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

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Synopsis

In this 30-minute course, learn about fraud, waste, and abuse (FWA) laws and regulations, potential violation consequences and penalties, and how Medicare Part C and Part D employees can recognize and prevent FWA.

- Introduction
- Lesson 1: What's Fraud, Waste, & Abuse?
- Lesson 2: Your Role in the Fight Against Fraud, Waste, & Abuse
- Assessment

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups.

Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

Why Do I Need Training?

Each 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're part of the solution.
Combating FWA is everyone's responsibility. As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

Training Requirements: Plan Employees, Governing Body Members, & First-Tier, Downstream, or Related Entity Employees

Certain training requirements apply to people involved in Medicare Parts C and D administration. All Medicare Advantage Organization (MAO) and Medicare Drug Plan (Part D) (collectively referred to in this course as sponsors) employees must get training to prevent, detect, and correct FWA.

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

Compliance Training, Education & Outreach for Medicare Parts C & D Programs webpage has more information.
Medicare Part C, or Medicare Advantage (MA), is a health insurance option available to Medicare patients. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to patients 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.

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to patients enrolled in Part A and or Part B

who enroll in a Part D 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.

Welcome to the Combating Medicare Parts C & D Fraud, Waste, & Abuse Course

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

Lesson 1: Introduction & Learning Objectives

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

After completing this lesson, you should be able to:

- Recognize FWA in the Medicare Program
- Identify major FWA laws and regulations
- Recognize potential consequences and violation penalties

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

Waste & 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.

Section 20 of Medicare Managed Care Manual, Chapter 21 and Prescription Drug Benefit Manual, Chapter 9 have fraud, waste, and abuse definitions.

Fraud, Waste, & Abuse Examples

Medicare fraud examples:

- Knowingly billing for services of higher complexity than services actually 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

Medicare waste examples:

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive lab tests

Medicare abuse examples:

- Billing unnecessary medical services
- 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

Fraud, Waste, & Abuse Differences

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to get payment and knowledge the actions are wrong. Waste and abuse may involve getting an improper payment or creating unnecessary Medicare Program costs but don't require the same intent and knowledge.

Understanding Fraud, Waste, & Abuse

To detect FWA, you need to know the law.

The next pages provide high-level information about these laws:

* Federal Civil False Claims Act (FCA)
* Criminal Health Care Fraud Statute
* Anti-Kickback Statute (AKS)
* 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, review the applicable statute and regulations.

Federal Civil False Claims Act

The civil False Claims Act (FCA) (31 USC 3729–3733) makes a person liable to pay damages to the government if they knowingly:

- Conspire to violate the FCA
- Carry out other acts to get government property 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 Florida Medicare Part C plan:

- Hired an outside company to review medical records to find additional diagnosis codes it could submit to increase CMS risk capitation payments
- 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 California medical clinic:

- 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 & 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.

Whistleblower: A person who exposes information or activity that's 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 gets at least 15%, but not more than 30%, of the money the government collects

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 doesn’t require proof the violator knew the law or had specific intent to violate it.

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.
18 USC 1347 has more information

Examples:

A Pennsylvania pharmacist:

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

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

- Falsely represented themselves as 1 of a nonprofit health maintenance organization’s (that administered a Medicare Advantage plan) authorized vendors
- Didn’t provide DME to any patients as claimed
- Submitted almost $1 million in false claims to the nonprofit; was paid $300,000
- Pleaded guilty to 1 count of conspiracy to commit health care fraud

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.

Damages & Penalties

Violations are punishable by:

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

Section 1128B(b) of the Social Security Act has more information.

Example:

A physician operating a Rhode Island pain management practice:

- Conspired to solicit and get kickbacks for prescribing a highly addictive version of the opioid Fentanyl
- Reported patients had breakthrough cancer pain to secure insurance payments
- Got $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 was required to pay more than $750,000 in restitution.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (42 USC 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 service
- Radiology and other imaging services
- Radiation therapy services and supplies
- DME and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Damages & Penalties

We don't pay Medicare claims tainted by an arrangement that doesn't comply with the Stark Statute. A penalty of appoximately $25,000 can be imposed for each service provided. There may also be a fine over $160,000 for entering into an unlawful arrangement or scheme.

Physician Self-Referral webpage and section 1877 of the Social Security Act have more information.

Example:

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

Civil Monetary Penalties 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.

Example:
A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted unsubstantiated Medicare Part D claims for brand name prescription drugs the pharmacy couldn't have dispensed based on inventory records.

Damages & Penalties

Penalties and assessments vary based on the type of violation. Penalties can be approximately $10,000–$50,000 per violation. CMPs may also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received.

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) website.

The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), 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 aren't the same. 42 CFR 1001.1901 has more information.

Example:

A pharmaceutical company pleaded guilty to 2 felony counts of criminal fraud for not filing required reports with the FDA about oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. When 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

The Health Insurance Portability and Accountability Act (HIPAA) created greater access to health care insurance, strengthened health care data privacy protection, and promoted health care industry standardization and efficiency.

HIPAA safeguards deter unauthorized access to protected health care information. As someone with access to protected health care information, you must comply with HIPAA.

Example:

A former hospital employee pleaded guilty to criminal HIPAA charges after getting 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 CMPs. In some cases, criminal penalties may apply.

Lesson 1 Summary

There are differences between 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 getting an improper payment but not the same intent and knowledge.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws include:

- Civil Monetary Penalties
- Civil prosecution
- Criminal conviction, fines, or both
- Exclusion from all federal health care program participation
- Imprisonment
- Loss of professional license

Review Questions (Select the correct answer)

Which of these requires intent to get paid and knowing the actions are wrong?

A. Fraud
B. Abuse
C. Waste

Which of these is NOT a potential penalty for violating laws or regulations prohibiting fraud, waste, and abuse (FWA)?

A. Civil Monetary Penalties (CMPs)
B. Deportation
C. Exclusion from participation in all federal health care programs

Lesson 2: Introduction & Learning Objectives

This lesson explains your role in the fight against fraud, waste, and abuse (FWA), including your responsibilities to prevent, report, and correct it. It should take you about 10 minutes to complete.
After completing this lesson, you should be able to identify how to prevent, report, and correct FWA.

Where Do I Fit In?

As someone who provides health or administrative services to a Medicare Part C or Part D enrollee, you're likely an employee of a:

- Sponsor: Medicare Advantage Organization (MAO) or a Prescription Drug Plan (PDP)
- First-Tier Entity: Pharmacy Benefit Manager (PBM), hospital or health care facility, provider group, doctor's office, clinical lab, customer service provider, claims processing and adjudication company, a company that handles enrollment, disenrollment, and membership functions, and contracted sales agents
- Downstream Entity: Pharmacies, doctors' offices, firms providing agent or broker services, marketing firms, and call centers
- Related Entity: Entity with common ownership or control of a sponsor, health promotion provider, or SilverSneakers®

A 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. Medicare Part C Plan Sponsor first-tier and related entities 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 and 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 and 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 relating to the sponsor's Medicare Part D contracts. Medicare Part D Plan 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, 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 an important role 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 you may know
- **Third**, you have a duty to follow your organization's Code of Conduct that describes you and your organization's commitment to standards of conduct and ethical rules of behavior

How Do You Prevent Fraud, Waste, & Abuse?

- Look for suspicious activity
- Conduct yourself ethically
- 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 information you get

Stay Informed About Policies & Procedures

Know your entity's policies and procedures.

Every sponsor and FDR must have FWA policies and procedures. 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 ethically
- 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 that compliance is everyone's responsibility, from the organization's top to bottom.

Report Fraud, Waste, & Abuse

Everyone must report suspected FWA. Your sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith reporting effort.

Report any potential FWA concerns to your compliance department or your sponsor's compliance department. They will investigate and make the proper determination. Often, sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain a FWA hotline.

Every sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Sponsors must accept anonymous reports and can't retaliate against you for reporting. Review your organization's materials for how to report FWA.

When in doubt, call your compliance department or FWA hotline.

Reporting Fraud, Waste, & Abuse Outside Your Organization

If warranted, sponsors and FDRs must report potentially fraudulent conduct to government authorities, like the Office of Inspector General (OIG), 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 costs and disruptions of a government-directed investigation and civil or administrative litigation.

Details to Include When Reporting Fraud, Waste, & Abuse

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: OIG.HHS.gov/report-fraud
- Mail:
  U.S. Department of Health & Human Services Office of Inspector General
  ATTN: OIG Hotline Operations
  P.O. Box 23489
  Washington, DC 20026

Medicare Parts C and D:

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

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

Corrective Action

Once FWA 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 how to develop a corrective action plan. The actual plan varies depending on the circumstances. In general:

- Design the corrective action to fix the underlying problem that results in FWA violations and prevents future noncompliance
- Tailor the corrective action to address the particular FWA problem or identified deficiency; include timeframes for specific actions
- Document corrective actions addressing noncompliance or FWA committed by a sponsor's or FDR's employee, and include consequences for failing to satisfactorily complete the corrective action
- Monitor corrective actions continuously to ensure effectiveness

Corrective actions may include:

- Adopting new prepayment edits or document review requirements
- Conducting mandated training
- Providing educational materials
- Revising policies or procedures
- Sending warning letters
- Taking disciplinary action, like marketing, enrollment, or payment suspension
- Terminating an employee or provider

Potential Fraud, Waste, & Abuse Indicators

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 next 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 enrollee benefits.

Key Indicators: Potential Patient Issues

- Does a prescription, medical record, or lab test look altered or possibly forged?
- Does a patient's medical history support requested services?
- Have you filled numerous identical prescriptions for this patient, possibly from different doctors?
- Is the person getting the medical service the actual patient (identity theft)?
- Is the prescription appropriate based on patient's other prescriptions?

Key Indicators: Potential Provider Issues

- Are the provider's prescriptions appropriate for patient's health condition (medically necessary)?
- Does the provider bill sponsor for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily controlled substances?
- Does the provider perform medically unnecessary patient services?
- Does the provider prescribe a higher quantity than medically necessary for the condition?
- Does the provider's prescription include their active and valid National Provider Identifier (NPI)?
- Is the provider's patient diagnosis supported in the medical record?

Key Indicators: Potential Pharmacy Issues

- Are drugs being diverted (drugs meant for nursing homes, hospices, and other entities being sent somewhere else)?
- Are dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when prescription requires dispensing brand drugs?
- Are PBMs billed for unfilled or never-picked-up prescriptions?
- Are proper provisions made if entire prescription isn't filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?
- Are Eligibility Facilitations Services (E1s) and their information being used for purposes other than 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, or AIDS clinics, marking up prices, and sending to other smaller wholesalers or pharmacies?

Key Indicators: Potential Manufacturer Issues

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

Key Indicators: Potential Sponsor Issues

- Does the sponsor encourage or support submitting inappropriate risk adjustments?
- Does the sponsor lead patient to believe the benefits cost a certain price, when the actual cost is higher?
- Does the sponsor offer patients cash incentives to join the plan?
- Does the sponsor use unlicensed agents?

Lesson 2 Summary

As someone providing health or administrative services to a Medicare Part C or D enrollee, you play an important part 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 potential FWA indicators

Report potential FWA. Every sponsor must have a mechanism to report potential FWA. Sponsors must accept anonymous reports and can't retaliate against you for reporting

Promptly correct identified FWA with an effective corrective action plan

Review Questions (Select the correct answer)

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

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

You're responsible for submitting a risk diagnosis to CMS for payment purposes. You use a specific process to verify the data is accurate. Your immediate supervisor tells you to ignore the process and adjust or add risk diagnosis codes for certain individuals. What should you do?

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

You're responsible for paying provider claims. You notice a certain diagnostic provider (Doe Diagnostics) requested substantial payment for a large patient group. Many claims are for a specific procedure. You review the same procedure type 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 ask for additional claim information
B. Contact your immediate supervisor for next steps or contact the compliance department (via compliance hotline, Special Investigations Unit [SIU], or other mechanism)
C. Reject the claims
D. Pay the claims

You're performing regular inventory of the pharmacy's controlled substances. 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