

By reviewing this information, you agree to understand that this training is:

Classified: Restricted

Only VSP Employees or other persons specifically authorized by VSP may access this information.



FRAUD, WASTE, AND ABUSE

Annual VSP Compliance Training Program

LET'S GET STARTED →



TRAINING REQUIREMENTS

As an employee, contingent worker, consultant, vendor, or board member (“**resource**”), it's your moral and ethical responsibility to protect the company, its assets, clients, and members. It's also your duty to assist in the VSP anti-fraud, waste, and abuse efforts. All types of fraudulent or abusive activity practiced by healthcare providers, contract laboratories, VSP employees, clients, agents, and members must 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 the fraud, waste, and abuse prevention efforts of VSP. All resources are required to report their good-faith belief of any violation of the Fraud, Waste, and Abuse Program or applicable laws immediately to our SIU.

Please refer to the Fraud, Waste, and Abuse (FWA) Policy, found in the Compliance Policies under Managing Risk or 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 operations, the concepts, laws, and regulations referenced do apply.

DEFINITIONS

As a strategic partner in the healthcare industry, it is important that all VSP **resources** are familiar with fraud, waste, and abuse details.

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

TERM	DEFINITION
FDR	First-tier, downstream, and related entities. <i>VSP is considered a first-tier, downstream (FDR) provider to our federally funded health plan clients.</i>
FWA	Fraud, Waste, and Abuse
Medicaid	Provides coverage for those with limited income and resources and is regulated by the states.
Medicare Part B	Medical/outpatient coverage
Medicare Part C	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, healthcare services to the beneficiaries who elect to enroll in an MA plan. <i>Example: VSP Strategic Alliance and Health Plan clients</i>
Medicare Part D	Prescription drug coverage

TRAINING OBJECTIVES



IDENTIFY

fraud and abuse



UNDERSTAND

fraud and abuse,
laws and penalties



AWARENESS

government agencies and
partnerships dedicated to
fighting fraud and abuse



RECOGNIZE

risk areas or **red flags**:
claims, utilization
management, member
services, documentation,
and coding



HOW TO REPORT FRAUD AND ABUSE



WHAT HAPPENS AFTER DETECTION?

FRAUD, WASTE, AND ABUSE IS A SERIOUS PROBLEM

Fraud can cost taxpayers

BILLIONS

of dollars.

You must know how to

PROTECT

your organization from
potential abusive practices,
civil liability, and possible
criminal activity.

YOU

play a vital role in
protecting the
integrity of VSP.

LESSON 1

WHAT IS FWA?

Introduction and Learning Objectives

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

- Recognize FWA
- Identify the major laws and regulations pertaining to FWA

WHAT IS FRAUD?

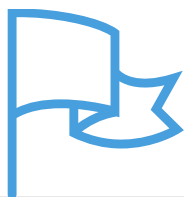
Intentionally...

submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain payment.

receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal or private healthcare programs.

making prohibited referrals for certain designated health services.

documenting a verbal denial falsely attributed to a medical professional.



RED FLAGS

RED FLAGS are warnings or discrepancies that attract attention to potential fraud and abuse. Although not evidence of fraud and abuse, a pattern of red flags can increase suspicion and justify further investigation.

RED FLAGS can be general or specific to a line of business and should be **reported immediately**.

WHAT IS WASTE?

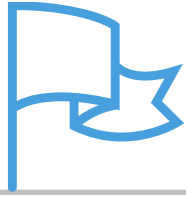
Waste includes practices that, directly or indirectly, result in unnecessary costs to Medicare or other Programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

WHAT IS ABUSE?

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to our VSP programs. Abuse includes any practice inconsistent with providing members necessary services, meeting professionally recognized standards of care, and charging fair prices.

The difference between “fraud” and “abuse” depends on specific facts, circumstances, intent, and knowledge.

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



RED FLAGS

- Billing for services that are
 - **Unnecessary**
 - **Inappropriate**
 - **Unwarranted**
 - **Questionable**
- Rendering treatment/care which does not meet professionally recognized standards of care
- Rendering services or supplies which are not covered

**PROGRAM
INTEGRITY
(PI) = “Pay It Right”**

PI FOCUS

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

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

Examples of improper payments

MISTAKES	RESULT IN ERRORS: INCORRECT CODING	
INEFFICIENCIES	RESULT IN WASTE: ORDERING EXCESSIVE DIAGNOSTIC TESTS	
BENDING THE RULES	RESULT IN ABUSE: IMPROPER BILLING PRACTICES (LIKE UPCODING)	
INTENTIONAL DECEPTIONS	RESULT IN FRAUD: BILLING FOR SERVICES OR SUPPLIES THAT WERE NOT PROVIDED	

EXAMPLES OF FRAUD

- Falsifying documents to indicate notifications approving, modifying, or denying requests for authorization were sent to the member and/or provider.
- Altering claims 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 members at physical risk solely for the purpose of financial gain.

EXAMPLES OF WASTE



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 ABUSE



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

FRAUD, WASTE, AND ABUSE



Jeopardize quality healthcare and services, and threaten the integrity of VSP programs by fostering the misconception that healthcare means easy money



Cost VSP and taxpayer resulting in waste and unintentionally financing criminal activities

FRAUD, WASTE, AND ABUSE DIFFERENCES

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:

- False Claims Act (FCA)
- Anti-Kickback Statute
- Stark Statute (Physician Self-Referral Law)
- Criminal Health Care Fraud Statute
- Social Security Act Exclusion Statute
- Civil Monetary Penalties Law (CMPL)

For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations or contact the VSP Compliance Department.

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 287](#)

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.

EXAMPLES

- 1 A provider knowingly submits claims for services not provided or for a higher level of services than actually provided.
- 2 Changing dates, records and/or condition/ diagnosis treated (e.g., service is not supported by the member’s record).

- 3 Service is miscoded.
- 4 Service is already covered under another claim.

FEDERAL LAWS

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 healthcare 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/>

EXAMPLE

A provider receives cash or below-fair-market-value rent for office space in exchange for referrals.

FEDERAL LAWS

Physician Self-Referral Prohibition (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>.

EXAMPLE

A provider refers a member for a designated service to a clinic where the provider (or an immediate family member) has an investment interest.

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, healthcare benefits, items, or services to defraud a healthcare benefit program, or prescribed by an excluded individual or entity.

EXAMPLE

Several providers and clinics conspired to defraud by submitting claims for services not actually provided.

FEDERAL LAWS

Social Security Act Exclusion Statute

42 USC 1320a-7

Prohibits the excluded individual or entity from participating in all Federal healthcare programs. The exclusion means no Federal healthcare program pays for items or services given, ordered, or prescribed by an excluded individual or entity.

Enforced by the HHS-OIG and GSA.

EXAMPLES

1

A Provider employs an excluded optometrist who provides items or services to Medicare beneficiaries, even if the optometrist's services are not separately billed and are paid as part of a Medicare diagnosis-related group payment the provider receives.

2

The excluded optometrist violates their exclusion thereby causing the provider to submit claims for items or services they provide.

FEDERAL LAWS

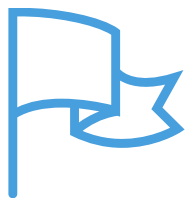
Civil Monetary Penalties Law (CMPL)

Civil monetary penalties (CMPs) apply to a variety of conduct violations and assessing the CMP amount depends on the violation. Penalties up to **\$100,000** (in 2020) per violation may apply. CMPs may also include an assessment of up to **three times** the amount claimed for each item or service, or up to **three times** the amount offered, paid, solicited, or received.

EXAMPLES

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

- 1 Arranging for services or items from an excluded individual or entity.
- 2 Providing services or items while excluded.
- 3 Knowing of and failing to report or return overpayment.
- 4 Making false claims.



RED FLAGS

- Obstructing an investigation or audit by withholding or delaying information or documentation.
- A provider group alters documents to pass an audit by changing dates on a case file to give appearance of compliance to timeframes.

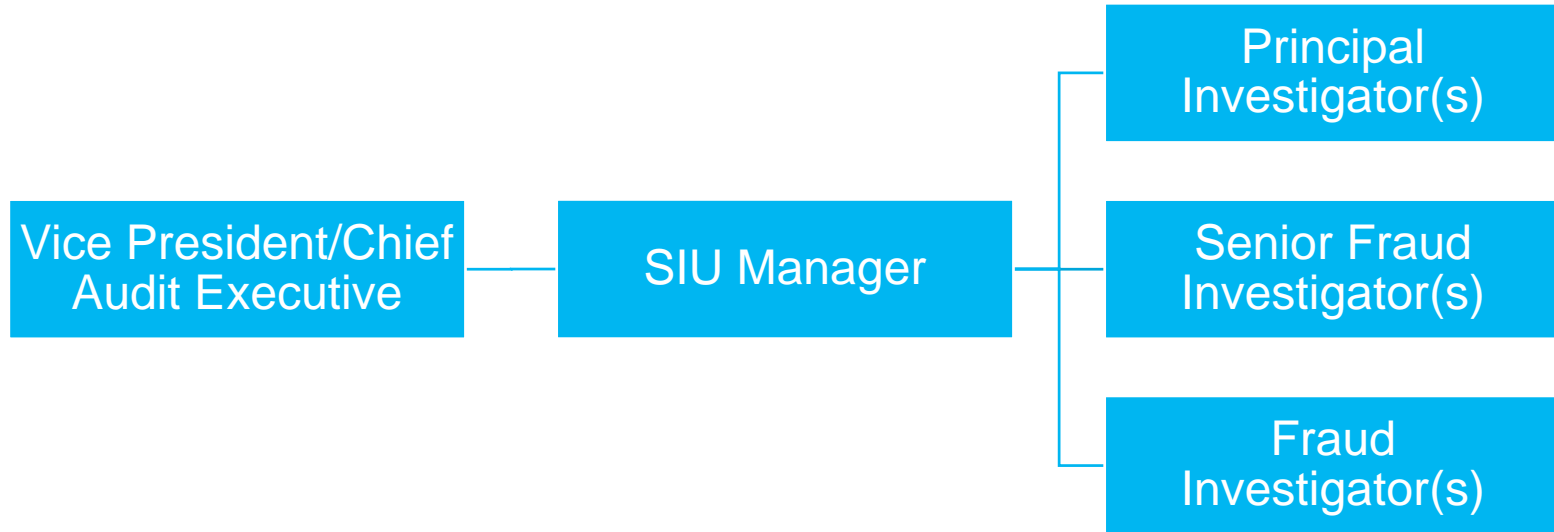
VSP INVESTIGATIONS

FUNCTION AND PURPOSE OF THE SIU

The Special Investigation Unit (SIU) is established to detect, prevent, mitigate and correct instances of health care fraud against VSP. The SIU reviews and investigates allegations of potential fraud, waste and abusive billing practices to determine the best course of action VSP should pursue concerning each incident. The SIU also creates partnerships with state and federal law enforcement and regulatory agencies to report instances of fraud. This supports VSP's fiduciary and regulatory responsibilities by ensuring our health care dollars are appropriately paid.

SIU ORGANIZATIONAL CHART

The SIU is a VSP internal resource, separate from all underwriting and claims units. Located in the VSP Internal Audit department.



VSP INVESTIGATIONS

Examples of potential fraud, waste, and abuse **investigated** by the VSP Special Investigative Unit (SIU):

- 1** 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.
- 2** 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.

VSP INVESTIGATIONS

Examples of potential fraud, waste, and abuse **discovered** by the VSP Special Investigative Unit (SIU):

- 1** 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.
- 2** 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.

LESSON 1 SUMMARY

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.

THINK ENTERPRISE

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 healthcare programs

Imprisonment

Loss of professional license

LESSON 1 COMPLETED

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.

LESSON 2

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 ten 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

WHERE DO I FIT IN?

As a person who provides health or administrative services to a Health Plan Medicare Part C or Part D, or Medicaid enrollee, you are likely a:



SPONSOR

A VSP Strategic Alliance or Health Plan clients (e.g., 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, healthcare facility, clinical laboratory.



DOWNSTREAM ENTITY

A vendor (e.g., 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®.

WHERE DO I FIT IN?

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, Downstream, and Related Entities (FDRs) such as VSP. This stakeholder relationship flow chart shows examples of functions relating to the Sponsor’s Medicare Part C contracts. FDRs of the Medicare Part C Plan Sponsor may contract with downstream entities (VSP vendors) to fulfill the VSP contractual obligations to the Sponsor.

WHERE DO I FIT IN?

FDR EXAMPLES

INDEPENDENT PRACTICES

A provider

CALL CENTERS

HEALTH SERVICES/ HOSPITAL GROUPS

Radiology, hospital, or
mental health facilities

FULFILLMENT VENDORS

FIELD MARKETING ORGANIZATIONS

Agents may be the
downstream entity.

CREDENTIALING ORGANIZATIONS

DOWNSTREAM ENTITY

Downstream entities may contract with other downstream entities.
Hospitals and mental health facilities may contract with providers.

WHAT ARE YOUR RESPONSIBILITIES?

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

1

You must comply with all applicable statutory, regulatory, Medicare Part C and Part D, and Medicaid requirements—including adopting and using an effective compliance program.

2

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

3

You have a duty to follow the VSP Code of Conduct that articulates the company and your commitment to standards of conduct and ethical rules of behavior.

REPORT SUSPECTED FWA

WHO TO REPORT TO



Your organization's Compliance Officer.



The Compliance Officer, SIU, or Fraud Division of the applicable Sponsor or government regulatory agency.

HOW TO REPORT



You can report suspected fraud and abuse by phone HOTLINE: **(800) 877-7236**, email: siumailbox@VSP.com, or mail to:

**VSP Special Investigative Unit
3333 Quality Drive
Rancho Cordova, CA 95670**



All information about the individual/entity reporting is kept confidential to the extent allowed by law.



You can report suspected fraud and abuse **anonymously**—however, lack of contact information may prevent a comprehensive review of the complaint. Sponsors and the OIG encourage you to provide contact information for follow-up.

HOW DO YOU PREVENT FWA?

THINK ENTERPRISE

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 FDRs that:
*Compliance is everyone's responsibility, from the top to the bottom of the organization.***

EVERYONE MUST REPORT SUSPECTED INSTANCES OF FWA

The VSP Code of Conduct clearly states this obligation. VSP may not retaliate against you for making the effort to report in good faith.

Report any potential FWA concerns you have the VSP Special Investigations Unit (SIU) by using the [SIU Case Referral Form](#) in **Globalview**, in Collaboration, Business Processes & Reference 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.

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.

REPORTING FWA OUTSIDE YOUR ORGANIZATION

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 the 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 Medicare or other program rules violated
-  Alleged FWA details
-  The suspect's history of compliance, education, training, and communication with VSP or other entities

WHERE TO REPORT FWA



1.800.HSS.TIPS (1.800.447.8477)
or TTY 1.800.377.4950



HHSTips@oig.hhs.gov



tips.oig.hhs.gov



1.800.223.8164



National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
1.877.7SafeRx (1.877.772.3379)



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



www.medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud

CORRECTING THE FWA ISSUE

**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

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

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, office, pharmacy, or other entity involved in the delivery of Medicare Parts C and D or Medicaid.

KEY INDICATORS: POTENTIAL BENEFICIARY ISSUES



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?

KEY INDICATORS: POTENTIAL PROVIDER ISSUES



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?

KEY INDICATORS: POTENTIAL SPONSOR ISSUES



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?

LESSON 2 SUMMARY

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.

LESSON 2 COMPLETED

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 12 questions about Fraud, Waste, and Abuse (FWA).

QUESTION 1 OF 12

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

- A. Telephone hotline
- B. Mail drops 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

QUESTION 2 OF 12

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

- A. True
- B. False

Answer: A

QUESTION 3 OF 12

All of these government agencies except one are involved in fraud and abuse prevention, which one?

- A. Centers for Medicare and Medicaid Services (CMS)
- B. Office of Inspector General (OIG)
- C. Legal Delivery Regulator (LDR)
- D. Department of Managed Health Care (DMHC)

Answer: C

QUESTION 4 OF 12

What is/are cause(s) for improper payment?

- A. Upcoding
- B. Billing for services not needed or not rendered
- C. Misrepresentation of facts
- D. All of the above

Answer: D

QUESTION 5 OF 12

Abuse may be intentional or unintentional—improper practice that either directly or indirectly results in unnecessary costs to the healthcare program.

- A. True
- B. False

Answer: A

QUESTION 6 OF 12

It is acceptable to make claim changes at the request of a VSP doctor who called VSP and requested we manually make the claim changes

- A. True
- B. False

Answer: B

QUESTION 7 OF 12

The Exclusion Statute is a federal law which bans any provider or entity convicted of fraud from participating in any federally funded programs.

- A. True
- B. False

Answer: A

QUESTION 8 OF 12

An example of fraud being an intentional act for gain is making prohibited referrals for certain designated services.

- A. True
- B. False

Answer: A

QUESTION 9 OF 12

It is acceptable for a provider to receive cash or below-fair-market-value rent for a medical office space in exchange for referrals.

- A. True
- B. False

Answer: B

QUESTION 10 OF 12

Which is NOT an example of Best Practices for Preventing FWA.

- A. Developing a compliance program
- B. Providing effective education of physicians, providers, suppliers, and members
- C. When encountering a potential violation of laws, regulations, policies, or contractual obligations, it is not our responsibility to report immediately
- D. Monitoring claims and medical records

Answer: C

QUESTION 11 OF 12

Red flags are warnings or discrepancies that attract attention to potential fraud and abuse and do not require reporting until you have specific evidence of fraud and abuse.

- A. True
- B. False

Answer: B

QUESTION 12 OF 12

When fraud is identified, it must be reported internally and/or to affected Clients.

- A. True
- B. False

Answer: A

RESOURCES

[42 Code of Federal Regulations \(CFR\) Section 422.503](#)

[42 CFR Section 423.504](#)

[Chapter 21 of the Medicare Managed Care Manual](#)

[CMS Compliance Program Policy and Guidance](#)

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 Prohibition (Stark Law)

42 U.S.C. Section 1395nn

Criminal Health Care Fraud Statute

18 U.S.C. Section 1347

Social Security Act Exclusion Statute

42 USC 1320a-7

[Welfare and Institutions Code False Claims and Anti-Kickback](#)

[Compliance Education Materials: Compliance 101](#)

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

[Office of Inspector General's \(OIG's\) Provider Self-Disclosure
Protocol](#)

[Part C and Part D Compliance and Audits – Overview](#)

[Physician Self-Referral](#)

[Safe Harbor Regulations](#)

[Medicare and Medicaid Services \(CMS\) Glossary](#)

THINK ENTERPRISE