

Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training

Combating Medicare Parts C and D Fraud, Waste, and Abuse Introduction

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This Web-Based Training (WBT) course was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the WBT for your reference.

This WBT course was prepared as a service to the public and is not intended to grant rights or impose obligations. This WBT may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

This training module will assist Medicare Parts C and D plan Sponsors employees, governing body members, and their first-tier, downstream, and related entities (FDRs) in satisfying the annual Fraud, Waste, and Abuse (FWA) training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C);
- 42 CFR Section 423.504(b)(4)(vi)(C);
- CMS-4159-F, Medicare Program Contract Year 2015 Policy and Technical Changes in the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; and
- Section 50.3.2 of the Compliance Program Guidelines (Chapter 9 of the "Medicare Prescription Drug Benefit Manual" and Chapter 21 of the "Medicare Managed Care Manual").

Sponsors and their FDRs may use this module to satisfy FWA training requirements. Sponsors and their FDRs are responsible for providing additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

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The MLN is home for education, information, and resources for the health care professional community. The MLN provides access to the Centers for Medicare & Medicaid Services (CMS) Program information you need, when you need it, so you can focus more on providing care to your patients.

Serving as the umbrella for a variety of CMS education and communication activities, the MLN offers:

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5. MLN Connects® Provider eNews (<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg>) ; and
6. Provider electronic mailing lists (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243324.html>) .

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Why Do I Need Training?

Every year **billions** of dollars are improperly spent because of FWA. It affects everyone – **including you**. This training will help you detect, correct, and prevent FWA. **You** are part of the solution.

Combating FWA is **everyone's** responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this WBT course as “Sponsors”) must receive training for preventing, detecting, and correcting FWA.

FWA training must occur within 90 days of initial hire and at least annually thereafter.

- **Learn more about Medicare Part C**

Medicare Part C, or Medicare Advantage (MA), is a health plan choice available to Medicare beneficiaries. MA is a program run by Medicare-approved private insurance companies. These companies arrange for, or directly provide, health care services to the beneficiaries who elect to enroll in an MA plan.

MA plans must cover all services that Medicare covers with the exception of hospice care. MA plans provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

- **Learn more about Medicare Part D**

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare Prescription Drug Plan

(PDP) or an MA Prescription Drug (MA-PD) plan. Insurance companies or other companies approved by Medicare provide prescription drug coverage to individuals who live in a plan's service area.

FWA Training Requirements Exception

There is one exception to the FWA training and education requirement. FDRs will have met the FWA training and education requirements if they have met the FWA certification requirement through:

- Accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; or
- Enrollment in Medicare Part A (hospital) or B (medical) Program.

If you are unsure if this exception applies to you, please contact your management team for more information.

Course Content

This WBT course consists of two lessons:

1. What Is FWA?
2. Your Role in the Fight Against FWA

Anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. You may use this WBT course to satisfy the FWA requirements.

You do not have to complete this course in one session; however, you must complete at least one lesson before exiting this course. Do not click the "X" button in the upper right-hand corner of the window as this will cause you to exit the WBT course without properly saving your progress. You can complete the entire course in about 30 minutes.

Successfully completing the course requires completing all lessons and course evaluation, and scoring 70 percent or higher on the Post-Assessment. After successfully completing the Post-Assessment, you'll get instructions to complete the course evaluation and print your certificate. If you do not successfully complete the course, you will be given the opportunity to review the course material and retake the Post-Assessment.

Course Cues

This course uses cues at various times to provide additional information. The cues are hyperlinks, buttons, acronyms, pop-up windows, and printing cues. For more information on course cues, click the "HELP" button in the upper right corner.

Screen Resolution

If you need to adjust your screen resolution, access instructions through the "HELP" button in the upper right corner and go to the "Screen Resolution" section.

Course Objectives

When you complete this course, you should be able to correctly:

- Recognize FWA in the Medicare Program;
- Identify the major laws and regulations pertaining to FWA;
- Recognize potential consequences and penalties associated with violations;
- Identify methods of preventing FWA;
- Identify how to report FWA; and
- Recognize how to correct FWA.

Click on the “MAIN MENU” button to return to the WBT Main Menu. Then, select “Lesson 1: What Is FWA?”

Combating Medicare Parts C and D Fraud, Waste, and Abuse Lesson 1: What Is FWA?

Lesson 1: Introduction and Learning Objectives

This lesson describes Fraud, Waste, and Abuse (FWA) and the laws that prohibit it. It should take about 10 minutes to complete. Upon completing the lesson, you should be able to correctly:

- Recognize FWA in the Medicare Program;
- Identify the major laws and regulations pertaining to FWA; and
- Recognize potential consequences and penalties associated with violations.

Fraud

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to \$250,000.

In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

Waste and Abuse

Waste includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

For the definitions of fraud, waste, and abuse, refer to Chapter 21, Section 20 of the “[Medicare Managed Care Manual \(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf\)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf)” and Chapter 9 of the “[Prescription Drug Benefit Manual \(https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf\)](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf)” on the Centers for Medicare & Medicaid Services (CMS) website.

Examples of FWA

Examples of actions that may constitute Medicare **fraud** include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments that the patient failed to keep;
- Billing for non-existent prescriptions; and
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Examples of actions that may constitute Medicare **waste** include:

- Conducting excessive office visits or writing excessive prescriptions;
- Prescribing more medications than necessary for the treatment of a specific condition; and
- Ordering excessive laboratory tests.

Examples of actions that may constitute Medicare **abuse** include:

- Billing for unnecessary medical services;
- Billing for brand name drugs when generics are dispensed;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.

Differences Among Fraud, Waste, and Abuse

There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge that the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program, but does not require the same intent and knowledge.

Understanding FWA

To detect FWA, you need to know the **law**.

The following screens provide high-level information about the following laws:

- Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud;
- Anti-Kickback Statute;
- Stark Statute (Physician Self-Referral Law);
- Exclusion; and
- Health Insurance Portability and Accountability Act (HIPAA).

For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

Civil False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA;
- Carries out other acts to obtain property from the Government by misrepresentation;
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government;
- Makes or uses a false record or statement supporting a false claim; or
- Presents a false claim for payment or approval.

For more information, refer to 31 United States Code (U.S.C.) Sections 3729-3733 (<http://www.gpo.gov/fdsys/pkg/USCODE-2013-title31/pdf/USCODE-2013-title31-subtitleIII-chap37-subchapIII.pdf>) on the Internet.

EXAMPLE

A Medicare Part C plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from the Centers for Medicare & Medicaid Services (CMS);
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported;
- Failed to report the unsupported diagnosis codes to Medicare; and
- Agreed to pay \$22.6 million to settle FCA allegations.

Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty.

Civil FCA (continued)

Whistleblowers

A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent but not more than 30 percent of the money collected.

Health Care Fraud Statute

The Health Care Fraud Statute states that “Whoever knowingly and willfully executes, or attempts to execute, a scheme to ... defraud any health care benefit program ... shall be fined ... or imprisoned not more than 10 years, or both.”

Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law. For more information, refer to [18 U.S.C. Section 1346](http://www.gpo.gov/fdsys/pkg/USCODE-2013-title18/pdf/USCODE-2013-title18-part1-chap63-sec1346.pdf) (<http://www.gpo.gov/fdsys/pkg/USCODE-2013-title18/pdf/USCODE-2013-title18-part1-chap63-sec1346.pdf>) on the Internet.

EXAMPLES

A Pennsylvania pharmacist:

- Submitted claims to a Medicare Part D plan for non-existent prescriptions and for drugs not dispensed;
- Pleaded guilty to health care fraud; and
- Received a 15-month prison sentence and was ordered to pay more than \$166,000 in restitution to the plan.

The owners of two Florida Durable Medical Equipment (DME) companies:

- Submitted false claims of approximately \$4 million to Medicare for products that were not authorized and not provided;
- Were convicted of making false claims, conspiracy, health care fraud, and wire fraud;
- Were sentenced to 54 months in prison; and
- Were ordered to pay more than \$1.9 million in restitution.

Criminal Fraud

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to \$250,000;
- Imprisonment for up to 20 years; or
- Both.

If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

For more information, refer to [18 U.S.C. Section 1347](http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-part1-chap63-sec1347.pdf) (<http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-part1-chap63-sec1347.pdf>) on the Internet.

Anti-Kickback Statute

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including the Medicare Program).

For more information, refer to [42 U.S.C. Section 1320A-7b\(b\)](http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXI-partA-sec1320a-7b.pdf) (<http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXI-partA-sec1320a-7b.pdf>) on the Internet.

EXAMPLE

A radiologist who owned and served as medical director of a diagnostic testing center in New Jersey:

- Obtained nearly \$2 million in payments from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests;
- Paid doctors for referring patients;
- Pleaded guilty to violating the Anti-Kickback Statute; and
- Was sentenced to 46 months in prison.

The radiologist was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

Damages and Penalties

Violations are punishable by:

- A fine of up to \$25,000;
- Imprisonment for up to 5 years; or
- Both.

For more information, refer to the [Social Security Act \(the Act\), Section 1128B\(b\)](https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm) (https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm) on the Internet.

Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest; or
- A compensation arrangement (exceptions apply).

For more information, refer to 42 U.S.C. Section 1395nn (<http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXVIII-partE-sec1395nn.pdf>) on the Internet.

EXAMPLE

A physician paid the Government \$203,000 to settle allegations that he violated the physician self-referral prohibition in the Stark Statute for routinely referring Medicare patients to an oxygen supply company he owned.

Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of up to **\$15,000** may be imposed for each service provided. There may also be up to a **\$100,000** fine for entering into an unlawful arrangement or scheme.

For more information, visit <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral> on the CMS website and refer to [the Act, Section 1877](https://www.ssa.gov/OP_Home/ssact/title18/1877.htm) (https://www.ssa.gov/OP_Home/ssact/title18/1877.htm) on the Internet.

Civil Monetary Penalties Law

The Office of Inspector General (OIG) may impose Civil penalties for a number of reasons, including:

- Arranging for services or items from an excluded individual or entity;
- Providing services or items while excluded;
- Failing to grant OIG timely access to records;
- Knowing of an overpayment and failing to report and return it;
- Making false claims; or
- Paying to influence referrals.

For more information, refer to the Act, Section 1128A(a) (https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm) on the Internet.

EXAMPLE

A California pharmacy and its owner agreed to pay over \$1.3 million to settle allegations they submitted claims to Medicare Part D for brand name prescription drugs that the pharmacy could not have dispensed based on inventory records.

Damages and Penalties

The penalties range from \$10,000 to \$50,000 depending on the specific violation. Violators are also subject to three times the amount:

- Claimed for each service or item; or
- Of remuneration offered, paid, solicited, or received.

Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE). You can access the LEIE at <https://exclusions.oig.hhs.gov> on the Internet.

The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS at <https://www.sam.gov> on the Internet.

If looking for excluded individuals or entities, make sure to check both the LEIE and the EPLS since the lists are not the same. For more information, refer to 42 U.S.C. Section 1320a-7 (<http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXI-partA-sec1320a-7.pdf>) and 42 Code of Federal Regulations Section 1001.1901 (<http://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol5/pdf/CFR-2014-title42-vol5-sec1001-1901.pdf>) on the Internet.

EXAMPLE

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the Food and Drug Administration concerning oversized morphine sulfate tablets. The executive of the pharmaceutical firm was excluded based on the company's guilty plea. At the time the

executive was excluded, he had not been convicted himself, but there was evidence he was involved in misconduct leading to the company's conviction.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards help prevent unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.

For more information, visit <http://www.hhs.gov/hipaa> on the Internet.

EXAMPLE

A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

Damages and Penalties

Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

Lesson 1 Summary

There are differences among FWA. One of the primary differences is intent and knowledge. Fraud requires that the person have intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment but do not require the same intent and knowledge.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

- Civil Monetary Penalties;
- Civil prosecution;
- Criminal conviction/fines;
- Exclusion from participation in all Federal health care programs;
- Imprisonment; or
- Loss of provider license.

Lesson 1 Review

Now that you have completed Lesson 1, let's do a quick knowledge check. The following questions do not contribute to your overall course score in the Post-Assessment.

Knowledge Check

Which of the following requires intent to obtain payment and the knowledge that the actions are wrong?

Select the correct answer.

- A. Fraud (CORRECT)
- B. Abuse
- C. Waste

Knowledge Check

Which of the following is NOT potentially a penalty for violation of a law or regulation prohibiting Fraud, Waste, and Abuse (FWA)?

Select the correct answer.

- A. Civil Monetary Penalties
- B. Deportation (CORRECT)
- C. Exclusion from participation in all Federal health care programs

You completed Lesson 1: What Is FWA?

Now that you have learned about FWA and the laws and regulations prohibiting it, let's look closer at your role in the fight against FWA.

Click the "MAIN MENU" button to return to the Web-Based Training (WBT) Main Menu. Then select "Lesson 2: Your Role in the Fight Against FWA" to begin Lesson 2.

Combating Medicare Parts C and D Fraud, Waste, and Abuse Lesson 2: Your Role in the Fight Against FWA

Lesson 2: Introduction and Learning Objectives

This lesson explains the role you can play in fighting against Fraud, Waste, and Abuse (FWA), including your responsibilities for preventing, reporting, and correcting FWA. It should take about 10 minutes to complete. Upon completing the lesson, you should be able to correctly:

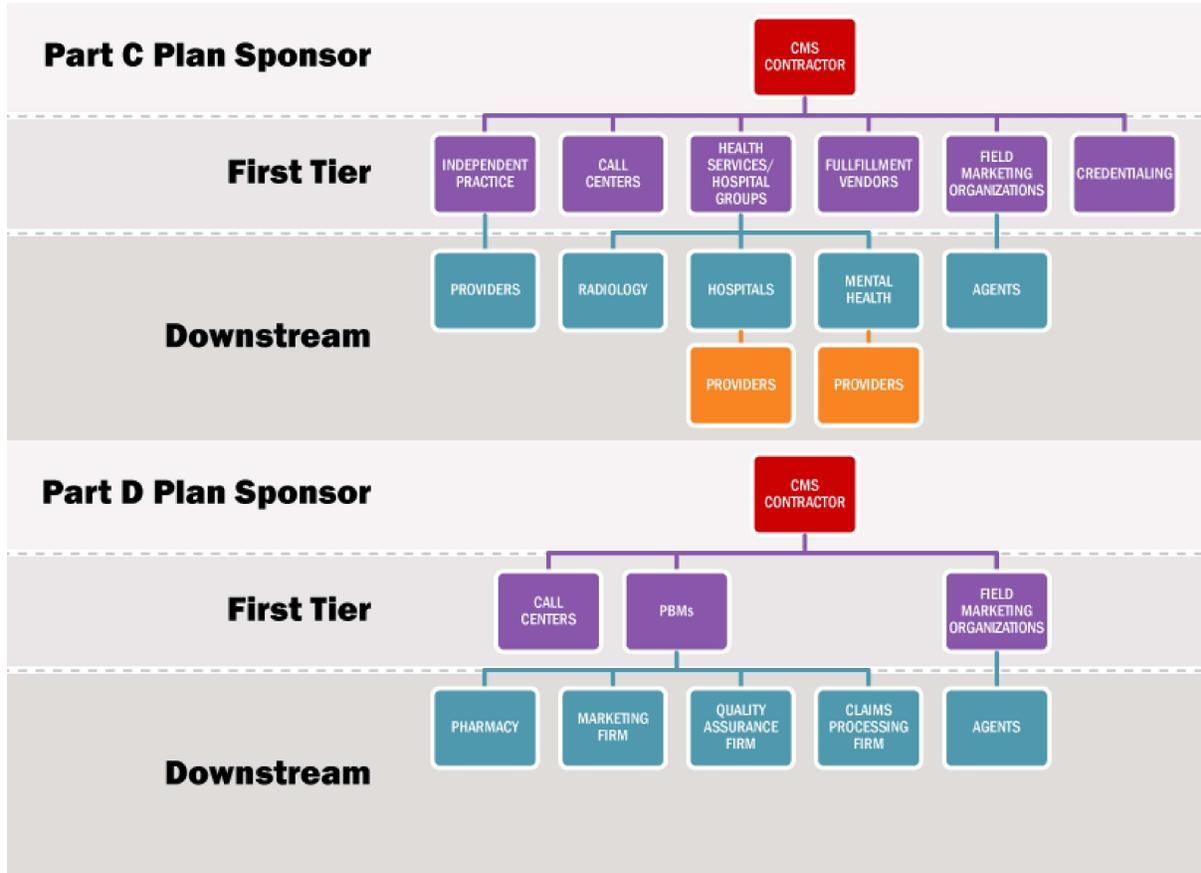
- Identify methods of preventing FWA;
- Identify how to report FWA; and
- Recognize how to correct FWA.

Where Do I Fit In?

As a person who provides health or administrative services to a Medicare Part C or Part D enrollee, you are either an employee of a:

- Sponsor;
- First-tier entity (Examples: Pharmacy Benefit Management (PBM), hospital or health care facility, provider group, doctor office, clinical laboratory, customer service provider, claims processing and adjudication company, a company that handles enrollment, disenrollment, and membership functions, and contracted sales agent);
- Downstream entity (Examples: pharmacies, doctor office, firms providing agent/broker services, marketing firms, and call centers); or
- Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®).

Where Do I Fit In? (continued)



What Are Your Responsibilities?

You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare non-compliance.

- **FIRST**, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
- **SECOND**, you have a duty to the Medicare Program to report any compliance concerns, and suspected or actual violations that you may be aware of.
- **THIRD**, you have a duty to follow your organization’s Code of Conduct that articulates your and your organization’s commitment to standards of conduct and ethical rules of behavior.

How Do You Prevent FWA?

- Look for suspicious activity;
- Conduct yourself in an ethical manner;
- Ensure accurate and timely data/billing;
- Ensure you coordinate with other payers;
- Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance; and
- Verify all information provided to you.

Stay Informed About Policies and Procedures

Familiarize yourself with your entity's policies and procedures.

Every Sponsor and First-Tier, Downstream, or Related Entity (FDR) must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.

Standards of Conduct should describe the Sponsor's expectations that:

- All employees conduct themselves in an ethical manner;
- Appropriate mechanisms are in place for anyone to report non-compliance and potential FWA; and
- Reported issues will be addressed and corrected.

Standards of Conduct communicate to employees and FDRs that compliance is everyone's responsibility, from the top of the organization to the bottom.

Report FWA

Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your compliance department or your Sponsor's compliance department. Your Sponsor's compliance department area will investigate and make the proper determination. Often, Sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain an FWA Hotline.

Every Sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting. Review your organization's materials for the ways to report FWA.

When in doubt, call your Compliance Department or FWA Hotline.

Reporting FWA Outside Your Organization

If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General, the Department of Justice, or CMS.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.

Details to Include When Reporting FWA

When reporting suspected FWA, you should include:

- Contact information for the source of the information, suspects, and witnesses;
- Details of the alleged FWA;
- Identification of the specific Medicare rules allegedly violated; and
- The suspect's history of compliance, education, training, and communication with your organization or other entities.

WHERE TO REPORT FWA

HHS Office of Inspector General:

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Fax: 1-800-223-8164

Email: HHSTips@oig.hhs.gov

Online: <https://forms.oig.hhs.gov/hotlineoperations>

For Medicare Parts C and D:

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRx (1-877-772-3379)

For all other Federal health care programs:

CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

HHS and U.S. Department of Justice (DOJ): <https://www.stopmedicarefraud.gov>

[Print this contact information](#)

Correction

Once fraud, waste, or abuse has been detected, it must be promptly corrected. Correcting the problem saves the Government money and ensures you are in compliance with CMS requirements.

Develop a plan to correct the issue. Consult your organization's compliance officer to find out the process for the corrective action plan development. The actual plan is going to vary, depending on the specific circumstances. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance;
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions;
- Document corrective actions addressing non-compliance or FWA committed by a Sponsor's employee or FDR's employee and include consequences for failure to satisfactorily complete the corrective action; and
- Once started, continuously monitor corrective actions to ensure they are effective.

CORRECTIVE ACTION EXAMPLES

Corrective actions may include:

- Adopting new prepayment edits or document review requirements;
- Conducting mandated training;
- Providing educational materials;
- Revising policies or procedures;
- Sending warning letters;
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment; or
- Terminating an employee or provider.

Indicators of Potential FWA

Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.

The following pages present issues that may be potential FWA. Each page provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy, or other entity involved in the delivery of Medicare Parts C and D benefits to enrollees.

Key Indicators: Potential Beneficiary Issues

- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the medical service the actual beneficiary (identity theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

Key Indicators: Potential Provider Issues

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Does the provider bill the Sponsor for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Is the provider's diagnosis for the member supported in the medical record?

Key Indicators: Potential Pharmacy Issues

- Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires that brand drugs be dispensed?
- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?

Key Indicators: Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics and then marking up the prices and sending to other smaller wholesalers or pharmacies?

Key Indicators: Potential Manufacturer Issues

- Does the manufacturer promote off-label drug usage?

- Does the manufacturer provide samples, knowing that the samples will be billed to a Federal health care program?

Key Indicators: Potential Sponsor Issues

- Does the Sponsor encourage/support inappropriate risk adjustment submissions?
- Does the Sponsor lead the beneficiary to believe that the cost of benefits is one price, only for the beneficiary to find out that the actual cost is higher?
- Does the Sponsor offer cash inducements for beneficiaries to join the plan?
- Does the Sponsor use unlicensed agents?

Lesson 2 Summary

- As a person who provides health or administrative services to a Medicare Parts C or D enrollee, you play a vital role in preventing FWA. Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.
- Report potential FWA. Every Sponsor must have a mechanism for reporting potential FWA. Each Sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting.
- Promptly correct identified FWA with an effective corrective action plan.

Lesson 2 Review

Now that you have completed Lesson 2, let's do a quick knowledge check. The following questions do not contribute to your overall course score in the Post-Assessment.

Knowledge Check

A person comes to your pharmacy to drop off a prescription for a beneficiary who is a "regular" customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery. What is your next step?

Select the correct answer.

- A. Fill the prescription for 160
- B. Fill the prescription for 60
- C. Call the prescriber to verify the quantity (CORRECT)
- D. Call the Sponsor's compliance department
- E. Call law enforcement

Knowledge Check

Your job is to submit a risk diagnosis to the Centers for Medicare & Medicaid Services (CMS) for the purpose of payment. As part of this job you verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the Sponsor's process and to adjust/add risk diagnosis codes for certain individuals. What should you do?

Select the correct answer.

- A. Do what your immediate supervisor asked you to do and adjust/add risk diagnosis codes

- B. Report the incident to the compliance department (via compliance hotline or other mechanism) (CORRECT)
- C. Discuss your concerns with your immediate supervisor
- D. Call law enforcement

Knowledge Check

You are in charge of payment of claims submitted by providers. You notice a certain diagnostic provider ("Doe Diagnostics") requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics' claims far exceed any other provider that you reviewed. What should you do?

Select the correct answer.

- A. Call Doe Diagnostics and request additional information for the claims
- B. Consult with your immediate supervisor for next steps or contact the compliance department (via compliance hotline, Special Investigations Unit (SIU), or other mechanism) (CORRECT)
- C. Reject the claims
- D. Pay the claims

Knowledge Check

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

Select the correct answer.

- A. Call local law enforcement
- B. Perform another review
- C. Contact your compliance department (via compliance hotline or other mechanism)
- D. Discuss your concerns with your supervisor
- E. Follow your pharmacy's procedures (CORRECT)

You completed Lesson 2: Your Role in the Fight Against FWA

Now that you have learned how to fight FWA, let's take a post-assessment to see how much you've learned!

Click the "MAIN MENU" button to return to the Web-Based Training (WBT) Main Menu. Then select "Post-Assessment" to begin the Post-Assessment.

Statutory and Regulatory Provisions

Under section 1140 of the Social Security Act (the Act), there are restrictions regarding the use of certain words, letters, emblems and symbols in connection with advertisements, solicitations or other productions. Specifically, the words "Social Security," "Social Security Account," "Social Security System," "Social Security Administration," "Medicare," "Health Care Financing Administration," "Department of Health and Human Services," "Health and Human Services," "Supplemental Security Income Program," or "Medicaid" may not be used in a manner that gives (or could give) the impression that the solicitation, advertisement or other production is endorsed, authorized, affiliated with or approved by the Centers for Medicare and Medicaid Services or by the Department of Health and Human Services.

Similarly, letters such as "SSA," "HCFA," [1] "DHHS," "HHS," "SSI," or other combinations or variations also may not be used to imply approval or involvement by the Department of Health and Human Services or CMS. The same rules apply to the use of symbols and emblems associated with the Department of Health and Human Services or with the Centers for Medicare and Medicaid Services, such as the design of the social security card, the Medicare card, or envelopes or stationery used by either entity. State agencies or political subdivisions of state agencies are exempt from these restrictions.

Government publications are not subject to copyright law.[2] However, section 1140(a)(2)(B) of the Act prohibits the reproduction, reprinting or distribution of items consisting of forms, applications or other publications of the Social Security Administration or the

Department of Health and Human Services for a fee unless specific, written authorization is obtained as prescribed by regulations published by the Commissioner of Social Security or the Secretary of the Department of Health and Human Services.[3] Violations of Section 1140 are punishable by a civil money penalty of \$5,000 for each piece of advertisement, solicitation or other production, and up to \$25,000 for each instance where a broadcast or telecast is used as the means of transmission for the solicitation or advertisement. See 42 C.F.R. § 1003.102(b)(7). Section 1140 is enforced by the Office of the Inspector General. It should be noted that the use of a disclaimer to inform the public that a given solicitation or advertisement is not endorsed or approved of by any governmental entity does not waive the requirements of section 1140.

Analysis

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[1]We would also expect that the initials "CMS" would be included in this list in light of the agency's new name.

[2]17 U.S.C. § 105.

[3]The Department has yet to publish regulations pursuant to subsection 1140(a)(2)(B); however, we believe that CMS has the authority to disapprove reproduction of its publications.