



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



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TO: All State Medicaid Fraud Control Units

FROM: Suzanne Murrin 
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: State Fraud Policy Transmittal No. 2018-1:
MFCU Authority to Receive Federal Funding to Investigate and Prosecute
Diversion and Misuse of Pharmaceuticals

The purpose of this policy transmittal is to clarify the authority of Medicaid Fraud Control Units (MFCUs or Units) to receive Federal financial participation (FFP) for investigations and prosecutions of potentially fraudulent conduct related to the diversion or misuse of pharmaceuticals. This guidance provides information on Federal funding authority for the MFCUs to the extent a Unit chooses to investigate or prosecute such a case, and does not address whether a MFCU has the jurisdiction or authority under State law to pursue a case.

Background

This is an issue of particular significance since the President, on October 26, 2017, declared the opioid crisis a national Public Health Emergency. MFCUs are an important part of the law enforcement response to the opioid crisis, and the Office of Inspector General (OIG) encourages MFCUs to pursue appropriate cases of Medicaid provider fraud, as well as patient abuse or neglect, to protect program beneficiaries and other citizens from the fraudulent prescription and misuse of opioids and other pharmaceuticals.

General Principles

Generally, to qualify for FFP, a fraud investigation concerning the prescribing, dispensing, or use of pharmaceuticals must involve, as one component of the investigation, a potentially fraudulent claim either to Medicaid, or to another Federal health care program, if the Unit has received “extended investigative authority” for the case. See [Policy Transmittal 2000-1](#), September 7, 2000, for receiving authority to investigate and prosecute cases that primarily involve Medicaid

but also involve Medicare, the Children’s Health Insurance Program, or other Federal health care programs.

Fraud investigations concerning prescription drugs may involve participation by multiple actors: (1) a doctor or other prescriber; (2) a pharmacy or other dispenser; (3) a managed care organization or other entity under contract with the program (such as a pharmacy benefits manager); and/or (4) one or more beneficiaries.

As a general principle applicable to MFCUs, FFP is available for the investigation¹ and prosecution of a case involving prescription drugs if there are credible allegations that the conduct of any of the actors – whether prescriber, dispenser, managed-care-related intermediary, or beneficiary – was committed with knowledge that it would cause the submission of a potentially fraudulent claim to the Medicaid program.² Such claims could be submitted as part of a fee-for-service delivery system or through a managed care network.

Scenarios

OIG provides below some hypothetical scenarios that illustrate cases that would be eligible for FFP, and others that would require further facts to determine if they are eligible for FFP. These scenarios are intended to be illustrative only and do not address other potential scenarios that a MFCU may encounter. We encourage Units to contact OIG if they have questions about other factual scenarios as they arise.

Scenarios that are eligible for FFP

Scenario 1

A doctor bills the Medicaid program (directly or through a contract with a managed care entity) for an office visit with a Medicaid beneficiary and writes a prescription, but there is evidence that the doctor fabricated the diagnosis to permit the beneficiary to misuse the pharmaceutical or to divert it for financial gain.

Case eligible for FFP. On a larger scale, this is the classic “pill mill” scenario where a doctor’s office issues fraudulent prescriptions on a routine basis to

¹ MFCUs, in the early stages of an investigation, are encouraged to pursue a case until and unless it becomes clear to the Unit that a potentially fraudulent Medicaid claim will not be established in a cost effective timeframe. When the Unit determines that it lacks authority, or the case can no longer be pursued in a cost-effective manner, further investigation and prosecution should be appropriately referred to other law enforcement agencies.

² For “extended authority” cases involving Medicare or other Federal health care programs, a similar analysis would apply to the ability of a Unit to receive FFP for such cases.

defraud the program. The Unit may receive FFP to investigate and potentially charge the doctor for health care fraud or other criminal conduct. If the pharmacy or beneficiary were also a part of the scheme, they could potentially be investigated and charged as well.

Scenario 2

An employee of a facility steals drugs from the facility that are paid for by Medicaid and intended to be administered to a Medicaid beneficiary residing in the facility. The drugs are then diverted for financial gain or other illicit purposes.

Case eligible for FFP. The Unit may receive FFP for investigating and prosecuting the case, if the investigation can establish that the stolen drugs were paid for by Medicaid and intended to be administered to a Medicaid beneficiary. Finally, regardless of the funding source for the drugs, if the theft or diversion resulted in harm to a particular patient – for example, because the patient did not receive critically important medications – the employee could also be investigated and charged for patient abuse or neglect.

Scenario 3

A Medicaid beneficiary visits one or more doctors in an effort to obtain a prescription that will be misused or diverted. There is evidence the beneficiary is healthy but feigns a medical condition, such as back pain, to obtain a prescription. The beneficiary finds a doctor to write a prescription, as well as a pharmacy to fill it, and the cost of the medical exam and the prescription are billed to the Medicaid program. There is no evidence that the doctor or the pharmacy is aware of the intended misuse of the prescription.

Case eligible for FFP. A MFCU may receive FFP to investigate the diversion of the prescribed drugs by the beneficiary. Although the drugs may have been prescribed by a doctor in good faith and/or dispensed by a pharmacy in good faith, the beneficiary caused the submission of false claims through the false representation of symptoms to the doctor. The beneficiary's false representation of symptoms led to the prescription being written, dispensed, and ultimately misused or diverted.

Scenario 4

A Medicaid provider is the victim of identity theft, in which the non-provider suspect uses the provider's information (e.g., NPI, DEA registration number, medical license number) to create forged or manufactured prescriptions. As one common scheme, the suspect passes the fraudulent prescriptions (for such Schedule II drugs as oxycodone and hydrocodone) to "runners," who in turn present the fraudulent prescriptions to pharmacies to fill. Suspects commonly pay cash to the runners, who may also use their own Medicaid benefits to cover the

prescriptions. The prescriptions may also be later reimbursed by Medicaid when they are filled.

Case eligible for FFP. A MFCU may receive FFP to investigate identity theft cases in which a third-party non-provider forges or manufactures a prescription for which a Medicaid claim is paid.

Scenarios in which eligibility for FFP would be in question or require further information

Scenario 5

A doctor sees a Medicaid patient seeking a prescription for medically unnecessary painkillers and does not bill Medicaid for the clinical visit, but charges the patient cash for the visit.

The case may not be eligible for FFP, unless further investigation reveals: (1) another provider bills Medicaid for a service related to the claim; or (2) the prescription is later filled by the patient and billed to the Medicaid program.

It should be noted that a cash payment, especially for an individual who would have the ability to submit a claim to the program, may be an indicator of fraud or other criminal activity. If the above scenario was determined not to be within the authority of the MFCU, it should be timely referred to another law enforcement agency for investigation of potential criminal activity. Also, some States prohibit a provider from seeking payment by a beneficiary for the cost of services that are covered by Medicaid, which may be a relevant consideration in choosing whether to investigate a case.

Scenario 6

A doctor bills for an office visit with a Medicaid beneficiary and writes a prescription for a medication that is designed to be taken once a day for 30 days, but instead prescribes 90 pills for the 30-day period.

This type of “over-prescribing” case would be eligible for FFP if evidence reveals no legitimate medical purpose for the size of the prescription and an intent by either the doctor or patient to misuse or divert the prescription. However, the case could become ineligible if further investigation revealed legitimate, clinical reasons that the patient was prescribed a high amount of medication. On the other hand, even with a clinical basis for the prescription, the case could be eligible for FFP if the pharmacy fills the prescription and submits a claim to the Medicaid program as part of a larger fraud scheme, such as those involving kickbacks to the doctor or pharmacy.

If you have any questions, please contact Richard Stern, Director, Medicaid Fraud Policy and Oversight Division, at 202-619-0480.