

1. Combating Medicare Parts C and D Fraud, Waste and Abuse

2. Navigation Instructions

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4. Introduction

The Medicare Learning Network® (MLN) offers free educational materials for health care professionals on the Centers for Medicare & Medicaid Services (CMS) programs, policies, and initiatives. Get quick access to the information you need.

Publications & Multimedia

<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/mln-publications>)

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5. Introduction

This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual general compliance training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503 (b)(4)(vi)(C)
(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422#se42.3.422_1503)
- 42 CFR Section 423.504 (b)(4)(vi)(C)
(https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423#se42.3.423_1504)
- Medicare Program and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly
(<https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf>)
- Section 50.3.2 of the Compliance Program Guidelines (Medicare Prescription Drug Benefit Manual, Chapter 9
[<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf>] and Medicare Managed Care Manual, Chapter 21, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c21.pdf>)

Sponsors and their FDRs (First-tier, Downstream, and Related Entities) are responsible for providing additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

6. 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.

7. Training Requirements: 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.

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

Learn more about Medicare Part C

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

MA plans must cover all services Medicare covers with the exception of hospice care. They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Learn more about Medicare Part D

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

8. Course Objectives

After completing this course, you should be able to:

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

9. Introduction and Learning Objectives

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

After completing the lesson, you should be able to correctly:

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

10. Fraud

Fraud is knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to get a federal health care payment when no entitlement would otherwise exist. Knowingly soliciting, getting, offering, or paying remuneration (for example, kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by federal health care programs. Making prohibited referrals for certain designated health services is another example. Fraud requires intent to get payment and knowledge the actions are wrong.

The Criminal Health Care Fraud Statute (18 United States Code (USC) 1347) makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years. It is also subject to criminal fines up to \$250,000. The statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:

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

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare program by submitting medically unnecessary power wheelchair claims.

Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

11. Waste and Abuse

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

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

For the definitions of fraud, waste, and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf>) and Chapter 9 of the Prescription Drug Benefit Manual on the Centers for Medicare & Medicaid Services (CMS) (<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf>) website.

12. Examples of FWA

Examples of actions that may constitute Medicare **fraud** include:

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

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 lab tests

Examples of actions that may constitute Medicare **abuse** include:

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

13. 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 unnecessary Medicare Program costs but do not require the same intent and knowledge.

14. Understanding FWA

To detect FWA, you need to know the **law**.

The following pages provide high-level information about the following laws:

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

For details about specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

15. Federal Civil False Claims Act (FCA)

The civil provisions of the FCA (31 USC 3729-3733) make a person liable to pay damages to the Government if they knowingly:

- Conspire to violate the FCA
- Carry out other acts to obtain property from the Government by misrepresentation
- Conceal or improperly avoid or decrease an obligation to pay the Government
- Make or use a false record or statement supporting a false claim
- Present a false claim for payment or approval

Additionally, under the criminal FCA (18 USC 287), individuals or entities may face criminal penalties, including fines, imprisonment, or both for submitting false, fictitious, or fraudulent claims.

Examples:

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.

Damages and Penalties

Penalties for violating the civil FCA may include recovery of up to 3 times the amount of the government's damages due to the false claims, plus \$11,000 per false claim filed.

16. Federal Civil FCA (continued)

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

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

Rewarded: A person who brings a successful whistleblower lawsuit receives at least 15 percent, but not more than 30 percent, of the money collected.

17. Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 USC 1346-1349) states, “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program or 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 ... 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.

Examples:

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

18. Criminal Health Care Fraud Statute, continued

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

- Criminal fines up to \$250,000
- Imprisonment for up to 10 years (up to 20 years if bodily injury)

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

For more information, refer to 18 USC Section 1347 (<https://www.govinfo.gov/content/pkg/USCODE-2017-title18/pdf/USCODE-2017-title18-part1-chap63-sec1347.pdf>).

19. Anti-Kickback Statute

The Anti-Kickback Statute (AKS) (42 USC 1320a-7b(b)) makes it a crime to knowingly and willfully offer, pay, solicit, or get any remuneration directly or indirectly to induce. Or reward patient referrals or business generation involving any item or service payable by a federal health care program. When a provider offers, pays, solicits, or gets unlawful remuneration, they violate the AKS.

The safe harbor regulations (42 CFR 1001.952) describe various payment and business practices that, although they potentially implicate the AKS, aren't treated as AKS offenses if they meet certain regulatory requirements. Individuals and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their businesses.

Comparison of the Anti-Kickback Statute and Stark Law handout has more information.

Example:

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.

Damages and Penalties

Violations are punishable by:

- A fine up to \$25,000
- Imprisonment up to 5 years, or both

For more information, refer to the Social Security Act (the Act), Section 1128B(b)(https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm).

20. Physician Self-Referral Law (Stark Law)

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

Designated health services:

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

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.

Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of approximately **\$25,000** can be imposed for each service provided. There may also be around a **\$160,000** fine for entering into an unlawful arrangement or scheme.

[Physician Self-Referral webpage](#) and [section 1877 of the Social Security Act](#) have more information.

21. Civil Monetary Penalties (CMP) Law

The Civil Monetary Penalties Law (CMPL) (42 USC 1320a-7a) authorizes The Office of Inspector General (OIG) to seek Civil Monetary Penalties (CMPs) and sometimes exclusions for a variety of health care fraud violations. Violations that may justify CMPs include:

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

Section 1128A(a) of the Social Security Act has more information (https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm).

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

Penalties and assessments ([https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1003#p-1003.210\(a\)](https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1003#p-1003.210(a))) vary based on the type of violation. The penalties can be around \$10,000 to \$50,000 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

22. Exclusion Statute

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

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

The OIG also maintains the List of Excluded Individuals and Entities (LEIE)(<https://exclusions.oig.hhs.gov/>).

The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS)(https://sam.gov/search/?index=ex&page=1&pageSize=25&sort=-relevance&sfm%5Bstatus%5D%5Bis_active%5D=true&sfm%5BsimpleSearch%5D%5BkeywordRadio%5D=ALL) which enables various federal agencies, including the OIG, to take debarment actions.

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 Code of Federal Regulations (CFR) Section 1001.1901 [https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001#p-1001.1901\(a\)](https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001#p-1001.1901(a)).

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.

23. Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) created greater access to health care insurance, strengthened health care data privacy protection, 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 and Penalties

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

24. Lesson 1 Summary

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

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

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

25. Introduction and 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

26. 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®)

27. Where Do I Fit In? (Continued)

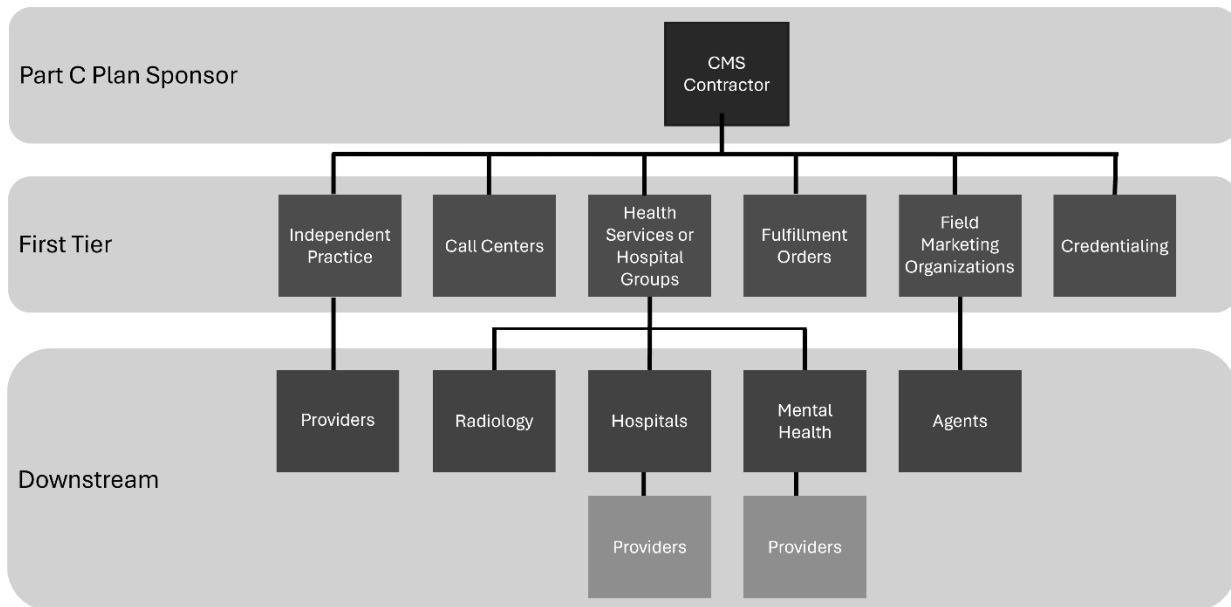
The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with first-tier downstream, or related entities (FDRs). This stakeholder relationship flow chart shows examples of functions relating to the Sponsor's Medicare Part C contracts. First-tier and related entities 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.

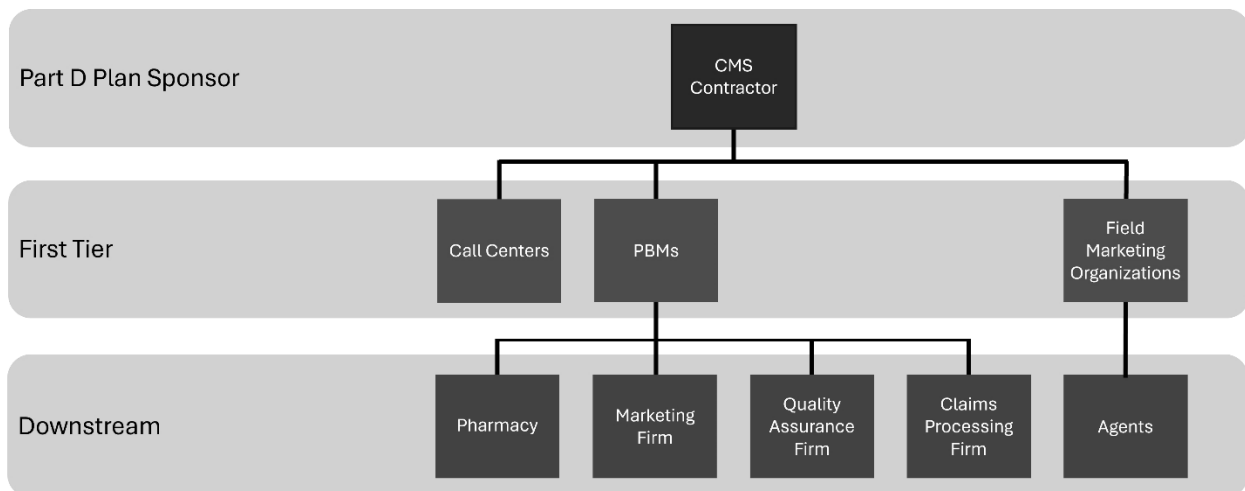
A Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions that relate to the Sponsor's Medicare Part D contracts. Medicare Part D Sponsor first-tier and related entities may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Examples of first-tier entities include call centers, pharmacy benefit managers (PBMs), and field marketing organizations (FMO). 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 FMO, then agents could be a downstream entity.

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



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



28. 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.

29. 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

30. 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.

31. 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.

32. 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
- Suspect's history of compliance, education, training, and communication with your organization or other entities

Where to Report FWA

Medicare Providers:

HHS Office of Inspector General:

- Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
- Fax: 1-800-223-8164
- Online: (<https://oig.hhs.gov/fraud/report-fraud/>)
- Mail: U.S. Department of Health & Human Services Office of Inspector General
ATT: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

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 Patients:

Online: Help Fight Medicare Fraud

33. Corrective Action

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

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

34. 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.

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

36. Key Indicators: Potential Providers 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 patient services?
- 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 (NPI) on it?
- Is the provider's diagnosis for the member supported in the medical record?

37. Key Indicators: Potential Pharmacy Issues

- Are drugs being diverted (drugs meant for nursing homes, hospices, 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 Dispensed as Written)?
- Are [Eligibility facilitation services \(E1s\)](#) and the information they provide being used for purposes other than for determining patient eligibility?

38. 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?

39. Key Indicators: Potential Manufacturers 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?

40. 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?

41. 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.