

2024 Combating Medicare Parts C and D Fraud, Waste, and Abuse

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

Certain training requirements apply to people involved in performing or delivering the Medicare Parts C and D benefits. All employees and board members of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) must receive training about compliance with CMS program rules.

Acronyms	
CFR	Code of Federal Regulations
CMS	Center for Medicare & Medicaid Services
FDR	First-tier, Downstream, and Related Entity
FWA	Fraud, Waste, and Abuse
HHS	US Dept of Health & Human Services
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MA-PD	MA Prescription Drug
OIG	Office of Inspector General
PDP	Prescription Drug Plan

Course Objectives

- ✓ 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
- ✓ Recognize how to correct FWA

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 up to 10 years. It is also subject to criminal fines up to \$250,000 for individuals and \$500,000 for a corporation.

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 practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. 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 paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

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 the patient failed to keep
- Billing for nonexistent prescriptions
- 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 treating a specific condition
- Ordering excessive laboratory tests

Examples of actions that may constitute Medicare abuse include:

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly 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 the actions are wrong.

Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.

Understanding FWA

To detect FWA, you need to know the law.

The following pages 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 from all Federal health care programs
- Health Insurance Portability and Accountability Act (HIPAA)

For details about 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
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

For more information, refer to 31 United States Code (USC) Sections 3729–3733.

Example: A Medicare Part C plan in Florida hired an outside company to review medical records to find additional diagnosis codes it could submit to increase risk capitation payments from CMS. The plan was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported. The plan failed to report the unsupported diagnosis codes to Medicare. Ultimately, the plan agreed to pay \$22.6 million to settle FCA allegations.

Civil FCA, cont.

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, “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program ... shall be fined under this title or imprisoned not more than 10 years, or both.”

Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law.

For more information, refer to 18 USC Sections 1346–1347.

Example: A Pennsylvania pharmacist submitted claims to a Medicare Part D plan for non-existent prescriptions and drugs not dispensed. The pharmacist 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.

Criminal Health Care Fraud



For more information, refer to 18 USC Section 1347.

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).

Example: From 2012 through 2015, a physician operating a pain management practice in Rhode Island conspired to solicit and receive kickbacks for prescribing a highly addictive version of the opioid Fentanyl. Reported patients had breakthrough cancer pain to secure insurance payments. The physician received \$188,000 in speaker fee kickbacks from the drug manufacturer and admitted the kickback scheme cost Medicare and other payers more than \$750,000. The physician must pay more than \$750,000 restitution and is awaiting sentencing.

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 may apply. For more information, refer to 42 USC Section 1395nn.

Example: A California hospital was ordered to pay more than \$3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician groups outside the fair market value standards or that were improperly documented as exceptions.

Civil Money Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for several 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 and failing to report and return an overpayment
- Making false claims
- Paying to influence referrals

Example

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

Damages and Penalties

- The penalties can be around \$15,000 to \$70,000 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).

The U.S. 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 on the System for Award Management (SAM) website.

When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same. For more information, refer to 42 USC Section 1320a-7 and 42 Code of Federal Regulations (CFR) Section 1001.1901.

Example: A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the U.S. Food and Drug Administration concerning oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. At the time the unconvicted executive was excluded, 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, strengthened the protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards deter 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 www.hhs.gov/hipaa

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.

Lesson 1 Summary

THERE ARE DIFFERENCES AMONG FRAUD, WASTE, AND ABUSE (FWA).

- One of the primary differences is intent and knowledge. Fraud requires the person have intent to obtain payment and the knowledge his or her actions are wrong.
- Waste and abuse may involve obtaining an improper payment but not 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, or both
- Exclusion from all Federal health care program participation
- Imprisonment
- Loss of professional license

Knowledge Check

Which of the following is NOT potentially a penalty for violation of a law or regulation prohibiting fraud, waste, and abuse (FWA)?

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

The correct answer is B.

Knowledge Check

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

- A. Fraud
- B. Abuse
- C. Waste

The correct answer is A.

Lesson 2: Your Role in the Fight Against FWA

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 correctly:

- Identify methods of preventing FWA
- Identify how to report FWA
- Recognize how to correct FWA

Where Do I Fit In?

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

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

Where Do I Fit In, cont.?

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

The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. First-tier and related entities of the Medicare Part C Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Examples of first-tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations.

Where Do I Fit In, cont.?

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

The Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. First-tier and related entities of the Part D Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Examples of first-tier entities include call centers, PBMs, and field marketing organizations.

What Are Your Responsibilities?

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

- **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 of which you may be aware.
- **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 and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS' guidance
- Verify all received information

Stay Informed About Policies and Procedures

Know your entity's policies and procedures.

Every Sponsor and First-Tier, Downstream, and 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 noncompliance and potential FWA
- Reported issues will be addressed and corrected

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

The United Health Group Code of Conduct and KCA Compliance policies can be accessed at:

<https://www.kelseycareadvantage.com/medicare-compliance/compliance-and-fraud>

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.

Report any potential FWA concerns you have to your compliance department or your Sponsor's compliance department. Your Sponsor's compliance department 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.

If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), 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).

Reporting FWA Outside Your Organization

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: Forms.OIG.hhs.gov/hotlineoperations/index.aspx

For Medicare Parts C and D:

Investigations Medicare Drug Integrity Contractor (I 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

Medicare beneficiary website: [Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/help-fight-medicare-fraud](https://www.Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/help-fight-medicare-fraud)

Correction

Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with CMS requirements.

Develop a plan to correct the issue. Ask your organization's compliance officer about the development process for the corrective action plan. 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 noncompliance.
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions.
- Document corrective actions addressing noncompliance or FWA committed by a Sponsor's employee or FDR's employee and include consequences for failure to satisfactorily complete the corrective action.
- Monitor corrective actions continuously to ensure effectiveness.

Corrective actions may include:

- Adopting new prepayment edits or document review requirements
- Conducting mandated training
- Providing educational materials

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 slides present potential FWA issues. Each slide 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 Medicare Parts C and D benefits to enrollees.

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 beneficiary (identity theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

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?
- Does the provider's prescription have their active and valid National Provider Identifier on it?
- Is the provider's diagnosis for the member supported in the medical record?

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 dispensing brand drugs?
- Are PBMs billed for unfilled or never picked up prescriptions?
- Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?

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, marking up the prices, and sending to other smaller wholesalers or pharmacies?

Potential Manufacturer Issues

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

Potential Sponsor Issues

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

Summary

- As a person providing health or administrative services to a Medicare Part C or D enrollee, you play a vital role in preventing fraud, waste, and abuse (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 accept anonymous reports and cannot retaliate against you for reporting.
- Promptly correct identified FWA with an effective corrective action plan.

Now that you completed Lesson 2, let's do a quick knowledge check.

Knowledge Check

A person drops 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?

- 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

The correct answer is C.

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 use a process to verify the data are accurate. Your immediate supervisor tells you to ignore the Sponsor's process and to adjust or add risk diagnosis codes for certain individuals.

What should you do?

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

The correct answer is B.

Knowledge Check

You oversee paying claims submitted by providers. You notice a certain diagnostic provider (“Doe Diagnostics”) requested a substantial payment for many members. Many of these claims are for a certain procedure. You review the same type of procedure 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 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)
- C. Reject the claims
- D. Pay the claims

The correct answer is B.

Additional Resources

For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:

Anti-Kickback Statute [42 USC Section 1320a-7b\(b\)](#)

Civil False Claims Act [31 USC Sections 3729–3733](#)

Civil Monetary Penalties Law [42 USC Section 1320a-7a](#)

Criminal False Claims Act [18 USC Section 287](#)

Exclusion [42 USC Section 1320a-7](#)

Criminal Health Care Fraud Statute [18 USC Section 1347](#)

Physician Self-Referral Law [42 USC Section 1395nn](#)

Summary

Thank you for completing the *“2024 Combating Medicare Parts C and D Fraud, Waste, and Abuse Training.”*

Should you have any questions, please contact the Medicare Compliance Officer, Thomas Wilson. She can be reached at: Shelly.Garcia@kelsey-seybold.com or directly by calling (713) 442-9502.

Please submit your completed attestation that accompanies this training to: Shelly.Garcia@kelsey-seybold.com or mail:

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Compliance Department
11511 Shadow Creek Parkway
Pearland, Texas 77584

The United Health Group Code of Conduct and KCA Compliance policies can be accessed at: <https://www.kelseycareadvantage.com/medicare-compliance/compliance-and-fraud>