

2023-24

Medicare Parts C & D General Compliance Training



ADAPTED FROM THE WEB-BASED TRAINING COURSE ON
THE MEDICARE LEARNING NETWORK (MLN)



Acronyms

❖ The following acronyms are used throughout the course:

ACRONYM	TITLE TEXT
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
FDR	First-tier, Downstream and Related Entity
FWA	Fraud, Waste & Abuse
HHS	U.S. Department of Health & Human Services
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MA-PD	MA Prescription D
MLN	Medicare Learning Network [®]
OIG	Office of Inspector General
PDP	Prescription Drug Plan
DSH	Department of Health Services



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 helps you detect, correct, and prevent FWA. You are part of the solution.
- ❖ Compliance 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



Course Objectives

- ✦ After completing this course, you should correctly:
 - ✦ Recognize how a compliance program operates
 - ✦ Recognize how compliance program violations should be reported
- ✦ Let's Get Started!



Compliance Program Requirement

The Centers for Medicare & Medicaid Services (CMS) requires Sponsors to implement and maintain an effective compliance program for its Medicare Parts C and D plans. An effective compliance program must:

- ❖ Articulate and demonstrate an organization's commitment to legal and ethical conduct
- ❖ Provide guidance on how to handle compliance questions and concerns
- ❖ Provide guidance on how to identify and report compliance violations



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 noncompliance as well as fraud, waste, and abuse (FWA). It must, at a minimum, include the seven core compliance program requirements



Seven Core Compliance Program Elements

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 preventing, 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 accessible 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 FDRs performing 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 respond promptly to non-compliance and undertake appropriate corrective action.



Compliance Training: Sponsors & Their FDRs

- ❖ CMS expects all Sponsors will apply their training requirements and “effective lines of communication” to their FDRs. Having “effective lines of communication” means employees of the Sponsor and the Sponsor’s FDRs have several avenues to report compliance concerns.



Ethics: Do the Right Thing!

- ❖ As part of the Medicare Program, you must conduct yourself in an ethical and legal manner. It's about doing the right thing!
 - Act fairly and honestly
 - Adhere to high ethical standards in all you do
 - Comply with all applicable laws, regulations, and CMS requirements
 - Report suspected violations



How Do You Know What is Expected of You?

- ❖ Now that you've read 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. Organizational Standards of Conduct vary. The organization should tailor the Standards of Conduct content to their individual organization's culture and business operations. Ask management where to locate your organization's Standards of Conduct.
- ❖ 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:



Best Practices for Avoiding Non-Compliance

Medical Billing Guidelines and Clinical Documentation:

- ✦ Patient care is a priority for healthcare professionals whether the professional is a physician, advanced practice provider, therapist, or any of the many other types of medical professionals.
- ✦ Meeting ongoing patient needs is impossible without documenting each patient encounter completely, accurately, and in a timely manner.
- ✦ Documentation should be clear, complete, and specific documentation is the conduit for, and provides evidence of, the quality, continuity of patient care, medical necessity, and billing and coding.
- ✦ Most providers document reasonably well for medical care, but many are unaware of the details needed for accurate coding.
- ✦ Quality Clinical Documentation should be:
 - Patient centered – Reflect the patient’s current condition and trajectory of illness.
 - Timely – Up-to-date and projecting the most current picture of the patient’s status.
 - Appropriately concise and relevant – Avoid note bloat, include information that is timely, pertinent and relevant to the patient’s current condition.
 - Accurate – The author is responsible for all documentation that is signed or cosigned whether the content is original, copied, pasted or imported.
 - Compliant – Documentation must be in compliance with all existing department/service, hospital regulatory, legal and billing requirements.
 - Appropriately reviewed by supervisor – Trainee notes must be appropriately reviewed in accordance with department/service policy and level of supervision required.
- ✦ Another reason for comprehensive medical record documentation is the need to comply with Federal and State laws that require providers to maintain the records necessary to “fully disclose the extent of the services,” care, and supplies furnished to beneficiaries, as well as support claims billed



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
- ❖ Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in noncompliant 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

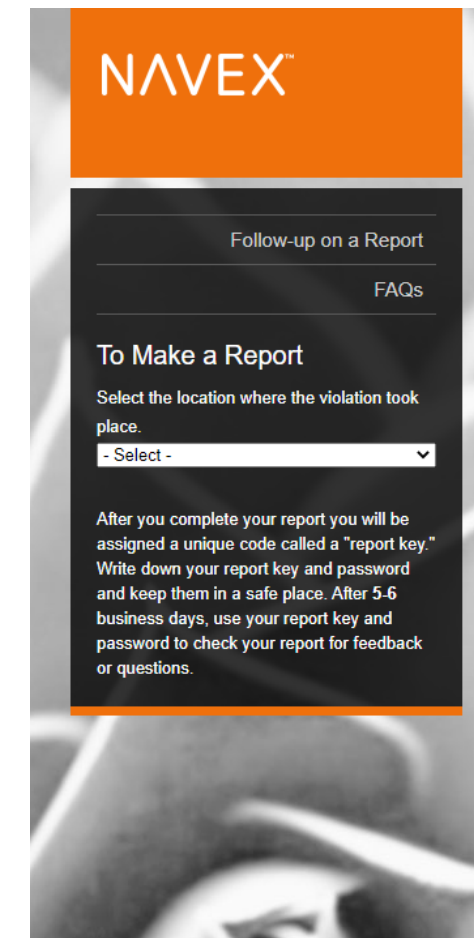
- ❖ Less money for everyone, due to:

- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower Star Ratings
- Lower profits



How to Report Compliance Concerns

- ❖ Altais' Hotline is available 24 hours a day, 7 days a week, and is toll-free. Anonymous reports may be submitted to EthicsPoint by using one of the following methods:
- ❖ To make an anonymous Compliance report:
 - Call (888) 201-7305
 - Go to [EthicsPoint](#) and follow the instructions online
- ❖ Contact us at:
 - Compliance@btmg.com
 - Kara Ricci, Chief Legal Officer, Kara.Ricci@altais.com
 - Jimmy Holman, Compliance Counsel & Privacy Officer, JHolman@btmg.com



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Our Commitment

We are organizations with strong values of responsibility and integrity. We are committed to conducting business with the highest standards of ethics and to fostering an environment where open, honest communications are the expectation, not the exception. We want you to feel comfortable in approaching your supervisor or management in instances where you believe violations of policies or standards have occurred.

In situations where you prefer to place an anonymous report in confidence, you are encouraged to use this hotline, hosted by a third party hotline provider, EthicsPoint. You are encouraged to submit reports relating to violations of our ethical standards, compliance protocols, or anything else you may be concerned about.

The information you provide will be sent to us by EthicsPoint in a totally confidential and anonymous manner.

See the [EthicsPoint FAQs](#) for more information.

EthicsPoint is NOT a 911 or Emergency Service:
Do not use this site to report events presenting an immediate threat to life or property. Reports submitted through this service may not receive an immediate response. If you require emergency assistance, please contact your local authorities.



What Happens After Non-Compliance is Detected?

- ❖ Non-Compliance must be investigated immediately and corrected promptly.
- ❖ 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 & 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.



Conflicts of Interest

- ❖ A conflict of interest (COI) is a situation in which a decision-maker or someone in a position of trust, has competing professional or personal interests.
- ❖ COI may arise when affiliations or activities conflict with business interests.
- ❖ Common Forms of COI include:
 - Outside employment
 - Financial interest
 - Gifts and business courtesies
- ❖ Altais expects everyone to conduct their business relationships with integrity.
- ❖ Please reach out to Compliance@btmg.com for any questions or disclosures.



Lesson 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 noncompliance.
- ❖ 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 noncompliance!

Detect & Report

- Report detected non-compliance!

Correct

- Correct noncompliance to protect beneficiaries and save money



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

ADAPTED FROM THE WEB-BASED TRAINING COURSE
ON THE MEDICARE LEARNING NETWORK (MLN)

For Internal Use Only



Outline

When you complete this course, 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



Introduction & Learning Objectives

This lesson describes fraud, waste, and abuse (FWA) and the laws that prohibit it. Upon completing the lesson, you should be able to correctly:

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



Fraud

- ❖ Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.
- ❖ The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years. It is also subject to criminal fines up to \$250,000.

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



Waste & 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.
- ❖ For the definitions of fraud, waste, and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual on the Centers for Medicare & Medicaid Services (CMS) website



Examples of FWA

Examples of actions that may constitute Medicare fraud include:

- ✦ Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments 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, & 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.



Examples of FCA Violations

❖ 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

❖ 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



Whistleblower

- ❖ 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.



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.



Examples of Health Care Fraud Statute Violations

❖ 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

❖ 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



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).
- ❖ Damages & Penalties – Violations are punishable by:
 - A fine up to \$25,000
 - Imprisonment up to 5 years



Examples of Anti-Kickback Statute Violations

- ❖ ➤ 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 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.
- ❖ Damages & 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.



Civil Monetary 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

❖ ➤ Damages & 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:
 - o Claimed for each service or item or
 - o Of remuneration offered, paid, solicited, or received



Example of CMP Violation

- ❖ 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

- ❖ 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.



Example of Exclusion

- ❖ 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 un-convicted executive was excluded, there was evidence he was involved in misconduct leading to the company's conviction.



Health Insurance Portability 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.
- ❖ Example: A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.
- ❖ Damages & Penalties:
 - Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.



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



Lesson 2 Learning Objectives

- ❖ This lesson explains the role you can play in fighting against fraud, waste, and abuse (FWA), including your responsibilities for preventing, reporting, and correcting FWA. It should take about 10 minutes to complete. Upon completing the lesson, you should 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, or health promotion provider)



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.
 - The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions relating to the Sponsor's Medicare Part C contracts. 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. If the first-tier entity is an independent practice, then a provider could be a downstream entity. If the first-tier entity is a health service/hospital group, then radiology, hospital, or mental health facilities may be the downstream entity. If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.
- ✦ 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. This stakeholder relationship flow chart shows examples of functions that relate to the Sponsor's Medicare Part D contracts. 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. If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a field marketing organization, then agents could be a downstream entity.



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 & 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.



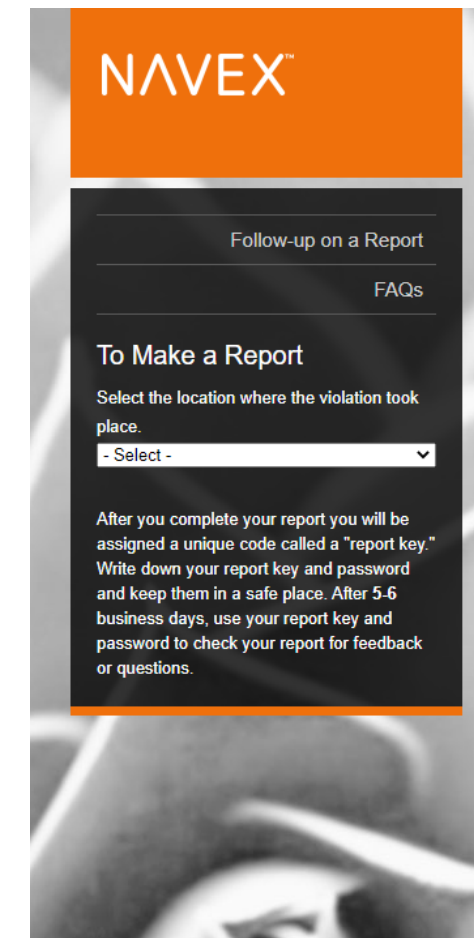
Report FWA

- ❖ Everyone must report suspected instances of FWA. They 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.



How to Report Altais Compliance Concerns

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 - Go to [EthicsPoint](#) and follow the instructions online
- ❖ Contact us at:
 - Compliance@btmg.com
 - Kara Ricci, Chief Legal Officer, Kara.Ricci@altais.com
 - Jimmy Holman, Compliance Counsel & Privacy Officer, JHolman@btmg.com



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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 the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.
- ❖ Details to Include When Reporting FWA – When reporting suspected FWA, 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 Outside Your Organization

HHS Office of Inspector General (OIG)

- 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

CMS

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



Correction

- ❖ Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with CMS & DHS 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 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 Medicare Parts C and D benefits to enrollees



Key Indicators: Potential Beneficiary Issues

These are helpful questions to ask to help identify potential fraud, waste, or abuse for **patients**:

- ❖ 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?



Key Indicators: Potential Provider Issues

These are helpful questions to ask to help identify potential fraud, waste, or abuse for **providers**:

- ❖ 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

These are helpful questions to ask to help identify potential fraud, waste, or abuse for **pharmacies**:

- ❖ 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 Sponsor Issues

These are helpful questions to ask to help identify potential fraud, waste, or abuse for sponsors:

- ✦ 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?



Lesson 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.



Thank You

