors*: A pharmacist provides the incorrect number of refills prescribed by the provider.
- *Illegal remuneration schemes*: Pharmacy is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the pharmacy to switch

patients to different drugs, influence prescribers to prescribe different drugs, or steer patients to plans.

- *TrOOP manipulation:* When a pharmacy manipulates TrOOP to either push a beneficiary through the coverage gap, so the beneficiary can reach catastrophic coverage before they are eligible, or manipulates TrOOP to keep a beneficiary in the coverage gap so that catastrophic coverage is never realized.
- *Failure to offer negotiated prices:* Occurs when a pharmacy does not offer a beneficiary the negotiated price of a Part D drug.

Pharmacy Benefit Manager (PBM) Fraud, Waste and Abuse

- *Prescription drug switching:* The PBM receives a payment to switch a beneficiary from one drug to another or influence the prescriber to switch the patient to a different drug.
- *Unlawful remuneration:* PBM receives unlawful remuneration in order to steer a beneficiary toward a certain plan or drug, or for formulary placement. Includes unlawful remuneration from vendors beyond switching fees.
- *Inappropriate formulary decisions:* PBM or their P&T committee makes formulary decisions where cost takes precedence over clinical efficacy and appropriateness of formulary drugs.
- *Prescription drug splitting or shorting:* PBM mail order pharmacy intentionally provides less than the prescribed quantity and does not inform the patient or make arrangements to provide the balance but bills for the fully-prescribed amount. Splits prescription to receive additional dispensing fees.
- *Failure to offer negotiated prices:* Occurs when a PBM does not offer a beneficiary negotiated price of a Part D drug.