Medicare Fraud, Waste, and Abuse Training and General Compliance Training

Developed by the Centers for Medicare & Medicaid Services

2016 Training
This training module consists of two parts:

(1) Medicare Fraud, Waste, and Abuse (FWA) Training

(2) Medicare General Compliance Training. All persons who provide health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements.
Part 1:
Fraud, Waste, and Abuse Training

Developed by the Centers for Medicare & Medicaid Services
Why Do I Need Training?

Every year millions of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone. Including YOU.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

YOU are part of the solution.
Objectives

• Meet the regulatory requirement for training and education
• Provide information on the scope of fraud, waste, and abuse
• Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
• Provide information on how to report fraud, waste, and abuse
• Provide information on laws pertaining to fraud, waste, and abuse
Where Do I Fit In?

As a person who provides health or administrative services to a Medicare enrollee you are either:

• Part C or D Sponsor Employee
• First Tier Entity
  • Examples: PBM, a Claims Processing Company, contracted Sales Agent
• **Downstream Entity**
  • Example: Clinic, Hospital, Pharmacy
• Related Entity
  • Example: Entity that has a common ownership or control of a Part C/D Sponsor
What are my responsibilities?

You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory and regulatory requirements, including adopting and implementing an effective compliance program.
- **SECOND** you have a duty to the Medicare Program to report any violations of laws that you may be aware of.
- **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.
Prevention
How Do I Prevent Fraud, Waste, and Abuse?

• Make sure you are up to date with laws, regulations, policies.
• Ensure you coordinate with other payers.
• Ensure data/billing is both accurate and timely.
• Verify information provided to you.
• Be on the lookout for suspicious activity.
Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.
Detection
Understanding Fraud, Waste and Abuse

In order to detect fraud, waste, and abuse you need to know the Law.
FRAUD

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.

18 United States Code §1347
What Does That Mean?

Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.
Waste and Abuse

**Waste**: overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

**Abuse**: includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.
Differences Between Fraud, Waste, and Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.
Indicators of Potential Fraud, Waste, and Abuse

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.
Indicators of Potential Fraud, Waste, and Abuse

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your job duties.
Key Indicators: Potential Beneficiary Issues

• Does the prescription look altered or possibly forged?
• Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
• Is the person receiving the service/picking up the prescription the actual beneficiary (identity theft)?
• Is the prescription appropriate based on beneficiary’s other prescriptions?
• Does the beneficiary’s medical history support the services being requested?
Key Indicators: Potential Provider Issues

• Does the provider write for diverse drugs or primarily only for controlled substances?
• Are the provider’s prescriptions appropriate for the member’s health condition (medically necessary)?
• Is the provider writing for a higher quantity than medically necessary for the condition?
• Is the provider performing unnecessary services for the member?
Key Indicators: Potential Provider Issues

- Is the provider’s diagnosis for the member supported in the medical record?
- Does the provider bill the sponsor for services not provided?
How Do I Report Fraud, Waste, or Abuse?
Everyone is required to report suspected instances of fraud, waste, and abuse.

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your Compliance Department. The Compliance Department will investigate and make the proper determination.
Correction
Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government money and ensures you are in compliance with CMS’ requirements.
Once issues have been identified, a plan to correct the issue needs to be developed. Consult your compliance officer to find out the process for the corrective action plan development.

The actual plan is going to vary, depending on the specific circumstances.
Laws You Need to Know About
False Claims Act

Prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it’s true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733
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 (which includes the Medicare program).

42 United States Code §1320a-7b(b)
Stark Statute
(Physician Self-Referral Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn
Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.
Consequences
Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs
Part 2: Medicare Compliance Training

Developed by the Centers for Medicare & Medicaid Services
Why Do I Need Training?

Compliance is **EVERYONE’S** responsibility!

As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare program, or the Medicare trust fund.
To understand the organization’s commitment to ethical business behavior

To understand how a compliance program operates

To gain awareness of how compliance violations should be reported
A culture of compliance within an organization:

- Prevents noncompliance
- Detects noncompliance
- Corrects noncompliance
At a minimum, a compliance program must include the 7 core requirements:

1. Written Policies, Procedures and Standards of Conduct;
2. Compliance Officer
3. Effective Training and Education;
4. Effective Lines of Communication;
5. Well Publicized Disciplinary Standards;
6. Effective System for Routine Monitoring and Identification of Compliance Risks; and
7. Procedures and System for Prompt Response to Compliance Issues

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual ("IOM"), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9
As a part of the Medicare program, it is important that you conduct yourself in an ethical and legal manner. It’s about doing the right thing!
How Do I Know What is Expected of Me?

The Orthopaedic & Fracture Clinic’s Code of Conduct states compliance expectations and the principles and values by which OFC operates.

(Available on the Staff Portal)
What Is Noncompliance?

Noncompliance is conduct that does not conform to the law, and Federal health care program requirements, or to an organization’s ethical and business policies.
Noncompliance Harms Enrollees

Without programs to prevent, detect, and correct noncompliance there are:

- Delayed services
- Difficulty in using providers of choice
- Denial of benefits
- Hurdles to care
Noncompliance Costs Money

Non Compliance affects EVERYBODY!

Without programs to prevent, detect, and correct noncompliance you risk:

- Higher Premiums
- Higher Insurance Copayments
- Lower benefits for individuals and employers
- Lower Star ratings
- Lower profits
I’m Afraid to Report Noncompliance

There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.

Employers must offer reporting methods that are:

- **Anonymous**
- **Confidential**
- **Non-Retaliatory**
How Can I Report Potential Noncompliance?

**Employees of an MA, MA-PD, or PDP Sponsor**
- Call the Medicare Compliance Officer
- Make a report through the Website
- Call the Compliance Hotline

**FDR Employees (OFC)**
- Talk to your Supervisor
- Talk to the Compliance Officer

**Beneficiaries**
- Call the Sponsor’s compliance hotline
- Make a report through Sponsor’s website
- Call 1-800-Medicare
What Happens Next?

Correcting Noncompliance

- Avoids the recurrence of the same noncompliance
- Promotes efficiency and effective internal controls
  - Protects enrollees
  - Ensures ongoing compliance with CMS requirements

After noncompliance has been detected...

It must be investigated immediately...

And then promptly correct any noncompliance...
How Do I Know the Noncompliance Won’t Happen Again?

- Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.
- Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.
- Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.
Your organization is required to have disciplinary standards in place for non-compliant behavior. Those who engage in non-Compliant behavior may be subject to any of the following:

- Mandatory Training
- Re-Training
- Disciplinary Action
- Termination
Compliance is EVERYONE’S Responsibility!!

**PREVENT**
- Operate within your organization’s ethical expectations to PREVENT noncompliance!

**DETECT & REPORT**
- If you DETECT potential noncompliance, REPORT it!

**CORRECT**
- CORRECT noncompliance to protect beneficiaries and to save money!
What Governs Compliance?

- **Social Security Act:**
  - Title 18
- **Code of Federal Regulations***:
  - 42 CFR Parts 422 (Part C) and 423 (Part D)
- **CMS Guidance:**
  - Manuals
  - HPMS Memos
- **CMS Contracts:**
  - Private entities apply and contracts are renewed/non-renewed each year
- **Other Sources:**
  - OIG/DOJ (fraud, waste and abuse (FWA))
  - HHS (HIPAA privacy)
- **State Laws:**
  - Licensure
  - Financial Solvency
  - Sales Agents

* 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)
Additional Resources

- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
  - Title XVIII of the Social Security Act
  - Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
  - Civil False Claims Act (31 U.S.C. §§ 3729-3733)
  - Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
  - Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
  - Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
CONGRATULATIONS!

You have completed FWA/Compliance Training Slides

Please complete your training by taking the lesson quiz.