

Slide 1



Slide notes

Welcome to the Medicare Compliance and Fraud, Waste, and Abuse course.

Click the Launch button to begin.

Slide 2

Navigation Tutorial

Rewind
Click to restart the lesson

Back
Click to go to the previous page

Play/Pause
Click to pause or resume the lesson

Forward
Click to go to the next page

Audio
Click to mute or unmute the audio

Closed Caption
Click to toggle on or off closed caption

Click Forward to continue.

Slide notes

Please take a moment to review the navigation instructions displayed on the screen. Also, ensure you are using the Chrome browser to view this course. If not, please exit and restart this course in the Chrome browser. It's important to close other applications while taking this course.

Click the Forward button when you're ready to continue.

Slide 3

Introduction

 GuideWell employees, our governing body, and the first-tier, downstream, and related entities (FDRs), with which we contract to provide administrative or health care services for our members, must receive training about compliance.

 Anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and Fraud, Waste, and Abuse (FWA) training requirements.

Successful completion of this course requires:

- Accessing and viewing every page of this course
- Scoring 100% in the course assessment

[Click Forward to continue.](#)

Slide notes

GuideWell is a contracting Medicare Plan Sponsor providing Medicare Parts C and D coverage to Medicare enrollees. GuideWell employees, our governing body, and the first-tier, downstream, and related entities (FDRs), with which we contract to provide administrative or health care services for our members, must receive training about compliance with the Centers for Medicare and Medicaid Services or CMS program rules upon hire or contracting, and annually thereafter. Also, anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and Fraud, Waste, and Abuse (FWA) training requirements.

In order to complete this course and comply with the CMS training requirements, you must complete the entire course. Successful completion of this course requires accessing and viewing every page within the course and scoring 100% in the course assessment.

Click the Forward button to review what you will learn in this course.

Slide 4

Course Objectives

Why Is
This
Course
Important?



Describe the Medicare program and its four parts.



Explain how a compliance program operates.



Recognize FWA in the Medicare program.



Explain the major laws and regulations pertaining to FWA and penalties associated with violations.



Report compliance program and FWA violations.



Recognize how to correct non-compliance and FWA.

[Click Forward to continue.](#)

Slide notes

After completing this course, you will be able to:

Describe the Medicare program and its four parts.

Explain how a compliance program operates.

Recognize FWA in the Medicare program.

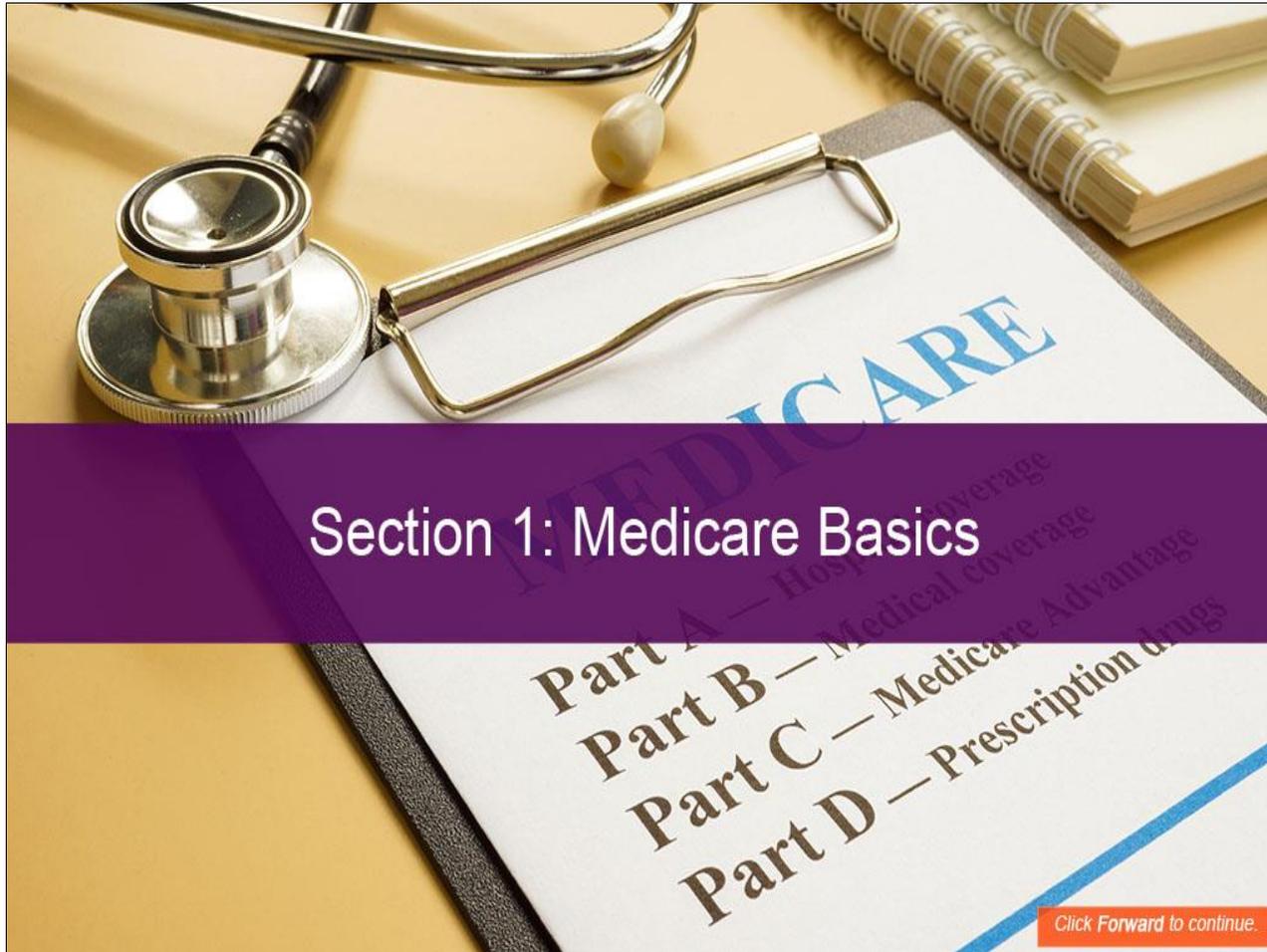
Explain the major laws and regulations pertaining to FWA and penalties associated with violations.

Report compliance program and FWA violations.

And recognize how to correct non-compliance and FWA.

Click the Forward button to continue.

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Slide notes

Section 1: Medicare Basics

In this section, we will cover the basics of Medicare.

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What is Medicare?

Medicare is a federal health insurance program that is part of the Social Security Act and is strictly regulated by the Centers for Medicare and Medicaid Services (CMS).

The Medicare program covers medical services for individuals who are:

- 65 years and older
- Under age 65 with certain disabilities
- Of any age with End-Stage Renal Disease (ESRD)



[Click Forward to continue.](#)

Slide notes

Medicare is a federal health insurance program that is part of the Social Security Act and is strictly regulated by the Centers for Medicare and Medicaid Services (CMS).

The Medicare program covers medical services for individuals who are of age 65 and older, individuals under age sixty-five with certain disabilities that would qualify the individual for social security, and individuals of any age with End-Stage Renal Disease (ESRD).

Click the Forward button to learn the various Medicare parts.

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Medicare Parts

The diagram illustrates the structure of Medicare Parts. At the top, a dashed box labeled 'Administered by Medicare Administrative Contractors (MACs)' contains 'Part A Hospital coverage' and 'Part B Medical coverage'. Below this, a purple box states: 'Standalone prescription drug coverage for beneficiaries enrolled in Parts A, B, or both, who elect to enroll in a Medicare Prescription Drug Plan (PDP)'. At the bottom, another dashed box contains 'Part C Medicare Advantage (MA)' and 'Part D Prescription drug coverage'. Lines connect the PDP box to both Part C and Part D. To the right of the diagram is a photograph of a female doctor in a white coat with a stethoscope, smiling and talking to a patient. A red button at the bottom right of the photo says 'Click Forward to continue.'

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The Medicare program consists of four parts: A, B, C, and D. All parts are federally funded programs strictly regulated by CMS. Parts A and B, also known as Original Medicare, are administered by Medicare Administrative Contractors (MACs) such as GuideWell's subsidiaries, First Coast Service Options (FCSO), and Novitas Solutions.

Part C and Part D plans are approved by CMS, but unlike Original Medicare Parts A and B, these plans are developed, offered, and administered by Medicare-approved private organizations or Plan Sponsors, like GuideWell. Part A helps cover inpatient care in hospitals, at-home care, skilled nursing facility care, hospice care, and home health care. Part B helps cover medical costs, such as doctor visits, screenings, therapy, emergency and ambulatory care, medical supplies and equipment, and lab services.

Medicare Part C is also called Medicare Advantage (MA). MA plans are a coverage option available to Medicare beneficiaries. Essentially, Part C replaces Original Medicare Parts A and B, and may include benefits not covered in Parts A and B, such as vision, dental, and hearing. It may also include additional supplemental benefits, such as gym membership and transportation. Except for hospice care, Part C plans offer the same services covered by Parts A and B.

MA is only available to beneficiaries enrolled in, or eligible for, Original Medicare.

Medicare Part D, also referred to as the Medicare Prescription Drug benefit, provides prescription drug coverage to all beneficiaries enrolled in Part A, Part B, or both, who elect to enroll in a Medicare Prescription Drug Plan (PDP). Part D benefits are often included in MA plans and, if so, are referred to as Medicare Advantage Prescription Drug plans, or MA-PDs.

Now that you have reviewed the basics of Medicare, let's proceed to the next section.

Click the Forward button to continue.

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Section 2: Medicare General Compliance

In this section, we will explain the requirements of Medicare compliance.

Click the Forward button to continue.

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Compliance Program Requirements

CMS requires Plan Sponsors, like GuideWell, to implement and maintain an effective compliance program for its Medicare Parts C and D plans.



Click Forward to continue.

Slide notes

CMS requires Plan Sponsors, like GuideWell, to implement and maintain an effective compliance program for its Medicare Parts C and D plans.

An effective compliance program must articulate and demonstrate an organization’s commitment to legal and ethical conduct, provide guidance on how to handle compliance questions and concerns, and provide guidance on how to identify and report compliance violations.

Click the Forward button to continue.

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Effective Compliance Program

An effective compliance program:

- Prevents, detects, and corrects non-compliance and FWA
- Is fully implemented and tailored to an organization's unique operations and circumstances
- Has adequate resources
- Promotes the organization's standards of conduct
- Establishes clear lines of communication for reporting non-compliance and FWA
- Includes the seven core compliance program requirements

An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as FWA.



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An effective compliance program fosters a culture of compliance within an organization and, at a minimum, prevents, detects, and corrects non-compliance and FWA. It is also fully implemented and is tailored to an organization's unique operations and circumstances, has adequate resources, promotes the organization's standards of conduct, and establishes clear lines of communication for reporting non-compliance and FWA.

Additionally, it must, at a minimum, include the seven core compliance program requirements. Remember, an effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as FWA.

Let's review the seven core compliance program requirements.

Click the Forward button to continue.

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Seven Core Compliance Program Requirements

CMS requires that an effective compliance program must include seven core requirements.

Effective lines of communication

Effective training and education

Well-publicized disciplinary standards

Compliance officer, compliance committee, and high-level oversight

An effective system for routine monitoring, auditing, and identifying compliance risks

Written policies, procedures, and standards of conduct

Procedures and a system for prompt response to compliance issues

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Slide notes

CMS requires that an effective compliance program must include seven core requirements. These are:

Written policies, procedures, and standards of conduct

Compliance officer, compliance committee, and high-level oversight

Effective training and education

Effective lines of communication

Well-publicized disciplinary standards

An effective system for routine monitoring, auditing, and identifying compliance risks

Procedures and a system for prompt response to compliance issues

Let's learn about these.

Click the Forward button to continue.

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Seven Core Compliance Program Requirements

CMS requires that an effective compliance program must include seven core requirements.



Written policies, procedures, and standards of conduct

- Articulate the Sponsor’s commitment to comply with all applicable federal and state requirements.
- Describe compliance expectations according to the standards of conduct.

Slide notes

Written policies and procedures articulate the Sponsor’s commitment to comply with all applicable federal and state requirements and describe compliance expectations according to the standards of conduct.

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Seven Core Compliance Program Requirements

CMS requires that an effective compliance program must include seven core requirements.

Compliance officer,
compliance committee, and
high-level oversight



- The Sponsor must designate a responsible compliance officer and a compliance committee to identify, investigate, and resolve issues.
- The Sponsor's senior management and the governing body must engage and exercise reasonable oversight of the Sponsor's compliance program.

Slide notes

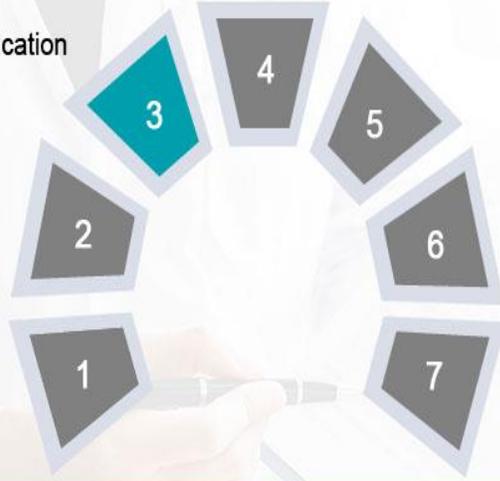
The Sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program. The Sponsor's senior management and the governing body must be engaged and must exercise reasonable oversight of the Sponsor's compliance program.

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Seven Core Compliance Program Requirements

CMS requires that an effective compliance program must include seven core requirements.

Effective training and education



This covers the elements of the compliance program as well as preventing, detecting, and reporting FWA.

Slide notes

Effective training and education covers the elements of the compliance program as well as preventing, detecting, and reporting FWA.

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Seven Core Compliance Program Requirements

CMS requires that an effective compliance program must include seven core requirements.

Effective lines of communication



This includes making effective lines of communication accessible to all, ensuring confidentiality, and providing methods for anonymous and good faith reporting of compliance issues at Sponsor and FDR levels.

Slide notes

Effective lines of communication includes making effective lines of communication accessible to all, ensuring confidentiality, and providing methods for anonymous and good faith reporting of compliance issues at Sponsor and FDR levels.

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Seven Core Compliance Program Requirements

CMS requires that an effective compliance program must include seven core requirements.



The Sponsor must enforce standards through well-publicized disciplinary guidelines.

Slide notes

The Sponsor must enforce standards through well-publicized disciplinary guidelines.

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Seven Core Compliance Program Requirements

CMS requires that an effective compliance program must include seven core requirements.



An effective system for routine monitoring, auditing, and identifying compliance risks

- The Sponsor must conduct routine monitoring and auditing of its operations, and of its FDRs, to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.
- The Sponsor must also ensure that FDRs performing delegated administrative or health care service functions concerning its Medicare Parts C and D programs comply with Medicare requirements.

Slide notes

The Sponsor must conduct routine monitoring and auditing of its operations, and of its FDRs, to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program. The Sponsor must also ensure that FDRs performing delegated administrative or health care service functions concerning its Medicare Parts C and D programs comply with Medicare requirements.

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Seven Core Compliance Program Requirements

CMS requires that an effective compliance program must include seven core requirements.



Procedures and a system for prompt response to compliance issues

- Use effective measures to respond promptly to non-compliance.
- Undertake appropriate corrective action.

[Click Forward to continue.](#)

Slide notes

The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

Click the Forward button to learn about routine monitoring and auditing.

Slide 19

Routine Monitoring and Auditing

Monitoring

Monitoring activities include regular reviews to confirm ongoing compliance, and taking effective corrective actions timely.

It includes:

- Conducting analyses
- Tracking trends to correct issues

Routine monitoring can be performed internally (within each operational area), and by the Business Ethics, Integrity and Compliance team.

Auditing

Auditing activities are formal reviews of compliance with a particular set of standards, used as base measures.

Auditing is:

- Performed periodically
- A more comprehensive review

It is performed by an independent party not employed in the department being audited.

[Click Forward to continue.](#)

Slide notes

Monitoring activities include regular reviews to confirm ongoing compliance, and taking effective corrective actions timely. It is an ongoing event that includes conducting analyses and tracking trends to correct issues “in real-time” at the lowest level of detection. Routine monitoring can be performed internally (within each operational area), and by the Business Ethics, Integrity and Compliance team.

Auditing activities are formal reviews of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures. Auditing is performed periodically, though less often than monitoring. An audit is a more comprehensive review than monitoring. Those performing audits must be independent and not employed in the department being audited.

Click the Forward button to learn about non-compliance.

Slide 20

Non-Compliance

Non-compliance affects everyone!

Non-compliance is conduct that does not conform to the law, federal health care program requirements, or an organization's ethics and business policies. Without programs to prevent, detect, and correct non-compliance, we are all at risk.

It harms our Medicare members by causing:

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Other hurdles to care

Financially, non-compliance means:

- Higher insurance copayments
- Higher premiums
- Fewer benefits for individuals and employers
- Lower Star ratings
- Lower profits



For more information, refer to the Compliance program Guidelines in the [Medicare Prescription Drug Benefit Manual](#) and [Medicare Managed Care Manual](#).

Click **Forward** to continue.

Slide notes

Non-compliance affects everyone! Non-compliance is conduct that does not conform to the law, federal health care program requirements, or an organization's ethics and business policies. Without programs to prevent, detect, and correct non-compliance, we are all at risk. It harms our Medicare members by causing delayed services, denial of benefits, difficulty in using providers of choice, and other hurdles to care.

Financially, non-compliance means higher insurance copayments, higher premiums, fewer benefits for individuals and employers, lower Star ratings, and lower profits. Click the links displayed on the screen for more information on CMS guidelines.

Click the Forward button to learn about the consequence of non-compliance.

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Consequences of Non-Compliance

Non-compliance puts GuideWell at risk.

Failure to follow Medicare program requirements and CMS guidance can lead to:

- Contract termination
- Criminal penalties
- Exclusion from participating in all federal health care programs
- Civil money penalties

Non-compliant behavior may be subject to:

- Mandatory training or re-training
- Disciplinary action
- Termination

[Click Forward to continue.](#)

Slide notes

It is important to understand the consequences of non-compliance. It puts GuideWell at risk. Failure to follow Medicare program requirements and CMS guidance can lead to serious consequences, including contract termination, criminal penalties, exclusion from participating in all federal health care programs, and civil money penalties.

Additionally, GuideWell must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of these actions, such as mandatory training or re-training, disciplinary action, and termination.

Click the Forward button to continue.

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What Is Expected of You?

- The standards of conduct (or Code of Conduct) state the organization's compliance expectations and its operational principles and values.
- The organization should tailor the standards of conduct content to its individual organization's culture and business operations.
- Reporting standards of conduct violations and suspected non-compliance is everyone's responsibility.
- The organization's standards of conduct and policies and procedures should identify this obligation and provide you with information on how to report suspected non-compliance.

At GuideWell, we have adopted the [Compass Code of Ethical Business Conduct](#) as our standards of conduct.

Click Forward to continue.

Slide notes

Now that you've read the general compliance guidelines, how do you know what is expected of you in a specific situation?

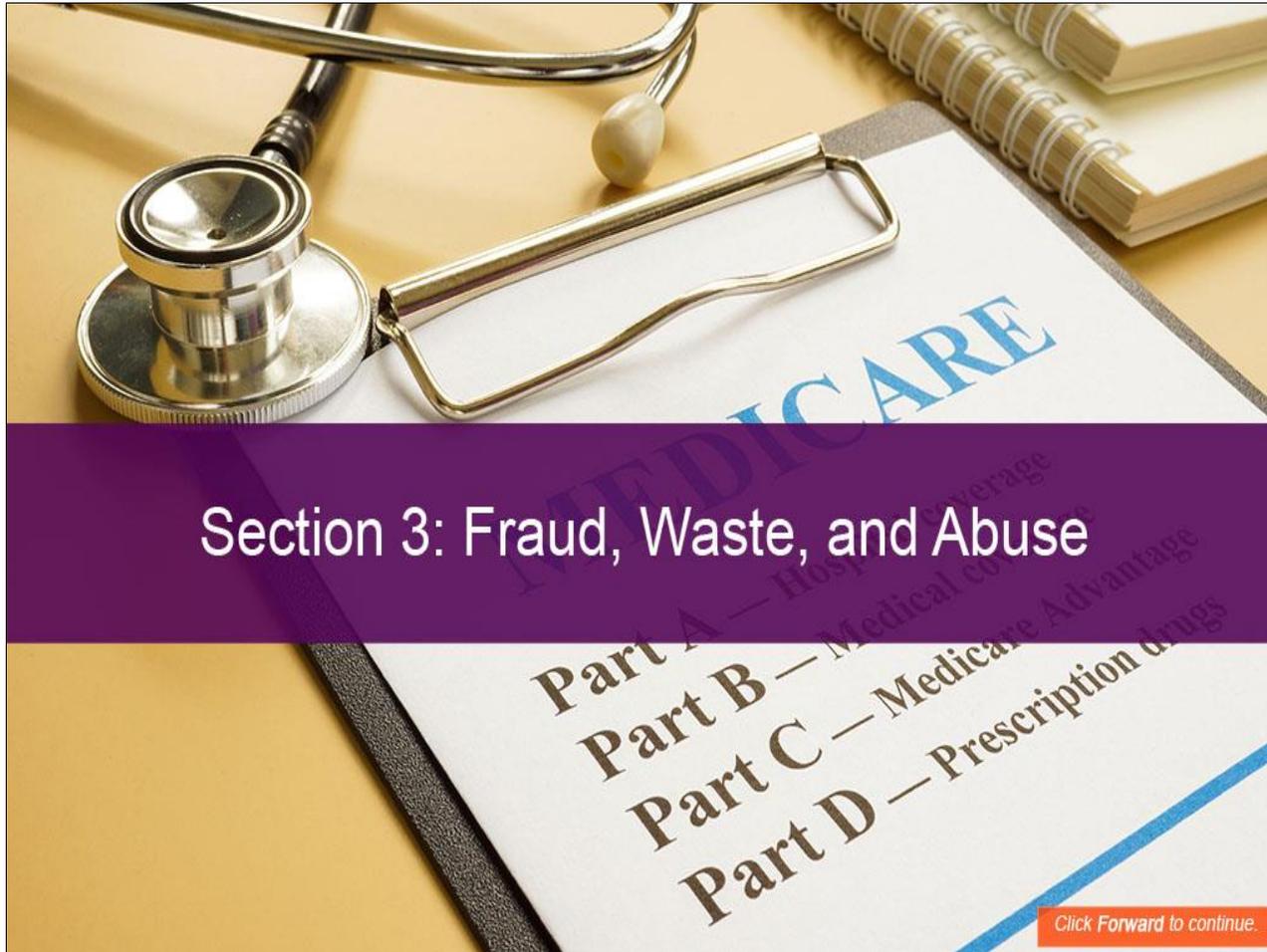
The standards of conduct (or Code of Conduct) state the organization's compliance expectations and its operational principles and values.

Organizational standards of conduct vary. The organization should tailor the standards of conduct content to its individual organization's culture and business operations. Reporting standards of conduct violations and suspected non-compliance is everyone's responsibility.

The organization's standards of conduct and policies and procedures should identify this obligation and provide you with information on how to report suspected non-compliance. At GuideWell, we have adopted the [Compass Code of Ethical Business Conduct](#) as our standards of conduct. Click the link on your screen to view GuideWell's [Compass Code of Conduct](#).

Click the Forward button to continue.

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Slide notes

Section 3: Fraud, Waste, and Abuse

This section describes fraud, waste, and abuse and the laws that prohibit it.

Click the Forward button to continue.

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Why Do I Need This Training?

Billions of dollars are improperly spent because of FWA.



Detect



Correct



Prevent

You are a part of the solution.

Remember, compliance is everyone's responsibility.

[Click Forward to continue.](#)

Slide notes

Every year, billions of dollars are improperly spent because of FWA. It affects everyone, including you. This course helps you understand how to detect, correct, and prevent FWA. You are a part of the solution. Remember, 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.

Click the Forward button to continue.

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Examples of Fraud, Waste, and Abuse



Slide notes

This course will help you become familiar with the definitions and scenarios involving fraud, waste and abuse and how to help combat potential fraudulent, abusive, or wasteful situations.

Click the Forward button to learn about fraud.

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Examples of Fraud, Waste, and Abuse



Fraud

Fraud:

- Is knowingly and willfully executing/attempting to execute a scheme/artifice to defraud any health care benefit program, or to obtain any of the money/property owned by, or under the custody/control of any health benefit program
- May be committed by providers, members, employees, vendors, temporary workers, contractors, sales representatives, and other entities



Waste

Examples:

- Knowingly billing for services not furnished or supplies not provided
- Knowingly billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment



Abuse

[Click Forward to continue.](#)

Slide notes

Fraud is knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any health care benefit program, or to obtain (using 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. In other words, fraud is intentionally submitting false information to the government or a government contractor to get money or a benefit.

Fraud may be committed by providers, members, employees, vendors, temporary workers, contractors, sales representatives, and other entities.

Examples of actions that may constitute Medicare fraud include knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep; knowingly billing for nonexistent prescriptions; and knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Click the Forward button to next learn about waste.

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Examples of Fraud, Waste, and Abuse

Fraud

Waste:

- Includes practices that, directly or indirectly, result in unnecessary costs to the Medicare program

Waste

Examples:

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

Abuse

[Click Forward to continue.](#)

Slide notes

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.

Examples of actions that may constitute Medicare waste include conducting excessive office visits or writing excessive prescriptions, prescribing more medications than necessary for treating a specific condition, and ordering excessive laboratory tests.

Click the Forward button to next learn about abuse.

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Examples of Fraud, Waste, and Abuse

Fraud

Waste

Abuse

Abuse:

- Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare program
- Involves paying for items or services when there is no legal entitlement to that payment

Examples:

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim

Click Forward to continue.

Slide notes

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.

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.

Click the Forward button to continue.

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Differences Among Fraud, Waste, and Abuse

One of the primary differences is **intent and knowledge**.

Fraud	Waste and Abuse
Intent and Knowledge ↑ Fraud requires intent to obtain payment and knowledge that the actions are wrong.	Intent and Knowledge ↓ Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare program, but do not require the same intent and knowledge.



Slide notes

There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and 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 do not require the same intent and knowledge.

Click the Forward button to continue.

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Indicators of Potential Fraud, Waste, and Abuse

The following sections list some key issues that may indicate signs of FWA at the following levels.

Beneficiary

Provider

Pharmacy

Sponsor

[Click Forward to continue.](#)

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The following sections list some key issues that may indicate signs of FWA at the beneficiary, provider, pharmacy, or Sponsor level. These lists include questions to ask yourself depending on your role as an employee of a Sponsor, pharmacy, or another entity involved in delivering Medicare Parts C and D benefits to enrollees.

Click the Forward button to continue.

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Key Indicators: Potential Beneficiary Issues

Here are some beneficiary issues that may indicate potential FWA.

Beneficiary

Provider

Pharmacy

Sponsor

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

[Click Forward to continue.](#)

Slide notes

Here are some beneficiary issues that may indicate potential FWA.

Does the prescription, medical record, or laboratory test look altered or possibly forged?

Does the beneficiary's medical history support the services requested?

Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?

Is the person receiving the medical service the beneficiary (or is this a case of identity theft)?

Is the prescription appropriate based on the beneficiary's other prescriptions?

Click the Forward button to continue.

Slide 32

Key Indicators: Potential Provider Issues

Here are some provider issues that may indicate potential FWA.

Beneficiary

Provider

Pharmacy

Sponsor

- Is the provider's prescription appropriate for the member's health conditions (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 his/her active and valid National Provider Identifier on it?
- Is the provider's diagnosis for the member supported in the medical record?

[Click Forward to continue.](#)

Slide notes

Here are some provider issues that may indicate potential FWA.

Is the provider's prescription appropriate for the member's health conditions? Is it 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 his/her active and valid National Provider Identifier on it?

Is the provider's diagnosis for the member supported in the medical record?

Click the Forward button to continue.

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Key Indicators: Potential Pharmacy Issues

Here are some pharmacy issues that may indicate potential FWA.



- Are drugs being diverted (drugs meant for nursing homes, hospices, 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 Pharmacy Benefit Managers (PBMs) billed for unfilled or never picked up prescriptions?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?

[Click Forward to continue.](#)

Slide notes

Here are some pharmacy issues that may indicate potential FWA.

Are drugs being diverted? For example, are drugs meant for nursing homes, hospices, 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 Pharmacy Benefit Managers (PBMs) billed for unfilled or never picked up prescriptions?

Are proper provisions made if the entire prescription cannot be filled?

For example, there should not be additional dispensing fees for split prescriptions.

Do you see prescriptions being altered? For example, change in quantities or Dispense As Written?

Click the Forward button to continue.

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Key Indicators: Potential Sponsor Issues

Here are some Sponsor issues that may indicate potential FWA.

Beneficiary

Provider

Pharmacy

Sponsor

- 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?

[Click Forward to continue.](#)

Slide notes

Finally, here are some Sponsor issues that may indicate potential FWA.

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?

Click the Forward button to continue.

Slide 35

Understanding Fraud, Waste, and Abuse



In order to understand how to detect FWA, you need to know the law.

Applicable laws:

- The False Claims Act (FCA)
- The Health Care and Criminal Fraud Statutes
- The Anti-Kickback Statute
- The Stark Law (Physician Self-Referral Law)
- The Civil Monetary Penalties (CMP) Law
- Exclusion from all federal health care programs
- The Health Insurance Portability and Accountability Act (HIPAA)

[Click Forward to continue.](#)

Slide notes

In order to understand how to detect FWA, you need to know the law.

The following slides provide high-level information about applicable laws, including the False Claims Act (FCA), the Health Care Fraud Statute, and the Criminal Fraud Statute; the Anti-Kickback Statute; the Stark Law, also known as the Physician Self-Referral Law; the Civil Monetary Penalties (CMP) Law; exclusion from all federal health care programs; and the Health Insurance Portability and Accountability Act, HIPAA. For details about other specific laws and regulations, such as safe harbor provisions, consult the applicable statute and regulations.

Let's take a closer look at each of these laws.

Click the Forward button to continue.

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False Claims Act (FCA)

A person is 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/improperly avoids/decreases an obligation to pay the government
- Makes/uses a false record/statement supporting a false claim
- Presents a false claim for payment/approval

[Click here for more information about the FCA.](#)



Any person who knowingly submits a false claim to the government is liable for three times the government's damages caused by the violator plus a penalty.

[Click Forward to continue.](#)

Slide notes

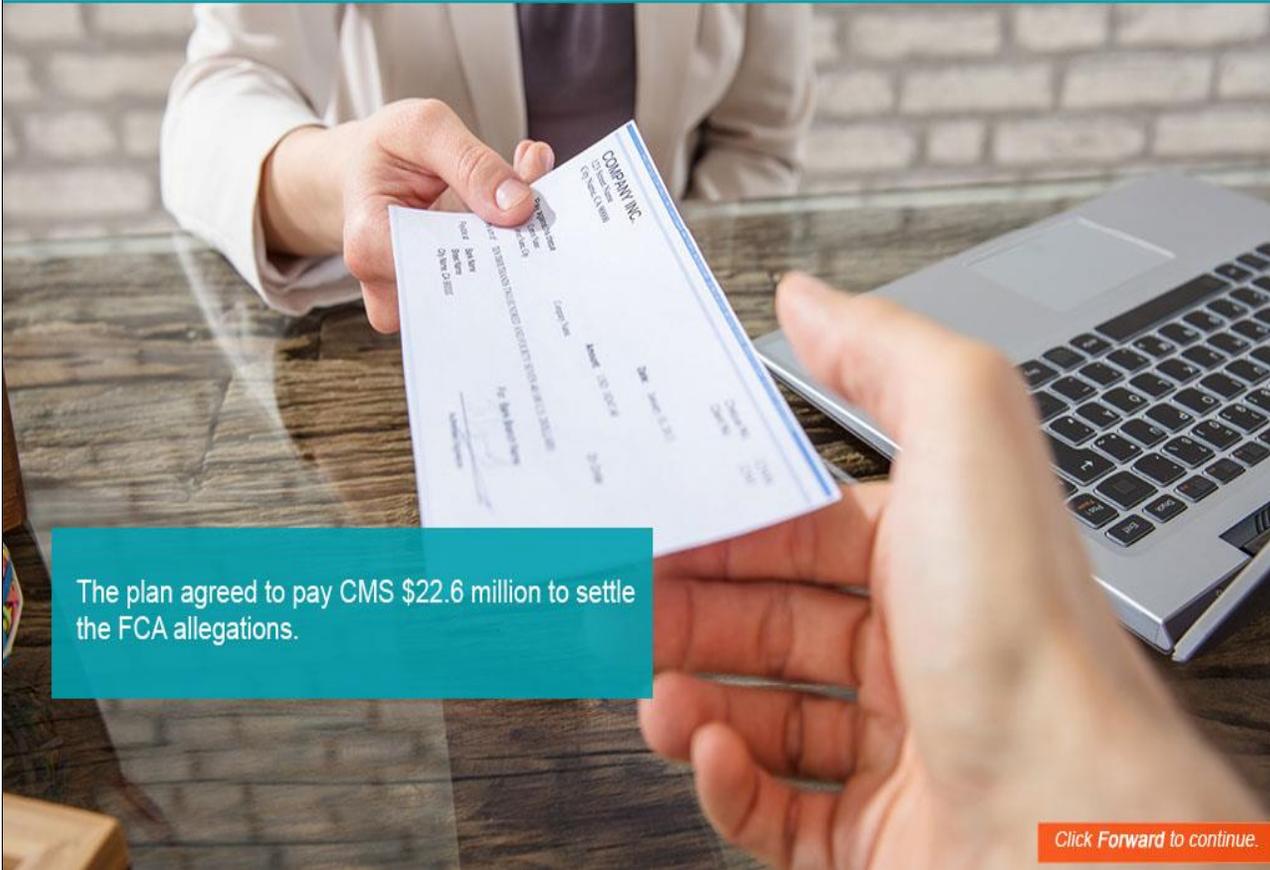
The civil provisions of the FCA make a person liable to pay damages to the government if he or she knowingly conspires to violate the FCA, carries out other acts to obtain property from the government by misrepresentation, conceals or improperly avoids or decreases an obligation to pay the government, makes or uses a false record or statement supporting a false claim, or presents a false claim for payment or approval.

Any person who knowingly submits a false claim to the government is liable for three times the government's damages caused by the violator plus a penalty. Click the link on your screen to view more information about the FCA.

Click the Forward button to look at an example of the FCA law.

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False Claims Act (FCA): Example



The plan agreed to pay CMS \$22.6 million to settle the FCA allegations.

Click Forward to continue.

Slide notes

A Medicare Part C plan in Florida hired an outside company to review medical records to find additional diagnosis codes it could submit to increase risk capitation payments from CMS. The plan was informed by the vendor that certain diagnosis codes previously submitted to CMS were undocumented or unsupported, and yet the plan failed to report these unsupported codes to CMS. The plan agreed to pay CMS \$22.6 million to settle the FCA allegations.

Click the Forward button to continue.

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False Claims Act (FCA): Definitions



Whistleblower

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%, but not more than 30%, of the money collected.

[Click Forward to continue.](#)

Slide notes

Let's review some definitions applicable to the civil FCA.

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

Protected means persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded means persons who bring a successful whistleblower lawsuit receive financial compensation, usually between 15-30% of the money collected.

Click the Forward button to learn about the Health Care Fraud Statute.

Slide 39

Health Care Fraud Statute

Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program shall be fined (up to \$250,000) 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.

[Click here to learn more about the Health Care Fraud Statute.](#)



 People who knowingly make a false claim may be subject to criminal fines up to \$250,000 or imprisonment for up to 10 years.

[Click Forward to continue.](#)

Slide notes

The Health Care Fraud Statute states that “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program shall be fined (up to \$250,000) or imprisoned (not more than ten years), or both.” Conviction under the statute does not require proof the violator knew the law or had specific intent to violate the law.

Under the Criminal Health Care Fraud Statute, people who knowingly make a false claim may be subject to criminal fines up to \$250,000 or imprisonment for up to 10 years. If the violations resulted in death, the individual may be imprisoned for any term of years, or life. Click the link on your screen to learn more about the Health Care Fraud Statute.

Click the Forward button to look at an example of the Health Care Fraud Statute.

Slide 40

Health Care Fraud Statute: Example

The defendant was ordered to repay the affected government health care programs and the insurance company.

The court also ordered him to forfeit numerous assets.

[Click Forward to continue.](#)

Slide notes

A South Florida man was sentenced to 15 years for his role in two health care fraud conspiracies and for making false statements regarding a health care benefit program. Between 2018 and 2020, the defendant and his co-conspirators harvested beneficiary information through a telemarketing scheme and used it to create fictitious orders for Durable Medical Equipment (DME).

The operation amassed a network of “telemedicine” providers who signed the fake DME orders in exchange for a fee. These false orders were then submitted as claims to CMS. During its lifespan, the operation spanned eight storefronts, amassing approximately \$18.3 million in false Medicare payments.

Ultimately, the defendant was ordered to repay the affected government health care programs and the insurance company. The court also entered a monetary judgment against the defendant for over \$10.1 million and ordered him to forfeit numerous assets, including seizure of various financial accounts, high-end automobiles, jewelry, and his lakefront home.

Click the Forward button to learn about the Anti-Kickback Statute.

Slide 41

Anti-Kickback Statute

The Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration for referrals for services that are paid for, in whole or in part, under a federal health care program.

 Damages and penalties may be punishable by a fine of up to \$100,000 and imprisonment up to 10 years.

[Click here](#) for more information about the Anti-Kickback Statute.



Click Forward to continue.

Slide notes

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 for, in whole or in part, under a federal health care program (including the Medicare program). Damages and penalties may be punishable by a fine of up to \$100,000 and imprisonment up to 10 years. Click the link on your screen to view more information about the Anti-Kickback Statute.

Click the Forward button to look at an example of the Anti-Kickback Statute.

Slide 42

Anti-Kickback Statute: Example



Slide notes

A Massachusetts-based web development firm agreed to an \$18.25 million settlement to resolve claims that it paid kickbacks to promote sales of its Electronic Health Record (EHR) product. One allegation stated that the firm used unlawful marketing techniques to promote its EHR product including inviting prospective customers to all-inclusive, all-expense-paid sporting, entertainment, and recreational events with travel and luxury accommodations.

The second allegation was that the firm paid illegal bribes of around \$3,000 to its customers for “lead generation” regardless of whether they generated leads for the firm. Finally, the firm allegedly targeted other companies that were discontinuing their health information technology products and offered to pay them for successful customer referrals to its product.

Click the Forward button to learn about the Stark Law.

Slide 43

Stark Law (Physician Self-Referral Law)

The Stark Law prohibits a physician from making referrals for certain designated health services to an entity when the physician has an ownership or investment interest or compensation arrangement as a result of the referral.

 A penalty of up to \$15,000 can be imposed for each service provided. There may also be a fine up to \$100,000 for entering into an unlawful arrangement or scheme.

[Click here for more information on the Stark Law \(Physician Self-Referral Law\).](#)



Click Forward to continue.

Slide notes

The Stark Law, also referred to as the Physician Self-Referral law, prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of the physician's family) has an ownership or investment interest or compensation arrangement as a result of the referral.

Medicare claims tainted by an arrangement that does not comply with the Stark Law are not payable. A penalty of up to \$15,000 can be imposed for each service provided. There may also be a fine up to \$100,000 for entering into an unlawful arrangement or scheme. Click the link on your screen for more information on the Stark Law (Physician Self-Referral Law).

Click the Forward button to look at an example of the Stark Law.

Slide 44

Stark Law (Physician Self-Referral Law): Example

The hospital provided personal loans to two physicians without requiring repayment for more than two years after the loans had matured in an attempt to boost referrals of patients.

Personal Loan Application



Gender
 Male

Phone Number

[Click Forward to continue.](#)

Slide notes

An Indiana hospital paid \$3.6 million to resolve allegations that it paid kickbacks to two doctors in exchange for patient referrals. Allegations state that the hospital, under the direction of its management organization, provided personal loans to two physicians without requiring repayment for more than two years after the loans had matured in an attempt to boost referrals of patients from the two providers.

Click the Forward button to learn about the Civil Monetary Penalties (CMP) Law.

Slide 45

Civil Monetary Penalties (CMP) Law

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

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



[Click this link for more information on the Civil Monetary Penalties law.](#)



The penalties can be approximately \$20,000 to \$100,000 depending on the specific violation.

[Click Forward to continue.](#)

Slide notes

The Office of Inspector General (OIG) may impose civil monetary 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 an overpayment and failing to report and return it, making false claims, or paying to influence referrals.

The penalties can be approximately \$20,000 to \$100,000 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

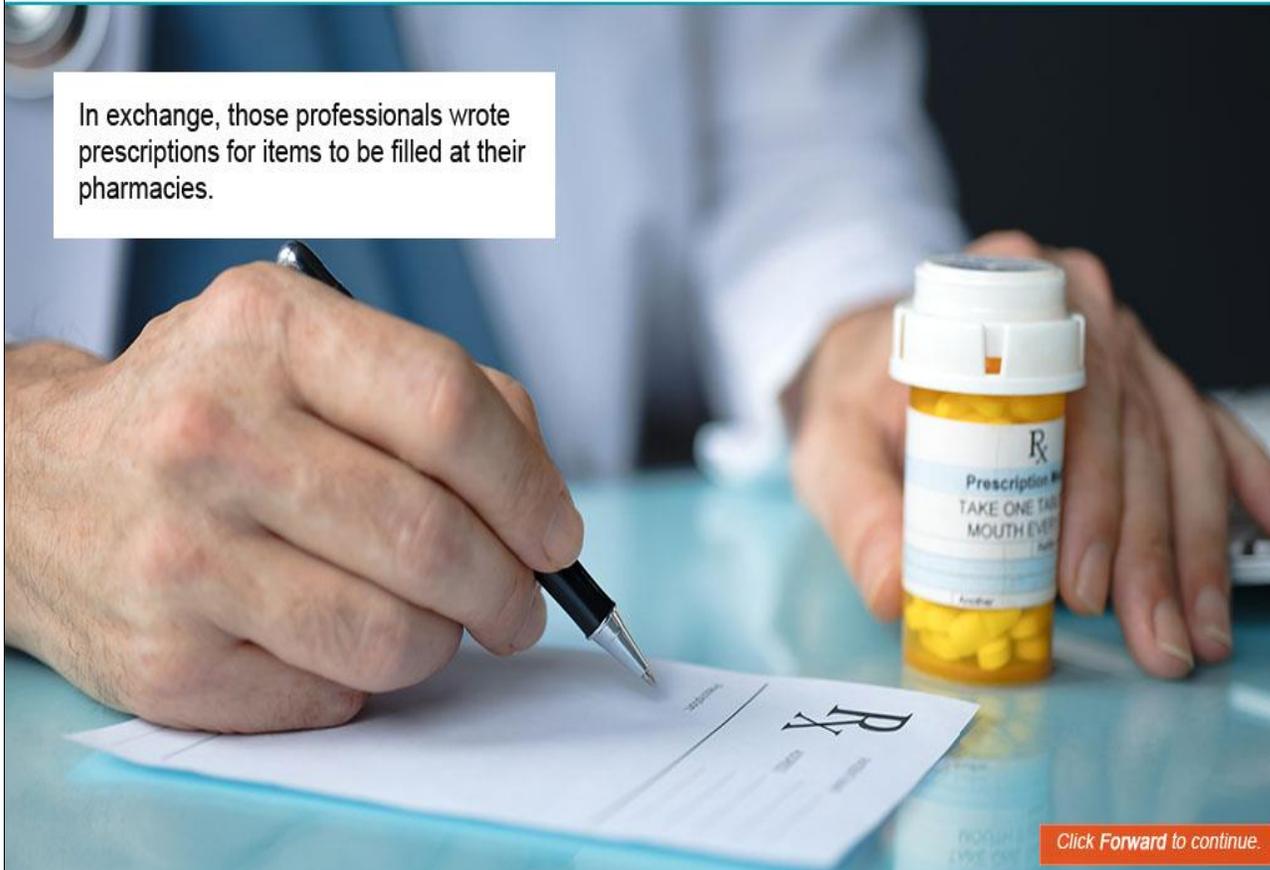
Click the link on your screen for more information on the Civil Monetary Penalties law.

Click the Forward button to look at an example of the Civil Monetary Penalties Law.

Slide 46

Civil Monetary Penalties (CMP) Law: Example

In exchange, those professionals wrote prescriptions for items to be filled at their pharmacies.



Slide notes

In Puerto Rico, a major retail pharmacy paid \$512,000 to settle allegations that it paid remuneration to health care professionals in the form of discounts on retail purchases at their stores when those professionals wrote prescriptions for items to be filled at their pharmacies.

Click the Forward button to learn about the Exclusion law.

Slide 47

Exclusion From All Federal Health Care Programs

No federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG.

The OIG has the 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.

[Click this link for more information on the exclusion requirements.](#)



Slide notes

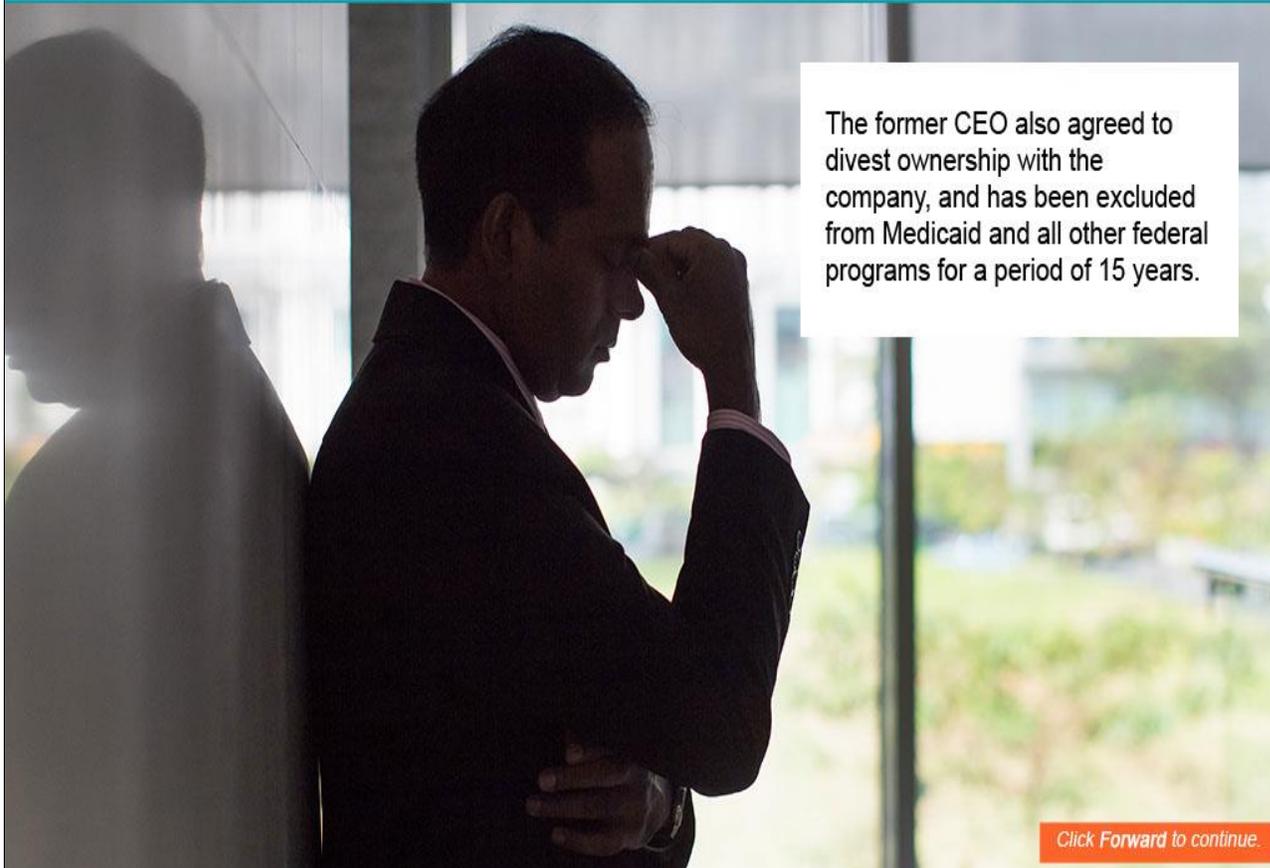
No federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has the authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals 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. Click the link on your screen for more information on the exclusion requirements.

Click the Forward button to look at an example of this.

Slide 48

Exclusion From All Federal Health Care Programs: Example



The former CEO also agreed to divest ownership with the company, and has been excluded from Medicaid and all other federal programs for a period of 15 years.

[Click Forward to continue.](#)

Slide notes

A New York City substance abuse treatment facility and its owner reached a \$6 million settlement in December 2020 resolving charges that the center provided kickbacks and used fraudulent means to enroll patients into their treatment center to bill Medicaid. Allegations state that the center targeted homeless individuals, bribing them with food, cash, and other goods to entice them into enrolling in the center's treatment program.

A second allegation states that the center created sham employment for a woman tasked with referring patients to the center's programs. Finally, the lawsuit states that the center used photocopied physicians' signatures on its admission forms to give the appearance that its new patients were being evaluated by qualified health professionals.

Of the \$6 million settlement, half of those funds were charged to the former CEO and primary owner personally. The former CEO also agreed to divest ownership with the company and has been excluded from Medicaid and all other federal programs for a period of 15 years.

Click the Forward button to continue.

Slide 49

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency of the health care industry. In addition, HIPAA safeguards help prevent unauthorized access to protected health information.

We all must comply with HIPAA.

 HIPAA violations may result in Civil Monetary Penalties.

[Click here for more information on HIPAA.](#)



Click Forward to continue.

Slide notes

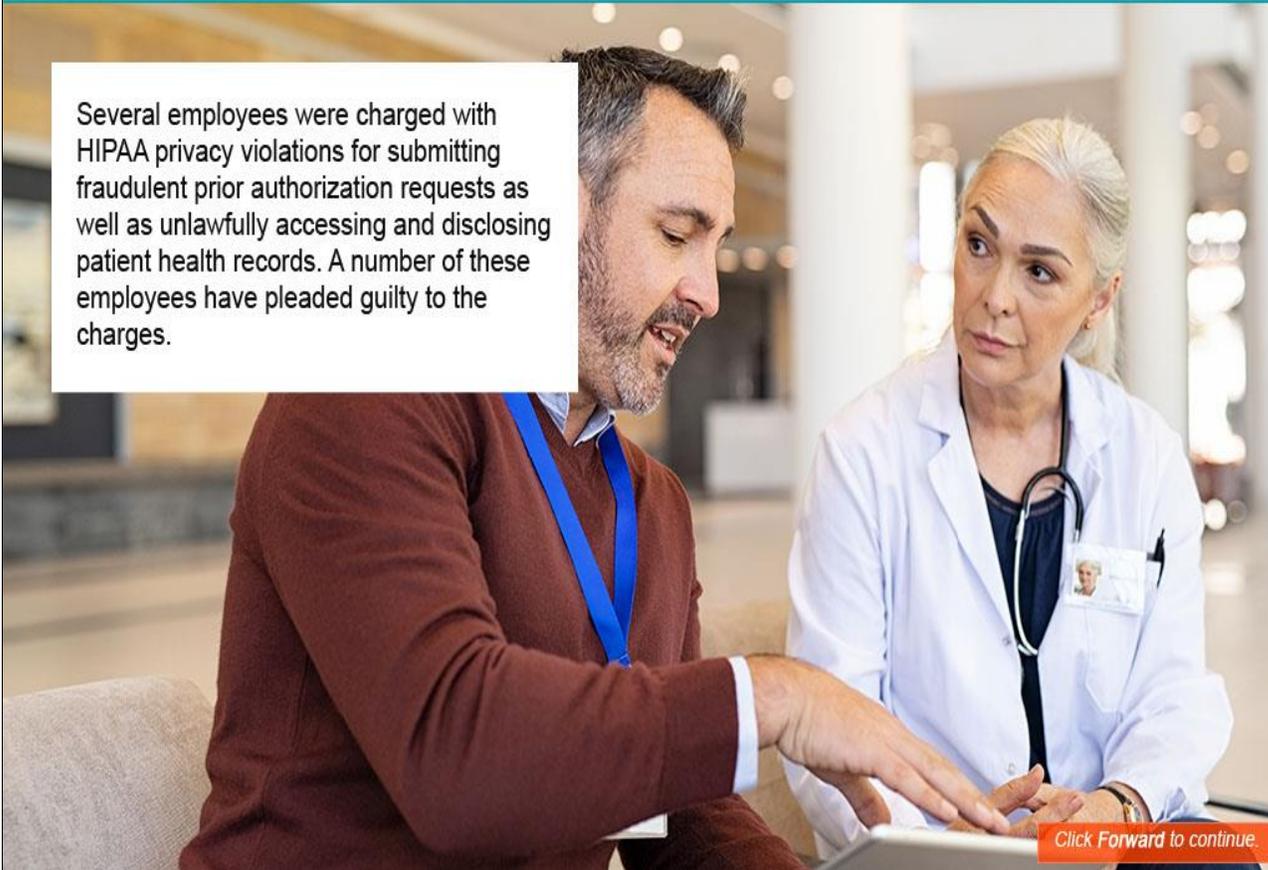
The Health Insurance Portability and Accountability Act created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency of the health care industry. HIPAA safeguards also help prevent unauthorized access to protected health information. As individuals with access to protected health information, we must all comply with HIPAA. HIPAA violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply. Click the link on your screen to visit the HIPAA webpage.

Click the Forward button to look at an example of HIPAA.

Slide 50

Health Insurance Portability and Accountability Act (HIPAA): Example

Several employees were charged with HIPAA privacy violations for submitting fraudulent prior authorization requests as well as unlawfully accessing and disclosing patient health records. A number of these employees have pleaded guilty to the charges.



Slide notes

A pharmaceutical manufacturer plead guilty to charges of health care fraud and agreed to pay a settlement of \$125 million.

In the guilty plea, the company admitted to paying kickbacks to physicians for prescribing its drugs,

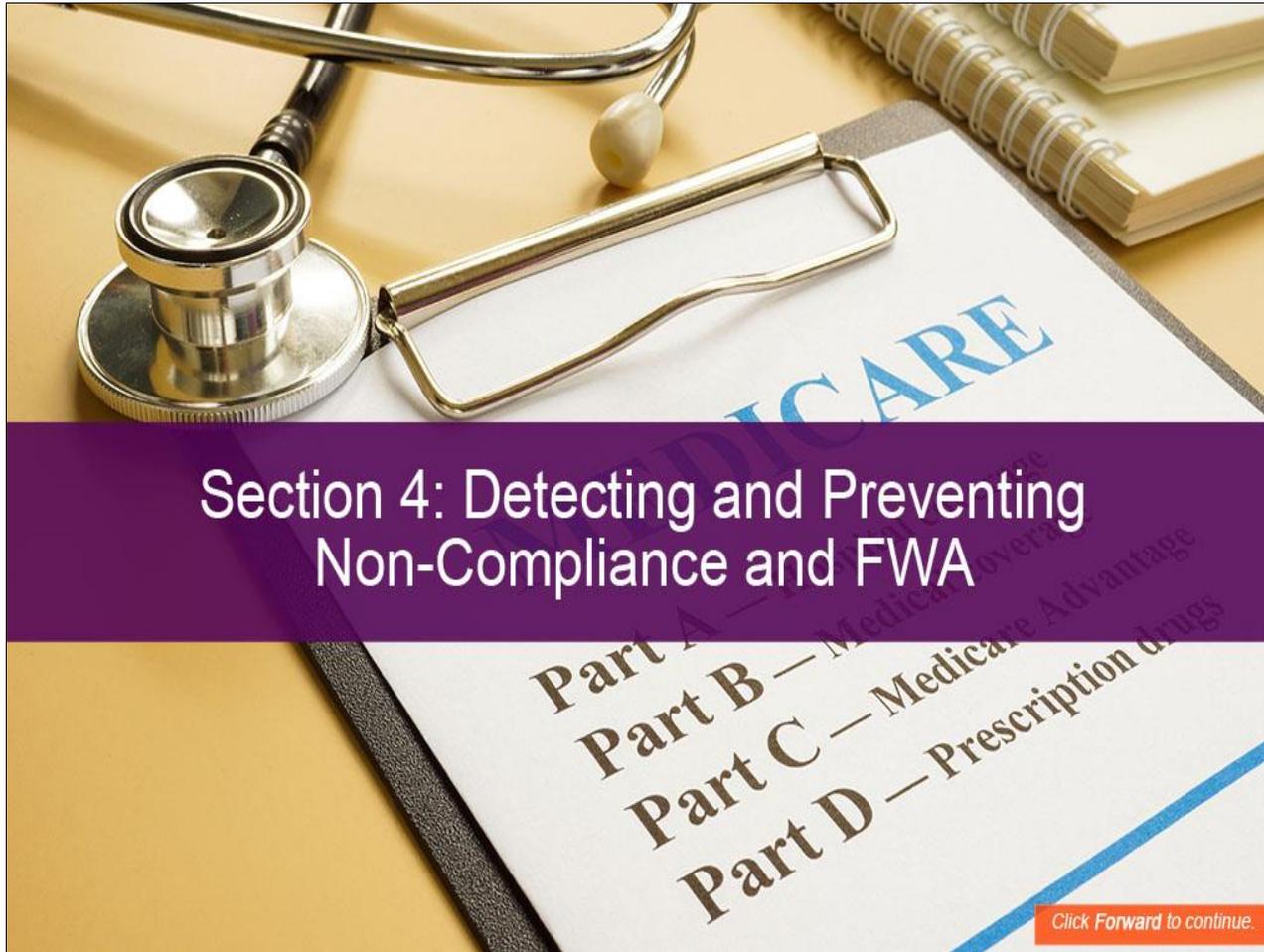
manipulating prior authorization with insurance companies, and making unsubstantiated marketing claims to boost sales for one of its higher-cost drugs.

Several employees were charged with HIPAA privacy violations for submitting fraudulent prior authorization requests as well as unlawfully accessing and disclosing patient health records.

A number of these employees have pleaded guilty to the charges.

Click the Forward button to continue.

Slide 51



Slide notes

Section 4: Detecting and Preventing Non-Compliance and FWA

This section will cover your role and responsibilities in preventing, reporting, and correcting non-compliance and FWA.

Click the Forward button to continue.

Slide 52

Where Do I Fit In?

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

Sponsor	First-tier entity	Downstream entity	Related entity
<ul style="list-style-type: none"> Medicare Advantage Organization (MAO) Prescription Drug Plan (PDP) 	<ul style="list-style-type: none"> Pharmacy Benefit Manager (PBM) Hospital or health care facility Provider group Doctor's office Clinical laboratory Customer service provider Claims processing and adjudication company Company handling enrollment, disenrollment, and membership functions Contracted sales agent 	<ul style="list-style-type: none"> Pharmacies Doctors' offices Agent and brokerage firms Marketing firms Call centers 	<ul style="list-style-type: none"> Entities with common ownership Entities with common control

Click Forward to continue.

Slide notes

As a person providing health or administrative services to a Medicare Part C or Part D enrollee, you are likely to be an employee of a Sponsor that is a Medicare Advantage Organization (MAO) or a Prescription Drug Plan (PDP).

You may be an employee of a first-tier entity, such as a Pharmacy Benefit Manager (PBM), a hospital or health care facility, a provider group, a doctors' office, a clinical laboratory, a customer service provider, a claims processing and adjudication company, a company that handles enrollment, disenrollment, and membership functions, or a contracted sales agent.

You may even be an employee of a downstream entity that includes pharmacies, doctor's offices, firms providing agent and broker services, marketing firms, and call centers or a related entity that includes entities with common ownership or control of a Sponsor.

Click the Forward button to learn about your responsibilities.

Slide 53

Your Responsibilities

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

- **Comply** with all statutory, regulatory, and other Medicare Part C or Part D requirements.
- **Report** any compliance concerns and suspected or actual violations of which you may be aware.
- **Follow** your Compass Code of Ethical Business Conduct.



Click Forward to continue.

Slide notes

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

Firstly, you must comply with all statutory, regulatory, and other Medicare Part C or Part D requirements, including following the GuideWell compliance program.

Secondly, you have a duty to the Medicare program to report any compliance concerns and suspected or actual violations of which you may be aware.

And finally, you have a duty to follow your Compass Code of Ethical Business Conduct that articulates your and GuideWell's commitment to standards of conduct and ethical rules of behavior.

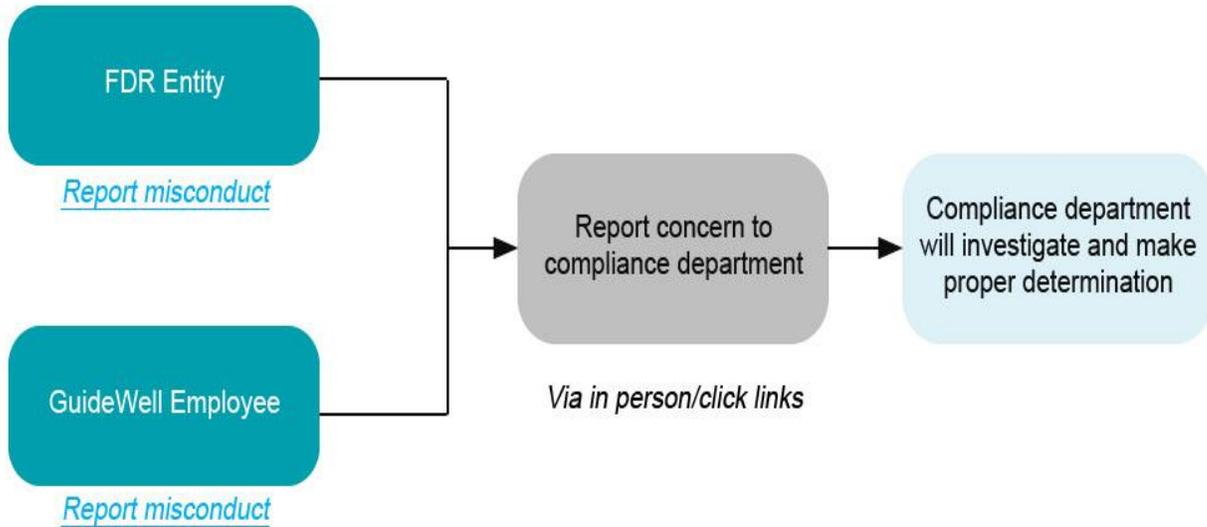
Click the Forward button to learn how to report non-compliance.

Slide 54

Reporting Potential Non-Compliance

Everyone must report suspected instances of non-compliance.

GuideWell offers reporting methods that are anonymous, confidential, and non-retaliatory.



Click Forward to continue.

Slide notes

Everyone must report suspected instances of non-compliance. The Compass Code of Conduct clearly states this obligation. When you report suspected non-compliance, GuideWell cannot retaliate against you. GuideWell offers reporting methods that are anonymous, confidential, and non-retaliatory. If you are an FDR or a GuideWell employee, you need to report any potential concerns to your compliance department in person or by using the links displayed on your screen.

GuideWell’s compliance department will investigate and make the proper determination.

Click the Forward button to learn how to report FWA.

Slide 55

Reporting Potential Fraud, Waste, and Abuse



If you suspect fraud, waste, or abuse involving providers, agents, beneficiaries, or other people who are not our employees, you need to:

- Call the GuideWell fraud hotline: (800) 678-8355
- Email the Special Investigation Unit (SIU): specinvestunit@bcbsfl.com
- Submit an online fraud and abuse report form: <https://www.floridablue.com/general/fraud-form>
- Write to GuideWell:

GuideWell
Special Investigation Unit
P.O. Box 44193
Jacksonville, FL 32231-4193

[Click Forward to continue.](#)

Slide notes

If you suspect fraud, waste, or abuse involving providers, agents, beneficiaries, or other people who are not our employees, you have a responsibility to report the situation by calling the GuideWell fraud hotline, emailing the Special Investigation Unit (SIU), submitting an online fraud and abuse report form, or writing to GuideWell's Special Investigation Unit.

Click the Forward button to continue.

Slide 56

Reported by	Reporting ways	
Federal HHS programs		https://oig.hhs.gov/fraud/report-fraud/index.asp
		1-800-HHS-TIPS (1-800-447-8477)
		800-223-8164
		1-800-377-4950
		U.S. Department of Health and Human Services Office of Inspector General ATTN: OIG HOTLINE OPERATIONS P.O. Box 23489 Washington, DC 20026

Click Forward to continue.

Slide notes

Sometimes, it may be necessary for GuideWell to report fraudulent conduct outside of the organization to the OIG, the U.S. Department of Justice, or CMS. Individuals or entities that wish to voluntarily disclose self-discovered potential fraud to the OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives people the opportunity to avoid the costs and disruptions associated with a government-directed investigation and civil or administrative proceedings.

When reporting suspected FWA, you should include contact information for the source of the information, suspects, and witnesses; details of the alleged FWA; identification of the specific Medicare rules allegedly violated; and the suspect’s history of compliance, education, training, and communication with your organization or other entities.

To report suspected cases of fraud, waste, or abuse in Federal HHS programs, use the online OIG Hotline form. You may also call, mail, or fax HHS using the information provided on your screen.

For Medicare Parts C and D, contact the National Benefit Integrity Medicare Prescription Drug Integrity Contractor. For all other federal health care programs, contact the CMS Hotline or the Medicare beneficiary website.

Click the Forward button to continue.

Slide 57

What Happens After Non-Compliance or FWA is Detected?

Non-compliance and FWA must be investigated immediately and corrected promptly.



Design the corrective action.



Tailor the corrective action to address the particular FWA, problem, or deficiency identified.



Include timeframes for specific actions.



Document corrective actions.



Include consequences for failure to satisfactorily complete the corrective action.



Monitor corrective actions continuously to ensure effectiveness.



Slide notes

Non-compliance and FWA must be investigated immediately and corrected promptly. Ask your compliance department 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 non-compliance; tailor the corrective action to address the particular FWA, problem, or deficiency identified; include timeframes for specific actions; document corrective actions addressing non-compliance or FWA committed by a Sponsor’s employee or FDR’s employee; include consequences for failure to satisfactorily complete the corrective action; and finally, monitor corrective actions continuously to ensure effectiveness.

Monitoring should ensure no recurrence of the same non-compliance or FWA, ongoing compliance with CMS requirements, efficient and effective internal controls, and protected enrollees.

Click the Forward button to continue.

Slide 58

Course Summary

Here is a recap of what you learned:

- Medicare is a federal health insurance program that is part of the Social Security Act and is strictly regulated by CMS.
- An effective compliance program must articulate and demonstrate an organization's commitment to legal and ethical conduct, provide guidance on how to handle compliance questions and concerns, and provide guidance on how to identify and report compliance violations.
- At a minimum, an effective compliance program includes seven core requirements.
- Non-compliance is conduct that does not conform to the law, federal health care program requirements, or an organization's ethical and business policies.
- Fraud is intentionally submitting false information to the government, or a government contractor, to get money or a benefit.
- Waste and abuse includes practices that directly or indirectly result in unnecessary costs to the Medicare program.

Click Forward to continue.

Slide notes

Here is a recap of what you learned:

Medicare is a federal health insurance program that is part of the Social Security Act and is strictly regulated by CMS.

An effective compliance program must articulate and demonstrate an organization's commitment to legal and ethical conduct, provide guidance on how to handle compliance questions and concerns, and provide guidance on how to identify and report compliance violations.

At a minimum, an effective compliance program includes seven core requirements.

Non-compliance is conduct that does not conform to the law, federal health care program requirements, or an organization's ethical and business policies.

Fraud is intentionally submitting false information to the government, or a government contractor, to get money or a benefit.

Waste and abuse includes practices that directly or indirectly result in unnecessary costs to the Medicare program.

Click the Forward button to recap a few more points.

Slide 59

Course Summary

Here are a few more points to remember:

- In order to understand how to detect FWA, you need to know the False Claims Act (FCA); Health Care Fraud Statute and the Criminal Fraud Statute; the Anti-Kickback Statute; the Stark Law (Physician Self-Referral Law); the Civil Monetary Penalties (CMP) Law; exclusion from all federal health care programs requirements; and the Health Insurance Portability and Accountability Act (HIPAA).
- If you suspect fraud, waste, or abuse involving providers, agents, beneficiaries, or other persons who are not our employees, you have a responsibility to report the situation by calling the GuideWell fraud hotline, emailing the Special Investigation Unit (SIU), submitting an online fraud and abuse report form, or writing to GuideWell's SIU.



Click **Forward** to continue.

Slide notes

Here are a few more points to remember:

In order to understand how to detect FWA, you need to know the False Claims Act (FCA); Health Care Fraud Statute and the Criminal Fraud Statute; the Anti-Kickback Statute; the Stark Law (Physician Self-Referral Law); the Civil Monetary Penalties (CMP) Law; exclusion from all federal health care programs requirements; and the Health Insurance Portability and Accountability Act (HIPAA).

If you suspect fraud, waste, or abuse involving providers, agents, beneficiaries, or other persons who are not our employees, you have a responsibility to report the situation by calling the GuideWell fraud hotline, emailing the Special Investigation Unit (SIU), submitting an online fraud and abuse report form, or writing to GuideWell's SIU.

Click the Forward button to continue.

Slide 60

Assessment

Now it's time to take an assessment!

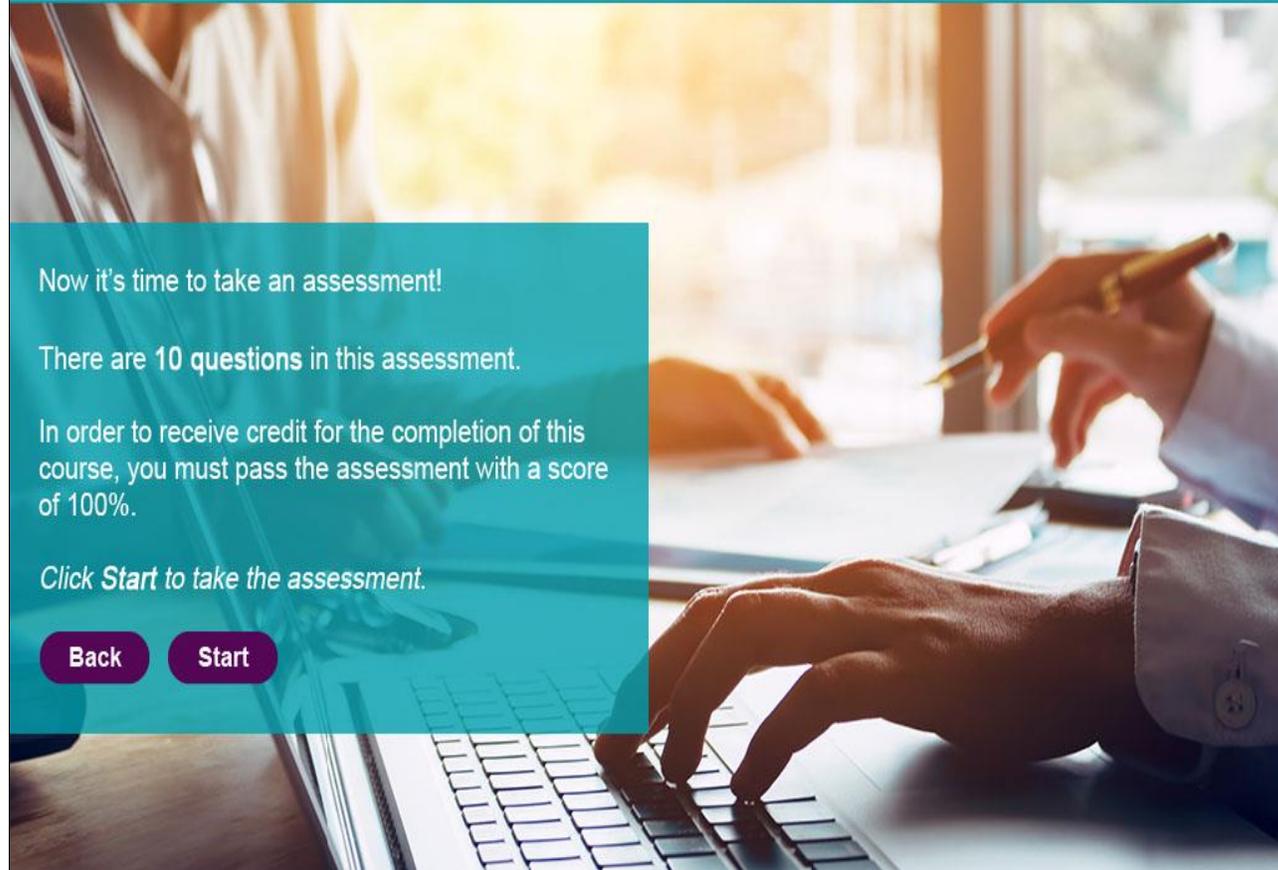
There are **10 questions** in this assessment.

In order to receive credit for the completion of this course, you must pass the assessment with a score of 100%.

Click Start to take the assessment.

Back

Start



Slide notes

Now it's time to take an assessment. There are 10 questions in this assessment. In order to receive credit for the completion of this course, you must pass the assessment with a score of 100%.

Click the Start button to take the assessment.

Slide 61

Assessment

Compliance is the responsibility of the compliance officer, compliance committee, and senior management only. Is this statement true or false?

Select the correct option and submit.

- A. True
- B. False

Submit

Slide notes

Question 1: Compliance is the responsibility of the compliance officer, compliance committee, and senior management only.

Is this statement true or false?

- A. True
- B. False

Select the correct option and submit.

Slide 62

Assessment

Medicare Parts C and D Plan Sponsors are not required to have a compliance program. Is this statement true or false?

Select the correct option and submit.

- A. True
- B. False

Submit

Slide notes

Question 2: Medicare Parts C and D Plan Sponsors are not required to have a compliance program. Is this statement true or false?

- A. True
- B. False

Select the correct option and submit.

Slide 63

Assessment

Which of the following methods are used to report a compliance issue or fraud, waste, and abuse?

Select the correct option(s) and submit.

- A. Telephone hotlines
- B. Mail drops
- C. In-person reporting to the compliance department or supervisor
- D. Email

Submit

Slide notes

Question 3: Which of the following methods are used to report a compliance issue or fraud, waste, and abuse?

- A. Telephone hotlines
- B. Mail drops
- C. In-person reporting to the compliance department or supervisor
- D. Email

Select the correct options and submit.

Slide 64

Assessment

At a minimum, an effective compliance program includes four core requirements. Is this statement true or false?

Select the correct option and submit.

- A. True
- B. False

Submit

Slide notes

Question 4: At a minimum, an effective compliance program includes four core requirements. Is this statement true or false?

- A. True
- B. False

Select the correct option and submit.

Slide 65

Assessment

What are some of the consequences for non-compliance, fraudulent, or unethical behavior?

Select the correct option(s) and submit.

- A. Disciplinary actions
- B. Termination of employment
- C. Exclusion from participating in all federal health care programs

Submit

Slide notes

Question 5: What are some of the consequences for non-compliance, fraudulent, or unethical behavior?

- A. Disciplinary actions
- B. Termination of employment
- C. Exclusion from participating in all federal health care programs

Select the correct options and submit.

Slide 66

Assessment

Suspected fraud, waste, and abuse; a potential health privacy violation; unethical behavior; and employee misconduct are examples of issues that should be reported to a compliance department. Is this statement true or false?

Select the correct option and submit.

- A. True
- B. False

Submit

Slide notes

Question 6: Suspected fraud, waste, and abuse; a potential health privacy violation; unethical behavior;

and employee misconduct are examples of issues that should be reported to a compliance department. Is this statement true or false?

- A. True
- B. False

Select the correct option and submit.

Slide 67

Assessment

Waste includes any misuse of resources, such as the overuse of services or other practices that directly or indirectly result in unnecessary costs to the Medicare program. Is this statement true or false?

Select the correct option and submit.

- A. True
- B. False

Submit

Slide notes

Question 7: Waste includes any misuse of resources, such as the overuse of services or other practices that directly or indirectly result in unnecessary costs to the Medicare program.

Is this statement true or false?

- A. True
- B. False

Select the correct option and submit.

Slide 68

Assessment

Which of the following are laws governing Medicare Parts C and D fraud, waste, and abuse?

Select the correct option(s) and submit.

- A. HIPAA
- B. The False Claims Act
- C. The Anti-Kickback Statute
- D. The Health Care Fraud Statute

Submit

Slide notes

Question 8: Which of the following are laws governing Medicare Parts C and D fraud, waste, and abuse?

- A. HIPAA
- B. The False Claims Act
- C. The Anti-Kickback Statute
- D. The Health Care Fraud Statute

Select the correct options and submit.

Slide 69

Assessment

Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented facts to obtain payment. Is this statement true or false?

Select the correct option and submit.

- A. True
- B. False

Submit

Slide notes

Question 9: Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented facts to obtain payment. Is this statement true or false?

- A. True
- B. False

Select the correct option and submit.

Slide 70

Assessment

Which of the following penalties are associated with violation of FWA laws?

Select the correct option(s) and submit.

- A. Civil monetary penalties
- B. Imprisonment
- C. Exclusion from participating in all federal health care programs

Submit

Slide notes

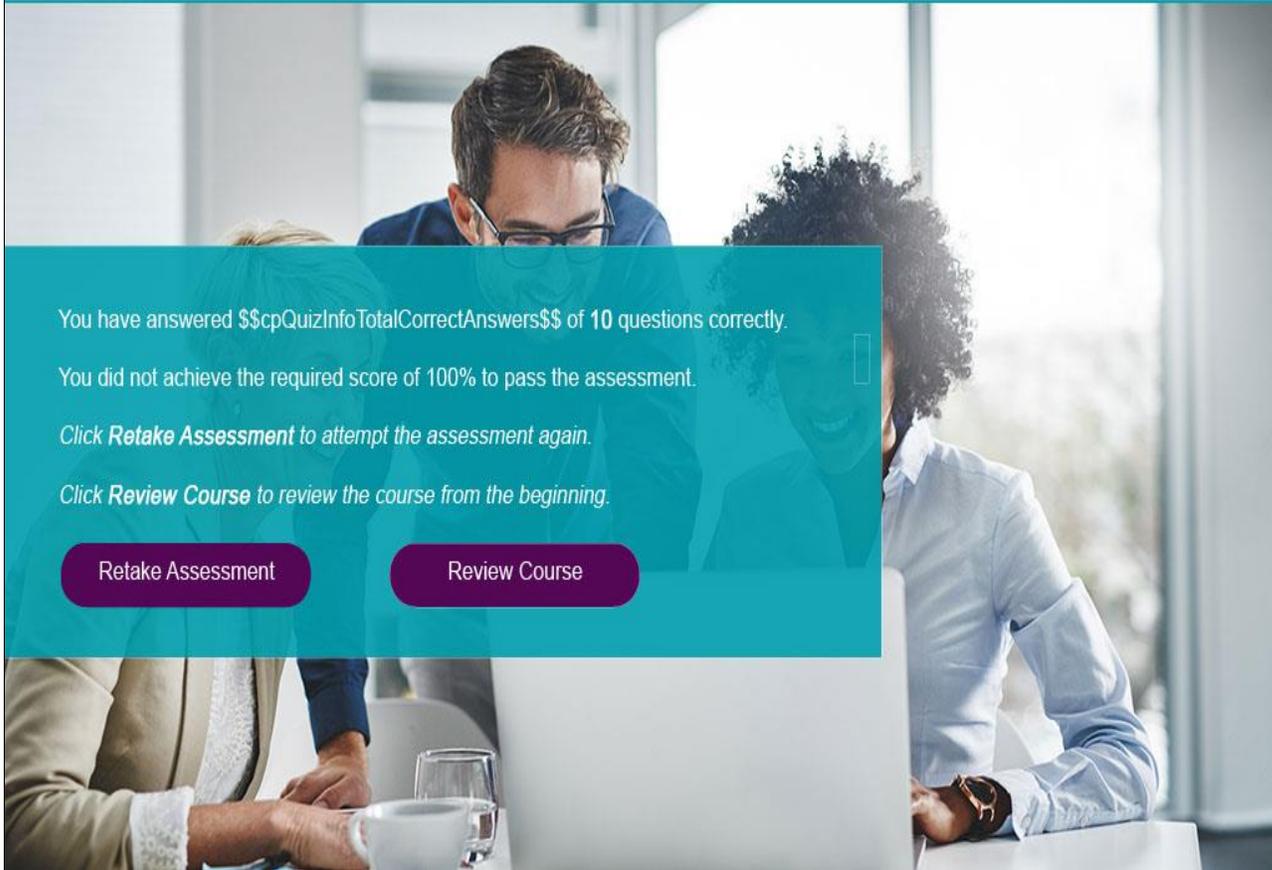
Question 10: Which of the following penalties are associated with violation of FWA laws?

- A. Civil monetary penalties
- B. Imprisonment
- C. Exclusion from participating in all federal health care programs

Select the correct options and submit.

Slide 71

Course Completion



Slide notes

Slide 72

Attestation Statement

If you agree with the following statements, click the **I Agree** button.

- I understand that I am responsible for reading the [Compass Code of Conduct](#) and complying with the Compass Program.
- I agree to comply with the Compass Code of Conduct as well as with the company policies, laws, and regulations that apply to my job.
- I understand [how to report](#) issues through the Compass Helpline, EthicsPoint, or the Special Investigation Unit.
- I understand that I have a responsibility to report any observed or suspected violations of the law or the Compass Program.
- I understand that the use of the Internet must comply with company policies and procedures and that failure to comply may result in corrective action up to and including termination.

Back

I Agree

Slide notes

If you agree with the following statements, click the I Agree button.

I understand that I am responsible for reading the Compass Code of Conduct and complying with the Compass Program.

I agree to comply with the Compass Code of Conduct as well as with the company policies, laws, and regulations that apply to my job.

I understand how to report issues through the Compass Helpline, EthicsPoint, or the Special Investigation Unit.

I understand that I have a responsibility to report any observed or suspected violations of the law or the Compass Program.

And I understand that the use of the Internet must comply with company policies and procedures

and that failure to comply may result in corrective action up to and including termination.

Slide 73

Thank You

Thank you for completing the Medicare Compliance and Fraud, Waste, and Abuse course.

In order to receive credit for completion, you must have:

- Viewed every slide within the course
- Passed the assessment
- Completed the Attestation Statement

You may now close the browser to exit.

Slide notes

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You may now close the browser to exit.