ANNUAL COMPLIANCE TRAINING PROGRAM

FRAUD, WASTE, AND ABUSE TRAINING
As an employee, contingent worker, consultant, vendor or board member ("resource"), it is your moral and ethical responsibility to protect the company, its assets and its public and to assist in the VSP anti-fraud, waste and abuse efforts. It is a requirement that all types of fraudulent or abusive activity practiced by health care providers, contract laboratories, VSP employees, clients, agents and members be reported to the Special Investigative Unit (SIU).

It is the responsibility of every resource to abide by applicable laws and regulations in support of VSP’s fraud, waste and abuse efforts. All resources are required to report their good faith belief of any violation of the Fraud, Waste, and Abuse Program or applicable laws as soon as possible but no later than 15 days after potential violation.

Please refer to the Fraud, Waste and Abuse (FWA) Policy, found in the Special Investigative Unit (SIU) portion of the Internal Audit home page or the Policy page on Globalview, for further details.
The information contained in this training meets industry standards outlined by the Centers for Medicare and Medicaid Services (CMS).

As a provider of Vision services to various state and federally funded health programs VSP is required to provide the CMS developed content. Although not all of this information is specific to VSP’s operations (e.g. references to medical/pharmacy) the concepts, laws and regulations referenced do apply.
As a strategic partner in the health care industry, it is important all VSP **resources** are familiar with fraud, waste and abuse details.

The following acronyms are mentioned throughout the presentation and we provide the definitions listed below to assist you.

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<td>FDR</td>
<td>First-tier, downstream and related entities. <strong>VSP is considered a first-tier, downstream (FDR) provider to our federally funded health plan clients.</strong></td>
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<td>Medicare Part B</td>
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| Medicare Part C | A Medicare Advantage (MA) is a health plan choice available to Medicare beneficiaries. MA is a program run by Medicare-approved private insurance companies. These companies arrange for, or directly provide, health care services to the beneficiaries who elect to enroll in an MA plan.  
  **Example: VSP Strategic Alliance and Health Plan clients** |
| Medicare Part D | Drug Prescriptions                                                          |
Every year billions of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone; including **YOU**.

This training will help you detect, correct, and prevent fraud, waste, and abuse. **YOU** are part of the solution.
When you complete the course, you should correctly:

• Recognize FWA in the Medicare and other programs
• Identify the major laws and regulations pertaining to FWA
• Recognize potential consequences and penalties associated with violations
• Identify how to report FWA
• Recognize how to correct FWA
Introduction and Learning Objectives

This lesson describes Fraud, Waste, and Abuse (FWA) and the laws that prohibit it. It should take about 10 minutes to complete. Upon completing the lesson, you should be able to correctly:

• Recognize FWA
• Identify the major laws and regulations pertaining to FWA
• Recognize potential consequences and penalties associated with violations.
**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.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to $250,000.

*In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.*
Waste includes practices that, directly or indirectly, result in unnecessary costs to Medicare or other Programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare or other Programs. Abuse involves paying for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

For the definitions of fraud, waste and abuse, refer to Chapter 21, Section 20 of the “Medicare Managed Care Manual” on the Centers for Medicare & Medicaid Services (CMS) website.
Examples of actions that may constitute **fraud** include:
- Knowingly billing for services not furnished or supplies not provided, including billing appointments that the member/patient failed to keep
- Billing for non-existent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

Examples of actions that may constitute **waste** include:
- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for the treatment of a specific condition
- Ordering excessive laboratory tests

Examples of actions that may constitute **abuse** include:
- Unknowingly billing for unnecessary services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes
One of the primary differences between Fraud, Waste and Abuse is intent and knowledge.

**Fraud** requires *intent* to obtain payment and the knowledge that the actions are wrong.

**Waste and Abuse** may involve obtaining an improper payment or creating an unnecessary cost to Medicare or other Programs, but do not require the same intent and knowledge.
To detect FWA, you need to know the law.

The following screens provide high-level information about the following laws:
• Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud
• Anti-Kickback Statute
• Stark Statute (Physician Self-Referral Law)
• Exclusion from all Federal health care programs
• Health Insurance Portability and Accountability Act (HIPAA)

For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations or contact the VSP Regulatory Compliance Department.
The civil provisions of the False Claims Act (FCA) make a person liable to pay damages to the Government if he/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
• Presents a false claim for payment or approval

For more information, refer to 31 United States Code (U.S.C.) Sections 3729-3733.
Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government’s damages caused by the violator plus a penalty.

**EXAMPLE**

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
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported
- Failed to report the unsupported diagnosis codes to Medicare
- Agreed to pay $22.6 million to settle FCA allegations.
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 percent but not more than 30 percent of the money collected.
HEALTH CARE FRAUD STATUTE

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

Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law. For more information, refer to 18 U.S.C. Sections 1346-1347 on the Internet.

EXAMPLES:
A Pennsylvania pharmacist:
• Submitted claims to a Medicare Part D plan for non-existent prescriptions and for drugs not dispensed
• Plead guilty to health care fraud
• Received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan

The owners of multiple Durable Medical Equipment (DME) companies in New York:
• Falsely represented themselves as one of a nonprofit health maintenance organizations (that administered a Medicare Advantage plan) authorized vendors
• Provided no DME to any beneficiaries as claimed
• Submitted almost $1 million in false claims to the nonprofit; $300,000 was paid
• Pleaded guilty to one count of conspiracy to commit health care fraud
Persons who knowingly make a false claim may be subject to:
• Criminal fines up to $250,000
• Imprisonment for up to 20 years

If the violations resulted in death, the individual may be imprisoned for any term of years or for life. For more information, refer to 18 U.S.C. Section 1347 on the Internet.
The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including the Medicare Program).

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

Damages and Penalties
Violations are punishable by:
• A fine of up to $25,000
• Imprisonment for up to 5 years

For more information, refer to the Social Security Act (the Act), Section 1128B(b) on the Internet.
**EXAMPLE:**
From 2012 through 2015, a physician operating a pain management practice in Rhode Island:

- Conspired to solicit and receive kickbacks for prescribing a highly addictive version of the opioid Fentanyl
- Reported patients had breakthrough cancer pain to secure insurance payments
- Received $188,000 in speaker fee kickbacks from the drug manufacturer
- Admitted the kickback scheme cost Medicare and other payers more than $750,000

The physician must pay more than $750,000 restitution and is awaiting sentencing.
The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest or
- A compensation arrangement

Exceptions may apply. For more information, refer to 42 U.S.C. Section 1395nn on the Internet.

**Damages and Penalties:**

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around $24,250 may be imposed for each service provided. There may also be around $161,000 fine for entering into an unlawful arrangement or scheme.

For more information, visit the Physician Self-Referral webpage on the CMS website and refer to the Act, Section 1877 on the Internet.

**EXAMPLE:**

A California hospital was ordered to pay more than $3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician groups outside the fair market value standards or that were improperly documented as exceptions.
The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:

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

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

Damages and Penalties:
The penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three times the amount:

- Claimed for each service or item or
- Of remuneration offered, paid, solicited, or received
EXAMPLE:
A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted claims to Medicare Part D for brand name prescription drugs that the pharmacy could not have dispensed based on inventory records.
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 authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).

The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.

When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same. For more information, refer to 42 U.S.C. Section 1320a-7 and 42 Code of Federal Regulations Section 1001.1901 on the Internet.

EXAMPLE:
A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the Food and Drug Administration concerning oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company’s guilty plea. At the time the unconvicted executive was excluded, there was evidence he was involved in misconduct leading to the company’s conviction.
HIPAA created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA. For more information, visit the HIPAA webpage on the Internet.

Damages and Penalties:
Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

EXAMPLE:
A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.
Examples of potential fraud, waste and abuse *investigated* by the VSP Special Investigative Unit (SIU):

- In one case, a doctor’s billing pattern showed that the office was dispensing an unusually high percentage of contact lenses for children. It turns out that these children did not have prescriptions and false claims were being submitted for non-existent materials.

- Another case showed that a provider had a pattern of billing entire families for the first and second pair benefits, which was out of the ordinary. Further inspection showed that first and second pair claims were submitted with different prescriptions.
Examples of potential fraud, waste and abuse discovered by VSP’s Special Investigative Unit (SIU):

- Fraud was also found in a case where VSP was contacted by the new owners of an office after a doctor sold their practice. The previous doctor left behind two sets of color coded files for their patients. One file showed the actual patient record, but the other showed modifications and was to be used if the doctor was audited.

- In another scenario it was discovered that plano sunglasses were dispensed to children, but eClaim showed the claim payments for prescription lenses. The office was working with the lab to dispense plano lenses even though the lab and doctor were being paid for prescription lenses.
There are differences among FWA. One of the primary differences is intent and knowledge. Fraud requires the person have intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment but not the same intent and knowledge.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

• Civil Monetary Penalties
• Civil prosecution
• Criminal conviction, fines or both
• Exclusion from participation in all Federal health care programs
• Imprisonment
• Loss of professional license
Which of the following requires intent to obtain payment and the knowledge that the actions are wrong?

A. Fraud
B. Abuse
C. Waste

Answer: A
Which of the following is NOT potentially a penalty for violation of a law or regulation prohibiting Fraud, Waste, and Abuse (FWA)?

A. Civil Monetary Penalties  
B. Deportation  
C. Exclusion from participation in all Federal health care programs

Answer: B
Which of the following are functions the VSP SIU performs?

A. Investigates instances of reported fraud  
B. Analyzes claims data to identify potential outliers  
C. Conducts on-site patient record audits at the doctor location  
D. All of the above

**Answer: D**
Now that you have learned about FWA and the laws and regulations prohibiting it, let’s look closer at your role in the fight against FWA.
Introduction and Learning Objectives

This lesson explains the role you can play in fighting against Fraud, Waste, and Abuse (FWA), including your responsibilities for preventing, reporting, and correcting FWA. It should take about 10 minutes to complete. Upon completing the lesson, you should correctly:

• Identify methods of preventing FWA
• Identify how to report FWA
• Recognize how to correct FWA
As a person who provides health or administrative services to a Health Plan Medicare Part C or Part D enrollee, you are likely a:

- **Sponsor** – A VSP Strategic Alliance or Health Plan clients (Example: Medicare Advantage Organizations MAO and/or Prescription Drug Plans)
- **First-tier entity** - VSP provider group, doctor office, customer service provider, claims processing, and adjudication company, a company that handles enrollment, disenrollment, membership functions and contracted sales agent, health care facility, clinical laboratory
- **Downstream entity** - a vendor (Examples: pharmacies, doctor office, firms providing agent/broker services, marketing firms, and call centers)
- **Related entity** – an example would be an entity with common ownership or control of a Plan Sponsor, health promotion provider, or SilverSneakers®.
I am a Part C Plan Sponsor or an employee, contingent worker, consultant, vendor or board member ("resource") of a Part C Plan Sponsors first-tier or downstream entity (i.e. VSP)

The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with First-tier and Related entities (FDR) such as VSP. This stakeholder relationship flow chart shows examples of functions relating to the Sponsor’s Medicare Part C contracts. FDR’s of the Medicare Part C Plan Sponsor may contract with downstream entities (VSP vendors) to fulfill the VSP contractual obligations to the Sponsor.

Examples of first-tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first-tier entity is an independent practice, then a provider could be a downstream entity. If the first-tier entity is a health services/hospital group, then radiology, hospital, or mental health facilities may be the downstream entity. If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.
You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare non-compliance.

- **FIRST**, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.

- **SECOND**, you have a duty to the Medicare Program to report any compliance concerns, and suspected or actual violations of which you may be aware.

- **THIRD**, you have a duty to follow the VSP Code of Conduct that articulates your and VSP’s commitment to standards of conduct and ethical rules of behavior.
HOW DO YOU PREVENT FWA?

• Look for suspicious activity
• Conduct yourself in an ethical manner
• Ensure accurate and timely data and billing
• Ensure you coordinate with other payers
• Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS’ guidance
• Verify all information
Know VSP policies and procedures.

Every Plan Sponsor and FDR must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.

The VSP Code of Conduct describes our expectation:
• Everyone conducts themselves in an ethical manner
• Appropriate mechanisms are in place for anyone to report non-compliance and potential FWA
• Reported issues will be addressed and corrected.

Standards of Conduct communicate to every person, including FDR’s that:

*Compliance is everyone’s responsibility, from the top of the organization to the bottom.*
Everyone must report suspected instances of FWA. The VSP Code of Conduct clearly states this obligation. VSP may not retaliate against you for making a good faith effort in reporting.

Report any potential FWA concerns you have the VSP Special Investigations Unit (SIU) by using the SIU Case Referral Form in GlobalView _ Reference Library tab under Forms.

Do not be concerned about whether it is fraud, waste, or abuse. The VSP SIU will investigate and make the proper determination. The SIU is dedicated to investigating FWA.

When in doubt, contact the SIU or call the HOTLINE: (800) 877-7236.
REPORTING FRAUD, WASTE & ABUSE

VSP must have a mechanism for reporting potential FWA.

- Reports may be anonymous
- No retaliation against you for reporting

When in doubt, contact the SIU or call the HOTLINE: (800) 877-7236
If warranted, Plan Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the 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

- Contact information for the information source, suspects, and witnesses
- Alleged FWA details
- Alleged Medicare or other program rules violated
- The suspect’s history of compliance, education, training, and communication with VSP or other entities.
WHERE TO REPORT FWA

HHS Office of Inspector General:
• Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
• Fax: 1-800-223-8164
• Email: HHSTips@oig.hhs.gov
• Online: Form.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
Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money, VSP and our clients money and ensures VSP is compliant with CMS requirements.

Develop a plan to correct the issue. Consult the VSP SIU or Compliance Officer for the corrective action plan development. 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 person at VSP or the FDR’s employee, consultant, contractor or vendor and include consequences for failure to satisfactorily complete the corrective action
- Monitor corrective actions continuously to ensure effectiveness.
CORRECTIVE ACTION EXAMPLES

Corrective actions may include:

• Adopting new prepayment edits or document review requirements
• Conducting mandated training
• Providing educational materials
• Revising policies or procedures
• Sending warning letters
• Taking disciplinary action, such as suspension of marketing, enrollment, or payment
• Terminating an employee or provider.
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, office, pharmacy, or other entity involved in the delivery of Medicare Parts C and D.
Does the prescription, medical record or lab test look altered or possibly forged?

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

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

Is the person receiving the medical service the actual beneficiary (identity theft)?

Is the prescription appropriate based on the beneficiary’s other prescriptions?
• Are the provider’s prescriptions appropriate for the member’s health condition (medically necessary)?

• Does the provider bill VSP for services not provided?

• 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 claim have their active and valid National Provider Identifier on it?

• Is the provider’s diagnosis for the member supported in the medical record?
• Does the Sponsor encourage/support inappropriate risk adjustment submissions?
• Does the Sponsor lead the beneficiary to believe that 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?
As a person who provides health or administrative services to a Medicare Parts C and D enrollee, you play a vital role in preventing FWA. Conduct yourself ethically, stay informed of VSP policies and procedures, and keep an eye out for key indicators of potential FWA.

Report potential FWA. VSP has mechanisms in place for reporting potential FWA. VSP accepts anonymous reports and will not retaliate against you for reporting.

Promptly correct identified FWA with an effective corrective action plan.
A person drops off a prescription for a beneficiary who is a “regular” customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery. What is your next step?

A. Fill the prescription for 160  
B. Fill the prescription for 60  
C. Call the prescriber to verify the quantity  
D. Call the Sponsor’s compliance department  
E. Call law enforcement

Answer: C
Your job is to submit a risk diagnosis to the Centers for Medicare & Medicaid Services (CMS) for the purpose of payment. As part of this job you verify the data is accurate. Your immediate supervisor tells you to ignore the Plans process and to adjust or add risk diagnosis codes for certain individuals. What should you do?

A. Do what your immediate supervisor asked you to do and adjust/add risk diagnosis codes
B. Report the incident to the compliance department (via compliance hotline or other mechanism)
C. Discuss your concerns with your immediate supervisor
D. Call law enforcement

Answer: B
You are in charge of paying claims submitted by providers. You notice a certain diagnostic provider (“Doe Diagnostics”) requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics’ claims far exceed any other provider that you reviewed. What should you do?

A. Call Doe Diagnostics and request additional information for the claims
B. Consult with your immediate supervisor for next steps or contact the compliance department (via compliance hotline, Special Investigations Unit (SIU), or other mechanism)
C. Reject the claims
D. Pay the claims

Answer: B
Now that you have learned how to fight FWA, let’s take a post-assessment to see how much you’ve learned!

This assessment asks you 10 questions about Fraud, Waste, and Abuse (FWA).
Once a corrective action plan is started, the corrective actions must be monitored annually to ensure they are effective.

A. True
B. False

Answer: True
Ways to report potential Fraud, Waste, and Abuse (FWA) include:

A. Telephone hotline  
B. Mail drops, paper or email  
C. In-person reporting to the compliance department or supervisor  
D. To the Special Investigation Unit (SIU)  
E. All of the above

Answer: E
Any person who knowingly submits false claims to the Government is liable for five times the Government’s damages caused by the violator plus a penalty.

A. True
B. False

Answer: False
These are examples of issues that should be reported to the *Compliance Department or **Special Investigative Unit:

- Suspected Fraud, Waste, and Abuse (FWA)
- Potential health privacy violation
- Unethical behavior/employee misconduct

A. True
B. False

Answer: True

Report to the:
*Compliance Department any potential health privacy violations through the “Report a Privacy Concern” form on GlobalView or
**Report unethical misconduct or potential FWA to SIU via Globalview __ Forms
Bribes or kickbacks of any kind for services that are paid under a Federal health care program (which includes Medicare) constitute fraud by the person making as well as the person receiving them.

A. True
B. False

Answer: True
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.

A. True
B. False

Answer: True
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.

A. True
B. False

Answer: True
Some of the laws governing Medicare Parts C and D Fraud, Waste, and Abuse (FWA) include the Health Insurance Portability and Accountability Act (HIPAA); the False Claims Act; the Anti-Kickback Statute and the Health Care Fraud Statute.

A. True
B. False

Answer: True
You can help prevent Fraud, Waste, and Abuse (FWA) by doing all of the following:

• Look for suspicious activity
• Conduct yourself in an ethical manner
• Ensure accurate and timely data and billing
• Ensure you coordinate with other payers
• Keep up to date with FWA policies and procedures, standards of conduct, state/federal laws and regulations and CMS guidance
• Verify all information provided to you

A. True
B. False

Answer: True
What are some of the penalties for violating Fraud, Waste, and Abuse (FWA) laws?

A. Civil Monetary Penalties
B. Imprisonment
C. Exclusion from participation in all Federal health care programs
D. All of the above

Answer: D
For the Centers for Medicare and Medicaid Services (CMS) Glossary, visit https://www.cms.gov/apps/glossary on the CMS website
# Applicable Laws for Reference

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## Resources

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<td><a href="https://oig.hhs.gov/compliance/provider-compliance-training">https://oig.hhs.gov/compliance/provider-compliance-training</a></td>
</tr>
<tr>
<td>Safe Harbor Regulations</td>
<td><a href="https://oig.hhs.gov/compliance/safe-harbor-regulations">https://oig.hhs.gov/compliance/safe-harbor-regulations</a></td>
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Congratulations you just completed Fraud, Waste & Abuse Training!

✓ If you haven’t already completed the Compliance training, remember to take it to be compliant!

Add VSP ACKNOWLEDGEMENT PAGE HERE!!!