
Medicare Fraud, Waste, and Abuse Training: Prevention and Compliance

Terms and Conditions

This training program is protected under United States Copyright laws, 17 U.S.C.A. §101, et seq. and international treaties. Except as provided below, the training program may not be reproduced (in whole or in part) in hard paper copy, electronically, or posted on any web site or intranet without the prior written consent of AHIP. Any AHIP member company in good standing sponsoring a Medicare Advantage or Part D plan may reproduce the training program for the limited purpose of providing training and education to the company's own employees and contractors on the subject matter contained in the training program. Employees or contractors participating in such training may not further reproduce (in whole or in part) the training program. No changes of any kind may be made to the training program and any reproduction must include AHIP's copyright notice. This limited license is terminable at will by AHIP.

The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

Learning Objectives

After completing this training, you will be able to:

- Understand why you are taking this training and your obligations related to FWA;
- define and distinguish healthcare fraud, waste, and abuse (FWA);
- discuss the costs of FWA, both economic and non-economic;
- state who is responsible for combating FWA;
- identify seven Federal laws used against FWA;
- Learn the kinds of disciplinary actions that can result from committing FWA or not reporting suspected FWA;
- understand how FWA can be detected, prevented and corrected;
- tell how to report suspected FWA; and
- describe the legal protections provided to those who report suspected FWA.

Please note: All example scenarios use fictitious names to illustrate concepts within this training.

Terminology

As used in these slides, the terms “Medicare plan” and “subcontractor” have the following meanings:

“Medicare plan” means a Medicare Advantage (MA) plan, a Medicare Advantage-Prescription Drug plan (MA-PD) or a Medicare Prescription Drug Plan (PDP).

“Subcontractor” means an individual or entity that provides services on behalf of a Medicare plan sponsor. This includes individuals and organizations with a direct relationship with the plan sponsor, or individuals or organizations with an indirect relationship, such as an agent who has a contract with an agency or field marketing organization that contracts with a Medicare plan.

FWA Training: A Compliance Program Component

All Medicare plans are required to have robust programs to assure compliance by plan employees and subcontractors with all applicable laws, regulations and program guidance. One required component of a compliance program is a fraud, waste and abuse (FWA) program to identify and address issues of compliance with fraud, waste and abuse laws.

It is important to remember that all Medicare plan sponsor employees and subcontractors are responsible for complying with all relevant Medicare requirements, even if lack of compliance may not be viewed as fraud, waste and abuse.

Why Participate in FWA Training

Fraud, waste, and abuse impacts everyone who receives or relies on healthcare in the United States—including you. The purpose of this training is to help you detect, correct, and prevent FWA—and your help is needed. You are part of the solution!

As a subcontractor to or an employee of a Medicare plan, you are required to participate in FWA training.

The Scope of Healthcare Fraud, Waste, and Abuse

Fraud, waste, and abuse are a major problem for the healthcare system in the United States. As a nation, we spend over \$2.7 trillion on healthcare every year, and it is estimated that tens of billions are lost each year to FWA.

Looking just at Medicare and Medicaid, one recent study estimated that fraud and abuse added as much as \$98 billion to annual spending.

Combating FWA: A Federal Priority

The Federal government, as sponsor of the Medicare and Medicaid programs, is a major payor of healthcare costs, and consequently combating healthcare fraud is an important Federal priority. The Centers for Medicare & Medicaid Services (CMS), the Federal agency responsible for administering these programs, takes its role in leading anti-fraud efforts very seriously and has issued strict requirements for those involved in providing Medicare Advantage and Medicare Part D coverage. The Office of Inspector General, a sister agency to CMS within the U.S. Department of Health and Human Services, is also actively involved in anti-fraud efforts.

Combating FWA: A Health Plan Priority

Medicare plans also recognize the seriousness of fraud, waste, and abuse, which not only result in lost dollars but can jeopardize the quality of healthcare received by plan members. Health plans seek your help in combating fraud, waste, and abuse, and this training is designed to help you recognize questionable activity and take steps to stop or prevent it.

The Human Cost of FWA: An Example

As mentioned, the cost of fraud, waste, and abuse (FWA) is not counted only in dollars; FWA can have serious implications for the health of Medicare plan members. An example: Maria Duarte becomes the victim of healthcare identity theft. Her Medicare plan member card is stolen and used by another person to obtain medication for high blood pressure. When Maria goes to renew her own blood pressure prescription, her request for benefits is denied because records show that medication has already recently been dispensed. Short of funds, Maria goes without medication and is later hospitalized for a minor stroke. And when this happens, because the person assuming her identity has received other treatment, Maria's health records, which her doctors rely on in treating her, are not accurate.

Steps by Medicare plans to Combat FWA

Medicare plans are very aware of the adverse effects of fraud, waste, and abuse on their members and have taken active steps to detect and combat it. These steps include:

- the establishment and operation of **special investigations units (SIUs)** or other existing departments that perform an internal investigation function.
- the analysis of claims data,
- collaboration with law enforcement agencies, and
- adherence to rules set forth by CMS regarding efforts against fraud, waste, and abuse.

CMS Anti-FWA Requirements for Medicare Plans

As mentioned, CMS administers the Medicare program. As part of this mission, CMS requires Medicare plans to adopt and implement an effective compliance program that includes measures that prevent, detect, and correct program non-compliance, including fraud, waste, and abuse. To do so, Medicare plans, with the cooperation of their contractors, have the responsibility to take the following steps:

- actively seek to prevent fraud, waste, and abuse;
- detect and investigate suspected fraud, waste, and abuse;
- implement corrective action when instances of fraud, waste, and abuse are uncovered;
- have a system in place 24-hours a day for employees and subcontractors to voluntarily, and confidentially, report suspected FWA or misconduct related to the Medicare Advantage and Part D programs to CMS or its designees; and
- put into place a compliance program that guards against, fraud, waste, and abuse.

CMS FWA Training Requirements for a Sponsor's Employees

CMS requires Medicare plan sponsors to provide training in fraud, waste, and abuse (FWA) to their employees involved in Medicare plan work. This training must occur within 90 days of hire and annually thereafter.

Training Requirements: Agents, Brokers, and Other Subcontractors

The fraud, waste, and abuse (FWA) training must be received not only by Medicare plan sponsor employees but also by subcontractors and their employees who are under contract to provide health or administrative services. The exceptions are limited to:

- accredited suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and
- healthcare providers who are enrolled in Medicare Part A or B are deemed to meet the FWA training requirements and, therefore, do not need to take additional training.

Those that are required to take the training include, but are not limited to:

- insurance agents and brokers as well as employees of agencies and field marketing organizations (FMOs) that are performing services for Medicare plans;
 - employees of other vendors and subcontractors (such as claim processing firms); and
 - pharmacists and employees of **pharmacy benefit managers (PBMs)**.
-

Fraud, Waste, and Abuse— Definitions and Examples

What Is Fraud, Waste, and Abuse (FWA)?

What is fraud, waste, and abuse (FWA)? Let's start with some brief definitions. Next we'll look at who commits FWA; define fraud, waste, and abuse in more detail; and give some examples to help you recognize situations where FWA can occur.

- **Fraud** is an intentional act of deception, misrepresentation, or concealment in order to gain something of value. Fraud often involves criminal behavior.
- **Abuse** results in unwarranted payments from or costs to a Federal health care program, but there is no action constituting fraud. In abuse, a healthcare consumer, provider, or other person obtains money to which they are not entitled, but there is not the intent to deceive that is necessary for fraud to have occurred. Abuse often involves actions which are inconsistent with accepted medical and/or business practices.
- **Waste** occurs when poor or inefficient practices result in unnecessary healthcare expenditures to a Government program.

Who Commits Medicare Fraud, Waste, and Abuse?

Who commits Medicare fraud, waste, and abuse? Many parties may do so, including:

- Medicare beneficiaries;
- physicians and other healthcare providers;
- pharmacies, pharmacists, and pharmaceutical manufacturers and wholesalers;
- health plan employees;
- insurance agents and brokers;
- parties who neither provide nor receive healthcare (such as professional criminals, including members of organized crime organizations); and
- combinations of the above working together in collusion.

Defining Fraud: A Closer Look

Before we look at examples of fraud, let's define it in more detail.

According to the health care fraud criminal statute (18 U.S.C. §1347) **health care fraud** is: “knowingly and willfully executing, or attempting to execute, a scheme or artifice (1) to defraud any health care benefit program; or (2) 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 benefit program.”

Health care fraud can result in civil and criminal penalties that include fines, monetary damages, and even imprisonment. Additionally, there is a penalty of up to 20 years in prison or life in prison if the violation resulted in a person's death.

Example of Fraud Committed by a Pharmacist

When Pharmacist James Wilson fills prescriptions for pain relievers, he deliberately puts fewer pills in the bottle than the prescribed number. His customers usually don't notice or think they have miscounted. James keeps the extra pills and sells them to a local drug dealer.

Examples of Fraud by Agents and Brokers

Agents and brokers involved in the sale of Medicare Advantage and Medicare Part D coverage can also commit fraud. Here are some examples of actions dishonest agents might engage in to earn a sales commission:

- An agent completes an application for a Part D plan for a Medicare beneficiary without the beneficiary's knowledge.
- An agent visits a nursing home, copies down the names of Medicare beneficiaries living there, and submits applications to a Medicare Part D plan in their names.
- An agent offers a cash payment to a Medicare beneficiary to enroll in a particular Part D plan.
- An agent misrepresents key information about benefits or cost sharing to prospective members in order to entice them to enroll.

Example of Fraud Committed by a Medicare Part D Beneficiary

Jacqueline Harris, a Medicare Part D enrollee, has a legitimate prescription from her doctor, but she alters it from 60 to 160 pills and sells the surplus to people she knows.

Example of Fraud Committed by a Medicare Plan Employee

Connie Jones works in a Medicare Plan's enrollment department. She backdates enrollment effective dates received on the first or second of a month in order to allow the enrollment to begin a month earlier

Example of Criminal Involvement

Medicare fraud can also be committed by persons who are neither providers nor consumers of healthcare. Professional criminals or even organizations may be involved.

What do health plans do to address this problem? Health plan employees can monitor their claim systems and review claim records for unusual patterns. They can conduct internal and external **audits**, which may involve other steps such as randomly testing claims to verify delivery of billed services and products.

Example: An organized crime ring sets up a phony company, posing as a supplier of durable medical equipment (such as walkers and wheelchairs). It submits numerous claims to Medicare and Medicare Advantage plans for equipment it claims to have delivered to Medicare beneficiaries. In fact, the equipment was neither ordered nor delivered. The bogus company receives millions of dollars before it is detected.

Example of Collusion

Medicare fraud can involve several parties, including beneficiaries, providers, pharmacists, and organized crime.

Example: A physician writes a series of prescriptions, a Medicare beneficiary submits them to a pharmacy, and the pharmacy fills them with over-the-counter medications and the beneficiary sells the prescribed drugs to a crime ring. The doctor, the beneficiary, and the crime ring all receive a cut.

Defining Abuse: A Closer Look

CMS provides this definition: “**Abuse** involves payment for items or services when there is no legal entitlement to that payment and the health care provider has not knowingly and/or intentionally misrepresented facts to obtain payment.”

An Example of Provider Abuse

Doctor Ben Jones commonly conducts tests that are viewed within the medical community as unnecessary. This is not fraud because Ben does not engage in deception for gain—he sincerely (although mistakenly) believes the tests to be necessary, and he bills only for tests that he actually performs. But it is abuse because he is receiving payments he is not legitimately entitled to because of his responsibility to provide only medically necessary services.

An Example of Health Plan Employee Abuse

Maria Adams works for a Medicare plan. She uses the plan's e-mail to send out information to enrollees of the plan promoting her husband's sports memorabilia business. (This activity would also be a violation of HIPAA privacy rules.)

Defining Waste: A Closer Look

CMS provides this definition in its compliance guidance for Medicare plans: “**Waste** is the 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.”

An Example of Waste by Provider

Doctor Mindy Wang prescribes an expensive brand-name medication instead of a generic version that is proven (and widely known) to be just as effective. This is waste, because it results in unnecessary healthcare expenditures. But it is not fraud because Mindy sincerely (but mistakenly) believes the brand-name medication to be necessary, and she makes no false statements for gain. And it is not abuse because Mindy does not receive any payments she is not entitled to.

An Example of Waste by Brokerage Agency

A Medicare plan has agreed to reimburse ABC Agency for its printing costs related to promoting the plan. The marketing agency does not shop around for a cost effective printer, but instead uses the most expensive printer in town because the agency owner is a friend of the owner of the printer. The agency forwards all the printer bills to the Medicare plan for reimbursement.

An Example of Waste by Health Plan Employee

Tom Miller is an employee of a Medicare Plan. Tom routinely sends mail to enrollees via one-day express using a private carrier whether or not the message is truly urgent. Tom neglects to consider more reasonable alternatives such as two-day shipping or priority mail.

Distinguishing Fraud, Waste and Abuse

Observations:

- It is often difficult to distinguish between abuse **and fraud**. This is because whether an action constitutes fraud or abuse depends on the specific facts and circumstances of the situation and the intent and prior knowledge of the individual committing the action.
- It is also difficult to distinguish between waste and abuse because of their similarity and the dependence on the specific facts of an issue.
- The good news is that you do not need to distinguish between fraud, waste, and abuse. Just report anything that you suspect could be fraud, waste, or abuse and those who investigate the activity will determine which category it falls in.

FWA Costs More Than Just Dollars

In closing this section, let's stress a point mentioned earlier: Fraud, waste, and abuse can result not only in monetary losses to the healthcare system but also in harm to the health and wellbeing of patients.

- A doctor bills Medicare (and falsifies medical records to support the billing) for services he never provided to Jane Chen. Jane later becomes ill and is admitted to the hospital. The doctors there rely on her medical records in making decisions about her condition and her treatment, but since these records are not accurate, the best medical outcome for Jane may not be achieved.
- Agent Marco Martinez markets MA-PD plans by focusing solely on premiums – stressing low monthly costs without mentioning the potentially sizeable cost sharing obligations that could be faced by a beneficiary. Maria Sanchez opts for a low premium policy and later forgoes needed medical services because of her inability to pay the cost sharing involved in her policy.

Legal Tools Against FWA

Legal Tools to Combat FWA

There are several legal tools that the government can employ in its fight against fraud, waste, and abuse (FWA), including the following statutes:

- Federal Civil False Claims Act
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Legislation)
- Criminal Health Care Fraud Statute
- Criminal False Statements Act
- Health Insurance Portability and Accountability Act (HIPAA) and the HITECH Act

Violations of these laws can result in non-payment of claims, imposition of **civil monetary penalties (CMPs)**, exclusions from the Medicare program, imprisonment and criminal and civil liability.

The Federal Civil False Claims Act

The Federal False Claims Act prohibits individuals and entities from knowingly presenting a false or fraudulent claim or a statement in support of a false or fraudulent claim to the federal government for payment or approval. Liability under the Federal Civil False Claims Act now extends to subcontractors who submit claims for reimbursement to government contractors, including Medicare plans.

The penalties for submitting false claims can be severe; they can include triple damages and fines. Those who submit false or fraudulent claims to the Federal government, including Medicare claims, or who participate in such submissions can be held personally liable for their actions. Additionally, individual states may have their own false claims act and similar penalties (e.g., Florida False Claims Act).

False Claim Examples

A pharmacy consistently bills a Medicare Advantage plan for more pills than are actually dispensed to the plan's members.

A physician knowingly submits claims for services never provided to Medicare enrollees.

The Federal Anti-Kickback Statute

The Federal Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal healthcare program, including Medicare. Remuneration includes anything of value in cash or in kind. The anti-kickback regulations do provide safe harbors, and if a payment arrangement fits within these safe harbors it is not treated as a violation of the law.

Penalties: Fine of up to \$25,000, imprisonment up to 5 years, or both.

Kickback Examples

Agent Maria Sanchez focuses a substantial part of her practice on senior citizens and the sale of Medicare Advantage Prescription Drug (MA-PD) plans. Maria notices that many of the elderly individuals in her neighborhood rely on Dr. Thomas Smith for medical care. Maria approaches Dr. Smith and works with him in an effort to move many of his patients from original Medicare fee-for-service into one of the MA plans Maria sells. In return, Maria gives a portion of her earnings to Dr. Smith for each new MA client.

Melvin Ross is employed by ABC Health Plan, which sponsors a Medicare Part D prescription drug plan. Melvin's responsibilities include deciding which drugs are included in ABC's Medicare Part D formulary. A drug manufacturer gives Melvin a free vacation trip in return for his decision to place the manufacturer's drug in the preferred tier of ABC's formulary.

Kickback Examples, Continued

Billco Pharmacy waives Medicare Part D copayments for certain drugs to encourage Part D enrollees to fill their prescriptions there.

XYZ Medicare Advantage plan provides to its independent agents that enroll a minimum number of new members a trip to Hawaii where the total value of the commission and the trip exceeds the amount permitted by CMS for each sale to promote its plan over its competitors.

Physician Self-Referral Law

The Physician Self-Referral Law (often called the Stark legislation after its sponsor) prohibits physicians from referring Medicare patients for certain specified designated health services to an entity with which the physician or an immediate family member of the physician has a financial relationship (unless an exception applies). Penalties for physicians who violate the Stark legislation include fines as well as exclusion from participation in all federal healthcare programs, including Medicare.

Dr. Frances Winters refers her patients needing routine blood tests to an outside independent laboratory that is owned by her husband

Criminal Health Care Fraud Statute

Section 1347 of Title 18 of the United States Code imposes criminal penalties for defrauding a health care benefit program or obtaining any money or property owned by or under the control of any health care benefit program. The penalties for violating this law are fines and up to 10 years in prison or longer if the action results in serious bodily injury or death.

Criminal False Statements Act

The United States Code provides that anyone who falsifies or conceals a material fact, makes materially false statements or representations, or uses any false documents knowing them to contain false statements in any matter within the jurisdiction of the Executive Branch, which includes CMS, shall be fined and imprisoned for up to 5 years. This criminal law would also apply if independent agents knowingly provide MA and Part D plans with false information that they know will be provided to CMS.

Health Insurance Portability and Accountability Act (HIPAA) and HITECH

The Health Insurance Portability and Accountability Act (HIPAA) imposes certain privacy and security requirements on Medicare Advantage and Part D plans with regard to the use and disclosure of protected health information. Severe penalties may be imposed on Medicare Advantage and Part D plans for violating these requirements. The Health Information Technology for Economic and Clinical Health (HITECH) Act modified the privacy and security provisions of HIPAA by (1) imposing penalties on business associates, including agents and brokers, for violating these laws and (2) by imposing obligations to report to the HHS Office for Civil Rights security breaches. Depending on culpability, a HIPAA violation may result in civil fines in **excess** of \$1,000,000. Individuals and entities that knowingly obtain and disclose individual health information in violation of HIPAA may be subject to criminal penalties including imprisonment and fines.

HIPAA Violation Examples

John Davidson, a Medicare plan employee, provides the plans' membership information, including addresses and Medicare numbers, to an organization for its use in marketing to the plan members.

Samuel Murchison, an agent, leaves completed MA applications that he just received on the backseat of his car when he goes to lunch. His car is broken into and the folder with the applications is stolen.

Civil Monetary Penalties (CMPs)

The Social Security Act (which governs Medicare) authorizes **civil monetary penalties (CMPs)** when CMS or other federal authorities determine that an individual or entity has violated Medicare rules or regulations. CMPs can be large—for instance, a health plan might be assessed \$25,000 for each Medicare Advantage enrollee adversely impacted.

Exclusion from Medicare Program

Violations of Medicare rules and regulations can also lead to exclusion from the Medicare program. A healthcare provider's Medicare identification number and privilege of providing services to Medicare beneficiaries can be revoked. Given the size and extent of the Medicare program, this can substantially limit a provider's future income and employment opportunities. Also, an agent that is excluded from the Medicare program could not sell coverage under Medicare Advantage or Part D as well as any other Federal health care programs.

Exclusion from Medicare Program, Continued

The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) and General Services Administration (GSA) maintain lists of individuals and entities banned from providing services to Medicare. Organizations sponsoring Medicare Advantage or Medicare Part D plans, along with others working with Medicare, are required to review these lists when hiring or contracting and at least monthly thereafter to ensure no employees or subcontractors that assist in the administration or delivery of services to Medicare beneficiaries are on these lists (The OIG's List of Excluded Individuals and Entities (LEIE):_The General Services Administration (GSA) database). The plan sponsor and/or its subcontractors must remove anyone appearing on either of these lists from supporting the sponsor's Medicare offerings.

A physician repeatedly bills Medicare for services that she did not in fact perform. As a result, she is barred from serving patients covered under Federal health care programs, including Medicare.

Reporting FWA

Your Responsibilities

As we said at the beginning of this training, in the efforts to detect and prevent fraud, waste, and abuse (FWA), you are part of the solution. You are expected to question and if appropriate report situations in which you suspect something improper, unethical or illegal is going on. You have a duty to promptly report any suspected violations of the laws that you become aware of ---even if you were not involved in the activity, you may be subject to discipline if you knew about it and did not report it. This can include, but not be limited to, termination of your employment or contract.

Reporting Suspected FWA

Every organization sponsoring a Medicare Advantage plan or Medicare Part D prescription drug plan (PDP) is required to have a mechanism in place for the reporting of suspected fraud, waste, and abuse (FWA) and related concerns by employees and subcontractors.

Medicare plans must allow you to report suspected FWA anonymously, if you wish. However, it is important that you provide sufficient information for the plan to conduct an investigation.

Medicare plans are prohibited by law from retaliating against an individual who makes a good faith report of suspected FWA. This means that employees or subcontractors of plan sponsors are also prohibited from intimidating anyone who suspects or reports suspicions of improper activity.

Ways to Report FWA

Reports of suspected fraud, waste, and abuse (FWA) go to a **special investigations unit (SIU)** or compliance department, and they can typically be made by several means, such as:

- telephone hotline,
- dedicated email address, and
- dedicated web portal.

When in doubt on how to report suspected FWA, search for “hotline” or “reporting fraud” on the Medicare plan’s website.

Whistleblower Protections

A whistleblower is someone who reports suspected or detected misconduct that could be considered a violation of company policies or federal or state laws, rules, or regulations. Many people are reluctant to report instances of misconduct for fear of retaliation, such as the loss of their job. The law addresses these fears and provides protection to whistleblowers under the Relief from Retaliatory Actions provision of the False Claims Act.

The Federal False Claims Act, as previously mentioned, prohibits retaliation against a whistleblower taking action in furtherance of a False Claims Act case. For instance, if a whistleblower is fired, she is entitled to:

- reinstatement with the same seniority,
- double the amount of back pay owed plus interest on back pay, and
- compensation for any special expenses (such as legal costs).

Note: Individual states may have their own false claims act and similar penalties (e.g., Florida False Claims Act).

Investigation and Your Cooperation

Once suspected fraud, waste, or abuse (FWA) has been identified, the Medicare plan will initiate an investigation to try to understand the nature and magnitude of the issue as well as its root cause. All subcontractors, including agents, performing services for the Medicare plan are required to cooperate in the investigation, if such assistance is requested. If the investigation results in a determination that any impropriety occurred and/or a process gap exists, then disciplinary measures may be taken.

This can include, but is not limited to, termination of employment or contract, and/or a corrective plan developed by the Medicare plan sponsor. If the underlying issues relate to sales practices, agents may anticipate a higher level of scrutiny or reporting to assure that any identified FWA issues have been corrected and will not reoccur.

Legal Differences Between Fraud, Waste, and Abuse

As we have discussed, there are nuanced legal differences between fraud, waste, and abuse, which depend primarily on intent and knowledge. Fraud requires the intent to obtain payment and an intentional misrepresentation. Waste and abuse lack the same level of intent and knowledge.

Do not be concerned about these differences. If you observe suspected fraud, waste, or abuse, report it to the applicable Medicare plan sponsor. Its compliance department or other responsible authorities will investigate, make the determination whether fraud, waste, or abuse is involved, and, when applicable, take disciplinary action.

Recognizing Possible FWA

Recognizing Possible FWA

Take these steps to prepare yourself to recognize, fraud, waste, and abuse (FWA):

- Make sure you are familiar with Medicare plan policies that explain the program requirements;
- Be familiar with any guidance that identifies behavior that may be viewed as FWA; and
- Be on the lookout for suspicious behavior.

Strengthening Your FWA Detection Abilities

In the remainder of this part of the course, we will point out some additional situations where fraud, waste, or abuse may be occurring. This will equip you with additional knowledge, strengthening your ability to be part of the solution.

FWA Involving Medicare Beneficiaries

- A pharmacist receives numerous prescriptions from different doctors for the same Medicare beneficiary for the same drug. The beneficiary may be reselling the drugs.
- The person picking up a Medicare beneficiary's prescription is not the beneficiary and does not seem to have a family relationship with her. The person may have stolen the beneficiary's Medicare Part D card.
- The healthcare service that a Medicare beneficiary is requesting does not make sense in light of her medical history. The person may not be the beneficiary but someone else using her card to obtain healthcare (with or without her knowledge).

FWA Involving Physicians and Prescriptions

- A physician writes an unusually large number of prescriptions for controlled substances. He may be running a “prescription mill,” that is, giving prescriptions to whoever wants them—for a price.
- A physician writes an unusually large number of prescriptions for drugs manufactured by one pharmaceutical company. He may be receiving some sort of kickback.
- A physician frequently writes prescriptions for larger quantities than are medically necessary for the conditions treated. While there may be no criminal intent, waste or abuse may be occurring.
- A large number of prescriptions for controlled substances are submitted in a short time. The physician’s prescription pad or identifying number may have been stolen.

FWA Involving Pharmacies and PBMs

- A pharmacist bills for brand-name drugs but dispenses lower-cost generics and pockets the difference in cost.
- A pharmacist alters a prescription, increasing the number of pills requested. She dispenses the original number but charges the pharmacy benefits manager (PBM) for the greater number.
- A pharmacist bills a PBM for prescriptions that were never picked up and never filled.
- Drugs scheduled for delivery to a nursing home never arrive. They may have been diverted and sold by a crime ring.

FWA Related to Agents and Brokers

- An agent offers Medicare beneficiaries cash or other impermissible incentives to enroll in the prescription drug plan he represents.
- An agent offers beneficiaries money for the names, addresses and phone numbers of friends and acquaintances who are Medicare beneficiaries.
- An agent tells a Medicare beneficiary that she represents the Social Security Administration or the Medicare program.
- An agent intentionally misrepresents, conceals, or distorts an enrollee's information or a sponsor's plan(s), including an enrollee's age or health status, or a plan's costs or benefits, for the purpose of attaining enrollment, or convincing someone to enroll.
- An individual solicits Medicare Advantage enrollments and gathers "initial premiums." She is not really an agent and disappears with the money.

FWA Involving Medicare Plan Sponsors

- The amount MA plan members must pay for certain services is greater than what the sponsor's literature implies.
- An MA plan realizes it had been overpaid by the Medicare program but fails to report it to CMS.

Summarizing the Importance of FWA Detection, Correction, and Prevention

Most providers, suppliers, pharmacists, and sales representatives who work with Medicare are honest and seek to do the right thing. But there are a few individuals and organizations that knowingly commit fraud, while others engage in practices that result in waste or abuse.

CMS and Medicare plan sponsors are committed to providing quality healthcare services to Medicare beneficiaries while reducing the costs of fraud, waste, and abuse. These costs take the form of not only lost dollars, but also of a negative impact on the quality of life of Medicare beneficiaries. Fraud, waste, and abuse can inflict real physical and emotional harm.

This training has been designed to provide you with the tools you need to participate in the ongoing efforts against fraud, waste, and abuse.

Fraud, Waste, and Abuse Website Resources

Federal government websites provide additional information about the detection, correction, and prevention of fraud, waste, and abuse.

- [Centers for Medicare and Medicaid Services \(CMS\)](#) – A CMS publication entitled: Medicare Fraud & Abuse: Prevention, Detection and Reporting can be accessed at:
Medicare Fraud & Abuse: Prevention, Detection and Reporting.
[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud and Abuse.Pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.Pdf)
- [Department of Health and Human Services Office of Inspector General](#)- CMS compliance guidance for MA and Part D plans.
<http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf>
- [The OIG's List of Excluded Individuals and Entities \(LEIE\)](#)
- [The General Services Administration \(GSA\) database](#)
- Definitions of fraud, waste, and abuse can be found in *Medicare Managed Care Manual (MMCM) Chap.21 Sec.20 Definition*

Glossary

Audit—A methodical examination and review of data or processes with the purpose of verifying the data's accuracy or whether established processes are in place or are properly followed. For purposes of fraud, waste, and abuse, an audit refers to a formal review of a company's, department's, employee's, or subcontractor's efforts, including contracted sales agents, to meet compliance requirements by using a set of internal (e.g. policies and procedures) or external (e.g. laws and regulations) standards as base measures.

Civil monetary penalties (CMPs)—Penalties that may be imposed for a variety of conduct including Medicare fraud, waste, and abuse. Different amounts of penalties and assessments may be authorized based on the type of violation and can range as high as \$50,000 per violation. CMPs can also include an assessment of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited or received. Examples of CMP violations include presenting a claim that a person knows or should know is for a service that was not provided as claimed or is false and fraudulent

Glossary, Continued

Pharmacy benefits manager (PBM)—a company that administers the prescription drug benefit program of a health plan or employer. PBMs process and pay prescription drug claims and are often responsible for creating and updating formularies. PBMs buy medications in large quantities from drug manufacturers and are therefore able to obtain and offer discounts.

Special investigation unit (SIU)—a unit of a health plan (often separate from the compliance office) dedicated to combating fraud, waste, and abuse (FWA). It is frequently staffed by former law enforcement personnel, such as veterans of the FBI. SIUs have traditionally focused their investigations on third-party claims submitted to health plans. In the case of Medicare Advantage and Part D plans, however, the scope of SIU investigations is likely to include identification of suspected FWA committed by subcontractors involved in the delivery of the Medicare Advantage or Prescription Drug benefits.