COMBATING MEDICARE PARTS C & D
FRAUD, WASTE, AND ABUSE

Web-Based Training Course

Created 09/2021

TABLE OF CONTENTS

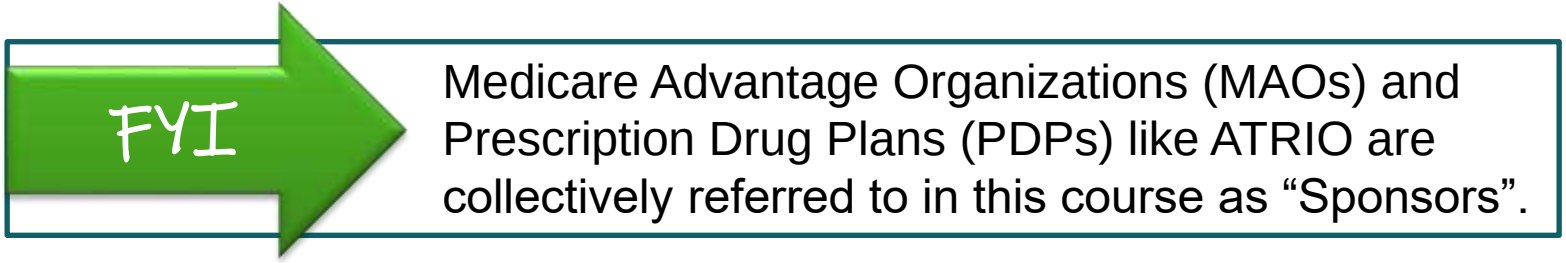
ACRONYMS

The following acronyms are used throughout the course.

ACRONYM	DEFINITION
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
EPLS	Excluded Parties List System
FCA	False Claims Act
FDRs	First-tier, Downstream, and Related Entities
FWA	Fraud, Waste, and Abuse
HIPAA	Health Insurance Portability and Accountability Act

ACRONYM	DEFINITION
LEIE	List of Excluded Individuals and Entities
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MLN	Medicare Learning Network®
NPI	National Provider Identifier
OIG	Office of Inspector General
PBM	Pharmacy Benefits Manager
WBT	Web-Based Training

INTRODUCTION PAGE 1



Training Requirements:

Certain training requirements apply to people involved in Medicare Parts C and D. As an employee or governing body member of a Sponsor, you must receive training about compliance for preventing, detecting, and correcting FWA within 90 days of initial hire or appointment, and at least annually thereafter.

More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website. Please contact your manager for more information.

INTRODUCTION PAGE 2

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.

INTRODUCTION PAGE 3

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 like ATRIO 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 that 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.

INTRODUCTION PAGE 3

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.

INTRODUCTION PAGE 3

ATRIO has:
Stand-alone Part C (MA) plans **and**
Part C and D (MA-PD) plans available for our members.

LESSON 1:
WHAT IS FWA?

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.

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 up to 10 years. It is also subject to criminal fines 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.

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*

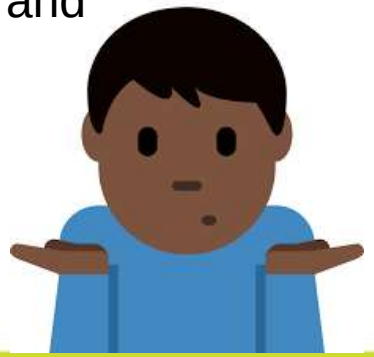
on the Centers for Medicare & Medicaid Services (CMS) website.

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 patients failed to keep • Billing for nonexistent prescriptions • Knowingly altering claim forms, medical records, or receipts to receive a higher payment
Examples of actions that may constitute Medicare ***waste*** include:	• Conducting excessive office visits or writing excessive prescriptions • Prescribing more medications than necessary for treating a specific condition • Ordering excessive laboratory tests
Examples of actions that may constitute Medicare ***abuse*** include:	• Unknowingly billing for unnecessary medical services • Unknowingly billing for brand name drugs when generics are dispensed • Unknowingly excessively charging for services or supplies • Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

DIFFERENCES AMONG FRAUD, WASTE, AND ABUSE

There are differences among fraud, waste, and abuse. One of the primary differences is **intent** and **knowledge**. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.



UNDERSTANDING FWA

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

The following pages provide high-level information about applicable laws.

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

CIVIL FALSE CLAIMS ACT (FCA)

What is it?	Examples	Damages and Penalties
The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly: ■ Conspires to violate the FCA ■ Carries out other acts to obtain property from the Government by misrepresentation ■ Conceals or improperly avoids or decreases an obligation to pay the Government ■ Makes or uses a false record or statement supporting a false claim ■ Presents a false claim for payment or approval ■ For more information, refer to: 31 United States Code (USC) Sections 3729-3733.	**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	*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.*

CIVIL 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

What is it?	Examples	Damages and Penalties
The Health Care Fraud Statute states, “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both.” Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law. For more information, refer to: 18 USC Sections 1346–1347.	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	*Persons who knowingly commit health care fraud 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

What is it?	Example	Damages and Penalties
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). For more information, refer to: *Social Security Act (the Act), Section 1128B(b).*	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.	*Violations are punishable by:* ■ *A fine up to $100,000* ■ *Imprisonment up to 10 years*

STARK STATUTE (PHYSICIAN SELF-REFERRAL LAW)

What is it?	Example	Damages and Penalties
The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has: ■ An ownership/investment interest or ■ A compensation arrangement Exceptions may apply. For more information, refer to: 42 USC Section 1395nn.	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	*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.* *For more information, visit the: Physician Self-Referral webpage and refer to: the Act, Section 1877.*

CIVIL MONETARY PENALTIES (CMP) LAW

What is it?	Example	Damages and Penalties
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 For more information, refer to: the Act, Section 1128A(a) OIG - CMP Authorities List	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.	*The penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three times the amount:* ■ *Claimed for each service or item or* ■ *Of remuneration offered, paid, solicited, or received*

EXCLUSION

What is it?	Example
No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE). The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website. When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same. For more information, refer to: 42 USC Section 1320a-7 and 42 Code of Federal Regulations (CFR) Section 1001.1901.	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)

What is it?	Example	Damages and Penalties
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.	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.	*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 1 REVIEW

Now that you completed Lesson 1, let’s do a quick review.

LESSON 1 REVIEW

Question 1:

Select the correct answer.

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

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

LESSON 1 REVIEW

Answer 1:

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

- **A. Fraud – Correct Answer**
- B. Abuse
- C. Waste

LESSON 1 REVIEW

Question 2:

Select the correct answer.

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

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

LESSON 1 REVIEW

Answer 2:

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

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

You completed Lesson 1: What is FWA?

Now that you have learned about FWA and the laws and regulations prohibiting it, let's look closer at your role in the fight against FWA.

LESSON 2:
YOUR ROLE IN THE FIGHT AGAINST FWA

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. 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?

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

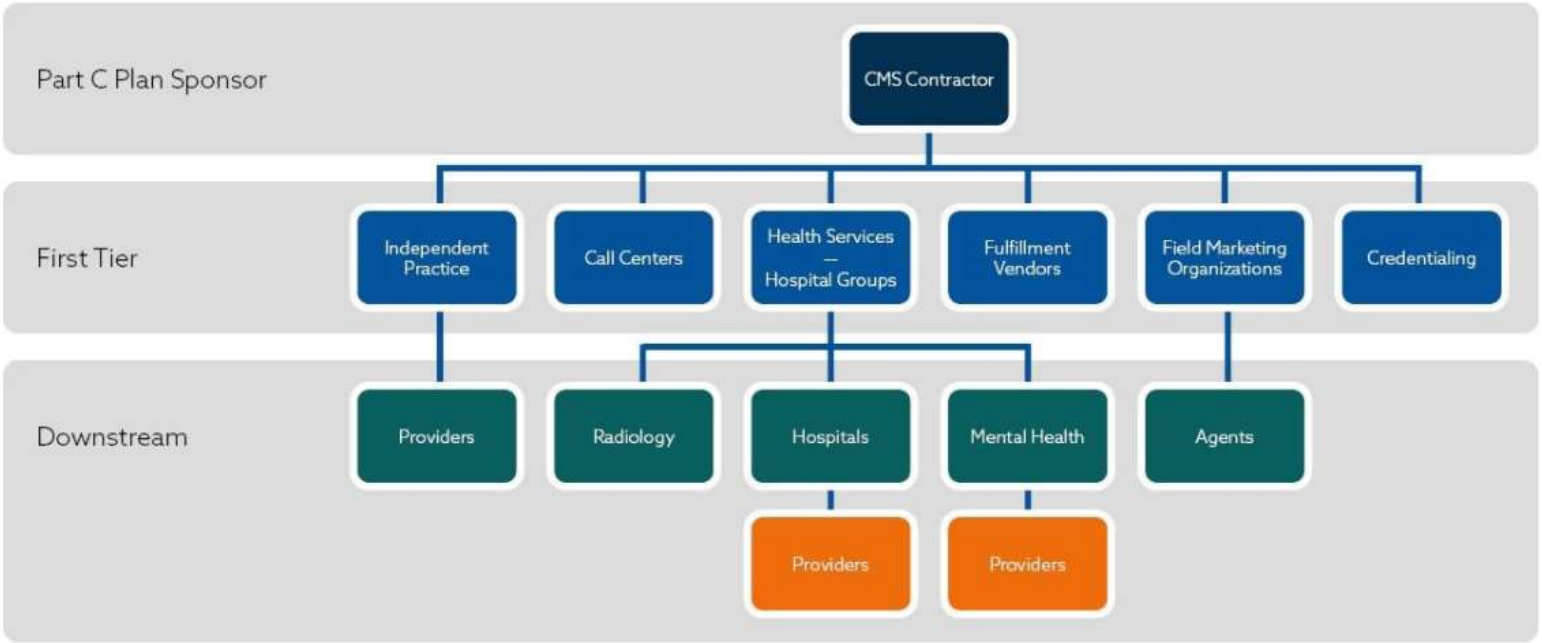
ATRIO is a Part C Plan Sponsor and a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. First-tier and related entities of a Part C Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

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

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

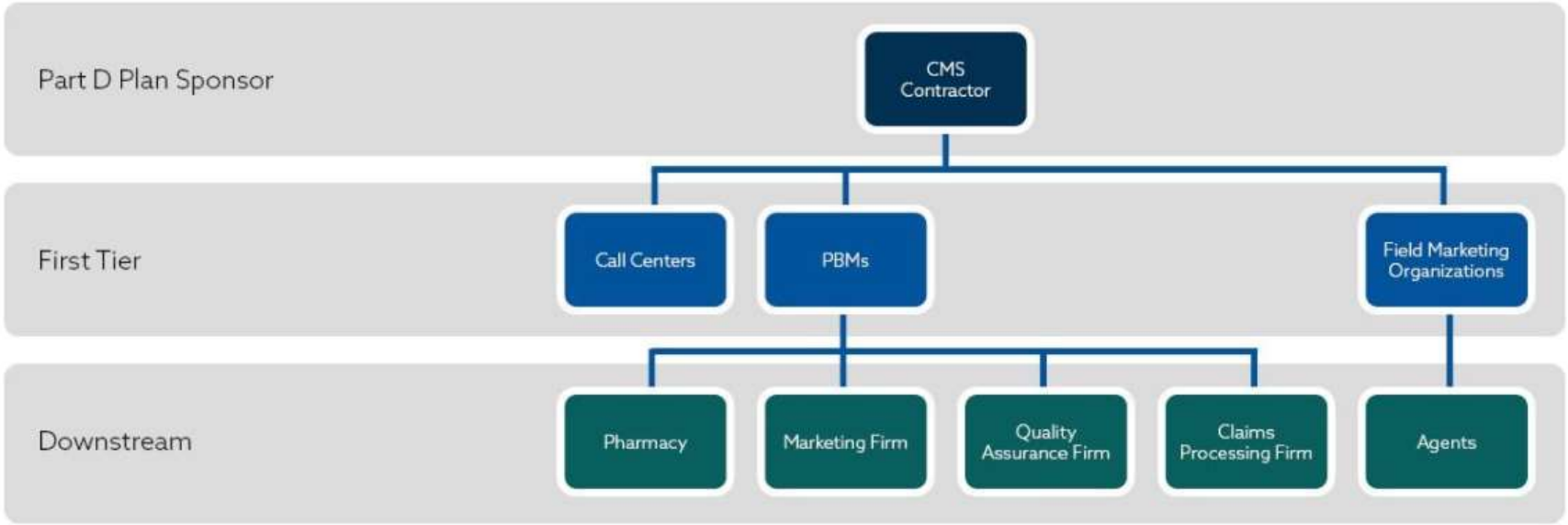
WHERE DO I FIT IN? (CONTINUED)

This stakeholder relationship flow chart shows examples of functions relating to the Sponsor's Medicare **Part C** contracts.



WHERE DO I FIT IN? (CONTINUED)

This stakeholder relationship flow chart shows examples of functions that relate to the Sponsor's Medicare **Part D** contracts



WHAT ARE MY 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 ATRIO's Code of Conduct that articulates your and ATRIO's commitment to standards of conduct and ethical rules of behavior.

HOW DO I 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 ATRIO'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.
- Know ATRIO's policies and procedures. These are always available on ATRIO's Shared Drive. If you have questions about where to find policies and procedures, please ask your supervisor.

ABOUT ATRIO'S CODE OF CONDUCT

ATRIO's Code of Conduct describes the 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
- Compliance is everyone's responsibility, from the top of the organization to the bottom

REPORT FWA

- **Everyone** must report suspected instances of FWA. ATRIO's Code of Conduct clearly states this obligation.
- Report any potential FWA concerns you have to ATRIO's compliance department. The Compliance Department will investigate and make the proper determination.

ATRIO must have a mechanism for reporting potential FWA by employees and FDRs.

ATRIO must accept anonymous reports and cannot retaliate against you for reporting.

Review ATRIO's materials for the ways to report FWA. When in doubt, contact your Compliance Department at **compliance@atriohp.com** OR call the Compliance Hotline at **1-877-309-9952**

DON'T HESITATE
TO REPORT FWA

- There can be **NO** retaliation against you for reporting suspected non-compliance of FWA in good faith. ATRIO does not support or tolerate this behavior.
- There can be **NO** acts of intimidation toward staff that would prevent them from reporting suspected non-compliance or FWA.
- Each reported issue will be handled confidentially and respectfully
- ATRIO is committed to protecting the job security and promotion opportunities of persons who, in good faith, report violations.

HOW TO REPORT FWA (INTERNAL REPORTING)

ATRIO Employees & Health Plan Members

- Email ATRIO Compliance Department: Compliance@atriohp.com

Anonymous and/or Confidentially Reporting:

- ATRIO Compliance Hotline at **1-877-309-9952.**
- Mail: ATRIO Health Plans, PO Box 12645, Salem, OR 97309
- Online Incident Reporting Form: http://www.atriohp.com
- Call 1-800-Medicare (1-800-633-4227), TTY 1-877-486-2048

External reporting options are:

- OIG:1-800-447-8477, TTY 1-800-277-4950
- HHSTips@oig.hhs.gov

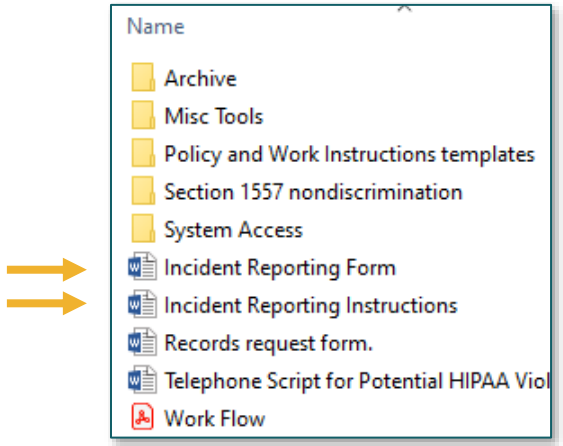
FDR Employees

In addition to methods used by ATRIO Employees and Health Plan members, FDRs can report by:

- Talking to a Manager or Supervisor, either at ATRIO or in their own facility.
- Calling Your Ethics/Compliance Help Line (If available).

HOW TO REPORT FWA (INTERNAL REPORTING - CONTINUED)

- In addition to the methods listed on the previous page, the most common way ATRIO employees report potential FWA is by completing an *Incident Report Form*
- Incident Report Forms and the instructions for completing them can be found on ATRIO's shared drive or by asking your manager.
  - **S:\COMPLIANCE\Compliance Forms**
- FWA should be reported as soon as possible, but no later than 72 hours after discovery. Even if you don't have all the details yet, notify Compliance by any of the methods listed in this training.



REPORTING FWA OUTSIDE YOUR ORGANIZATION

If warranted, ATRIO and our 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.

If ATRIO wishes to voluntarily disclose self-discovered potential fraud to OIG, we may do so under the Self-Disclosure Protocol (SDP). Self-disclosure provides 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:

- 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 ATRIO or other entities

WHERE TO REPORT FWA (EXTERNAL REPORTING)

HHS Office of Inspector General:

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Fax: 1-800-223-8164

Email: HHSTips@oig.hhs.gov

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

For Medicare Parts C and D:

Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)

For all other Federal health care programs:

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

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

CORRECTION

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

A plan to correct the issue can be developed through an Incident Report or a 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

- 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 ATRIO, or other entity involved in delivering 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 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 ATRIO 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)?
- Are Eligibility facilitations services and the information they provide being used for purposes other than for determining patient eligibility?

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?

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?

LESSON 2 SUMMARY

You play a vital role in preventing FWA. Conduct yourself ethically, stay informed of ATRIO's policies and procedures, and keep an eye out for key indicators of potential FWA.

Report potential FWA. ATRIO has mechanisms for reporting potential FWA. ATRIO accepts anonymous reports and cannot retaliate against you for reporting.

Promptly correct identified FWA with an effective corrective action plan.

LESSON 2 REVIEW

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

LESSON 2 REVIEW

Question 1:

Select the correct answer.

A person drops off a prescription for a beneficiary who is a “regular” customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery. What is your next step?

- A. Fill the prescription for 160
- B. Fill the prescription for 60
- C. Call the prescriber to verify the quantity
- D. Call the Sponsor’s compliance department
- E. Call law enforcement

LESSON 2 REVIEW

Answer 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?

- A. Fill the prescription for 160
- B. Fill the prescription for 60
- **C. Call the prescriber to verify the quantity – Correct Answer**
- D. Call the Sponsor’s compliance department
- E. Call law enforcement

LESSON 2 REVIEW

Question 2:

Select the correct answer.

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?

- 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

LESSON 2 REVIEW

Answer 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?

- 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) – Correct Answer**
- C. Discuss your concerns with your immediate supervisor
- D. Call law enforcement

LESSON 2 REVIEW

Question 3:

Select the correct answer.

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 Doe Diagnostics’ claims far exceed any other provider you reviewed. What should you do?

- A. Call Doe Diagnostics and request additional information for the claims
- B. Consult with your immediate supervisor for next steps or contact the compliance department
- C. Reject the claims
- D. Pay the claims

LESSON 2 REVIEW

Answer 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 Doe Diagnostics’ claims far exceed any other provider you reviewed. What should you do?

- A. Call Doe Diagnostics and request additional information for the claims
- **B. Consult with your immediate supervisor for next steps or contact the compliance department – Correct Answer**
- C. Reject the claims
- D. Pay the claims

LESSON 2 REVIEW

Question 4:

Select the correct answer.

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

- 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

LESSON 2 REVIEW

Answer 4:

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

- 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**

You completed Lesson 2: Your Role in the Fight Against FWA

Now that you have learned all about FWA, it’s time to check your knowledge.

CHECK YOUR KNOWLEDGE

This brief Knowledge Check asks 10 questions and should take about 15 minutes. After identifying your answer for each question, click to the next slide to see what the correct answer is.

KNOWLEDGE CHECK

Question 1 of 10

Select the correct answer.

Once a corrective action plan is started, the corrective actions must be monitored annually to ensure they are effective.

- A. True
- B. False

KNOWLEDGE CHECK

Answer 1 of 10

Once a corrective action plan is started, the corrective actions must be monitored annually to ensure they are effective.

- A. True
- **B. False – Correct Answer**

KNOWLEDGE CHECK

Question 2 of 10

Select the best answer.

Ways to report potential fraud, waste, and abuse (FWA) include:

- A. Phone hotlines
- B. Mail drops
- C. In-person reporting to the compliance department/supervisor
- D. All of the above

KNOWLEDGE CHECK

Answer 2 of 10

Ways to report potential fraud, waste, and abuse (FWA) include:

- A. Telephone hotlines
- B. Mail drops
- C. In-person reporting to the compliance department/supervisor
- **D. All of the above – Correct Answer**

KNOWLEDGE CHECK

Question 3 of 10

Select the correct answer.

Any person who knowingly submits false claims to the Government is liable for five times the Government's damages caused by the violator plus a penalty.

- A. True
- B. False

KNOWLEDGE CHECK

Answer 3 of 10

Any person who knowingly submits false claims to the Government is liable for five times the Government's damages caused by the violator plus a penalty.

- A. True
- **B. False – Correct Answer**

KNOWLEDGE CHECK

Question 4 of 10

Select the correct answer.

These are examples of issues that should be reported to a Compliance Department: suspected fraud, waste, and abuse (FWA); potential health privacy violation; unethical behavior; and employee misconduct.

- A. True
- B. False

KNOWLEDGE CHECK

Answer 4 of 10

These are examples of issues that should be reported to a Compliance Department: suspected fraud, waste, and abuse (FWA); potential health privacy violation; unethical behavior; and employee misconduct.

- **A. True – Correct Answer**
- B. False

KNOWLEDGE CHECK

Question 5 of 10

Select the correct answer.

Bribes or kickbacks of any kind for services that are paid under a Federal health care program (which includes Medicare) constitute fraud by the person making as well as the person receiving them.

- A. True
- B. False

KNOWLEDGE CHECK

Answer 5 of 10

Bribes or kickbacks of any kind for services that are paid under a Federal health care program (which includes Medicare) constitute fraud by the person making as well as the person receiving them.

- **A. True – Correct Answer**
- B. False

KNOWLEDGE CHECK

Question 6 of 10

Select the correct answer.

Waste includes any misuse of resources, such as the overuse of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.

- A. True
- B. False

KNOWLEDGE CHECK

Answer 6 of 10

Waste includes any misuse of resources, such as the overuse of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.

- **A. True – Correct Answer**
- B. False

KNOWLEDGE CHECK

Question 7 of 10

Select the correct answer.

Abuse involves payment 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.

- A. True
- B. False

KNOWLEDGE CHECK

Answer 7 of 10

Abuse involves payment 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.

- **A. True – Correct Answer**
- B. False

KNOWLEDGE CHECK

Question 8 of 10

Select the correct answer.

Some of the laws governing Medicare Parts C and D fraud, waste, and abuse (FWA) include the Health Insurance Portability and Accountability Act (HIPAA), the False Claims Act, the Anti-Kickback Statute, and the Health Care Fraud Statute.

- A. True
- B. False

KNOWLEDGE CHECK

Answer 8 of 10

Some of the laws governing Medicare Parts C and D fraud, waste, and abuse (FWA) include the Health Insurance Portability and Accountability Act (HIPAA), the False Claims Act, the Anti-Kickback Statute, and the Health Care Fraud Statute.

- **A. True – Correct Answer**
- B. False

KNOWLEDGE CHECK

Question 9 of 10

Select the correct answer.

You can help prevent fraud, waste, and abuse (FWA) by doing all of the following:

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure you coordinate with other payers
- Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance
- Verify all information provided to you

- A. True
- B. False

KNOWLEDGE CHECK

Answer 9 of 10

You can help prevent fraud, waste, and abuse (FWA) by doing all of the following:

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure you coordinate with other payers
- Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance
- Verify all information provided to you

- **A. True – Correct Answer**
- B. False

KNOWLEDGE CHECK

Question 10 of 10

Select the best answer.

What are some of the penalties for violating fraud, waste, and abuse (FWA) laws?

- A. Civil Monetary Penalties
- B. Imprisonment
- C. Exclusion from participation in all Federal health care programs
- D. All of the above

KNOWLEDGE CHECK

Answer 10 of 10

What are some of the penalties for violating fraud, waste, and abuse (FWA) laws?

- A. Civil Monetary Penalties
- B. Imprisonment
- C. Exclusion from participation in all Federal health care programs
- **D. All of the above – Correct Answer**

DON’T FORGET COMPLIANCE IS EVERYONE’S RESPONSIBILITY!!

Prevent

- Operate within ATRIO’s ethical expectations to PREVENT noncompliance!

Detect & Report

- If you DETECT potential noncompliance, REPORT it!

Correct

- CORRECT non-compliance to protect beneficiaries and to save money!

APPENDIX A: RESOURCES

Disclaimers

This Web-Based Training (WBT) course was current at the time it was published or uploaded onto the web.

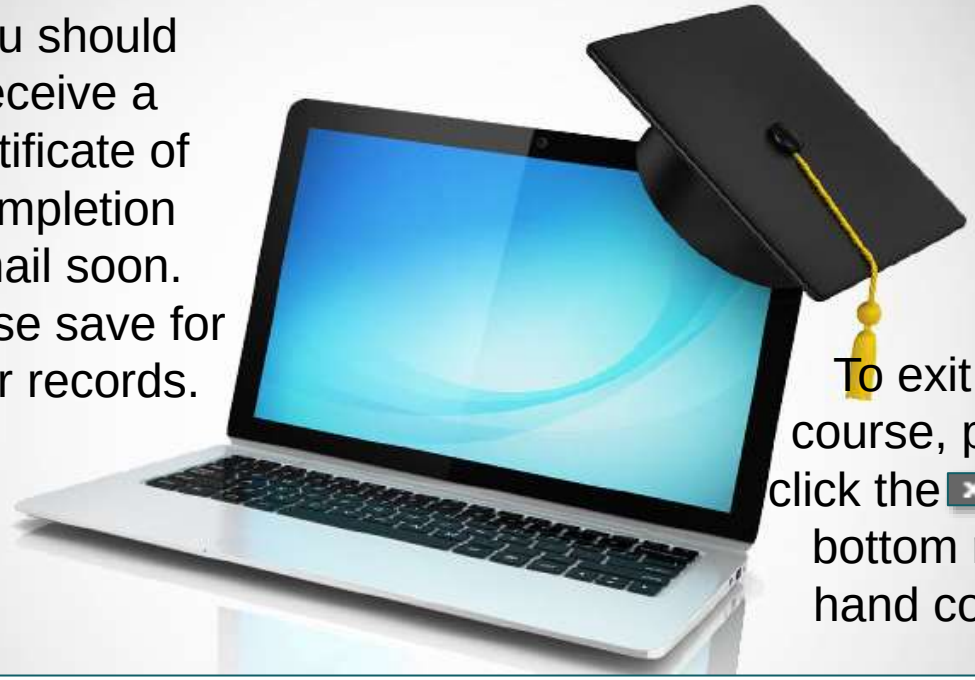
This course was prepared as a service to the organization and is not intended to grant rights or impose obligations. This course may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. Medicare policy changes frequently so we encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Glossary

For glossary terms, visit the Centers for Medicare & Medicaid Services Glossary.

You completed the course!

You should receive a certificate of completion email soon. Please save for your records.



To exit this course, please click the ✕ in the bottom right-hand corner.