Fraud, Waste, and Abuse Training

2022

Network Medical Management

TABLE OF CONTENTS

ACRONYMS

Acronym	Title Text
AKS	Anti-Kickback Statute
BMFEA	Bureau of Medi-Cal Fraud & Elder Abuse
CDI	California Department of Insurance
CFR	Code of Federal Regulations
CIA	Corporate Integrity Agreement
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
DMHC	Department of Managed Healthcare
DHCS	Department of Health Care Services
DOJ	Department of Justice
FBI	Federal Bureau of Investigation
FCA	False Claims Act
FDR	First-tier, Downstream, and Related Entity

Acronym	Title Text
FA	Fraud and Abuse
GSA	General Services Administration
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	U.S. Department of Health & Human Services
H&SC	CA Health & Safety Code
MAO / MA	Medicare Advantage Organization / Medicare Advantage
MA-PD / PDP	MA Prescription Drug / Prescription Drug Plan
MLN	Medicare Learning Network
NBI Medic	National Benefit Integrity Medicare Drug Integrity Contractor
OIG	Office of Inspector General
SIU	Special Investigations Unit
UPICs	Unified Program Integrity Contractors

INTRODUCTION

Welcome to the **Network Medical Management (NMM)** Combating Medicare Parts C and D Fraud, Waste, and Abuse Training (FWA). This training models was developed by CMS and incorporates additional information specific to NMM.

The training developed by CMS can be found in the Medicare Learning Network® (MLN) & Industry Collaboration Effort (ICE).

HEALTH CARE FRAUD & ABUSE PREVENT, DETECT, REPORT

OVERVIEW

- **WHAT:** Federal & state requirements you must know
- **WHY:** Detect prevent, & correct fraud & abuses; raise awareness
- **HOW**: Implement an effective compliance program
- **WHO:** Frist tier downstream, related entities (FDRs) & delegated entities
- **WHEN:** Training must be completed upon hire/initial contract & annually thereafter

TRAINING OBJECTIVES

- **Identify** fraud & abuse
- **Understand** fraud & abuse laws & penalties
- **Recognize** government agencies & partnerships dedicated to fighting fraud & abuse
- **Recognize** risk areas or red flags – claims, UM, member services, documentation & coding
- **How to report fraud & abuse**
- **What happens after detection?**

INTRODUCTION

Why Do I Need Training?

A Serious Problem Requiring Your Attention!

- Every year billions of dollars are improperly spent because of FWA. It affects everyone—**including you**. This training will help you detect, correct, and prevent FWA. **You** are part of the solution.
- Combating FWA is **everyone's** responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

You play a vital role in protecting the integrity of Health Care.

Do Your Part, Get Informed!

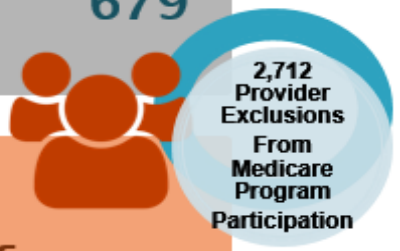
Committing Fraud Is Not Worth It

Medicare Trust Fund recovered approximately **$1.2 billion** **$232 million recovered** in Medicaid Federal money transferred to the Treasury	The Federal government convicted **497 defendants** of health care fraud	Department of Justice (DOJ) opened **1,139 new criminal** health care fraud investigations DOJ opened **918 new civil** health care fraud investigations

Consequences

HHS OIG Criminal Actions

FY 2016	765
FY 2017	766
FY 2018	679



HHS OIG Civil Actions

FY 2016	690
FY 2017	818
FY 2018	795

INTRODUCTION

Training Requirements: Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

- Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training for preventing, detecting, and correcting FWA.
- FWA training must occur within the orientation period of the initial hire (30 days) and annually thereafter.
- More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website.

INTRODUCTION

Navigating and Completing This Course

Anyone providing health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. You may use this WBT course to satisfy the FWA requirements.

LESSON 1: WHAT IS HEALTH CARE FRAUD?

FRAUD:

INTENTIONAL ACT FOR GAIN:

- Knowingly submitting, or causing to be submitted false claims, or making misrepresentations of facts to obtain overpayment.
- Knowingly receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal or private health care programs
- Making prohibited referrals for certain designated health services
- Documenting a verbal denial falsely attributed to a medical professional

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

LESSON 1: WHAT IS HEALTH CARE FRAUD?

DECEPTION:

- Falsifying documents to indicate notifications approving, modifying, or denying request for authorization were sent to the member &/or provider
- Altering claim audit files to fraudulently show compliance with health plan audits to hide failure to pay claims due to financial insolvency
- Submitting inaccurate financial reports related to outstanding claims liability
- Redirecting care from a contracted provider because of economic profile (cost) without regulatory approval

These actions represent the creation of false medical histories, which could potentially put patients at physical risk solely for the purpose of financial gain.

HEALTH CARE FRAUD
RED FLAGS!

- **Unusual provider billing practices or suspicious provider activity**
  - Altering dates of service
  - Unbundling or upcoding services
  - Offering to waive patient's co-payment or coinsurance
- **Discrepancy between diagnosis & treatment**
- **Resubmitting claims with unsupported coding changes** (i.e., altering service code, falsifying diagnosis) to gain payment or change financial responsible party
- **Intentional misrepresentation** to get higher payment by altering claim forms, medical records, or receipts
- **Deliberate provision of unwarranted/non-medically necessary services for financial gain**
- **Patients questioning services provided**
  - Services not rendered
  - Does not know provider
- **Modification of the provider of service to a different provider**
- **Verbal denials**

RED FLAG ALERT – ECONOMIC PROFILING

WHAT IS IT	• Any evaluation of contracted provider based on the economic cost or utilization patterns
HOW IS IT MISUSED	• Results may be used to redirect or divert access to an unpublicized or unapproved narrow network of preferred providers to contain cost.
DMHC REQUIREMENTS	• Follow economic profile policies filed by health plans OR submit delegate economic profile policies to health plan for DMHC filing, approval & attestation. • Follow rules as outlines in H&SC 1367.02.

RED FLAG ALERT – VERBAL DENIAL ODERS

WHAT IS IT	• Staff obtains a denial decision from a physician reviewer by phone and documents in the case file.
HOW IS IT MISUSED	• May lead to fraud as it is processed without physician validation of signature or electronic identifier.
DMHC REQUIREMENTS	• Prohibit or discourage verbal denials as an intangible method of physician review.

LESSON 1: WHAT IS HEALTH CARE ABUSE?

ABUSE

- Describes practices that, either directly or indirectly result in unnecessary cost to Health Care Programs
- Abuse includes any practice inconsistent with providing patients medically necessary services, meeting professional recognized standards of care, and charging fair prices.
- 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.

Both fraud & abuse can expose providers to criminal, civil, & administrative liabilities.

HEALTH CARE ABUSE
RED FLAGS!

- **Billing for medical services that are**
  - Unnecessary;
  - Inappropriate;
  - Unwarranted; or
  - Questionable/unproven treatments &/or care
- **Rendering treatment/care which does not meet professionally recognized standards of care**
- **Rendering services or supplies which are not medically necessary**
- Charging excessively for services or supplies
- Rendering, referring, or recommending treatment/care, test, services, or supplies which would not have been rendered or utilized in the absence of insurance
- Misusing claim codes, such as upcoding or unbundling codes
- Health plan denies requested specialty care or hospitalizations in order to reduce medical loss ratio and maximize profit
- Provider or health plan deliberately & systematically deters member from receiving medically necessary services in order to maximize service funds or capitation revenue

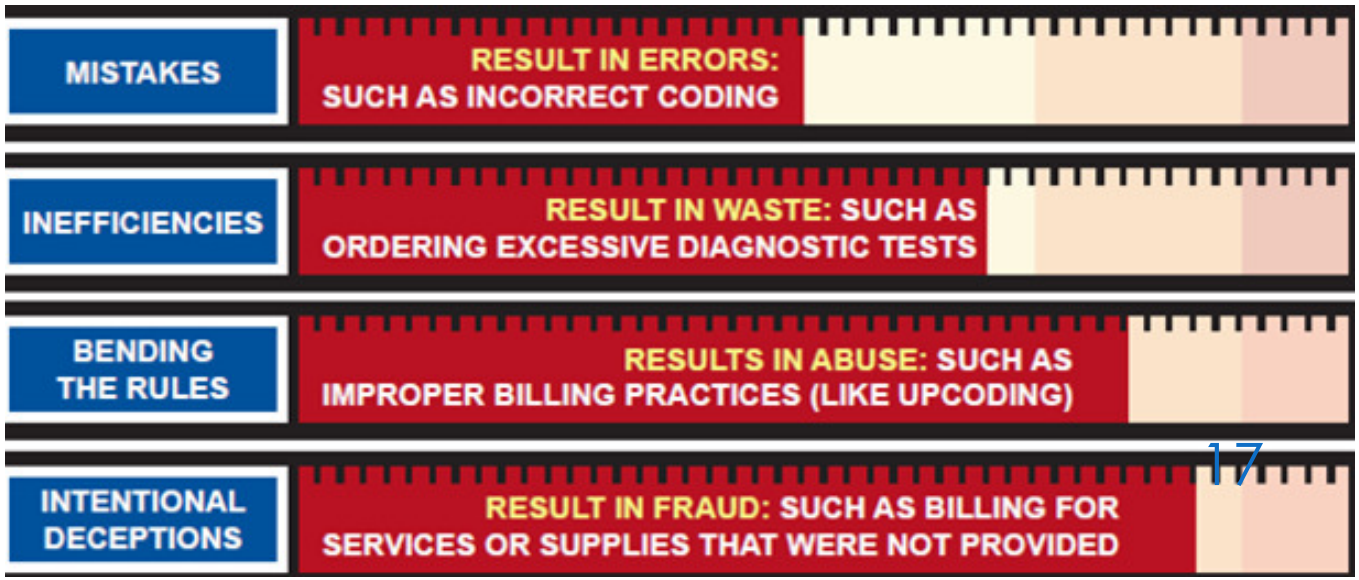
PROGRAM INTEGRITY

- Program integrity (PI) is simply "pay it right".
- PI focus is on:

- Paying the right amount to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries while taking aggressive actions to eliminate fraud, waste, and abuse.

- Program integrity includes a range of activities targeting various causes of improper payments.

Possible types of Improper Payments Examples:



SUMMARY – FRAUD & ABUSE

Drain billions of dollars from health care programs every year, putting patient health & welfare at risk by exposing them to unnecessary services, taking money away from care, & increasing cost

Jeopardize quality health care & services & threaten the integrity of health care programs by fostering the misconception that health care means easy money

Cost you as a health care provider & taxpayer – resulting in waste & unintentionally financing criminal activities

LAWS & PENALTIES
FEDERAL LAWS

False Claims Act (FCA)

Civil FCA — 31 United States Code (U.S.C) Sections 3729–3733

Criminal FCA — 18 U.S.C. Section 2817

- Imposes civil liability on a person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal government. Also called Lincoln Law.
- "*Should have known,*" "*knowing,*" or "*knowingly*" means deliberate ignorance or reckless disregard of the truth.

Anti–Kickback Statute (AKS)

42 U.S.C. Section 1320a – 7b(b)

- Prohibits knowingly and willfully offering, paying, soliciting, or getting remuneration in exchange for Federal health care program business referrals. The "*safe harbor*" regulations describe various payment and business practices that may satisfy regulatory requirements and may not violate AKS. https://oig.hhs.gov/compliance/safe-harbor-regulations/

Physician Self–Referral Law (Stark Law)

42 U.S.C. Section 1395nn

- Prohibits physicians from referring Medicare beneficiaries for designated health services to an entity where the physician (or an immediate family member) has ownership/investment interest or a compensation arrangement, unless an exception applies. See the Code List for Certain Designated Health Services (DHS) at https://www.cms.gov/Medicare

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LAWS & PENALTIES
FEDERAL LAWS

Criminal Health Care Fraud Statute
18 U.S.C. Section 1347

- Prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie for delivering, or paying for, health care benefits, items, or services to defraud a health care benefit program, or prescribed by an excluded individual or entity.

Social Security Act Exclusion Statute
42 USC 1320a–7

- Prohibits the excluded individual or entity from participating in all Federal health care programs. The exclusion means no Federal health care program pays for items or services given, ordered, or prescribed by an excluded individual or entity.
- Enforced by OIG & GSA.

Civil Monetary Penalties (CMPs)

- CMPs apply to a variety of conduct violations and assessing the CMP amount depends on the violation. Penalties up to ***$100,000*** (in 2018) per violation may apply. CMPs may also include an assessment of up to ***3 times*** the amount claimed for each item or service, or up to ***3 times*** the amount offered, paid, solicited, or received.

LAWS & PENALTIES
CALIFORNIA STATE LAWS

Welfare Institutions Code 14107 [False Claims]	• Prohibits claim submission with intent to defraud to obtain greater compensation than legally entitled.
Welfare Institutions Code 14107 (a–b) [Anti–Kickback]	• Solicits or receives any kickback, bribe or rebate to either refer or promise to refer person for service or merchandise
CA Penal Code 550(a)(6–7) [False claims]	• Imposes liability to knowingly make or cause to be made any false or fraudulent claim for health care benefit or which was not used by or on behalf of the claimant

LAWS & PENALTIES
CALIFORNIA STATE LAWS

Business & Professions Code 17200

- Any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising

CA Insurance Frauds Prevention Act ("IFPA") CA Ins. Code 1871.7

- Allows members of the public to file private qui tam suits against anyone who commits insurance fraud in the state.
- The Act states that employees suffering retaliation for their involvement in reporting insurance fraud "shall be entitled to all relief necessary to make the employee whole.

California False Claims Act (CFCA)

- A state law modeled after the Federal FCA. CFCA prohibits any person from submitting false or fraudulent claims valued at over $500 to state or local government.

LAWS & PENALTIES
DHCS RELATED LAWS

CA H&SC 1341 (a)	• DMHC to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.
CA H&SC 1386 (b) (7) [Fraud]	• Prohibits conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code
CA H&SC 1371.37 [Claim payment]	• A health care service plan is prohibited from engaging in an unfair payment pattern
CA H&SC 1367.02 [Economic Profiling]	• Medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. Prohibits fraud of concealing or restricting costly specialists from network unless economic profiling policies disclosed to the DMHC

LAW or STATUTE – EXAMPLES:

FCA	• A physician knowingly submits claims for medical services not provided or for a higher level of medical services than actually provided
FCA	• Changing dates, medical records &/or condition/ diagnosis treated (e.g., service is not supported by the patient's medical record)
FCA	• Service is miscoded • Service is already covered under another claim
AKS	• A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals

LAW or STATUTE – EXAMPLES:

Physician Self–Referral Law (Stark Law)	• A provider refers a patient for a designated health service to a clinic where the physician (or an immediate family member) has an investment interest
Criminal Health Care Fraud Statute	• Several doctors and medical clinics conspired to defraud by submitting claims for medically unnecessary power wheelchairs
Exclusion Statute – Denial of Payment	• A hospital employs an excluded nurse who provides items or services to Federal health care program beneficiaries, even if the nurse's services are not separately billed and are paid as part of a Medicare diagnosis–related group payment the hospital receives • The excluded nurse violates their exclusion thereby causing the hospital to submit claims for items or services they provide
Economic Profiling	• A medical group redirects a referral from a contracted physician to a less costly physician without disclosure of process to the DMHC

RED FLAG – EXAMPLES:

Health Care Fraud Red Flag

- Obstructing an investigation or audit by withholding or delaying information or documentation

Health Care Fraud Red Flag

- A medical group alters documents to pass an audit by changing dates on a case file to give appearance of compliance to timeframes

Health Care Fraud Red Flag

- A nurse writes a verbal denial for a decision that was not made by the doctor

POTENTIAL PENALTIES

Civil Monetary Penalties Law (CMPL)

- Payment for each service in non-compliance
- Payment up to ***3 times*** the amount claimed
- Exclusion from health care programs
- May require mandatory compliance program

Criminal & Civil Liability

- Fines
- Imprisonment
- Recoupment
- Restitution
- Loss of license

POTENTIAL SANCTIONS

OIG Corporate Integrity Agreement (CIA)

- Entity to carry out a compliance program
- Hiring of a compliance officer
- Development of written standards and policies
- Carry out an employee training program
- Annual audits and reviews

Mandatory Corrective Action

- Applicable measures to prevent reoccurrence
- Mandatory training or re-training
- Disciplinary action
- Termination

FEDERAL EXCLUSION

Excluded individuals & entities are banned from participating in healthcare programs either directly or indirectly.

Exclusion from Federal Healthcare Programs

- Excluded individual or entity may face additional penalties for submitting or causing the submission of claims
- Federal health care programs do **not** pay for items or services given, ordered, or prescribed by an excluded individual or entity

OIG List of Excluded Individuals/Entities (LEIE)

- Public list of individuals and entities currently excluded
- **Health care providers that knowingly hire an excluded party are subject to potential FCA liability and CMPs.**

General Service Administration (GSA)

System for Award Management (SAM)

- SAM incorporated the Excluded Parties List System (EPLS) and includes information on entities:
  - Debarred or proposed for debarment
  - Disqualified from certain types of Federal financial and non-financial assistance and benefits or from getting federal contracts or certain subcontracts
  - Excluded or Suspended

SUMMARY – LAWS & PENALTIES

The FCA, AKS, Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statue, the Social Security Act which includes the Exclusion Statute, & the CMPLs are the main Federal Laws that addresses fraud & abuse

The California Law Codes: Welfare & Institution Code, Penal Code, Business & Professional Code & Insurance Code are the State laws that addresses fraud & abuse

DMHC Related Laws, such as economic profiling & patient rights, are included in CA Health & Safety Codes

BEST PRACTICES FOR PREVENTING FRAUD & ABUSE

- Develop a compliance program & establish effective lines of communication
- Effective education of physicians, providers, suppliers, & members
- Monitor claims for accuracy – ensure coding reflects services provided
- Monitor medical records – ensure documentation supports services rendered
- Institute system safeguards, Perform regular internal audits
- Take action to correct identified problems
- **REMEMBER**, as a provider you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim
- **ULTIMATELY,** we are all responsible to speak up if we encounter a potential violation of laws, regulations, policies, or contractual obligations

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

What Are Your Responsibilities?

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

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

How Do You Prevent FWA?

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

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

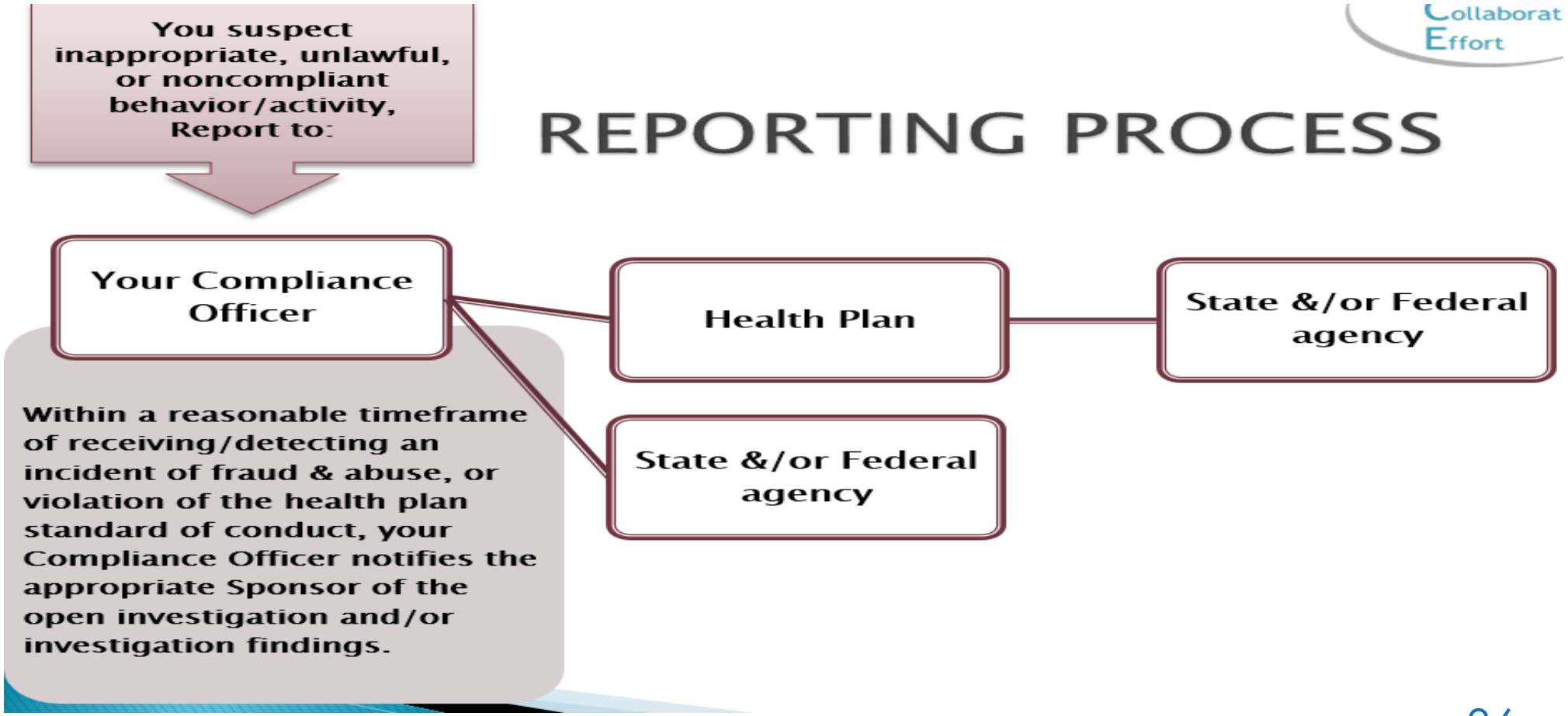
Report FWA

- Everyone must report suspected instances of FWA. NMM's Code of Conduct clearly states this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.
- Report any potential FWA concerns you have to your compliance department or NMM's compliance department. NMM's compliance department will investigate and make the proper determination. NMM has a Special Investigations Unit (SIU) dedicated to investigating FWA and utilizes the Compliance Hotline and reporting mechanisms for reporting FWA.

Every Sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.

- Review your organization's materials for the ways to report FWA.
- When in doubt, call your Compliance Department or FWA Hotline.

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA



LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

How to Report Potential FWA

NMM Employees:

Call NMM's Compliance Officer:
Jo Espino 626-943-6266

Compliance Hotline: 626-943-6286
24 hours a day/7 days a week
You may report anonymously and confidentially

Email: fwacompliance@nmm.cc

First-Tier, Downstream, or Related Entity (FDR) Employees

- Talk to a Manager or Supervisor
- Call your Ethics/Compliance Help Line
- Report to NMM or Sponsor

Beneficiaries

- Call NMM or Sponsor's Compliance Hotline or Customer Service
- Call 1-800-Medicare

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Reporting FWA Outside Your Organization

- If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), or CMS.
- Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government- directed investigation and civil or administrative litigation.

Details to Include When Reporting FWA

When reporting suspected FWA, include:

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

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

WHERE TO REPORT FWA

- As an FDR (Delegated IPA) Report to Health Plans (MAOs) as applicable.
- HHS Office of Inspector General:
  - Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
  - Fax: 1-800-223-8164
  - Email: HHSTips@oig.hhs.gov
  - Online: Forms.OIG.hhs.gov/hotlineoperations/index.aspx
- For Medicare Parts C and D:
  - National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRx (1-877-772-3379)
- For all other Federal health care programs:
  - CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

Medicare beneficiary website: Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

What happens after detection? How do you correct the problem?

Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves federally funded & private health care programs money & ensures you are in compliance with regulatory requirements..

Develop a plan to correct the issue. Ask your organization's compliance officer about the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future noncompliance.
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions.
- Document corrective actions addressing noncompliance or FWA committed by a Sponsor's employee or FDR's employee, and include consequences for failure to satisfactorily complete the corrective action in the required time period.
- Monitor corrective actions continuously to ensure effectiveness.

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Indicators of Potential FWA

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

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

All reports made are treated confidentially and you may choose to remain anonymous. Whistleblowers & persons who report suspected violations in good faith are protected against retaliation.

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Beneficiary Issues

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

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Provider Issues

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

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Pharmacy Issues

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

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics, marking up the prices, and sending to other smaller wholesalers or pharmacies?

Key Indicators: Potential Manufacturer Issues

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

APPENDIX A: REPORTING MECHANISMS

Government Authority	FWA / Ethics & Compliance Hotline	TTY; Email; or Mail	Online Tool
CMS Hotline	1-800-MEDICARE Or 1-800-633-4227	1-877-486-2048	https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud
HHS Office of Inspector General	1-800-HHS-TIPS Or 1-800-447-8477	TTY 1-800-377-4950 HHSTips@oig.hhs.gov	https://oig.hhs.gov/fraud/report-fraud/
HHS and US Department of Justice (DOJ)	N/A	N/A	https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud
For Medicare Parts C and D: National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)	1-877-7SafeRx Or 1-877-772-3379	N/A	N/A
State of California Bureau of Medi-Cal Fraud or Elder Abuse (BMFEA) Hotline	1-800-722-0432	Email using On-line Form: https://oag.ca.gov/bmfea/reporting	https://oag.ca.gov/bmfea/reporting
State of California Department of Health Care Services Hotline	1-800-822-6222	fraud@dhcs.ca.gov Medi-Cal Fraud Complaint - Intake Unit Audits and Investigations PO Box 997413, MS 2500 Sacramento, CA 95899-7413	https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

APPENDIX B:
REGULATIONS & SUB-REGULATORY GUIDANCE

Resources	Hyperlink URL
42 Code of Federal Regulations (CFR) Section 422.503	https://www.ecfr.gov/cgi-bin/text-idx?SID=c66a16ad53319afd0580db00f12c5572&mc=true&node=pt42.3.422&rgn=div5#se42.3.422_1503
42 CFR Section 423.504	https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5cff780d3df38cc4183f2802223859ba&mc=true&r=PART&n=pt42.3.423
Chapter 9 of the Medicare Prescription Drug Benefit Manual	https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf
Chapter 21 of the Medicare Managed Care Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf
CMS Compliance Program Policy and Guidance webpage	https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ComplianceProgramPolicyandGuidance.html
Federal False Claims Act	31 United States Code (U.S.C) Sections 3729-3733 18 U.S.C. Section 2817
Anti-Kickback Statute	42 U.S.C. Section 1320a - 7b(b)
Physician Self-Referral Law (Stark Law)	42 U.S.C. Section 1395nn

APPENDIX B:
REGULATION & SUB-REGULATORY GUIDANCE

Resources	Hyperlink URL
Criminal Health Care Fraud Statute	18 U.S.C. Section 1347
Exclusion Statute	42 USC 1320a-7
Welfare & Institutions Code False Claims and Anti-Kickback	http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14107.
CA Penal Code False Claims	http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN&sectionNum=550.
CA Health and Safety Code H&SC Ch. 2.2, §1341; 1367; 1371; 1386	https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=HSC&division=2.&title=&part=&chapter=2.2.&article=
CA Business & Professions Code	http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=17200.
CA Insurance Frauds Prevention Act (IFPA)	http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=INS&division=1.&title=&part=2.&chapter=12.&article=1.
CA False Claims Act (CFCA)	https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=12650.&article=9.&highlight=true&keyword=False%20Claims%20Act

APPENDIX B: ADDITIONAL RESOURCES

CMS Resources	Hyperlink URL
Compliance Education Materials: Compliance 101	https://oig.hhs.gov/compliance/101
Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training	https://oig.hhs.gov/compliance/provider-compliance-training
Office of Inspector General's (OIG's) Provider Self-Disclosure Protocol	https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp
Part C and Part D Compliance and Audits – Overview	https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits
Physician Self-Referral	https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral
Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254524.html
Safe Harbor Regulations	https://oig.hhs.gov/compliance/safe-harbor-regulations
Medicare Prescription Drug Benefit Manual	https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf
Medicare Managed Care Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

POST-ASSESSMENT QUIZ

QUESTIONS	SELECT THE BEST ANSWER
1. Allegations of fraud are limited to the intentional billing for service that do not meet professionally recognized standards	a. True b. False
2. What are some of the penalties for violating fraud and abuse laws?	a. Fines b. Imprisonment c. Exclusion from participating in all health care programs d. All of the above
3. All of these government agencies except one are involved in fraud and abuse prevention, which one?	a. CMS b. OIG c. LDR d. DMHC
4. Abuse may be intentional or unintentional: improper practice that either directly or indirectly results in unnecessary cost to health care program	a. True b. False
5. Which is NOT an example of Best Practice for Preventing Fraud & Abuse	a. Developing a compliance program b. Providing effective education of physicians, providers, suppliers, & members c. When encountering a potential violation of laws, regulations, policies, or contractual obligation it is not our responsibility to report immediately d. Monitoring claims & medical records
6. What are some of the consequences for non-compliance, fraudulent, or unethical behavior?	a. Disciplinary action b. Termination of employment c. Exclusion from participating in all Federal health care programs d. All of the answers

You've completed the lesson!

You have now learned about Fraud Waste & Abuse program.