



# **Combating Medicare Parts C and D Fraud, Waste and Abuse**

Health First Health Plans  
Associate New and Annual Training



# **What is Fraud, Waste and Abuse?**

# 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. 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; and
- 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 healthcare 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 healthcare benefit program.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a healthcare benefit program. Healthcare fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of 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 that the patient failed to keep;
- Billing for non-existent prescriptions; and
- 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 the treatment of a specific condition; and
- 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; and
- 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 that the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but does not require the same intent and knowledge.

# Understanding FWA

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

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

- Civil False Claims Act, Health Care Fraud Statute and Criminal Fraud;
- Anti-Kickback Statute;
- Stark Statute (Physician Self-Referral Law);
- Exclusion from all Federal health care programs; and
- Health Insurance Portability and Accountability Act (HIPAA)

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

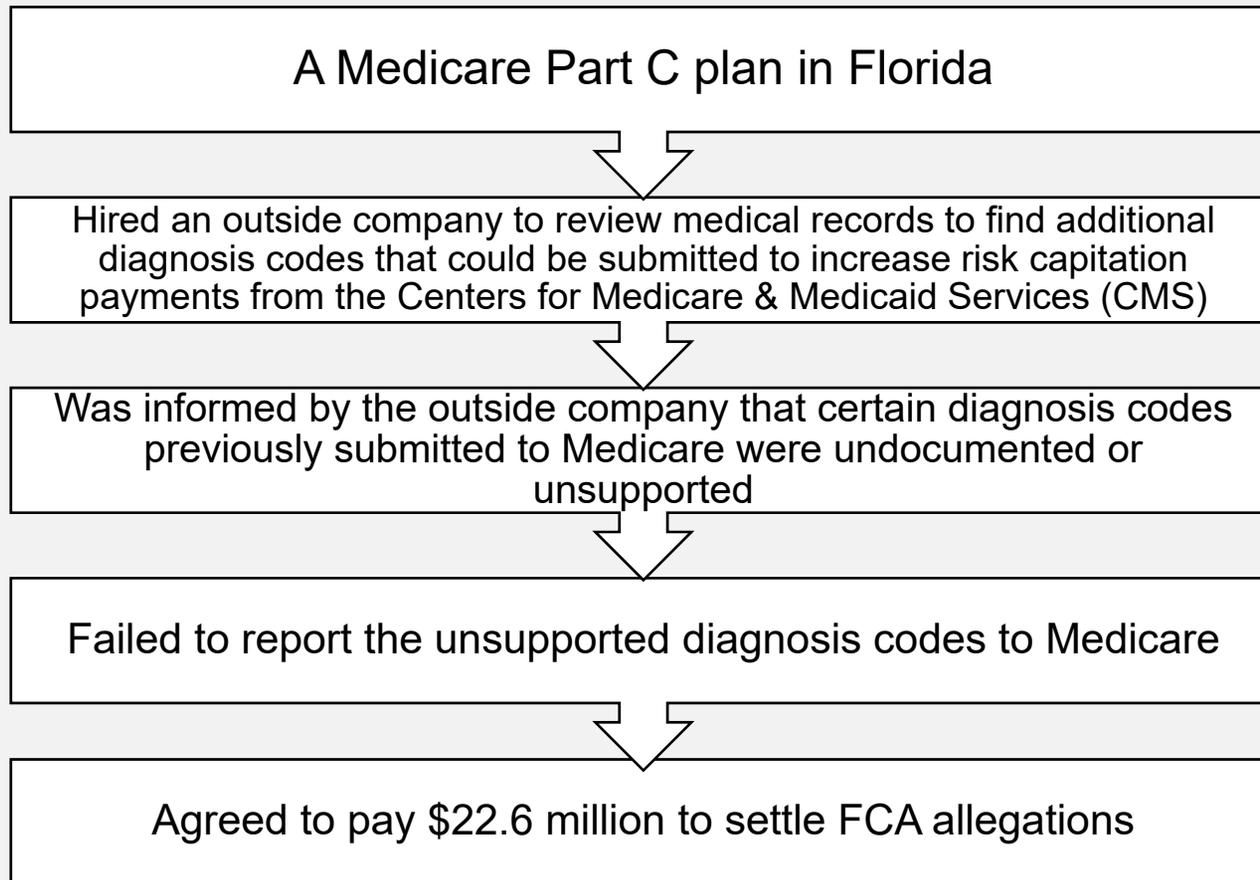
# Civil False Claims Act (FCA)

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; or
- Presents a false claim for payment or approval

For more information, refer to [31 United States Code \(U.S.C.\) Sections 3729-3733](#) on the Internet.

# Civil False Claims Act (FCA)



## **Damages and Penalties:**

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 False Claims Act (FCA)

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:**

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 False Claims (FCA)

## Whistleblowers

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

- **Protected:** Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- **Rewarded:** Persons who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent, of the money collected.

# Health Care Fraud Statute

The Health Care Fraud Statute states, “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program ... shall be fined under this title or imprisoned not more than 10 years, or both.”

Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law.

*For more information, refer to [18 USC Sections 1346–1347](#).*

# Health Care Fraud Statute

A Pennsylvania pharmacist:

Submitted claims to a Medicare Part D plan for non-existent prescriptions and for drugs not dispensed;

Pleaded guilty to healthcare fraud; and

Received a 15-month prison sentence and was ordered to pay more than \$166,000 in restitution to the plan.

# Health Care Fraud Statute

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 healthcare fraud

# Criminal Health Care Fraud

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

- Criminal fines up to \$250,000
- Imprisonment for up to 20 years

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

*For more information, refer to [18 U.S.C. Section 1347](#) on the Internet.*

# Anti-Kickback Statute

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including the Medicare program).

For more information, refer to [42 U.S.C. Section 1320a-7b\(b\)](#) on the Internet.

# Anti-Kickback Statute

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.

## Damages and Penalties:

Violations are punishable by:

- A fine of up to \$25,000;
- Imprisonment for up to 5 years

For more information, refer to the [Social Security Act \(the Act\), Section 1128B\(b\)](#) on the Internet.

# Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest; or
- A compensation arrangement

Exceptions may apply.

*For more information, refer to [42 U.S.C. Section 1395nn](#) on the Internet.*

# Stark Statute (Physician Self-Referral Law)

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 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](#) on the CMS website and refer to [the Act, Section 1877](#), on the Internet.

# Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:

- Arranging for services or items from an excluded individual or entity;
- Providing services or items while excluded;
- Failing to grant OIG timely access to records;
- Knowing of and failing to report and return an overpayment;
- Making false claims; or
- Paying to influence referrals

*For more information, refer to [42 U.S.C. 1320a-7a](#) and [the Act, Section 1128A\(a\)](#) on the Internet.*

# Civil Monetary Penalties (CMP) Law

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:**

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

No Federal healthcare 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 U.S.C. Section 1320a-7](#) and [42 Code of Federal Regulations Section 1001.1901](#) on the Internet.*

## Exclusion

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the U.S. Food and Drug Administration concerning oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. At the time the 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 healthcare insurance, strengthened the protection of privacy of healthcare data and promoted standardization and efficiency in the healthcare industry.

HIPAA safeguards deter unauthorized access to protected healthcare information. As an individual with access to protected healthcare information, you must comply with HIPAA.

For more information, visit the [HIPAA webpage](#) on the Internet.

# Health Insurance Portability and Accountability Act

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. In some cases, criminal penalties may apply.

# 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 healthcare program participation;
- Imprisonment; or
- Loss of professional license



# **Your Role in the Fight Against FWA**

# Introduction

## Your Role in the Fight against FWA

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 be able to correctly:

- Identify methods of preventing FWA;
- Identify how to report FWA; and
- Recognize how to correct FWA

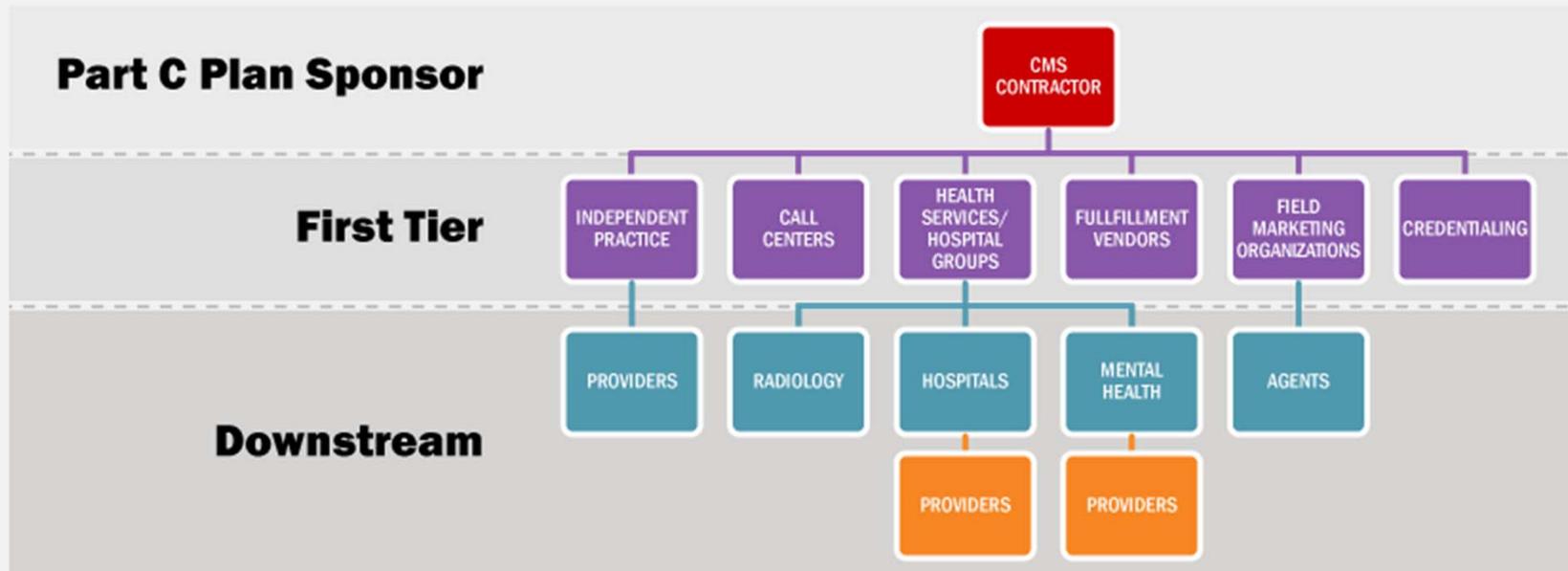
# Where Do I Fit In?

As a person providing health or administrative services to a Medicare Part C or Part D enrollee, you are likely an employee of a:

- Sponsor (Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
- First-tier entity (Examples: Pharmacy Benefit Management [PBM]; hospital or healthcare 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®)

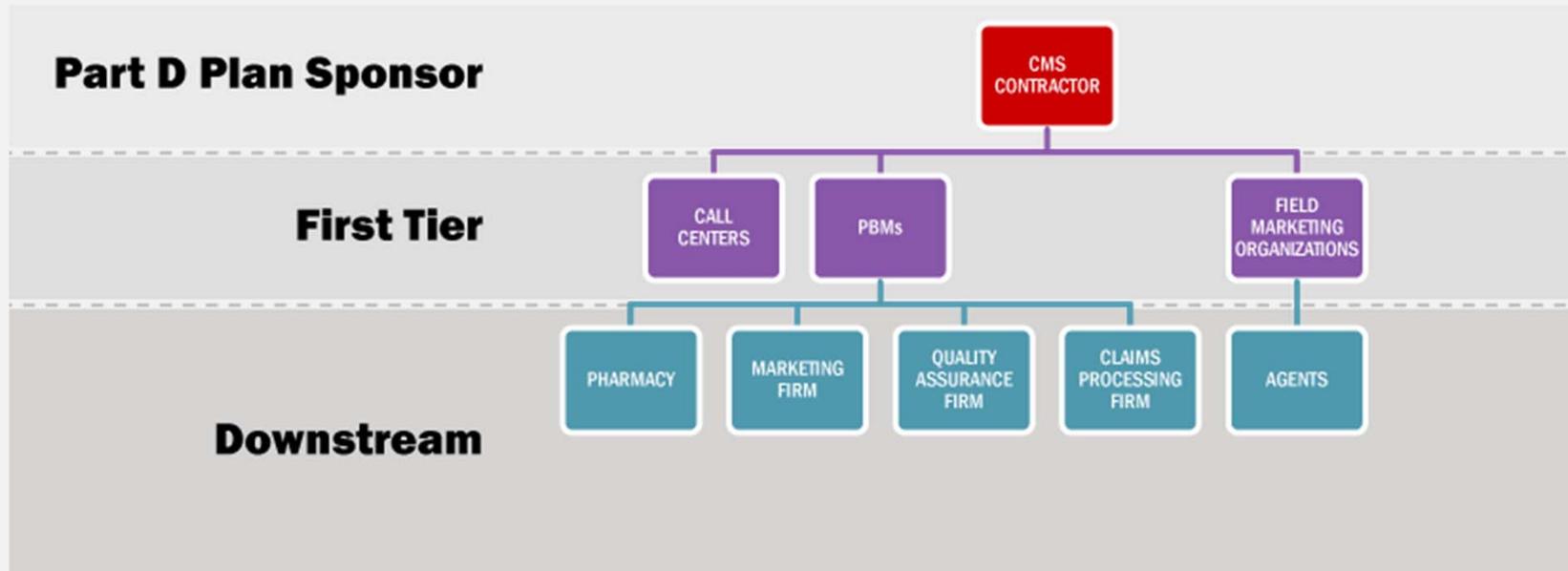
# Where Do I Fit In?

*I am an employee of a Part C Plan Sponsor or an employee of a Part C Plan Sponsor's first-tier or downstream entity.*



# Where Do I Fit In?

*I am an employee of a Part D Plan Sponsor or an employee of a Part D Plan Sponsor's first-tier or downstream entity.*



# What Are Your Responsibilities?

You play a vital part in preventing, detecting and reporting potential FWA, as well as Medicare non-compliance.

- **FIRST**, you must comply with all applicable statutory, regulatory and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
- **SECOND**, you have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations of which you may be aware.
- **THIRD**, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

## How Do You Prevent FWA?

- Look for suspicious activity;
- Conduct yourself in an ethical manner;
- Ensure accurate and timely data and billing;
- Ensure coordination with other payers;
- Know FWA policies and procedures, standards of conduct, laws, regulations and CMS' guidance; and
- Verify all received information

# 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; and
- Reported issues will be addressed and corrected.

Standards of Conduct communicate to employees and FDRs compliance is everyone's responsibility, from the top of the organization to the bottom.



# Report FWA

**Everyone must report suspected instances of FWA.  
Our Health First Code of Conduct clearly states this obligation.  
Do not be concerned about whether it is fraud, waste or abuse.**

- Preferred: Follow your chain of command
- Anonymous through the Compliance Hotline: 1.888.400.4512
- Through the Safety Zone Portal
- In Person: Compliance team member

***It is the strict policy of Health First that no retaliation or retribution can be made against any party for good faith reporting.***

# Report 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.

# Report FWA Outside Your Organization

## Details to Include When Reporting FWA

When reporting suspected FWA, include:

- Contact information for the information source, suspects and witnesses
- Alleged FWA details
- Alleged Medicare rules violated
- The suspect's history of compliance, education, training and communication with your organization or other entities



# Where to Report FWA

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](mailto:HHSTips@oig.hhs.gov)
- Online: [Forms.OIG.hhs.gov/hotlineoperations/index.aspx](https://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 healthcare programs:

- CMS Hotline at 1.800.MEDICARE (1.800.633.4227) or TTY 1.877.486.2048

Medicare beneficiary website: [Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html](https://www.Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html)

# Correction

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 Action Examples

Corrective actions may include:

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

# Indicators of Potential FWA

Now that you know about your role in preventing, reporting and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.

The following pages present potential FWA issues. Each page provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy or other entity involved in delivering Medicare Parts C and D benefits to enrollees.

## Key Indicators: Potential Beneficiary Issues

- 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 actual 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 the Sponsor for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Does the provider's prescription have their active and valid National Provider Identifier on it?
- Is the provider's diagnosis for the member supported in the medical record?

# Key Indicators: Potential Pharmacy Issues

- Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted or illegal?
- Are generic drugs provided when the prescription requires dispensing brand drugs?
- Are PBMs billed for unfilled or never picked up prescriptions?
- Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?

## Key Indicators: Potential 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 and then marking up the prices and sending to other smaller wholesalers or pharmacies?

## Key Indicators: Potential Manufacturer Issues

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer knowingly provide samples to entities that bill Federal healthcare 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?

# 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.

# References and Job Aids

Anti-Kickback Statute [42 USC Section 1320a-7b\(b\)](#)

Civil False Claims Act [31 USC Sections 3729–3733](#)

Civil Monetary Penalties Law [42 USC Section 1320a-7a](#)

Criminal False Claims Act [18 USC Section 287](#)

Exclusion [42 USC Section 1320a-7](#)

Criminal Health Care Fraud Statute [18 USC Section 1347](#)

Physician Self-Referral Law [42 USC Section 1395nn](#)

[Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training](#)

[OIG's Provider Self-Disclosure Protocol](#)

[Physician Self-Referral](#)

[Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians](#)

[Safe Harbor Regulations](#)