
mln
Web-Based Training Course
Combating Medicare Parts C & D Fraud, Waste & Abuse
Select anywhere to continue
CMS
Medicare Learning Network

1


Combating Medicare Parts C & D Fraud, Waste & Abuse
Course Menu
Combating Medicare Parts C & D Fraud, Waste & Abuse (45 minutes)
In this 45-minute course, learn about fraud, waste, and abuse (FWA) laws and regulations; consequences and penalties of violations; and how Medicare Parts C and D employees can recognize and prevent FWA.
Introduction (10 minutes)
Lesson 1: What's Fraud, Waste & Abuse? (10 minutes)
Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse (10 minutes)
Test (15 minutes)
Start Over
Get Certificate

2

Combating Medicare Parts C & D Fraud, Waste & Abuse

Introduction

The Medicare Learning Network® developed this content.

The Medicare Learning Network® (MLN) offers educational materials for health care professionals on CMS programs, policies, and initiatives.

3

Combating Medicare Parts C & D Fraud, Waste & Abuse

Introduction

Navigating the Course

This course uses cues, like hyperlinks, tabs, rollovers, and pop-up windows. Select HELP for more information. Select REFERENCE to view resources.

Completing the Course

To successfully complete this course, score 70% or higher. After you successfully complete the course, we'll tell you how to get your certificate.

4

Combating Medicare Parts C & D Fraud, Waste & Abuse

Introduction

Course Objectives

After completing this course, you should be able to:

- Recognize FWA in the Medicare Program
- Identify major FWA laws and regulations
- Recognize potential consequences and violation penalties
- Identify methods to prevent FWA
- Identify how to report FWA
- Recognize how to correct FWA

5

Combating Medicare Parts C & D Fraud, Waste & Abuse

Introduction

Course Overview

Lesson 1: What's Fraud, Waste & Abuse? describes FWA and the laws that prohibit it.

Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse explains your role in the fight against FWA, including your responsibilities to prevent, report, and correct it.

6

Combating Medicare Parts C & D Fraud, Waste & Abuse

Introduction

This training helps Parts C and D Plan sponsors' employees; governing body members; and their first-tier, downstream, and related entities (FDRs) satisfy their annual FWA training requirements in the regulations and sub-regulatory guidance at:

- 42 CFR 422.503(b)(4)(vi)(C)
- 42 CFR 423.504(b)(4)(vi)(C)
- Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program
- Medicare Prescription Drug Benefit Manual, Chapter 9, section 50.3.2 and Medicare Managed Care Manual, Chapter 21

Sponsors and their FDRs may provide added specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

7

Combating Medicare Parts C & D Fraud, Waste & Abuse

Introduction

Why Do I Need Training?

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

Combating FWA is **everyone's** responsibility. As a person 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.

8

Combating Medicare Parts C & D Fraud, Waste & Abuse

Introduction

Training Requirements: Plan Employees; Governing Body Members & First-Tier, Downstream, or Related Entity Employees

Learn more about Part C

Learn more about Part D

Certain training requirements apply to people involved in Parts C and D administration. All Medicare Advantage Organization and Medicare drug plan (Part D) (collectively referred to in this course as sponsors) employees must get training to prevent, detect, and correct FWA.

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

Compliance Training, Education & Outreach (CTEO) for Medicare Part C & D Programs has more information.

Select Next to return to the Course Menu. Then, select Lesson 1: What's Fraud, Waste & Abuse?

Part C, or Medicare Advantage (MA), is a health insurance option for Medicare enrollees. Private, Medicare-approved insurance companies run MA programs and arrange for, or directly provide, health care services to patients who enroll in an MA plan.

MA plans must cover all services Medicare covers (except hospice care). They provide Medicare Parts A and B benefits and may also include prescription drug coverage and other supplemental benefits.

Part D, the Prescription Drug Benefit, provides prescription drug coverage to patients enrolled in Medicare Part A or B who enroll in a Part D or an MA Prescription Drug (MA-PD) plan. Medicare-approved insurance and other companies provide prescription drug coverage to people living in a plan's service area.

Page 7 of 7

9

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 1: What's Fraud, Waste & Abuse?

Lesson 1: Introduction & Learning Objectives

This lesson describes fraud, waste, and abuse (FWA) and the laws that prohibit it. It should take you about 10 minutes to complete.

After completing this lesson, you should be able to:

- Recognize FWA in the Medicare Program
- Identify major FWA laws and regulations
- Recognize potential consequences of, and penalties for, FWA violations

Page 1 of 20

10

Fraud

Fraud is knowingly submitting, or causing to be submitted, false claims or making misrepresentations of facts to get a federal health care payment when no entitlement would otherwise exist.

Knowingly soliciting, getting, offering, or making payments (for example, kickbacks, bribes, or rebates) to encourage or reward referrals for items or services paid for by federal health care programs is fraud. Making prohibited referrals for certain designated health services is another example of fraud.

Fraud requires **intent** to get payment and **knowledge** the actions are wrong.

11

Fraud (continued)

The Criminal Health Care Fraud Statute (18 United States Code (USC) 1347) 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 up to 10 years.

It's also subject to criminal fines up to $250,000. The statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:

- Defraud any health care benefit program
- Get (by means of false or fraudulent pretenses, representations, or promises) money or property owned by, or controlled by, any health care benefit program

Example

Penalties

Example

Several doctors and medical clinics conspired in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary power wheelchair claims.

Penalties

Penalties for violating federal health care fraud laws include fines, imprisonment, or both.

12

Waste & Abuse

Waste describes practices that, directly or indirectly, result in unnecessary Medicare Program costs, like overusing services. Waste is generally not considered to be criminally negligent but rather a misuse of resources.

Abuse describes practices that, directly or indirectly, result in unnecessary Medicare Program costs. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards of care.

Medicare Managed Care Manual, Chapter 21, section 20 and Prescription Drug Benefit Manual, Chapter 9 have fraud, waste, and abuse definitions.

13

Fraud, Waste & Abuse Examples

Medicare **fraud** examples include:

- Knowingly billing for services of higher complexity than services actually provided or documented in patient medical records
- Knowingly billing for services or supplies not provided, including falsifying records to show an item was delivered
- Knowingly ordering medically unnecessary patient items or services
- Paying for federal health care program patient referrals
- Billing Medicare for appointments that patients don't keep

Medicare **abuse** examples include:

- Billing unnecessary medical services
- Charging excessively for services or supplies
- Misusing codes on a claim, like upcoding (assigning an inaccurate medical procedure or treatment billing code to increase payment) or unbundling codes

Medicare **waste** examples include:

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive lab tests

14

Fraud, Waste & Abuse Differences

There are differences among fraud, waste, and abuse. One of the primary differences is **intent and knowledge**. Fraud requires intent to get payment and knowledge the actions are wrong. Waste and abuse may involve getting an improper payment or creating unnecessary Medicare Program costs but don't require the same intent and knowledge.

15

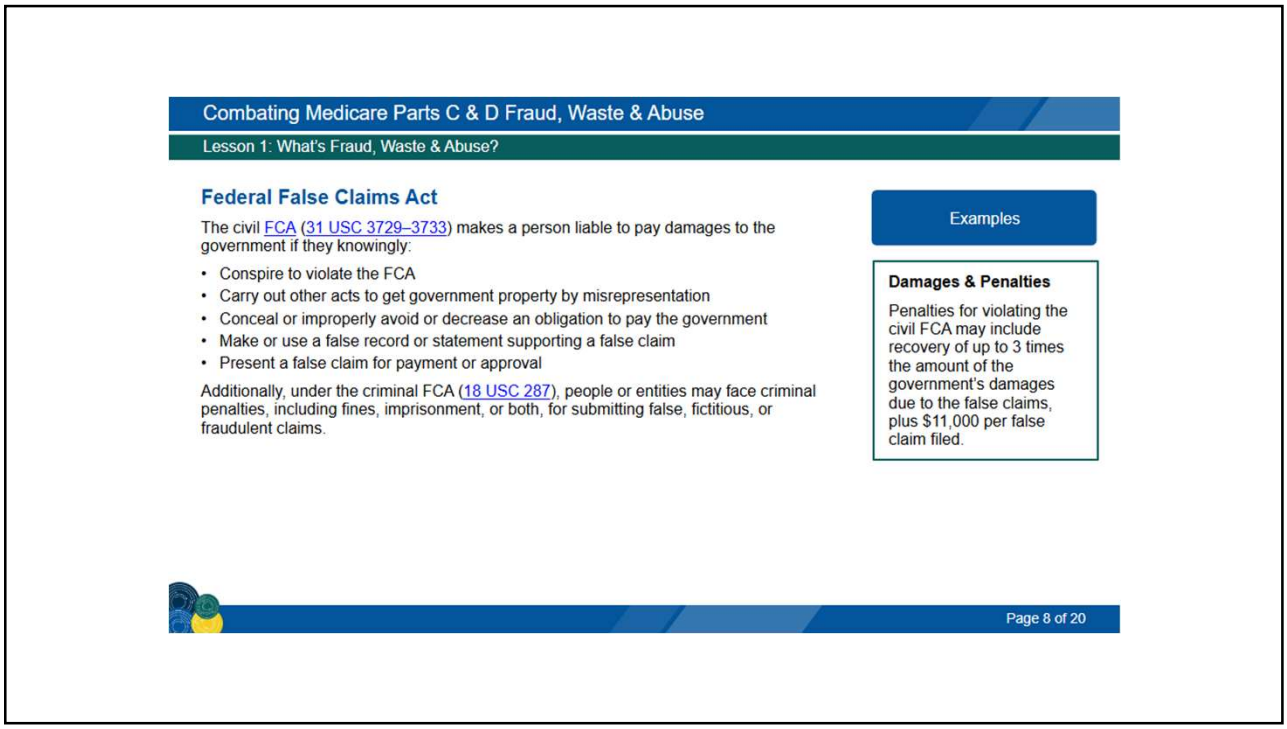
Understanding Fraud, Waste & Abuse

To detect FWA, you need to know the **laws**. The next pages provide high-level information about these laws:

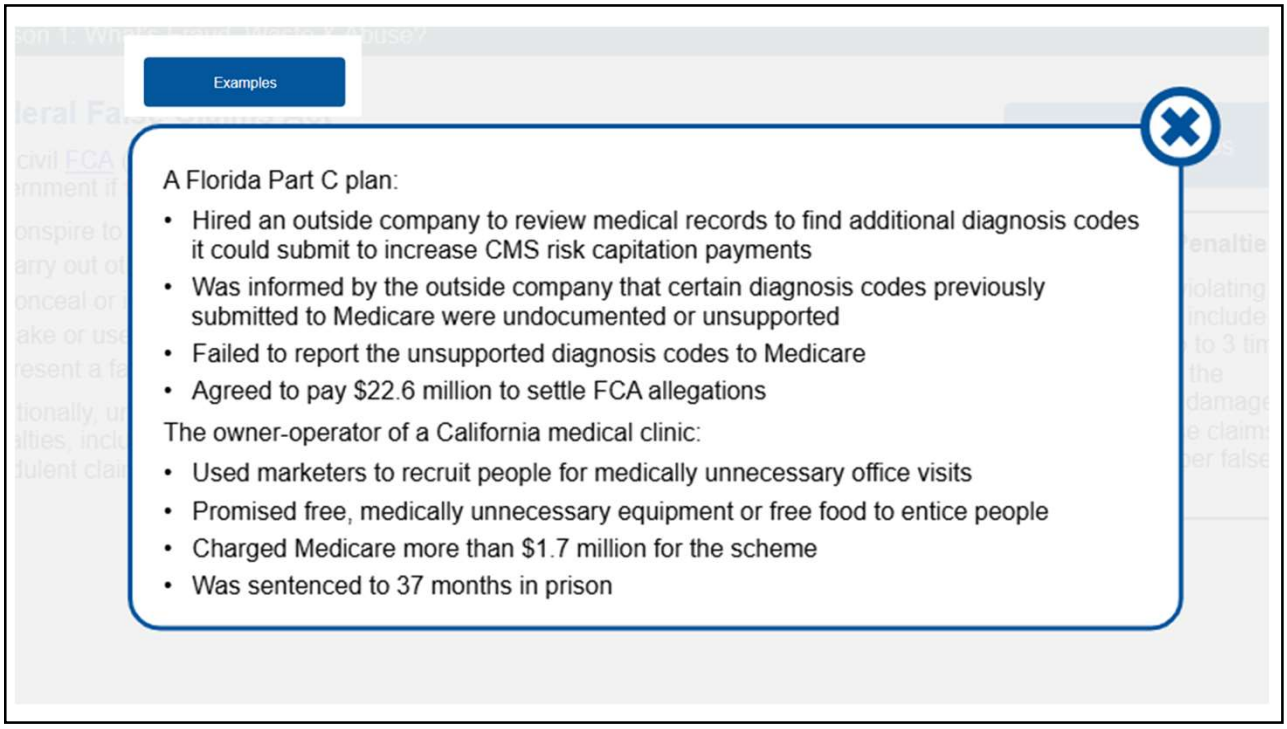
- Federal Civil False Claims Act (FCA)
- Criminal Health Care Fraud Statute
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark law)
- Civil Monetary Penalties Law (CMPL)
- Exclusion Statute
- Health Insurance Portability and Accountability Act (HIPAA)

For details about specific laws, review the applicable statute and regulations.

16


Combating Medicare Parts C & D Fraud, Waste & Abuse
Lesson 1: What's Fraud, Waste & Abuse?
Federal False Claims Act
The civil FCA (31 USC 3729–3733) makes a person liable to pay damages to the government if they knowingly:
• Conspire to violate the FCA
• Carry out other acts to get government property by misrepresentation
• Conceal or improperly avoid or decrease an obligation to pay the government
• Make or use a false record or statement supporting a false claim
• Present a false claim for payment or approval
Additionally, under the criminal FCA (18 USC 287), people or entities may face criminal penalties, including fines, imprisonment, or both, for submitting false, fictitious, or fraudulent claims.
Examples
Damages & Penalties
Penalties for violating the civil FCA may include recovery of up to 3 times the amount of the government's damages due to the false claims, plus $11,000 per false claim filed.
Page 8 of 20

17


Examples
A Florida Part C plan:
• Hired an outside company to review medical records to find additional diagnosis codes it could submit to increase CMS risk capitation payments
• 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
• Agreed to pay $22.6 million to settle FCA allegations
The owner-operator of a California medical clinic:
• Used marketers to recruit people for medically unnecessary office visits
• Promised free, medically unnecessary equipment or free food to entice people
• Charged Medicare more than $1.7 million for the scheme
• Was sentenced to 37 months in prison

18

Federal False Claims Act (continued)

Whistleblower: A person who exposes information or activity that's deemed illegal, is dishonest, or violates professional or clinical standards.

Protected: A person who reports false claims or brings legal actions to recover money paid for false claims is protected from retaliation.

Rewarded: A person who brings a successful whistleblower lawsuit gets at least 15%, but not more than 30%, of the money the government collects.

19

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 USC 1347–1348) makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program.

The statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:

- Defraud any health care benefit program
- Get (by means of false or fraudulent pretenses, representations, or promises) money or property owned or controlled by any health care benefit program

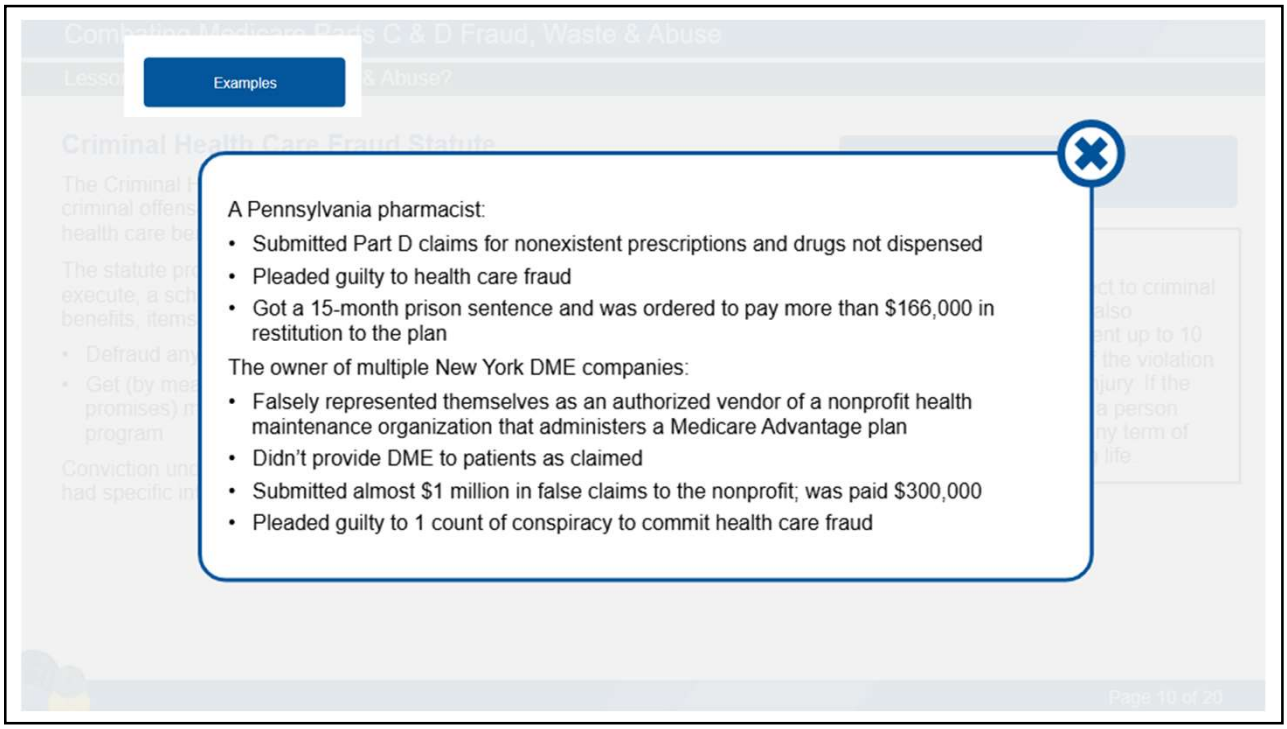
Conviction under the statute doesn't require proof the violator knew the law or had specific intent to violate it.

Examples

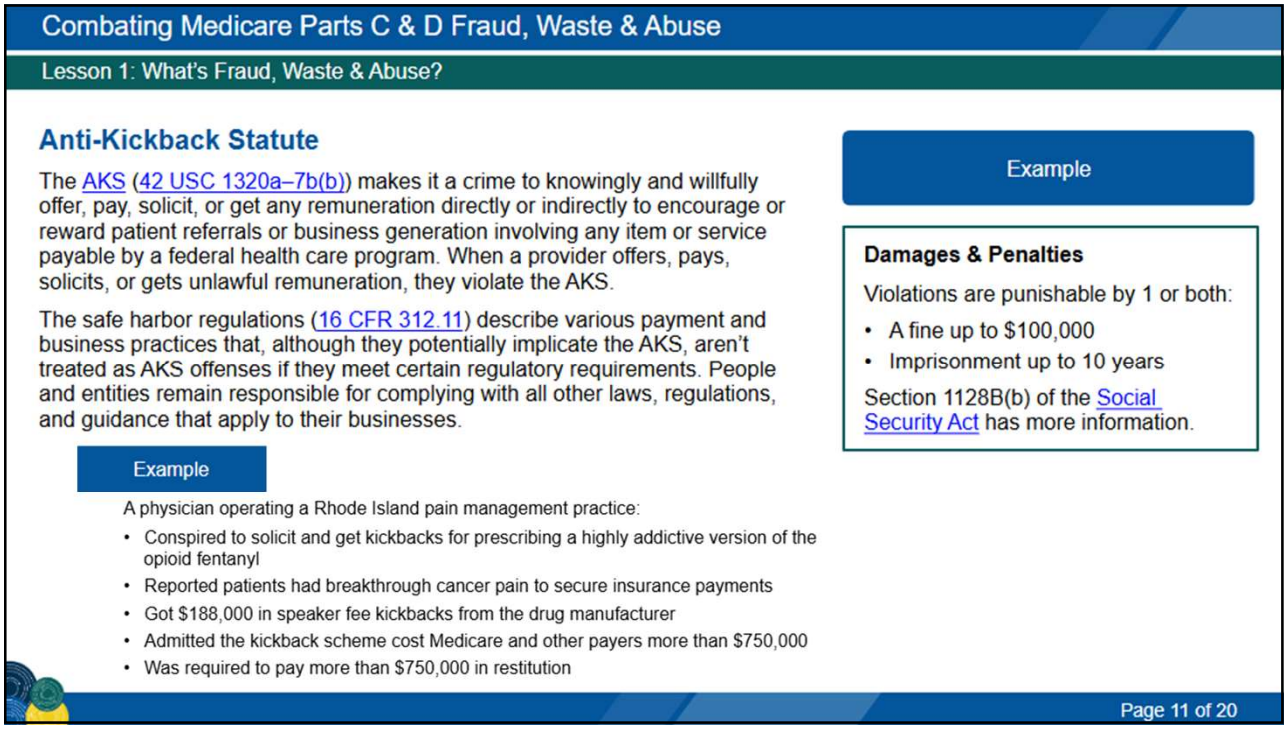
Damages & Penalties

Health care fraud is subject to criminal fines up to $250,000. It's also punishable by imprisonment up to 10 years, or up to 20 years if the violation results in serious bodily injury. If the violation results in death, a person could be imprisoned for any term of years, up to and including life.

20


Examples
A Pennsylvania pharmacist:
• Submitted Part D claims for nonexistent prescriptions and drugs not dispensed
• Pleaded guilty to health care fraud
• Got a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan
The owner of multiple New York DME companies:
• Falsely represented themselves as an authorized vendor of a nonprofit health maintenance organization that administers a Medicare Advantage plan
• Didn't provide DME to patients as claimed
• Submitted almost $1 million in false claims to the nonprofit; was paid $300,000
• Pleaded guilty to 1 count of conspiracy to commit health care fraud

21


Combating Medicare Parts C & D Fraud, Waste & Abuse
Lesson 1: What's Fraud, Waste & Abuse?
Anti-Kickback Statute
The AKS (42 USC 1320a–7b(b)) makes it a crime to knowingly and willfully offer, pay, solicit, or get any remuneration directly or indirectly to encourage or reward patient referrals or business generation involving any item or service payable by a federal health care program. When a provider offers, pays, solicits, or gets unlawful remuneration, they violate the AKS.
The safe harbor regulations (16 CFR 312.11) describe various payment and business practices that, although they potentially implicate the AKS, aren't treated as AKS offenses if they meet certain regulatory requirements. People and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their businesses.
Example
A physician operating a Rhode Island pain management practice:
• Conspired to solicit and get kickbacks for prescribing a highly addictive version of the opioid fentanyl
• Reported patients had breakthrough cancer pain to secure insurance payments
• Got $188,000 in speaker fee kickbacks from the drug manufacturer
• Admitted the kickback scheme cost Medicare and other payers more than $750,000
• Was required to pay more than $750,000 in restitution
Example
Damages & Penalties
Violations are punishable by 1 or both:
• A fine up to $100,000
• Imprisonment up to 10 years
Section 1128B(b) of the Social Security Act has more information.
Page 11 of 20

22

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 1: What's Fraud, Waste & Abuse?

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (42 USC 1395nn), often called the Stark law, prohibits a physician from referring a patient to get designated health services from a provider with whom a physician or a physician's immediate family member has a financial relationship, unless an exception applies.

Designated health services are:

- Clinical lab services
- DME and supplies
- Home health services
- Inpatient and outpatient hospital services
- Outpatient prescription drugs
- Parenteral and enteral nutrients, equipment, and supplies
- Physical therapy, occupational therapy, and outpatient speech-language pathology services
- Prosthetics, orthotics, and prosthetics devices and supplies
- Radiation therapy services and supplies
- Radiology and other imaging services

Example

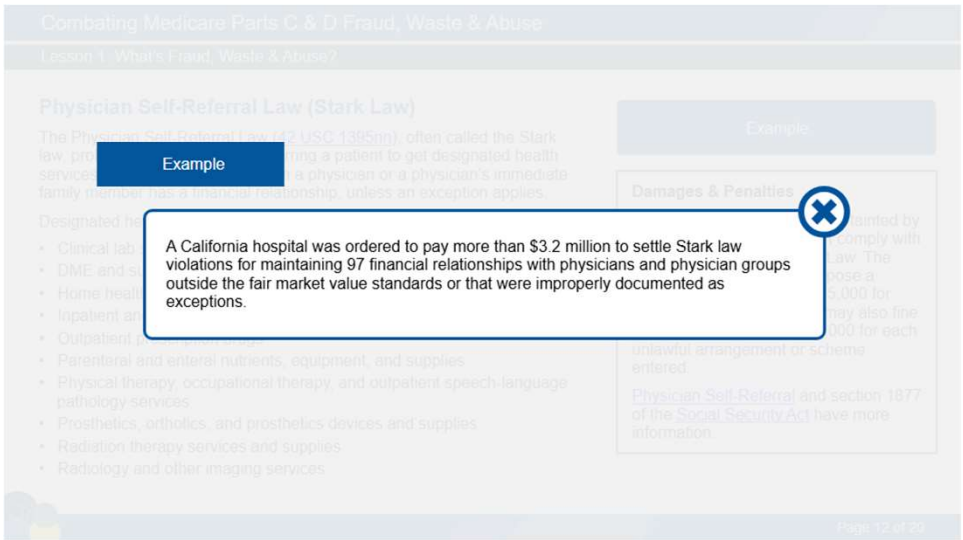
Damages & Penalties

We don't pay Medicare claims tainted by an arrangement that doesn't comply with the Physician Self-Referral Law. The federal government may impose a penalty of not more than $15,000 for each service provided and may also fine people not more than $100,000 for each unlawful arrangement or scheme entered.

Physician Self-Referral and section 1877 of the Social Security Act have more information.

Page 12 of 20

23



24

Civil Monetary Penalties Law

The CMPL (42 USC 1320a–7a) authorizes the Office of Inspector General (OIG) to seek civil monetary penalties (CMPs) and sometimes exclusions for a variety of health care fraud violations. Some violations that may justify CMPs include:

- Arranging for an excluded person's or entity's services or items
- Failing to grant OIG timely records access
- Filing a claim you know, or should know, is for an item or service that wasn't provided as claimed or is false or fraudulent
- Filing a claim you know, or should know, is for an item or service we won't pay for
- Violating the AKS
- Violating Medicare assignment provisions
- Violating the Medicare physician agreement
- Providing false or misleading information expected to influence a discharge decision
- Failing to provide an adequate medical screening exam for patients who come to a hospital emergency department with an emergency medical condition or in labor
- Making false statements or misrepresentations on applications or contracts to participate in federal health care programs

Section 1128A(a) of the Social Security Act has more information.

Example

Damages & Penalties

Penalties and assessments vary based on the type of violation. Penalties can be approximately $10,000–$100,000 per violation. CMPs may also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received.

25

Combating Medicare Parts C & D Fraud, Waste & Abuse
Lesson 1: What's Fraud, Waste & Abuse?
Civil Monetary Penalties Law

Example

A California pharmacy and its owner agreed to pay more than $1.3 million to settle allegations they submitted unsubstantiated Part D claims for brand name prescription drugs the pharmacy couldn't have dispensed based on inventory records.

26

Exclusion Statute

Example

The Exclusion Statute (42 USC 1320a–7) requires that OIG exclude people and entities convicted of these offenses from participating in all federal health care programs:

- Medicare or Medicaid fraud, including offenses related to delivering Medicare or Medicaid items or services
- Patient abuse or neglect
- Felony convictions for other health care fraud or theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescribing, or dispensing of controlled substances

OIG also maintains the List of Excluded Individuals and Entities (LEIE).

The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which enables various federal agencies, including OIG, to take debarment actions (excluding a company or person from doing business with the federal government).

Since the lists aren't the same, when looking for excluded people or entities, check both the LEIE and the EPLS. 42 CFR 1001.1901 has more information.

27

Combating Medicare Parts C & D Fraud, Waste & Abuse
Lesson 1: What's Fraud, Waste & Abuse?
Exclusion Statute
Example

Example

A pharmaceutical company pleaded guilty to 2 felony counts of criminal fraud for not filing required reports with FDA about oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. When the unconvicted executive was excluded, evidence showed he was involved in misconduct, which led to the company's conviction.

28

Health Insurance Portability and Accountability Act

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

HIPAA safeguards deter unauthorized access to protected health care information. As someone with access to protected health care information, you must comply with HIPAA.

Example

Damages & Penalties

Violations may result in CMPs. In some cases, criminal penalties may apply.

Example

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

29

Lesson 1 Summary

There are differences among FWA. One of the primary differences is **intent and knowledge**.

Fraud is knowingly submitting, or causing to be submitted, false claims or misrepresenting facts to get a federal health care payment for which no entitlement would otherwise exist.

Waste and abuse may involve getting an improper payment but not with the same intent and knowledge.

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

- Civil prosecution
- CMPs
- Criminal conviction, fines, or both
- Exclusion from all federal health care program participation
- Imprisonment
- Loss of professional license

30

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 1: What's Fraud, Waste & Abuse?

Review Questions

You've reviewed the differences among FWA. The next pages ask questions to help reinforce this knowledge.

31

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 1: What's Fraud, Waste & Abuse?

Review Question (1 of 2)

Select the correct answer.

Which of these requires intent to get paid and knowledge the actions are wrong?

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

32

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 1: What's Fraud, Waste & Abuse?

Review Question (2 of 2)

Select the correct answer.

Which of these is **NOT** a potential penalty for violating laws or regulations prohibiting fraud, waste, and abuse (FWA)?

- A. Civil monetary penalties (CMPs)
- B. Deportation
- C. Exclusion from participation in all federal health care programs

33

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 1: What's Fraud, Waste & Abuse?

You've completed Lesson 1: What's Fraud, Waste & Abuse?

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

Select Next to return to the Course Menu. Then, select Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse.

34

Lesson 2: Introduction & Learning Objectives

This lesson explains your role in the fight against fraud, waste, and abuse (FWA), including your responsibilities to prevent, report, and correct it. It should take you about 10 minutes to complete.

After completing this lesson, you should be able to identify how to prevent, report, and correct FWA.

35

Where Do I Fit In?

As someone who provides health or administrative services to a Part C or D enrollee, you're likely an employee of a:

- **Sponsor:** Medicare Advantage Organization or Prescription Drug Plan (PDP)
- **First-Tier Entity:** Pharmacy Benefit Manager (PBM); hospital or health care facility; provider group; doctor's office; clinical lab; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents
- **Downstream Entity:** Pharmacies, doctors' offices, firms providing agent or broker services, marketing firms, and call centers
- **Related Entity:** Entity with common ownership or control of a sponsor, or health promotion provider, such as SilverSneakers®

36

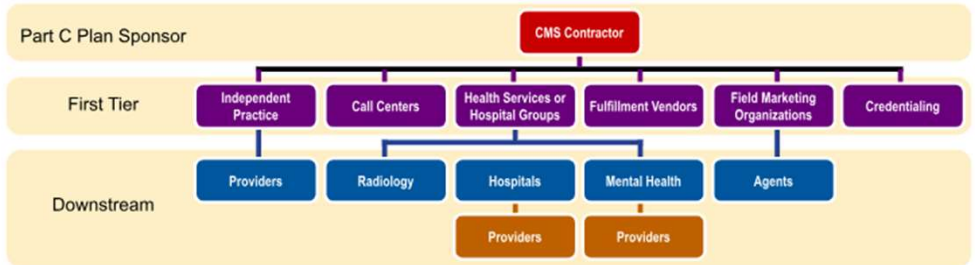
Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse

Where Do I Fit In? (continued)

Text Version

I'm an employee of a Part C Plan Sponsor or their first-tier or downstream entity.



I'm an employee of a Part D Plan Sponsor or their first-tier or downstream entity.

37

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse

What Are My Responsibilities?

You play an important role in preventing, detecting, and reporting potential FWA, as well as Medicare noncompliance.

First, you must comply with all applicable statutory, regulatory, and other Part C or 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 you may know about.

Third, you have a duty to follow your organization's code of conduct that describes your and your organization's commitment to standards of conduct and ethical rules of behavior.

38

How Do I Prevent Fraud, Waste & Abuse?

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance
- Verify all information you get

39

Stay Informed About Policies & Procedures

Know your entity's policies and procedures. Every sponsor and FDR must have FWA policies and procedures that should help you detect, prevent, report, and correct FWA.

Standards of conduct should describe the sponsor's expectations that:

- All employees conduct themselves ethically
- Appropriate mechanisms are in place for anyone to report noncompliance and potential FWA
- Reported issues are addressed and corrected

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

40

Report Fraud, Waste & Abuse

Everyone should report suspected FWA. Your sponsor's code of conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith reporting effort.

Report any potential FWA concerns to your or your sponsor's compliance department. They'll 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 should have a mechanism for reporting potential FWA by employees and FDRs. Sponsors must accept anonymous reports and can't retaliate against you for reporting. Review your organization's materials for how to report FWA.

When in doubt, call your compliance department or FWA hotline.

Reporting Fraud, Waste & Abuse Outside Your Organization

Where to Report FWA

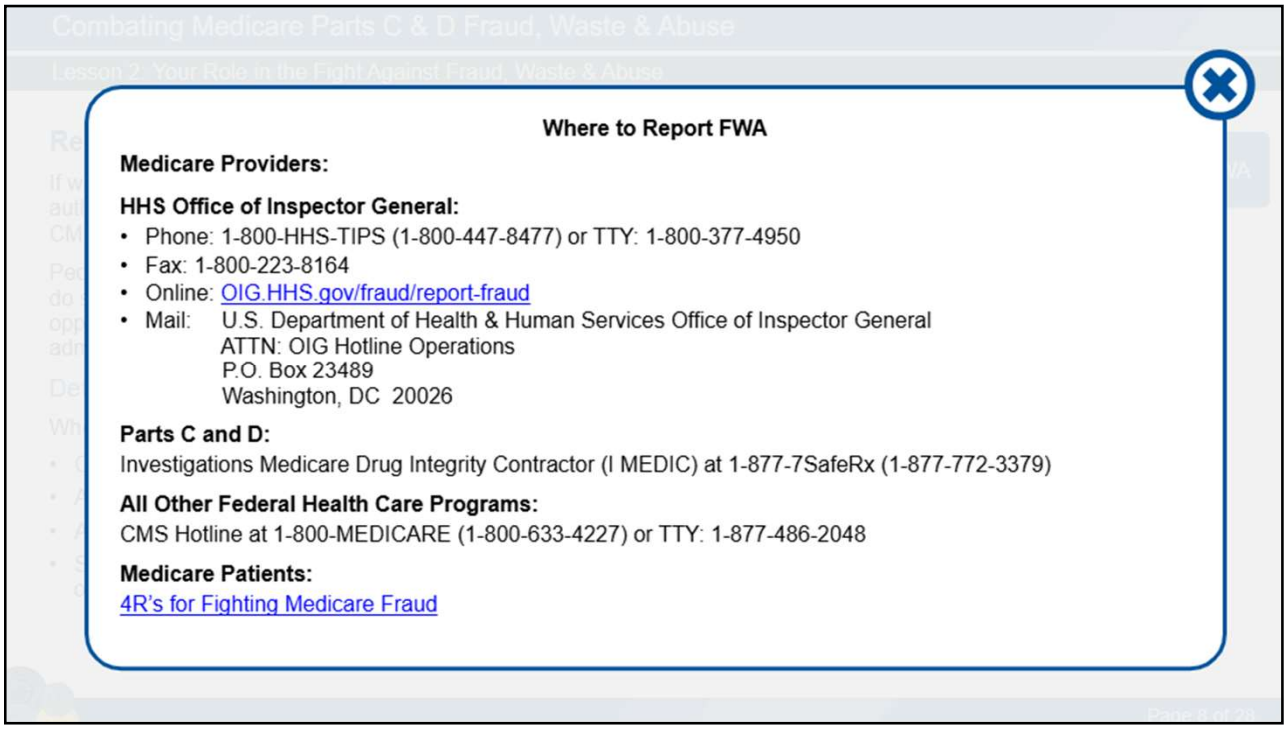
If warranted, sponsors and FDRs must report potentially fraudulent conduct to government authorities, like the Office of Inspector General (OIG), the Department of Justice (DOJ), or CMS.

People 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 costs and disruptions of a government-directed investigation and civil or administrative litigation.

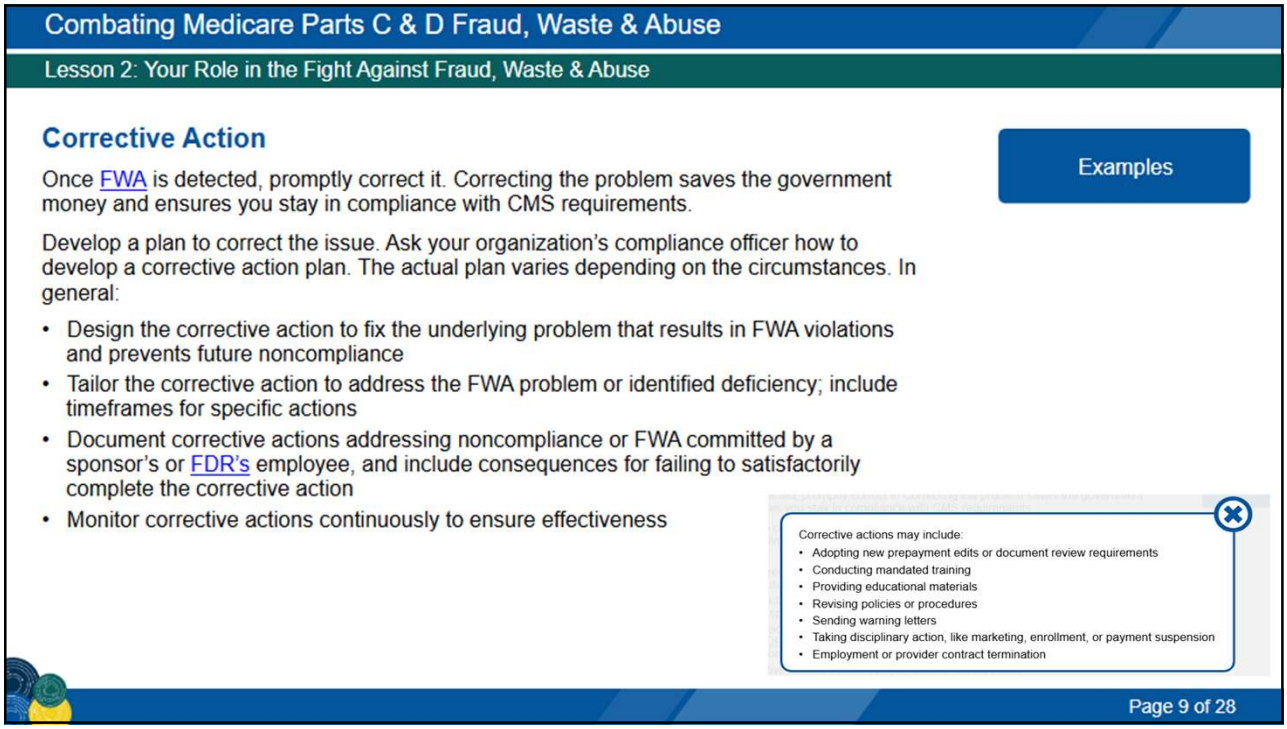
Details to Include When Reporting Fraud, Waste & Abuse

When reporting suspected FWA, include the:

- Contact information for the source, suspects, and witnesses
- Alleged FWA details
- Alleged Medicare rules violated
- Suspect's history of compliance, education, training, and communication with your organization or other entities


Where to Report FWA
Medicare Providers:
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
• Online: OIG.HHS.gov/fraud/report-fraud
• Mail: U.S. Department of Health & Human Services Office of Inspector General
ATTN: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026
Parts C and D:
Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)
All Other Federal Health Care Programs:
CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048
Medicare Patients:
4R's for Fighting Medicare Fraud

43


Combating Medicare Parts C & D Fraud, Waste & Abuse
Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse
Corrective Action
Once FWA is detected, promptly correct it. Correcting the problem saves the government money and ensures you stay in compliance with CMS requirements.
Develop a plan to correct the issue. Ask your organization's compliance officer how to develop a corrective action plan. The actual plan varies depending on the circumstances. In general:
• Design the corrective action to fix the underlying problem that results in FWA violations and prevents future noncompliance
• Tailor the corrective action to address the FWA problem or identified deficiency; include timeframes for specific actions
• Document corrective actions addressing noncompliance or FWA committed by a sponsor's or FDR's employee, and include consequences for failing to satisfactorily complete the corrective action
• Monitor corrective actions continuously to ensure effectiveness
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, like marketing, enrollment, or payment suspension
• Employment or provider contract termination
Page 9 of 28

44

Potential Fraud, Waste & Abuse Indicators

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 next pages present potential FWA issues. 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 delivering Parts C and D enrollee benefits.

Each page also includes a real-world example of FWA. Consider the example provided and how you might mitigate these situations.

45

Real-World Example: Potential Patient Issues

Patient: I'm calling to ask why I was billed for 5 urine pregnancy tests last month.

Lab: That seems a little high, but these types of tests are routine for women of a certain age.

Patient: I'm sure that's true, but I'm a 75-year-old man so I'm not sure it was necessary.

Lab: Oh my, that's suspicious. Let's investigate who billed these codes and make sure we report this for further investigation. It's possible your MBI has been compromised or a provider made a billing mistake.

Many plan sponsors provide detailed websites and consumer materials to help guide their patients on how to look for signs of identity theft and provide directions on what to do if they believe their medical identity has been compromised, which is likely in the scenario above.

46

Key Indicators: Potential Patient Issues

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

47

Real-World Example: Potential Provider Issues

In January 2024, Noridian Healthcare Solutions released a letter to clinicians advising them on the importance of indicating the administration method of insulin on prescriptions. Part B covers insulin provided through a non-disposable infusion pump. Part D covers insulin provided through a syringe or a disposable pump. Noridian's letter emphasized the importance of documenting this distinction to avoid improper billing to the incorrect payer.

48

Key Indicators: Potential Provider Issues

- Are the provider's prescriptions appropriate for the patient'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 controlled substances?
- Does the provider perform medically unnecessary patient services?
- Does the provider prescribe a higher quantity than medically necessary for the condition?
- Does the provider's prescription include their active and valid NPI?
- Is the provider's patient diagnosis supported in the medical record?

Real-World Example: Potential Pharmacy Issues

Several DOJ investigations identified pharmacies double billing for drugs dispensed in a single-use vial. These pharmacists were found to pool the remaining drug from partially used vials to use on a new patient or billing for 1 single-use vial as 2 separate vials. Some of these pharmacies also admitted to selling counterfeit or misbranded drugs. Whistleblowers in these pharmacies helped identify this fraudulent activity.

Key Indicators: Potential Pharmacy Issues

- Are drugs meant for nursing homes, hospices, and other entities being diverted somewhere else?
- Are dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires dispensing brand drugs?
- Are PBMs billed for unfilled or never-picked-up prescriptions?
- Are proper provisions made if the entire prescription isn't filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or "dispense as written")?
- Are eligibility facilitation services and their information being used for purposes other than determining patient eligibility?

Real-World Example: Potential Wholesaler Issues

In October 2023, industry trade group Pharmaceutical Cargo Security Coalition issued an alert warning its members that FDA is investigating trafficking schemes of counterfeit versions of weight loss drugs (Ozempic, Mounjaro, etc.) into U.S. pharmacies. FDA also found high rates of "no delivery schemes" where the purchaser made payment but never got the product from the wholesaler.

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, or HIV/AIDS clinics; marking up prices; and sending to other smaller wholesalers or pharmacies?

53

Real-World Example: Potential Manufacturer Issues

Most of Medicare's highest-priced drugs have been granted at least 1 orphan drug designation, qualifying their manufacturers for Orphan Drug Act financial incentives. This led to concerns of manufacturers benefiting from the financial incentives of the Orphan Drug Program.

54

Key Indicators: Potential Manufacturer Issues

- Does the manufacturer promote off-label drug use?
- Does the manufacturer knowingly provide samples to entities that then bill federal health care programs for them?

55

Real-World Example: Potential Sponsor Issues

Several plan sponsors were identified as using kickbacks to encourage patients to select their plan. In a recent case, agents were paid $200 for each patient they successfully referred to a subsidiary of a Medicare Advantage plan. This kickback disincentivized the agent from selecting the plan that was the best fit for the patient.

Report concerns related to sponsors violating the Anti-Kickback Statute to CMS.

56

Key Indicators: Potential Sponsor Issues

- Does the sponsor encourage or support submitting inappropriate diagnoses for risk adjustments?
- Does the sponsor lead patients to believe the benefits cost a certain price when the actual cost is higher?
- Does the sponsor offer patients cash incentives to join the plan?
- Does the sponsor use unlicensed agents?

57

Lesson 2 Summary

As someone providing health or administrative services to a Part C or D enrollee, you play an important part in preventing FWA. Conduct yourself ethically, stay informed of your organization's policies and procedures, and be aware of potential FWA indicators.

Report potential FWA. Every sponsor must have a mechanism to report potential FWA. Sponsors must accept anonymous reports and can't retaliate against you for reporting.

Promptly correct identified FWA with an effective corrective action plan.

58

Lesson 2 Review

You've reviewed the role you play in the fight against FWA, including your responsibilities to prevent, report, and correct it. The next pages ask questions to help reinforce this knowledge.

59

Review Question (1 of 3)

Select the correct answer.

A person drops off a prescription for a patient who's a regular pharmacy customer. The prescription is for a controlled substance with a quantity of 160. This patient normally gets a quantity of 60, not 160. You review the prescription and have concerns about possible forgery. What's your next step?

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

60

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse

Review Question (2 of 3)

Select the correct answer.

You're responsible for submitting a risk diagnosis to CMS for payment purposes. You use a specific process to verify the data is accurate. Your immediate supervisor tells you to ignore the process and adjust or add risk diagnosis codes for certain people. What should you do?

- A. Do what your immediate supervisor asked and adjust or add risk diagnosis codes
- B. Report the incident to your compliance department (via compliance hotline or other mechanism)
- C. Discuss your concerns with your immediate supervisor
- D. Call law enforcement

61

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse

Review Question (3 of 3)

Select the correct answer.

You're responsible for paying provider claims. You notice a certain diagnostic provider (Doe Diagnostics) requested substantial payment for a large patient group. Many claims are for a specific procedure. You review the same procedure type for other diagnostic providers and realize Doe Diagnostics' claims far exceed any other provider you reviewed. What should you do?

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

62

Combating Medicare Parts C & D Fraud, Waste & Abuse

Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse

You've completed Lesson 2: Your Role in the Fight Against Fraud, Waste & Abuse

Now that you've reviewed common problems that plans encounter and how you can help address them, it's time to test your knowledge. Select Next to return to the Course Menu. Then, select Test.

Page 28 of 28

63

Combating Medicare Parts C & D Fraud, Waste & Abuse

Test

Test

This test asks 10 questions and may take you about 15 minutes to complete.

You can change your answer until you select Submit. After you select Submit, select Continue. Once you select Continue, you can't exit and save your progress.

After successfully completing the course, you'll get instructions on how to get a certificate. Score 70% or higher to successfully complete this course.

64

Question 1 of 10

Select the correct answer.

After a corrective action plan is started, you must monitor the corrective actions annually to ensure they're effective.

- ○ A. True
- ◉ B. False

Question 2 of 10

Select the best answer.

Ways to report potential fraud, waste, and abuse (FWA) include:

- ○ A. Phone hotlines
- ○ B. Mail drops
- ○ C. In-person reporting to compliance department or supervisor
- ○ D. Special Investigations Units (SIUs)
- ◉ E. All the above

65

Question 3 of 10

Select the correct answer.

Any person who knowingly submits false claims to the government is liable for 5 times the government's damages caused by the violator plus a penalty.

- ○ A. True
- ◉ B. False

Question 4 of 10

Select the correct answer.

These are examples of issues that should be reported to a compliance department: suspected fraud, waste, and abuse (FWA); potential health privacy violation; unethical behavior; and employee misconduct.

- ◉ A. True
- ○ B. False

Question 5 of 10

Select the correct answer.

Bribes or kickbacks of any kind for services paid under a federal health care program (which includes Medicare) constitute fraud by the person making as well as the person getting them.

- ◉ A. True
- ○ B. False

66

Question 6 of 10

Select the correct answer.

Waste includes any misuse of resources, like overusing services or other practices that, directly or indirectly, result in unnecessary Medicare Program costs.

- (●) A. True
- ( ) B. False

Question 7 of 10

Select the correct answer.

Abuse involves payment for items or services when there's no legal entitlement to that payment and the provider hasn't knowingly or intentionally misrepresented facts to get paid.

- (●) A. True
- ( ) B. False

Question 8 of 10

Select the correct answer.

Some of the laws governing Parts C and D fraud, waste, and abuse (FWA) include the Health Insurance Portability and Accountability Act (HIPAA), the federal False Claims Act (FCA), the Anti-Kickback Statute (AKS), and the Criminal Health Care Fraud Statute.

- (●) A. True
- ( ) B. False

67

Question 9 of 10

Select the correct answer.

You can help prevent fraud, waste, and abuse (FWA) by doing all these:

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure you coordinate with other payers
- Stay current with FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance
- Verify all information provided to you

- (●) A. True
- ( ) B. False

Question 10 of 10

Select the best answer.

What are some penalties for violating fraud, waste, and abuse (FWA) laws?

- ( ) A. Civil monetary penalties (CMPs)
- ( ) B. Imprisonment
- ( ) C. Exclusion from participating in all federal health care programs
- (●) D. All the above

68