Fraud, Waste, and Abuse and HIPAA Training

Part 1 and 2

Why Do I Need Training?

Every year ***billions*** of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – **including you.**

This training will help you detect, correct, and prevent FWA.

You are part of the solution.

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

Training Requirements For:

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 course as “Sponsors”) must receive training for preventing, detecting, and correcting FWA.

Course Content

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

Anyone providing health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements.

Course Objectives

When you complete this training, you should 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
- 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.

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

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.

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 Fraud

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
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

Examples of Waste

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 Abuse

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).

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

Civil False Claims Act (FCA) - Continued

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.

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
- 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

Civil False Claims Act (FCA) - Continued

Example:

The owner-operator of a medical clinic in California:

- Used marketers to recruit individuals for medically unnecessary office visits
- Promised free, medically unnecessary equipment or free food to entice individuals
- Charged Medicare more than $1.7 million for the scheme
- Was sentenced to 37 months in prison

Civil False Claims Act (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.

Health Care Fraud Statute

EXAMPLE

A Pennsylvania pharmacist:

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

Health Care Fraud Statute

EXAMPLE

The owner of multiple Durable Medical Equipment (DME) companies in New York:

- Falsely represented themselves as one of a nonprofit health maintenance organization's (that administered a Medicare Advantage plan) authorized vendors
- Provided no DME to any beneficiaries as claimed
- Submitted almost $1 million in false claims to the nonprofit; $300,000 was paid
- Pleaded guilty to one count of conspiracy to commit health care fraud

Criminal Health Care Fraud

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

- Criminal fines up to $250,000
- Imprisonment for up to 20 years

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

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).

Anti-Kickback Statute
(continued)

Damages and Penalties

Violations are punishable by:

- A fine of up to $25,000
- Imprisonment for up to 5 years

Anti-Kickback Statute (continued)

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
- Received $188,000 in speaker fee kickbacks from the drug manufacturer
- 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 (DHS)*** to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest or
- A compensation arrangement

Stark Statute

(Physician Self-Referral Law) (continued)

The DHS categories defined by the Code List are:

- Clinical laboratory services
- Physical Therapy services, Occupational Therapy services, Outpatient Speech-language pathology services
- Radiology services, including MRI's, Cat Scans and Ultrasounds
- Radiation Therapy services and supplies
- Durable Medical Equipment and supplies
- Parenteral and Enteral nutrients, equipment and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home Health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services.

Stark Statute

(Physician Self-Referral law) (continued)

Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around **$24,250** can be imposed for each service provided. There may also be around a **$161,000** fine for entering into an unlawful arrangement or scheme.

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 Monetary Penalties (CMP) 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 and failing to report and return an overpayment
- Making false claims
- Paying to influence referrals

Civil Monetary Penalties (CMP) Law (continued)

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 remunerations offered, paid, solicited or received

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.

Exclusion

Office of Inspector General (OIG)

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).

Access the LEIE at https://exclusions.oig.hhs.gov

General Services Administration (GSA)

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.

Access the EPLS at https://www.sam.gov

Exclusion (continued)

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 the HIPAA webpage on the internet.
https://www.hhs.gov/hipaa

Health Insurance Portability and Accountability Act (HIPAA)

Damages and Penalties

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

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.

Basic HIPAA Privacy Rule

The **HIPAA** Privacy Rule consist of standards to protect the privacy of individually identifiable health information.

The Privacy Rule regulates how covered entities, *use* and *disclose* individually identifiable health information, called *Protected Health Information (PHI).*

PHI protects most "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or medium, whether electronic, on paper, or oral. However, excludes certain educational records and employment records.

HIPAA Communication Methods

HIPAA applies to PHI in ALL forms of communication, whether electronic, written or oral.

This means that HIPAA applies to:

- Face to face interactions
- Telephone conversations
- Faxed or scanned documents
- Printed materials and documents
- E-mail and other internet based communications

What is Considered PHI?

- Names, Addresses
- All elements of dates directly related to an individual, including birth date, admission date, discharge date, date of death
- Telephone or Fax number
- E-Mail Address
- Medical Record Number
- Health Plan Beneficiary Number
- Account Numbers
- Certificate/License Number
- Vehicle Identifier and Serial Numbers (License plates)
- Device Identifiers & Serial Numbers
- URL, IP Addresses
- Biometric Identifiers (finger and voice prints)
- Full-Face Photos and Comparable Images
- Any other unique identifying number, characteristic or code

PHI Use & Disclosure

Use = Information shared within our organizations

Disclosure = Information provided to individuals or entities outside our organizations

HIPAA prohibits use or disclosure of PHI unless:

- It is used to provide treatment, payment or health care operations
- It's use is authorized by or provided to our member or
- It is used for any one of 12 national priority purposes, such as if required by law, public health activities and safety, law enforcement, judicial or administrative proceedings, victims of abuse or domestic violence, or research, to name a few. Disclosure rules may apply.

Minimum Necessary

HIPAA requires our organization to share only the *minimum amount necessary.*

- *Before sharing PHI, ask yourself:*

  "Does this person need this PHI to treat the patient, receive payment or conduct eligibility?"

If you don't need to disclose an entire file or patient record – only disclose the limited portions that you need to disclose.

We must make reasonable efforts to use, disclose or request only the ***minimum amount*** of PHI required to accomplish the task at hand.

Do not ask for any information you do not need to investigate or resolve an issue.

Health Information Technology for Economic & Clinical Health (HITECH) Act

HITECH Act legislated was created 2009 to stimulate the adoption of ***Electronic Health Records (EHR).*** The act addresses privacy and security issues linked to electronic transmission of health information.

HITECH Act also revised certain sections of HIPAA for covered entities and their business associates regarding **health records, breach notifications, increased enforcement and penalties.**

HITECH

In 2011, HITECH ACT offered providers a financial incentives for demonstrating “meaningful use” of EHRs.

Meaningful Use is to utilizing certified EHR technology to improve the five pillars’ of health outcome policy priorities which are;

1) Improve quality, safety, efficiency, and reduce health disparities
2) Engage patients and family
3) Improve care coordination
4) Improve population and public health
5) Ensure adequate privacy and security protection for personal health information

Expectations – Ultimately, its expected that the “meaningful use” of EHR will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

Best Practices For You…

- Use the Print/Lock feature for copier/printers
- Remember to only ask for the *minimum amount* of information you need for the task at hand
- Discuss member information privately, and only when required. Never discuss a member in break rooms, elevators, lobbies, or corridors
- Any documents in your possession that contain member PHI should be faced down on your desk, in a closed file folder, or in a locked filing cabinet
- Verify the identity of any person requesting PHI
- Remove documents that contain PHI from copiers and printers immediately
- Dispose of unnecessary documents by shredding
- All plan documents must be retained by all departments including patient medical records for a minimum of 10 years

Part 1 – Summary

There are differences among fraud, waste and abuse (FWA). One of the primary differences is **intent** and **knowledge**.

Fraud requires that 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 #1

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

Knowledge Check #1

A. Fraud
B. Abuse
C. Waste

Correct Answer #1

A. Fraud

Fraud requires intent to obtain payment and the knowledge that the actions are wrong.

Knowledge Check #2

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

Knowledge Check #2

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

Correct Answer #2

B. Deportation

Deportation is **NOT** a potential penalty for violation of a law or regulations prohibiting Fraud, Waste, and Abuse (FWA).

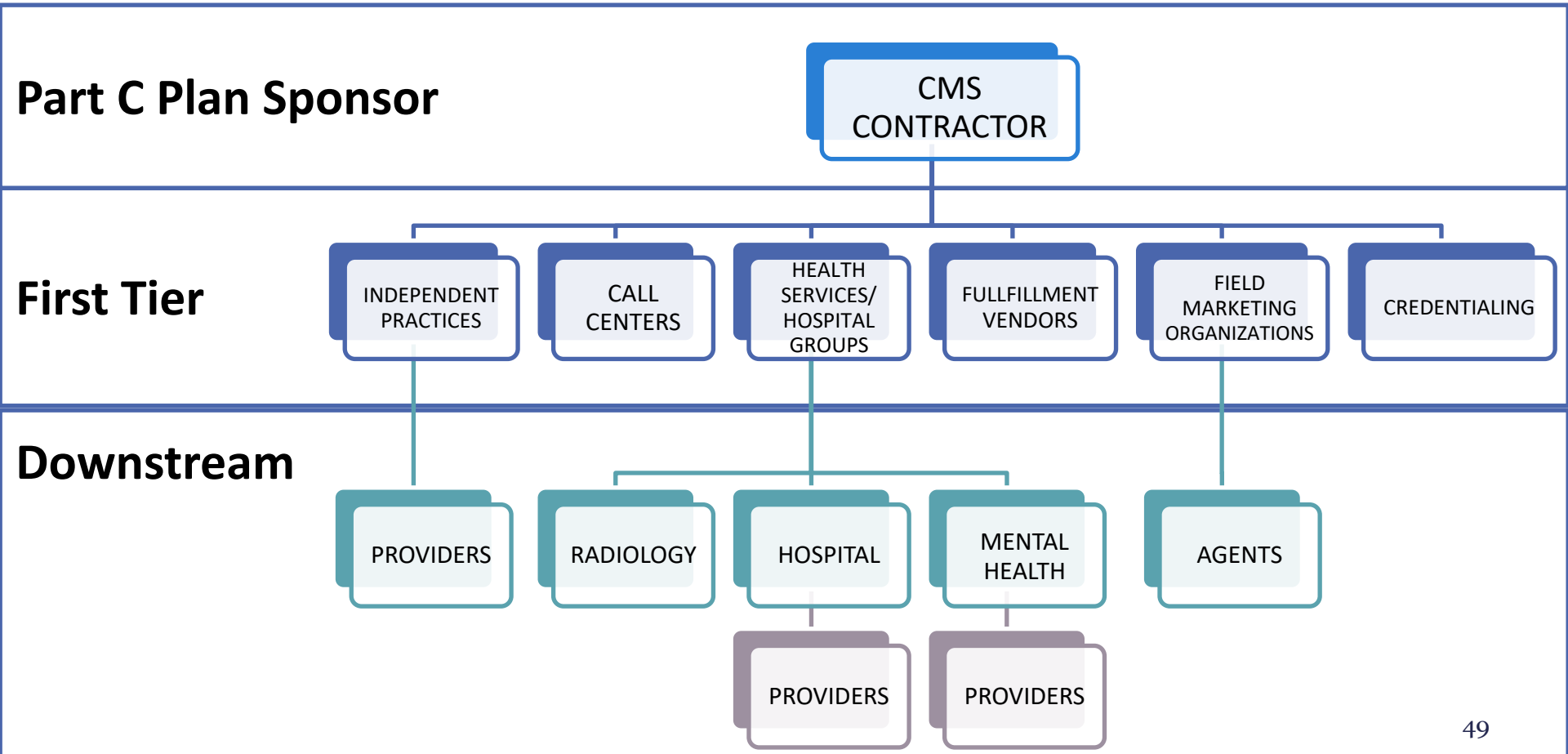
Where Do I Fit In?

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®)

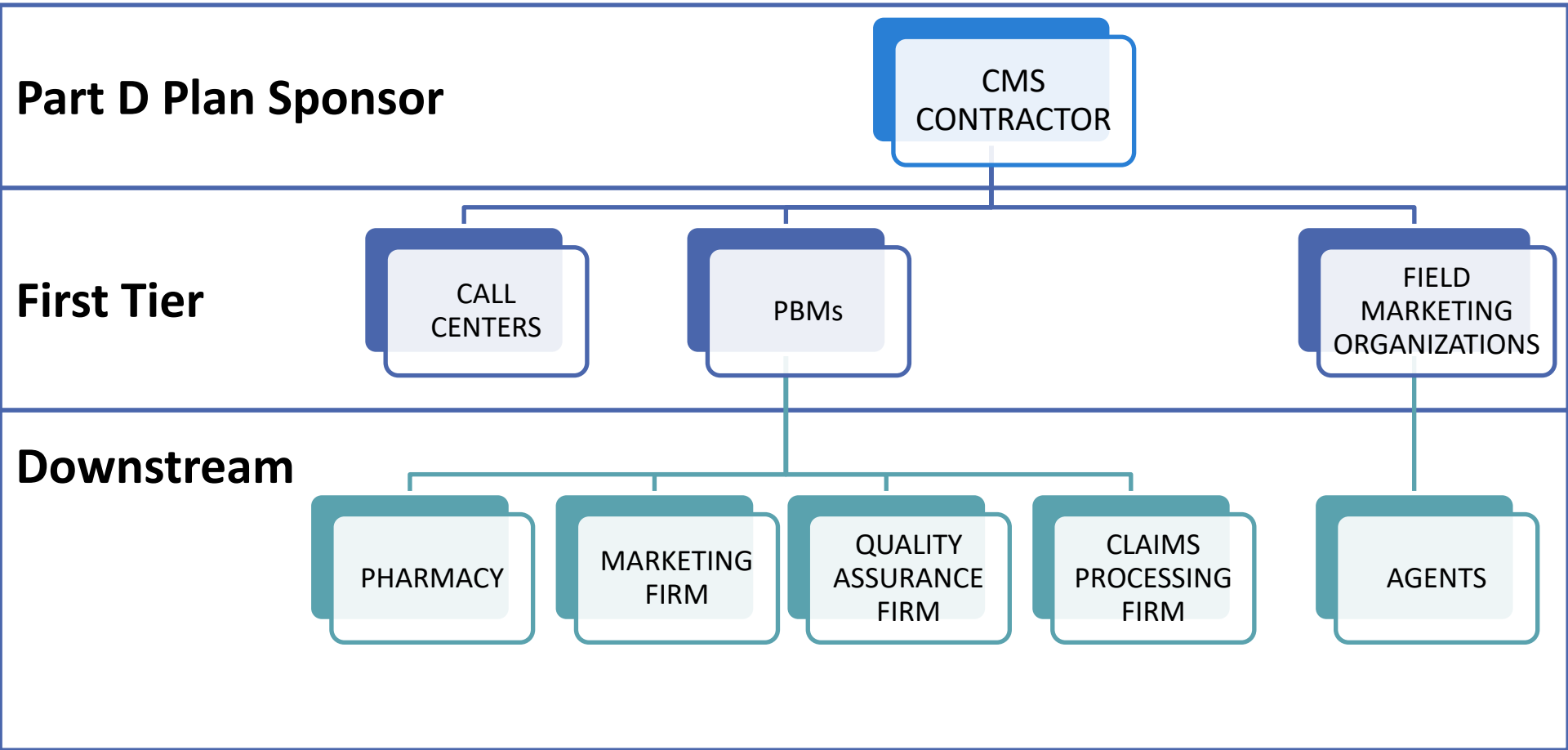
Where Do I Fit In? (continued)

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



Where Do I Fit In? (continued)

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



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 the 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 you coordinate 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 communicate to employees and FDRs 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.

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.

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 (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 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, include:

- Contact information for the information source, suspects, and witnesses
- Alleged FWA details
- Alleged Medicare rules violated
- 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/report-fraud-form.aspx

For Medicare Parts C and D:

- Investigations Medicare Drug Integrity Contractor (I MEDIC) 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:

- https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud

Correction

Once fraud, waste or abuse is detected, promptly corrected it.

Correcting the problem saves the Government money and ensures your compliance with CMS requirements.

Correction (continued)

Develop a plan to correct the issue. 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.
- Monitor corrective actions continuously to ensure effectiveness.

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
- 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 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 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?
- 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?

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 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)?

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, 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 knowingly provide samples to entities that bill Federal health care programs for them?

Key Indicators: 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?

Part 2 – 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.

Knowledge Check #1

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?

Knowledge Check #1

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

Correct Answer #1

The correct answer is:

C – Call the prescriber to verify the quantity

Knowledge Check #2

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 is 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?

Knowledge Check #2

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

Correct Answer #2

The correct answer is:

B – Report the incident to the compliance department (via compliance hotline or other mechanism)

Knowledge Check #3

You are in charge of paying 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?

Knowledge Check #3

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

Correct Answer #3

The correct answer is:

B – Consult with your immediate supervisor for next steps or contact the compliance department (via compliance hotline, Special Investigations Unit [SIU], or other mechanism)

Knowledge Check #4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy.

What should you do?

Knowledge Check #4

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 Answer #4

The correct answer is:

E – Follow your pharmacy's procedures

Compliance Program Training

Part 3

Introduction and Learning Objectives

This lesson outlines effective compliance programs. After completing this lesson, you should correctly:

- Recognize how a compliance program operates
- Recognize how compliance program violations should be reported

Training Requirements For:

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 course as "Sponsors") must receive training about compliance with CMS program rules.

What Is an Effective Compliance Program?

An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

- Prevents, detects, and corrects non-compliance
- Is fully implemented and is tailored to an organization's unique operations and circumstances
- Has adequate resources
- Promotes the organization's Standards of Conduct
- Establishes clear lines of communication for reporting non-compliance.

An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste, and abuse (FWA). It must, at a minimum, include the seven core compliance program requirements.

Seven Core Compliance Program Requirements

CMS requires an effective compliance program to include seven core requirements:

1. **Written Policies, Procedures, and Standards of Conduct**
   These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.

2. **Compliance Officer, Compliance Committee, and High-Level Oversight**
   The Sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

   The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

3. **Effective Training and Education**
   This covers the elements of the compliance plan as well as prevention, detecting, and reporting FWA. Tailor this training and education to the different employees and their responsibilities and job functions.

Seven Core Compliance Program Requirements
(continued)

4. **Effective Lines of Communication**
   Make effective lines of communication to all, ensure confidentiality, and provide methods for anonymous and good-faith compliance issues reporting at Sponsor and first-tier, downstream, or related entity (FDR) levels.

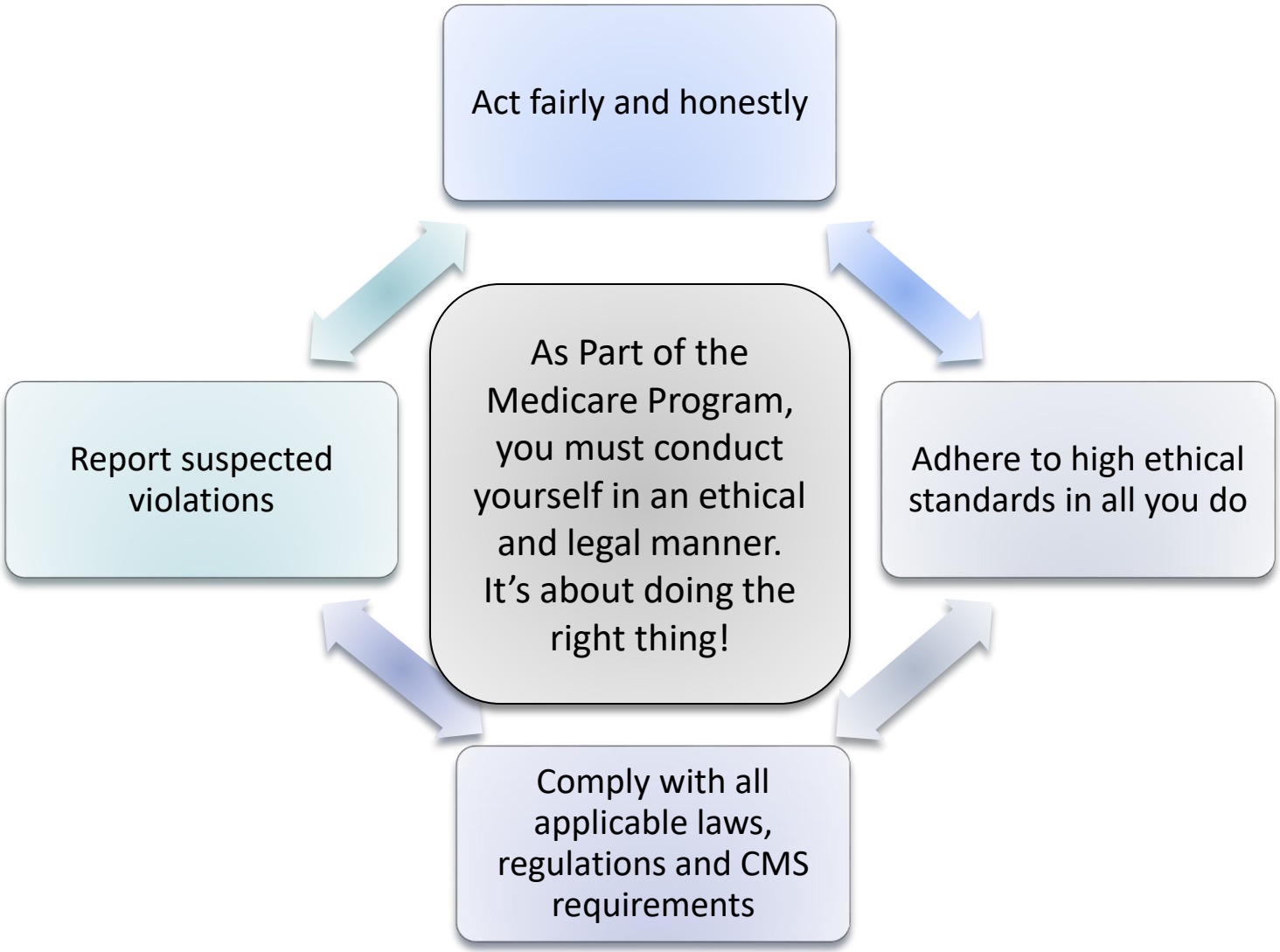
5. **Well-Publicized Disciplinary Standards**
   Sponsor must enforce standards through well-publicized disciplinary guidelines.

6. **Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks**
   Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

   NOTE: Sponsors must ensure that FDRs preforming delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

7. **Procedures and System for Prompt Response to Compliance Issues**
   The Sponsor must use effective measures to response promptly to non-compliance and undertake appropriate corrective action.

Ethics – Do The Right Thing!



How Do You Know What is Expected of You?

Beyond following the general ethical guidelines on the previous page, how do you know what is expected of you in a specific situation?

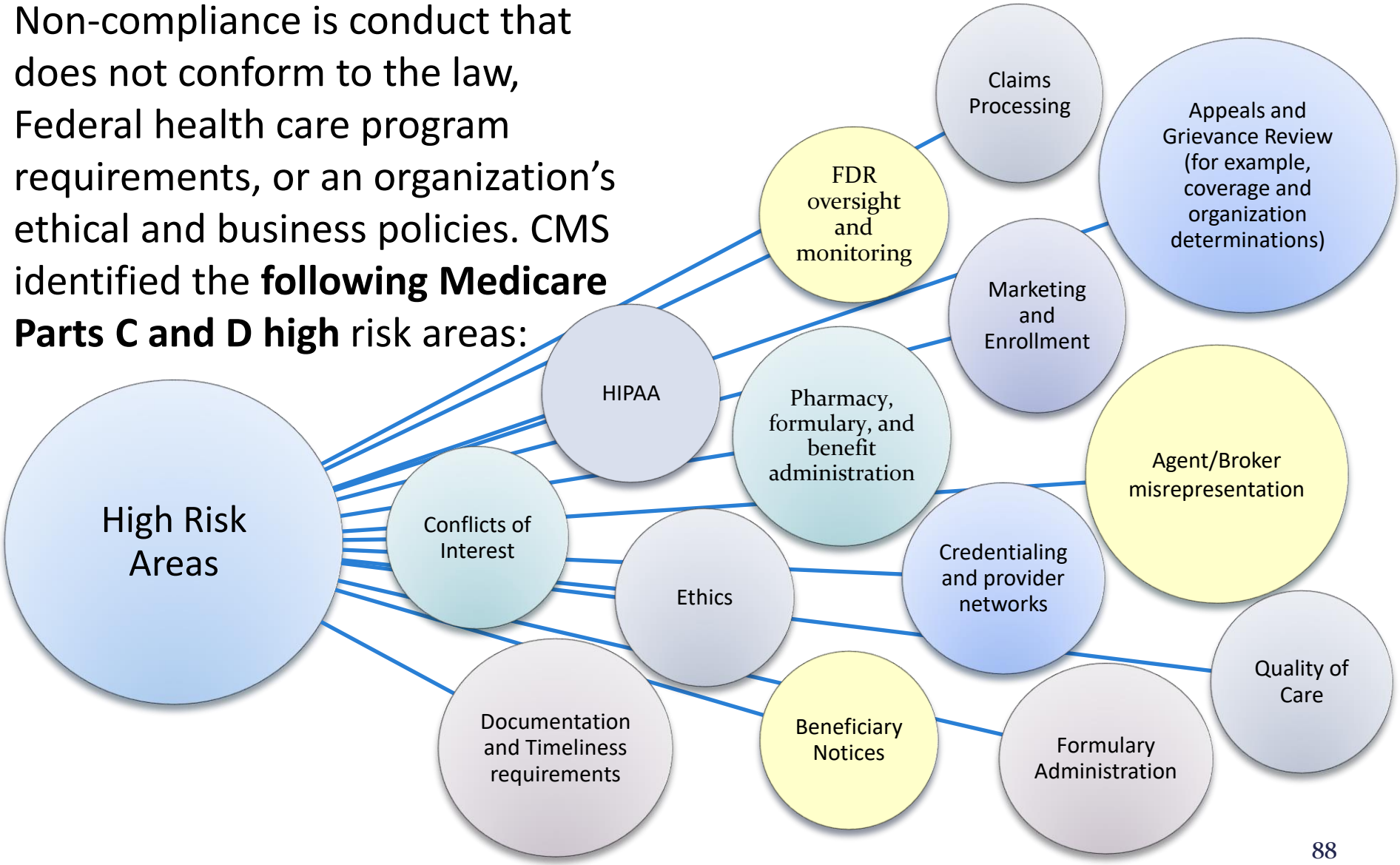
- Standards of Conduct (or Code of Conduct) state the organization's compliance expectations and their operational principles and values.
- If you are not aware of your organization's standards of conduct, ask management where they can be located.

Reporting Standards of Conduct violations and suspected non-compliance is *everyone's* responsibility

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

What Is Non-Compliance?

Non-compliance is conduct that does not conform to the law, Federal health care program requirements, or an organization's ethical and business policies. CMS identified the **following Medicare Parts C and D high** risk areas:



Know the Consequences of Non-Compliance

Failure to follow Medicare Program requirements and CMS guidance can lead to serious consequences, including:

- Contract termination
- Criminal penalties
- Exclusion from participating in all Federal health care programs
- Civil monetary penalties.

Those who engage in non-compliant behavior may be subject to any of the following:

- Mandatory training or re-training
- Disciplinary action
- Termination

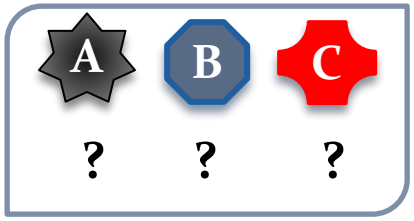
Non-Compliance Affects Everybody

Without programs to prevent, detect, and correct non-compliance, we all risk;

Harm to beneficiaries, such as

Delayed Services

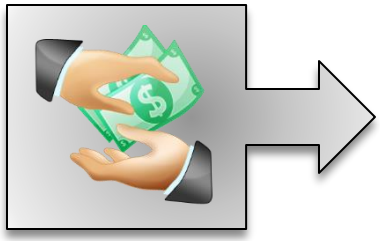
Denial of Benefits



Difficulty in using providers of choice

Other hurdles to care

Less money for everyone, due to

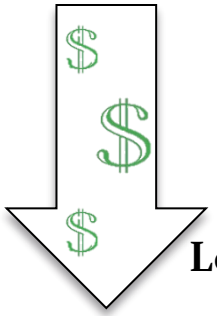


High Insurance Copayments

Higher Premiums

Lower star ratings

Lower benefits for individuals and employers



Lower profits

How to Report Potential Non-Compliance

Employees of a Sponsor

- Call the Medicare Compliance Officer
- Make a report through your organization's website
- Call the Compliance Hotline.

First-Tier, Downstream, or Related Entity (FDR) Employees

- Talk to a Manager or Supervisor
- Call Your Ethics/Compliance Help Line
- Report to the Sponsor

Beneficiaries

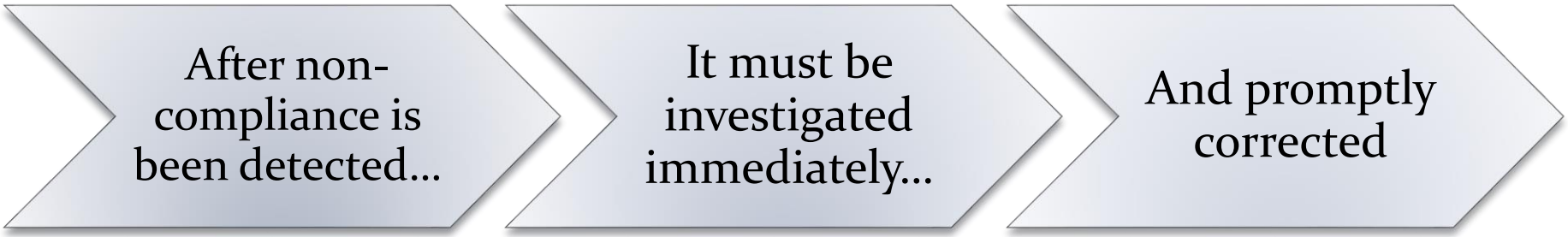
- Call the Sponsor's Compliance Hotline or Customer Service
- Make a report through the Sponsor's website
- Call 1-800-Medicare

Don’t Hesitate to Report Non-Compliance

When you report non-compliance in good faith, the Sponsor can’t retaliate against you.

Each Sponsor must offer reporting methods that are:

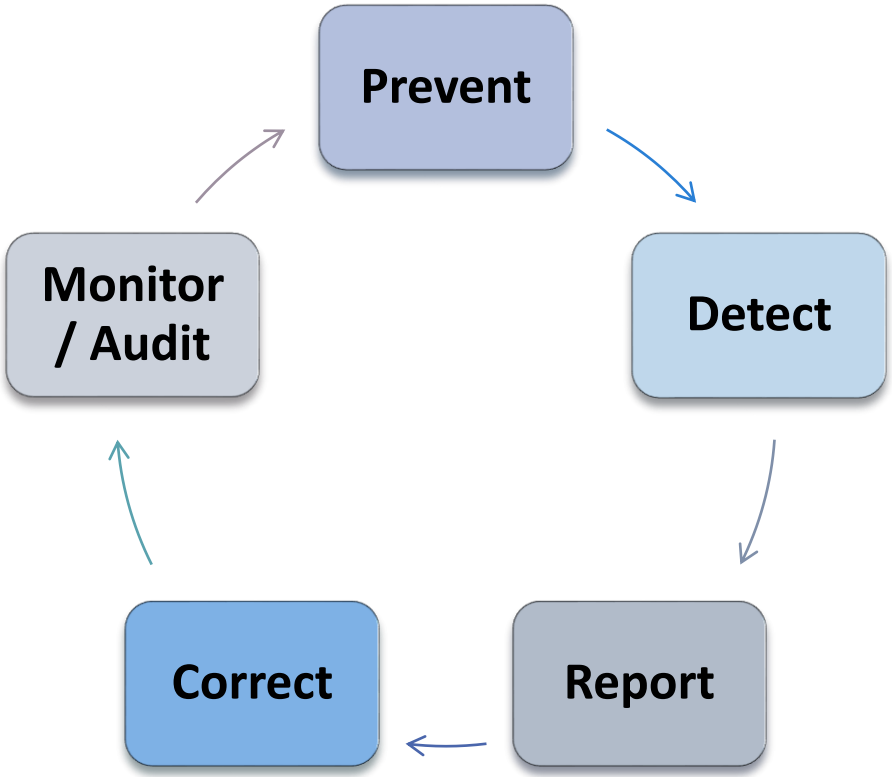
What Happens After Non-Compliance Is Detected?



Internal monitoring should ensure:

- No recurrence of the same non-compliance
- Ongoing CMS requirements compliance
- Efficient and effective internal controls
- Protected enrollees

What Are Internal Monitoring and Audits?



- Internal **monitoring** activities include regular reviews confirming ongoing compliance and taking effective corrective actions.
- Internal **auditing** is a formal review of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures.

Part 3: Summary

- Organizations must create and maintain compliance programs that, at a minimum, meet the seven core requirements. An effective compliance program fosters a culture of compliance.
- To help ensure compliance, behave ethically and follow your organization's Standards of Conduct. Watch for common instances of non-compliance, and report suspected non-compliance.
- Know the consequences of non-compliance, and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.

Compliance is Everyone's Responsibility!

Prevent:	• Operate within your organization's ethical expectations to prevent non-compliance!
Detect & Report:	• Report detected potential non-compliance!
Correct:	• Correct non-compliance to protect beneficiaries and save money!

Knowledge Check #1

You discover an unattended email address or fax machine in your office receiving beneficiary appeals request. You suspect no one is processing the appeals.

What should you do?

Knowledge Check #1

A. Contact law enforcement
B. Nothing
C. Contact your compliance department (via compliance hotline or other mechanism)
D. Wait to confirm someone is processing the appeals before taking further action
E. Contact your supervisor

Correct Answer #1

The correct answer is:

C – Contact your compliance department (via compliance hotline or other mechanism)

Knowledge Check #2

A sales agent, employed by the Sponsor's first-tier, downstream, or related entity (FDR), submitted an application for processing and requested two things: 1) to back-date the enrollment date by one month, and 2) to waive all monthly premiums for the beneficiary.

What should you do?

Knowledge Check #2

A. Refuse to change the date or waive the premiums, but decide not to mention the request to a supervisor or the compliance department
B. Make the requested changes because the sales agent determines the beneficiary's start date and monthly premiums
C. Tell the sales agent you will take care of it, but then process the application properly (without the requested revisions) – you will not file a report because you don't want the sales agent to retaliate against you
D. Process the application properly (without the requested revisions) – inform your supervisor and the compliance officer about the sales agent's request
E. Contact law enforcement and the Centers for Medicare & Medicaid Services (CMS) to report the sales agent's behavior

Correct Answer #2

The correct answer is:

D – Process the application properly (without the requested revisions) – inform your supervisor and the compliance officer about the sales agent's request

Knowledge Check #3

You work for a Sponsor. Last month, while reviewing a Centers for Medicare & Medicaid Services (CMS) monthly report, you identified multiple individuals not enrolled in the plan but for whom the Sponsor is paid. You spoke to your supervisor who said don't worry about it. This month, you identify the same enrollees on the report again.

What should you do?

Knowledge Check #3

A. Decide not to worry about it as your supervisor instructed – you notified your supervisor last month and now its his responsibility

B. Although you know about the Sponsor's non-retaliation policy, you are still nervous about reporting – to be safe, you submit a report through your compliance department's anonymous tip line to avoid identification

C. Wait until the next month to see if the same enrollees appear on the report again, figuring it may take a few months for CMS to reconcile its records – if they are, then you will say something to your supervisor again

D. Contact law enforcement and CMS to report the discrepancy

E. Ask your supervisor about the discrepancy again

Correct Answer #3

The correct answer is:

B - Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting – to be safe, you submit a report through your compliance department's anonymous tip line so you cannot be identified

Knowledge Check #4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy.

What should you do?

Knowledge Check #4

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 Answer #4

The correct answer is:

E – Follow your pharmacy's procedures

ADDITIONAL IMPORTANT INFORMATION

Part 4

How To Report Violations

REPORTING SUSPECTED VIOLATIONS

To report suspected violations of HIPAA, FWA, and non-compliance use the identified reporting methods below. All associates are expected to report suspected violations in good faith. Our organization has a no tolerance policy for retaliation or retribution against associates who in good faith report suspected violations.

In Florida, Contact Compliance Officer: Diane Kortsch

- **Compliance Officer Hotline: (888) 548-0094**
- **Secured E-mail: compliancereporting@americas1stchoice.com**
- **Secured website at: www.americas1stchoice.ethicspoint.com**
- **Fax: (888) 548-0092**
- **P.O. Box: Compliance Department P.O. Box 152137 Tampa, FL 33684**

In SC for HMO plans, Contact Compliance Officer: Diane Kortsch

- **Compliance Officer Hotline: (888) 548-0095**
- **Secured E-mail: compliancereporting@americas1stchoice.com**
- **Secured website: www.americas1stchoice.ethicspoint.com**
- **Fax: (888) 548-0092**
- **P.O. Box: Compliance Department P.O. Box 152137 Tampa, FL 33684**

The End