CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Parts C & D
Fraud, Waste, and Abuse Training

Developed by the Centers for Medicare & Medicaid Services and modified for Optima employees by the Compliance Department

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Important Notice

All persons who provide health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements.

Why Do I Need Training?

Every year *millions* of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

Including YOU.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

YOU are part of the solution.

Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse
- Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
- Provide information on how to report fraud, waste, and abuse
- Provide information on laws pertaining to fraud, waste, and abuse

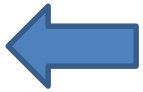
Requirements

The Social Security Act and CMS regulations and guidance govern the Medicare program, including parts C and D.

- Part C and Part D sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
- Optima Health must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Where Do I Fit In?

As a person who provides health or administrative services to a Part C or Part D enrollee you are either:

- Part C or D Sponsor Employee  *Optima Employees*
- First Tier Entity
  - Examples: PBM, a Claims Processing Company, contracted Sales Agent
- Downstream Entity
  - Example: Pharmacy
- Related Entity
  - Example: Entity that has a common ownership or control of a Part C/D Sponsor

What are my responsibilities?

You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Part C or Part D requirements, including adopting and implementing an effective compliance program.
- **SECOND** you have a duty to the Medicare Program to report any violations of laws that you may be aware of.
- **THIRD** you have a duty to follow the Optima Health Code of Compliance that articulates you and your organization's commitment to standards of conduct and ethical rules of behavior.

An Effective Compliance Program

- Is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste and abuse.
- Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)
- See WaveNet for more information on the Optima Health Compliance Program

Prevention

Employee Responsibilities

- It is essential that all employees of Optima Health understand what fraud and abuse is, how to detect it and how to assist members, providers, and other customers who may be reporting suspicious activities.
- Optima Health has measures in place to prevent, detect and investigate all forms of insurance fraud, including fraud involving employees or agents; fraud resulting from misrepresentations in the application, renewal or rating of insurance policies and claims fraud.
- Employees of Optima Health are all responsible for the detection and prevention of fraud, waste, and abuse. Each employee should become familiar with these types of improprieties and be alert for any irregularities.

Policies and Procedures

Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Make sure you are familiar with the Optima policies and procedures.

Detection

Understanding Fraud, Waste and Abuse

In order to detect fraud, waste, and abuse you need to know the **Law**

Criminal FRAUD

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.

18 United States Code §1347

What Does That Mean?

Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse

Waste: overutilization of 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 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.

Differences Between Fraud, Waste, and Abuse

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

Report Fraud, Waste, and Abuse

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to the your supervisor/manager, the Fraud and Abuse Hotline or the SIU department . The Optima SIU will investigate and make the proper determination.

Indicators of Potential Fraud, Waste, and Abuse

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your role as a sponsor, pharmacy, or other entity involved in the Part C and/or Part D programs.

Key Indicators: Potential Beneficiary Issues

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

Key Indicators: Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?

Key Indicators: Potential Provider Issues

- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill the sponsor for services not provided?

Key Indicators: Potential Pharmacy Issues

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Are generics provided when the prescription requires that brand be dispensed?

Key Indicators: Potential Pharmacy Issues

- Are Pharmacies being billed for prescriptions that are not filled or picked up?
- Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?

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 AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to 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 Optima offer cash inducements for beneficiaries to join the plan?
- Does Optima lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?
- Does Optima use unlicensed agents?
- Does Optima encourage/support inappropriate risk adjustment submissions?

How Do I Report Fraud, Waste, or Abuse?

Reporting Fraud, Waste, and Abuse

Everyone is required to report suspected instances of fraud, waste, and Abuse. The Optima Health Code of Compliance should clearly state this obligation. Optima Health may not retaliate against you for making a good faith effort in reporting.

Reporting Fraud, Waste, and Abuse

Every MA-PD and PDP sponsor is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities. Each sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting. Review Optima Health materials for the ways to report fraud, waste, and abuse.

When in doubt, call the Optima Health Compliance Hotline, email or call the SIU department.

Correction

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.

How Do I Correct Issues?

Once issues have been identified, a plan to correct the issue needs to be developed. Consult your manager or compliance department to find out the process for the corrective action plan development.

The actual plan is going to vary, depending on the specific circumstances.

Laws You Need to Know About

Laws

The following slides provide very high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

Civil Fraud
Civil False Claims Act

Prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it's true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733

Civil False Claims Act Damages and Penalties

The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

Criminal Fraud Penalties

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

18 United States Code §1347

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 (which includes the Medicare program).

42 United States Code §1320a-7b(b)

Anti-Kickback Statute Penalties

Fine of up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment.

Stark Statute (Physician Self-Referral Law)

Stark Law deals with referrals for the provisions of health care services. If a physician or an immediate family member has a financial relationship with an entity, the physician may not refer to the entity for health services where compensation may be made. This is to prevent physicians from making a financial gain and/or overutilization of services.

Social Security Act, 1877

42 United States Code §1395nn

Stark Statute Damages and Penalties

Up to a **$15,000** fine for each service provided.

Up to **a $100,000** fine for entering into an arrangement or scheme.

Deficit Reduction Act (DRA)

- DRA requires compliance for continued participation in the Medicare and Medicaid programs.
- The law requires:
  - the development of policies and education relating to false claims,
  - whistleblower protections and
  - procedures for detecting and preventing fraud, waste, and abuse.

Public Law No. 109-171

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 Office of Inspector General.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

Whistleblower Protection Act

- Whistleblower Protection Act states that a company is prohibited from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee because of lawful acts done by the employee on behalf of the employer or because the employee testifies or assists in an investigation of the employer.
- The FCA also includes the “qui tam” provision, which allows persons to sue those who defraud the government. Persons would be eligible to receive a percentage of recoveries from the defendant. The Whistleblower Act protects a person when they file a qui tam claim.

31 U.S.C. 3730 (h)

HIPAA

Health Insurance Portability and Accountability Act of 1996

Purpose: Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

45 CFR, Sections 160 & 164 (P.L. 104-191)

Consequences

Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs

Employee FWA Reporting

- Reports to the Optima Health Compliance Hotline may be made without fear of intimidation, coercion, threats, retaliation or discrimination.
- Employees may contact their immediate supervisor, or call the Compliance Hotline to file a complaint. The Hotline is available 24 hours a day. The Hotline number is 1-866-826-5277 or 757-687-6326. All hotline calls may remain anonymous.
- Employees may report suspicious claims activity to the Special Investigations Unit via Internal Service Form, or direct contact with the unit.
- Employees may also report via the SIU Compliance e-mail at any time. The Compliance e-mail is Compliancealert@sentara.com.