*care*Learning
Rights and Responsibilities Series

Overview
The Rights and Responsibilities Series contains 12 courses. These courses were chosen to be in this series based on feedback from our *care*Learning organizations. If you have any courses to recommend for this series, please contact technical support.

Course Transcripts
Each of the courses* is presented in "Lessons". On the pages that follow, you will find each of the courses in alphabetical order and each of the lessons within that course numbered 1, 2, 3, etc.

If you are following along with the online course please note that the "Lesson" numbers in these transcripts correspond to the "Lesson" numbers in the LMS. In each course "Lesson 1" always starts in Learning Unit 5 of the online table of contents. They are always in the same order however. The reason for this is that each of the courses contains the same opening pages.

- Learning Unit 1: Course Navigation
- Learning Unit 2: Course Completion and Features
- Learning Unit 3: Pre-course Facility Specific Information (optional)
- Learning Unit 4: Pretest (optional)
- Learning Unit 5: Lesson 1

* The Medicare Parts C & D General Compliance, Medicare Fraud & Abuse: Prevent, Detect, Report, and Combating Medicare Parts C & D Fraud, Waste, and Abuse courses are listed as Slides.

Spanish Transcripts
Transcripts for each of the courses are available in Spanish. You may elect to use the transcripts to make a Spanish version of the courses as private courses. The transcripts include the test questions.

Course Attributes
Attributes are any features that exist in a careLearning course that can be controlled by either the organization or in some cases the student.

- All organizationally controlled attributes (or features) can be controlled from the "Instructor" role of the LMS.

- There are six (6) attributes available in all** of the Rights and Responsibilities courses.

  They are:

- Pre-test control: Your organization can decide whether or not to permit a student to "test out" of the course by passing the course pre-test. Default Setting: YES

- Pre-course add-on material: You may wish to add your own information to the beginning of the course. Default: NONE

- Post-course add-on material: You may wish to add your own information to the end of the course. Default: NONE

- Closed captioning: Students that are hearing impaired or would like to see the words being spoken may turn on or off "CC" or "Display Text" anytime they wish. This is a student-controlled attribute.

- Passing Scores: You may determine the score required to pass the pre-test and/or post-test. Default Setting: 100%

- Survey: You may elect to not offer the built-in 2 question survey at the end of the course. Default Setting: YES

** These attributes are not available for the Medicare Parts C & D General Compliance, Medicare Fraud & Abuse: Prevent, Detect, Report, and Combating Medicare Parts C & D Fraud, Waste, and Abuse courses.

- The following are additional attributes that can be found throughout different courses. These attributes are noted within the transcripts when they are available.

    - **Additional Lesson-Specific Information (Add-on Material):** You have the option of adding more information to selected lessons. As an example, there are lessons that advise the student to refer to the organization's policy and/or procedure. You may wish to add this policy and/or procedure to the lesson. Default: NONE
    - **Display contact Information:** You have the option of displaying contact information to selected lessons. The lessons in which the contact information will be displayed are indicated in the transcript. The same contact information will appear in each lesson that offers this attribute. (Please note that the space is limited to 50 characters and you cannot use "special" characters such as commas). As an example, in the "EMTALA" course, you can add the name, title, and/or phone number for the person to contact at your facility to report an EMTALA violation.
      Default: NONE
      Remove or Add a Lesson: In some courses there are specific lessons that may be added or removed.

Final Notes:

- Pre-Test consists of 10 Questions randomly pulled from a pool. 6 multiple choice, 4 True/False.
  Post-Test consists of 5 Questions randomly pulled from a pool. 3 multiple choice, 2 True/False.***

*** The Medicare Parts C & D General Compliance, Medicare Fraud & Abuse: Prevent, Detect, Report and Combating Medicare Parts C & D Fraud, Waste, and Abuse courses consist of 10 questions.

- The use of attributes is optional. They are not required to take a course and are automatically set to their default settings.

- The use of attributes is FREE of charge and can be activated or deactivated anytime during the course of your *care*Learning year.

- Adding your own course material requires some brief training. Contact your *care*Learning representative.

- Despite our best efforts, occasionally someone will find a misspelled word in a course. If you find one please let us know which course and in what lesson the word appears and we will have it corrected.

- The questions that appear at the end of a lesson are NOT the test. These are practice (quiz) questions and are not scored or retained. These questions are not attributes and cannot be changed.

Combating Medicare Parts C & D Fraud, Waste, and Abuse

Slide 1: Title

Combating Medicare Parts C & D Fraud, Waste, and Abuse Training

January 2019

Slide 2: Introduction

The Combating Medicare Parts C and D Fraud, Waste, and Abuse course is brought to you by the Medicare Learning Network®

Slide 3: Introduction cont.

This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual fraud, waste, and abuse (FWA) training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
- 42 CFR Section 423.504(b)(4)(vi)(C)
- CMS-4159-F, Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs
- Section 50.3.2 of the Compliance Program Guidelines (Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual)

Sponsors and their FDRs are responsible for providing additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

Slide 4: Why Do I Need Training?

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.

Slide 5: Training Requirements – Plan 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 90 days of initial hire and at least annually thereafter. More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website.

Slide 6: Learn more about Medicare Parts C and D

Medicare Part C, or Medicare Advantage (MA), is a health insurance option available to Medicare beneficiaries. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to the beneficiaries who enroll in an MA plan.

Slide 7: Learn more about Medicare Parts C and D cont.

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to Medicare beneficiaries enrolled in Part A and/or Part B who enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Medicare-approved insurance and other companies provide prescription drug coverage to individuals living in a plan’s service area.

Slide 8: 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.

Slide 9: 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 10 minutes to complete. Upon completing the lesson, you should be able to correctly:

- Recognize FWA in the Medicare Program
- Identify the major laws and regulations pertaining to FWA
- Recognize potential consequences and penalties associated with violations

Slide 10: Fraud

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 up to 10 years. It is also subject to criminal fines 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.

Slide 11: Waste and Abuse

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

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

For the definitions of fraud, waste, and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual on the Centers for Medicare & Medicaid Services (CMS) website.

Slide 12: Examples of FWA

Examples of actions that may constitute Medicare **fraud** include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep
- Billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

Examples of actions that may constitute Medicare **waste** include:

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

Examples of actions that may constitute Medicare **abuse** include:

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Slide 13: Differences Among Fraud, Waste, and Abuse

There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.

Slide 14: Understanding FWA

To detect FWA, you need to know the **law**.

The following pages 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 specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

Slide 15: Civil False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

For more information, refer to 31 United States Code (USC) Sections 3729–3733.

Slide 16: Examples

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

Slide 17: Examples

The owner-operator of a medical clinic in California:

- Used marketers to recruit individuals for medically unnecessary office visits
- Promised free, medically unnecessary equipment or free food to entice individuals
- Charged Medicare more than $1.7 million for the scheme
- Was sentenced to 37 months in prison

Slide 18: 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.

Slide 19: Civil FCA (cont.)

Whistleblowers

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.

Slide 20: Health Care Fraud Statute

The Health Care Fraud Statute states, "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice 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 the violator had knowledge of the law or specific intent to violate the law. For more information, refer to 18 USC Sections 1346–1347.

Slide 21: Examples

A Pennsylvania pharmacist:

- Submitted claims to a Medicare Part D plan for non-existent prescriptions and drugs not dispensed
- Pleaded 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 owner of multiple Durable Medical Equipment (DME) companies in New York:

- Falsely represented themselves as one of a nonprofit health maintenance organization's (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

Slide 22: Criminal 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 USC Section 1347.

Slide 23: Anti-Kickback Statute

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 USC Section 1320a-7b(b).

Slide 24: 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.

Slide 25: Damages and Penalties

Violations are punishable by:
- A fine up to $25,000
- Imprisonment up to 5 years

For more information, refer to the Social Security Act (the Act), Section 1128B(b).

Slide 26: Stark Statute (Physician Self-Referral Law)

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 USC Section 1395nn.

Slide 27: 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.

Slide 28: 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** can be imposed for each service provided. There may also be around a **$161,000** fine for entering into an unlawful arrangement or scheme.

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

Slide 29: Civil Monetary Penalties (CMP) Law

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 an overpayment
- Making false claims
- Paying to influence referrals

For more information, refer to 42 USC 1320a-7a and the Act, Section 1128A(a).

Slide 30: Example

A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted unsubstantiated claims to Medicare Part D for brand name prescription drugs the pharmacy could not have dispensed based on inventory records.

Slide 31: 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

Slide 32: Exclusion

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

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

Slide 33: Example

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the U.S. 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.

Slide 34: Health Insurance Portability and Accountability Act (HIPAA)

HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency 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.

Slide 35: 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.

Slide 36: Damages and Penalties

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

Slide 37: Lesson 1 Summary

There are differences among fraud, waste, and abuse (FWA). One of the primary differences is intent and knowledge. Fraud requires the person have intent to obtain payment and the knowledge his or her 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 all Federal health care program participation
- Imprisonment
- Loss of professional license

Slide 38: Lesson 1 Review

Now that you completed Lesson 1, let's do a quick knowledge check. Your Post-Test course score is unaffected by the following questions.

Slide 39: Knowledge Check

Which of the following requires intent to obtain payment and the knowledge the actions are wrong?

A. Fraud
B. Abuse
C. Waste

Correct Answer – A

Slide 40: Knowledge Check

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

Correct Answer – B

Slide 41: You completed Lesson 1: What Is FWA?

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.

Slide 42: Lesson 2 – Your Role in the Fight Against FWA

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

Slide 43: Where Do I Fit In?

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

• Sponsor (Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
• First-tier entity (Examples: Pharmacy Benefit Management [PBM]; hospital or health care facility; provider group; doctor's office; clinical laboratory; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents)
• Downstream entity (Examples: pharmacies, doctor's office, firms providing agent/broker services, marketing firms, and call centers)
• Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®)

Slide 44: Where Do I Fit In? cont.

I am an employee of a Part C Plan Sponsor or an employee of a Part C Plan Sponsor's first-tier or downstream entity.

The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of

functions relating to the Sponsor's Medicare Part C contracts. First-tier and related entities of the Medicare Part C Plan Sponsor may contract with downstream entities to fulfill their 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 service/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.

Slide 45: Where Do I Fit In? cont.

Table

Slide 46: Where Do I Fit In? cont.

I am an employee of a Part D Plan Sponsor or an employee of a Part D Plan Sponsor's first-tier or downstream entity.

The Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions that relate to the Sponsor's Medicare Part D contracts. First-tier and related entities of the Part D Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.
Examples of first-tier entities include call centers, PBMs, and field marketing organizations. If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a field marketing organization, then agents could be a downstream entity.

Slide 47: Where Do I Fit In? cont.

Table

Slide 48: 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.

Slide 49: 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

Slide 50: Stay Informed About Policies and Procedures

Know your entity's policies and procedures.

Every Sponsor and First-Tier, Downstream, and Related Entity (FDR) must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.

Standards of Conduct should describe the Sponsor's expectations that:

• All employees conduct themselves in an ethical manner
• Appropriate mechanisms are in place for anyone to report noncompliance and potential FWA
• Reported issues will be addressed and corrected

Standards of Conduct communicate to employees and FDRs compliance is everyone's responsibility, from the top of the organization to the bottom.

Slide 51: Report FWA

Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state 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 your Sponsor's compliance department. Your Sponsor's compliance department will investigate and make the proper determination. Often, Sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain an FWA Hotline.

Slide 52: Report FWA cont.

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.

Slide 53: 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

Slide 54: 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: Forms.OIG.hhs.gov/hotlineoperations/index.aspx

For Medicare Parts C and D:

Investigations 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

Slide 55: Correction

Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with CMS 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.
- Monitor corrective actions continuously to ensure effectiveness.

Slide 56: Correct 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

Slide 57: 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.

Slide 58: 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?

Slide 59: 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?

Slide 60: 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)?

Slide 61: 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?

Slide 62: 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?

Slide 63: Key Indicators: Potential Sponsor Issues

• Does the Sponsor encourage or support inappropriate risk adjustment submissions?
• Does the Sponsor lead the beneficiary to believe the cost of benefits is one price, when the actual cost is higher?
• Does the Sponsor offer beneficiaries cash inducements to join the plan?
• Does the Sponsor use unlicensed agents?

Slide 64: Lesson 2 Summary

• As a person providing health or administrative services to a Medicare Part C or D enrollee, you play a vital role in preventing fraud, waste, and abuse (FWA). Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.
• Report potential FWA. Every Sponsor must have a mechanism for reporting potential FWA. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.
• Promptly correct identified FWA with an effective corrective action plan.

Slide 65: Lesson 2 Review

Now that you completed Lesson 2, let's do a quick knowledge check. The Post-Test course is unaffected by the following questions.

Slide 66: Knowledge Check

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

Correct Answer – C

Slide 67: Knowledge Check

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 use a process to verify the data is accurate. Your immediate supervisor tells you to ignore the Sponsor's 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 or 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

Correct Answer – B

Slide 68: Knowledge Check

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 Doe Diagnostics' claims far exceed any other provider 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

Correct Answer – B

Slide 69: Knowledge Check

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

A. Call local law enforcement
B. Perform another review
C. Contact your compliance department (via compliance hotline or other mechanism)
D. Discuss your concerns with your supervisor
E. Follow your pharmacy's procedures

Correct Answer – E

Slide 70: Appendix A: Resources

Disclaimers

This Web-Based Training (WBT) course was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the course for your reference.

This course was prepared as a service to the public and is not intended to grant rights or impose obligations. This course may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or

regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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For glossary terms, visit the Centers for Medicare & Medicaid Services Glossary.

Slide 71: Appendix B: Job Aids

Job Aid A: Applicable Laws for Reference

Anti-Kickback Statute 42 USC Section 1320a-7b(b)

Civil False Claims Act 31 USC Sections 3729–3733

Civil Monetary Penalties Law 42 USC Section 1320a-7a

Criminal False Claims Act 18 USC Section 287

Exclusion 42 USC Section 1320a-7

Criminal Health Care Fraud Statute 18 USC Section 1347

Physician Self-Referral Law 42 USC Section 1395nn

Slide 72: Appendix B: Job Aids cont.

Job Aid B: Resources

Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training

OIG's Provider Self-Disclosure Protocol

Physician Self-Referral

Safe Harbor Regulations

Slide 73: Appendix B: Job Aids cont.

Job Aid C: Where to Report Fraud, Waste, and Abuse (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: Forms.OIG.hhs.gov/hotlineoperations/index.aspx

For Medicare Parts C and D:

Investigations 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

HHS and U.S. Department of Justice (DOJ): Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

Slide 74: You completed Lesson 2: Your Role in the Fight Against FWA

Now that you have learned how to fight FWA, it's time to assess your knowledge.

This brief Post-Assessment asks 10 questions and should take about 10 minutes.

Successfully completing the course includes finishing all lessons and scoring 70 percent or higher on the Post-Test.

Test Questions (10 questions Post-Test)

MULTIPLE CHOICE

1. Ways to report potential Fraud, Waste, and Abuse (FWA) include;
    a. Telephone Hotlines
    b. Mail drops
    c. In-person reporting to the compliance department/supervisor
    d. Special Investigation Units (SIUs)
    e. All of the above

2. 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

TRUE/FALSE

3. Once a corrective action plan is started, the corrective actions must be monitored annually to ensure they are effective.

4. 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.

5. These are examples of issues that should be reported to a Compliance Department: suspected Fraud, Waste, and Abuse (FWA); potential health privacy violation; unethical behavior; and employee misconduct.

6. 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.

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

8. 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.

9. 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.

10. 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/billing;
    - Ensure you coordinate with other payers;
    - Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance; and
    - Verify all information provided to you.

Cultural Competence in the Workplace

Lesson 1: Objectives

At the completion of this course you will be able to:

- Define culture, cultural awareness, cultural imposition, cultural sensitivity, and cultural competence;
- Describe the Culturally and Linguistically Appropriate Services (CLAS) Standards;
- Provide examples of different cultural views and practices;
- Describe methods to provide effective care to individuals from various cultural backgrounds;
- Identify methods to improve communication across language barriers; and
- Recognize the benefits of a culturally competent workplace.

Introduction

Culture is a learned, patterned behavioral response gained over time. It includes beliefs, attitudes, values, customs, norms, taboos, arts and life ways accepted by a community of people. *Cultural awareness* is understanding one's values and attitudes as well as the ability to reflect on how these can affect one's interactions with others. Without cultural awareness you may force your values and patterns of behavior onto another individual, referred to as *cultural imposition*. *Cultural sensitivity* is experienced when language and actions reflect sensitivity and appreciation for the diversity of others. It simply means that you are aware that people are not all the same and that you recognize that your culture is no better than any other culture. *Cultural competence* in healthcare is defined as the ability of providers and organizations to effectively deliver health care services that meet social, cultural, and language needs to those in their care. A culturally competent organization can help improve health outcomes and quality of care and contribute to the elimination of racial and ethnic health inequalities.

Lesson 2: Becoming Culturally Competent

A set of national standards for Culturally and Linguistically Appropriate Services in Health and Health Care, otherwise known as the CLAS Standards, were issued by the U.S. Department of Health and Human Services' Office of Minority Health. The CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and healthcare organizations.

Standard 1 states that healthcare organizations must provide effective, fair, and impartial, understandable, and respectful quality care and services that are responsive

to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Standard 1 is the Principal Standard because the aim in applying the remaining Standards is to achieve Standard 1.

Quiz Question:

Drag and drop the words to their places.

The Culturally and Linguistically Appropriate Services Standards are intended to advance ***health equity**, improve ***quality**, and help eliminate ***health care disparities** by establishing a blueprint for health and healthcare organizations.

Lesson 3: Understanding Cultural Views and Practices

There are many different cultural views and practices. No one can know all cultures but having a basic knowledge can help you interact successfully with individuals from various groups.

Attitudes to time can differ between different cultures in significant ways. For example, being late for an appointment is the accepted norm in most Mediterranean and Arab countries. Such habits, though, are undesired in punctuality-conscious US, Japan, England, and Switzerland. In these countries time is scheduled, arranged and managed. Individuals from Latin America, Africa, Asia and Arab cultures have a much less formal perception of time and are not ruled by precise calendars and schedules. Even within a country, different sub-cultures may regard time differently. In the US, Mexican Americans differentiate between “hora inglesa” (the actual time on the clock) and “hora Mexicana” (which treats time considerably more casually) and Native Americans often distinguish between “Indian time” and regular time.

Cultural differences can be found in the use of personal space. Individuals from Northern Europe, the US, and Asia prefer to stand farther apart and touch less than individuals from South America, the Middle East, and Southern Europe.

Gender roles vary greatly across cultures and influence access to education, ownership, and choice of profession. In many cultures, it is the male who makes decisions for a female. Gender roles may even affect whether a woman can receive treatment without a male family member being present or the degree to which a woman’s body can be exposed during a clinical examination.

Cultural differences can be found in the view of the relationship of man to nature and human beings to other human beings, the importance of ancestors and the environment, and the degree of materialism. Hispanic cultures view family relationships as vital, treat authority figures (such as parents, elders, and priests) with upmost respect, and desire a personal interest in relationships.

The importance of work also varies with culture. Americans are defined by their work. People in many other cultures are defined by the groups to which they belong and their role in the community.

Quiz Question:

Select the correct statements regarding cultural views and practices. (Select all that apply)

Cultural differences can be found in…

a. ***the use of personal space.**
b. ***gender roles.**
c. ***the value of time.**
d. ***the relationship of man to nature.**
e. ***the view of human beings to other human beings.**
f. ***the importance of ancestors and the environment.**
g. ***the degree of materialism.**
h. ***the importance of work.**

Lesson 4: Cultural Practices and Healthcare

The influence of culture on health is limitless. It affects perceptions of health, illness and death, beliefs about causes of disease, approaches to health promotion, how illness and pain are experienced and expressed, where individuals seek help, and the types of treatment preferred. The healthcare provider must understand and respond effectively to the cultural needs brought by the individual to the healthcare encounter.

Persons with chronic diseases who believe in fatalism (or predetermined fate) often do not follow treatment plans because they believe that medical intervention cannot affect their outcomes. Worldviews and religious beliefs also affect how individuals view the connection to disease. Some see illness as having not only physical but also spiritual causes.

Folk medicine is the treatment of disease or injury based on tradition rather than on modern scientific practice and often uses native plants as remedies. Treatments or medicines that are considered folk medicine in the US are part of standard care in other countries. Root medicine is an African healing tradition common in the southern US in which healers or “root doctors” use spells to lift curses and heal the mind and body. Witchcraft and “fixing” (such as, casting spells to cause illness) are widely accepted but seldom discussed openly. Some Asian therapies, such as coining and cupping, may cause bruises and acupuncture is sometimes combined with smoldering herbs which may cause scars. Mongolian spots, common in Asian, Hispanic, and black infants,

resemble bruises and must not be mistaken with abuse. Religious faith and prayer remain powerful influences within the black Christian community. Religious healing is often the first resort for devout black Christians, and church involvement is associated with improved health and social well-being. Asian and Hispanic cultures believe that a "hot-cold" balance is necessary for health. In both cultures, hot conditions should be managed with cold therapies and vice versa, and any hot-cold imbalance is thought to promote disease.

The experience of birth and death involve rituals in every culture. The strong modesty norms of Muslims make issues that are related to reproductive health embarrassing. Most Dutch, German and Japanese women strive to give birth without the use of painkillers. In Orthodox Jewish culture the husband is typically not present in the room with his laboring wife because she is considered "unclean" at that time. The end-of-life process is a significant area for cultural differences. Some people believe that suffering and death are a natural part of the process while others may believe in prayer and shy away from any discussion or formal acceptance of death.

Diet and nutrition provide another opportunity for encompassing different cultural views and beliefs. It is important to assess culturally diverse diets to ensure adequate nutrition.

Different cultures have different views of the causes of developmental disabilities. Traditional Confucian beliefs see the birth of a child with a developmental disability as a punishment for parental violations of traditional teachings. Individuals from South-East Asian cultures may believe that disabilities are caused by "mistakes" made by parents or ancestors. In other cultures, the will of God or Allah, karma, evil spirits, black magic or punishment for sins may be seen as causes of disability.

Quiz Question:

Select the correct statements regarding cultural practices and healthcare. (Select all that apply)

Cultural differences can be found in…

a. ***birth rituals.**
b. ***death rituals.**
c. ***diet and nutrition.**
d. ***the perception of health.**
e. ***views related to the causes of developmental disabilities.**

Lesson 5: Communication

Communication is the product of a verbal code and non-verbal acts. Culturally competent healthcare providers are aware of both the verbal and nonverbal part of the communication exchange.

Eye contact varies among cultures. In US and European cultures, it is a sign of respect; however, in Asian and Muslim cultures, it may be a sign of disrespect. There are also gender differences regarding eye contact.

In the US, the gesture of shaking hands upon greeting is considered the norm. In fact, in America, to refuse a handshake is considered very rude. Pious Muslim men may not shake hands with women and Pious Muslim women do not shake the hands or touch men who are not in their families. The "thumbs up" sign in the US means things are good, but in Slovakia, China, East Asia, Malaysia, Singapore, the Philippines, and many other parts of the world it is a rude gesture.

Many Asians are comfortable with a minute or two of silence and consider it polite to pause for a few seconds before answering a question to show that you have reflected upon the question and your response. In contrast to this are many Western countries where silence is viewed as a void that must be filled.

Tips to improve communication:

- Ask the individual how they would like to be addressed.
- Ask them their preferred language and arrange for an interpreter or provide printed/multimedia materials in that language.
- Offer materials in Braille or read out loud to individuals with limited or no vision.
- Use video/audio media or offer to read out loud for individuals with poor reading skills.
- Speak slowly and avoid slang. Modify your pace, speak clearly and pronounce your words properly. Break your sentences into short, definable sections and give your listener time to digest your words as you go.
- Practice active listening. Restate or summarize what the other person has said to ensure that you have understood them correctly.
- Take turns to talk and ask open-ended questions.
- Be careful with humor and avoid gestures.
- Document the individual’s needs and inform others as appropriate.

Quiz Question:

Select the correct statements regarding communication. (Select all that apply)

Cultural differences can be found in the use of…

a. ***eye contact.**
b. ***gestures.**

c. ***silence.**

Lesson 6: Meeting the Standards for Language Assistance Resources

Healthcare organizations that receive federal financial assistance must provide services consistent with Standards 5 through 8. Failure to do so can result in a violation of Title VI of the Civil Rights Act of 1964. These Standards include:

Standard 5: Healthcare organizations must offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Standard 6: Healthcare organizations must inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Standard 7: Healthcare organizations must ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Standard 8: Healthcare organizations must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Tips when using interpreter services:

- Speak directly to the person in your care, not the interpreter.
- Be precise and try not to string questions together.
- Speak clearly and in a normal tone.
- Avoid using medical jargon or slang.
- If dealing with a highly technical situation, consider scheduling a longer appointment or pre-session.
- Make arrangements so the interpreter can be in place at the time of the health care encounter.
- Use an American Sign Language interpreter for the hearing impaired.

Quiz Question:

Select the best practices for using interpreter services: (Select all that apply)

a. Speak directly to the interpreter.
b. ***Be precise.**
c. Speak loudly.
d. ***Avoid using medical jargon.**

e. ***If dealing with a highly technical situation, consider scheduling a longer appointment or pre-session.**
f. ***Make arrangements so the interpreter can be in place at the time of the health care encounter.**
g. Use a member of the individual's family to interpret for the hearing impaired.

Lesson 7: Diversity in the Workplace

An organization that truly embraces and practices cultural awareness applies these principles to their employees as well as individuals in their care. Discrimination against employees must not be tolerated. Hiring, firing, compensating and promoting should be based on merit and achievements, not on culture, race, sex or religion.

Standards 2, 3 and 4 address the need to recruit, promote, and support a diverse staff, promote CLAS and health equity, and ensure ongoing education and training.

Standards 9, 10, 12, and 13 encourages the organization to establish culturally and linguistically appropriate goals, policies and management accountability, and to infuse these into the organization's planning and operations, conduct ongoing assessments of the organization's CLAS–related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities, conduct regular assessments of community health assets and needs and use the data to plan and implement services, and partner with the community to design, implement, and evaluate policies, practice, and services to ensure appropriateness.

Standard 11 encourages the healthcare organization collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Standards 14 and 15 address conflict and grievance resolution processes that are culturally and linguistically appropriate and communication of the organization's progress in CLAS.

Lesson 8: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Building culturally competent healthcare organizations means changing how people think about other cultures, how they communicate, and how they operate. It means that the structure, leadership, and activities of an organization must reflect many values, perspectives, styles, and priorities. It emphasizes the advantages of cultural diversity, celebrates the contributions of each culture, encourages the positive outcomes of

interacting with many cultures, and supports the sharing of power among people from different cultures. If you have any questions regarding cultural competence, please contact the appropriate individual within your organization for guidance and assistance.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. Cultural differences can be found in:
    a. Use of personal space
    b. Gender roles
    c. Value of time
    d. All of the above

2. Cultural differences can be found in:
    a. Birth rituals
    b. Death rituals
    c. Diet and nutrition
    d. All of the above

3. Cultural differences can be found in:
    a. Eye contact
    b. Gestures
    c. Use of silence
    d. All of the above

4. Hiring, firing, compensation, and promotions should be based on which of the following?
    a. Merit and achievements
    b. Cultural and religious practices
    c. Age and length of service
    d. Health and gender

5. A newly immigrated individual is noted as always late for her appointments and often needs more time than is allotted. Which of the following is the best explanation for this behavior?
    a. The individual is not respectful of the organization's policies.
    b. The individual has not bothered to read the posted signs.
    c. The individual needs more attention than others.
    d. The individual may come from a culture that is more "event" oriented.

6. Communication can be enhanced by which of the following?
    a. Asking the individual their preferred language and arranging for an interpreter as needed.
    b. Speaking louder and using gestures so they can understand you.
    c. Using one of the family members to interpret for the individual.

d. Touching the individual's hand when speaking to them.

7. One of the first steps in cultural awareness is to examine one's own thoughts and feelings. Which of the following best explains this process?

a. To help identify beliefs and bias's one may have.
b. To meet professional obligations.
c. To identify good and bad stereotypes.
d. To identify why certain traditions are not useful at work.

Pool 2 (4 or 2 questions)

TRUE/FALSE

8. Cultural assessments only need to be performed on specific ethnic groups.

9. Healthcare organizations must provide language assistance services at no cost to each patient with limited English proficiency.

10. Discrimination against employees must not be tolerated.

11. Recruiting diverse staff members is sufficient in developing cultural competency.

12. Once you learn how to communicate with a certain culture you can use the same method for all encounters with someone of that culture.

13. Once an employee is hired they need to conform to the organization's practices and avoid maintaining their cultural differences.

14. Rituals surrounding birth and death are the same in all cultures.

15. Anyone with vision problems should receive their information in Braille.

Customer Service

Lesson 1: Objectives

At the end of the course, participants will be able to:

- Better meet customer expectations;
- Make a strong, positive first impression;
- Display a positive attitude and engage in active listening;
- Handle a stressful customer service encounter; and
- Address workplace conflict including bullying.

Introduction

Customer service is the act of taking care of the customer's needs by providing professional, helpful, quality service and assistance before, during, and after the customer's expectations are met. A customer can be both internal and external to the organization. This can include patients/residents, visitors, team members, medical staff, volunteers, and more.

Customer service is something most people don't consider or appreciate until there is a problem. Customer service experiences can change the entire perception a customer has on an individual or even the entire organization that an employee represents. It can be an important factor in making your organization the healthcare facility of choice for the people in your service area. Good customer service will improve customer satisfaction and cooperation and improve outcomes.

Lesson 2: Meeting Customer Expectations

Customers expect certain things when they walk into a healthcare facility, and the facilities with the highest level of customer satisfaction know how to identify these expectations and meet them.

Some of the most common expectations that customers have for healthcare facilities are similar to other businesses. These include fast, efficient and accurate service, friendly and helpful staff, prompt responses to questions, trained team members that can handle their immediate questions without being transferred or placed on hold, and attentiveness to a customer's problems or complaints. The best way to determine how well you met your customers' expectations is to simply ask the question. Your organization may also provide a formal customer satisfaction survey. The goal of both is to discover ways to improve your customers' experiences. Remember, customers are savvy enough to take their business elsewhere if they are not receiving the service and attention they seek.

Lesson 3: Meeting and Greeting

Your customer will make early decisions about you and perhaps the organization based upon your appearance, attitude, body language, facial expressions, what you say and especially tone of voice. Making a strong, positive first impression will help you develop a good customer relationship. Be sure to make eye contact, display a nice warm smile, provide a friendly greeting, give the customer your undivided attention and listen to their needs and questions with empathy and compassion. The words you use will set your organization apart as well. Using words such as “May I” instead of “Can I”, and “Yes” instead of “Yup” as well as avoiding absolute extremes such as “every”, “all”, “never” and “always” will help.

Select all of the actions that can help develop a good customer relationship.

***Make eye contact**
Display a stern expression
***Provide a friendly greeting**
Multitask while listening to the customer so you can get more accomplished
***Listen to the customer’s needs/questions with empathy/compassion**
Use words such as “Can I” and “Yup”
Use absolute extremes such as “every”, “all”, “never” and “always”

Lesson 4: Positive Attitude

Good customer service begins with a positive attitude. It is not just what a person says; it is how they say it and how they behave while they are saying it. Your tone of voice and behavior speaks loudly to those we serve. It reinforces your competence and commitment to providing excellent, quality care towards the task at hand.

To display a positive attitude, pause, take a deep breath and think before you speak. Self-talk can also have a dramatic affect both positively and negatively. You have a choice about what you say to yourself. Positive words include “I can do it”. Negative words limit our potential and are self-defeating. Choose to be positive. Be flexible and adapt to new challenges. Providing customer service is not easy but with making good choices about one’s thoughts, anything is possible.

Sharing negative thoughts about your job, the organization, or other team members with the customer leads to doubt, anxiety and a negative experience for the people we serve. Avoid sharing these thoughts as many times we invite the type of behavior that we show to others.

Quiz Question:

Which of the following actions does <u>not</u> help you display a positive attitude?

A. Pausing, taking a deep breath and thinking before you speak
B. Saying positive words to yourself
C. Being flexible/adapting to new challenges

D. *Sharing negative thoughts about your job with your customers

Lesson 5: Active Listening

Hearing is not the same as listening. Active listening displays a concerned attitude, enhanced understanding and better customer satisfaction. It allows for greater productivity with fewer mistakes. Information that the customer provides is vital. You may even want to take notes. Active listening takes focus, energy, and attention. To do this you must recognize and remove physical barriers (such as turning off screens that could distract you), minimize internal barriers (such as allowing your mind to drift or make assumptions), use nonverbal encouragers (such as eye contact and head nods), and verbal encouragers (such as hmm, oh, ah…) to show that you are paying attention, ask open-ended questions, listen with purpose, and recap your understanding of the issue. Everyone can overcome these obstacles. Remember, listening is not passive, it is active. Stay alert and be energetic about listening, if not you may miss important information.

Quiz Question:

Fill in the blanks with the word options provided:

Active listening displays a concerned **attitude**, enhanced **understanding** and better customer **satisfaction**. It allows for greater **productivity** with fewer **mistakes**.

Lesson 6: Handling Customer Service Stress

Many people allow events to shape how they feel and what they do. However, events can only control your attitude if you allow it. When providing customer service, it is important to not allow stressful events to govern your attitude. If you are unprepared and unfocused when providing customer service, you may be caught off guard and perceive the event as a threat. Your natural reaction will be to respond to the threat either by fighting or running (also known as the fight or flight stress response). Most of the customer service events that you experience at work are not life threatening and therefore you must change your perception of the encounter. Good customer service does not include fighting with the customer or running away by making excuses or prematurely ending a conversation.

Your primary role in a stressful customer service encounter is to keep the situation under control and prevent things from getting worse. Always take into consideration the customer's frame of mind at the time of the event. Disarm a difficult customer with a greeting and an invitation to help. Smile even if the event takes place over the phone. Respond by conveying the truth and invite the customer in a two-way discussion with words like "I understand, I see, or I hear what you are saying, etc.". You are not in control of every event but you are in control of your own behavior and response to these events. There is no place for anger in customer service. Choose to stay calm. Be

prepared. Pause, take a deep breath, slow down your pace of speech, allow the customer to vent, take notes, listen actively, be emphatic, think rationally and focus on what you can control. Remember, the real problem is whatever is causing the customer to behave that way, not the customer's behavior. The root cause of the behavior must be fixed in order to meet the customers' expectations.

Quiz Question:

Avoid allowing stressful events to govern your attitude.

***True** or False

Lesson 7: Internal Customer Service

We often think of the importance of customer service in regard to individuals who visit our organization such as patients/residents and visitors. However, those you serve internally should be provided the same consideration. While all of the principles previously discussed can be applied, there are additional concerns when servicing those who work for the organization.

Lesson 8: Workplace Conflict

Workplace conflict is a normal and natural part of any workplace and can occur when there is a disagreement or opposition of interests or ideas. It has been estimated that managers spend at least 25 percent of their time resolving workplace conflicts. By learning to constructively resolve conflict, we can turn a destructive situation into an opportunity for creativity and enhanced work performance.

There are many causes of conflict in a work setting including ineffective communication, differences in values and interests, scarce resources, personality clashes, and poor performance. Sometimes what we are trying to communicate gets lost in translation despite our best intentions. These conflicts can be resolved through active listening, asking the appropriate questions, and making sure both parties are understood. The failure to accept or understand one another's differing values can lead to conflict. The way a person views or addresses a situation is not wrong just because it does not match your own. You may have differing interests as well. Sometimes an individual's personal goals can be at odds with your goals or even the organization's goals. This conflict can be addressed by finding a common ground and negotiating goals that work for everyone. Scarce resources can make employees feel they have to compete for available resources in order to do their job. This can be alleviated by teaching prioritization of time and resources, as well as ways to negotiate with one another. Personality clashes can cause conflict. All organizations are made up of different personalities and team members must strive to understand and accept each other's approach to work and problem-solving. Conflict can also occur when team members are not contributing their share of effort or not performing at the expected level of quality.

This can cause extra work and frustration for others. This issue can be resolved by their manager through coaching, feedback and evaluation.

Arriving at a positive resolution to conflict is always the ultimate goal. In resolving conflict, it is important that you clearly state the cause of the conflict and why and how you recommend it being resolved. It is best to address conflict face-to-face and stick to the issue at hand. Sometimes our emotions may interfere with arriving at a resolution. If this happens, take a time-out and continue resolving the conflict at another designated time. Avoiding conflict is often the easiest way to deal with it; however, it does not make it go away. By actively resolving conflict when it occurs, you can create a more positive work environment for everyone.

Lesson 9: Workplace Bullying

Workplace bullying refers to any repeated, intentional behavior directed at an employee with the purpose of degrading, humiliating, embarrassing, or otherwise undermining their performance. Bullying can come from team members, supervisors, or management, and is a problem for workers at all levels. By learning to recognize and address workplace bullying behavior, you can help to create a healthier, more productive environment for yourself and your co-workers.

Bullying is more than a simple misunderstanding or personal disagreement. Workplace bullying may include shouting, whether in private, in front of team members, or in front of customers, name calling, belittling or disrespectful comments, excessive monitoring, criticizing, or nitpicking someone's work, deliberately overloading someone with work, undermining someone's work by setting them up to fail, and excluding someone from staff room conversations and making them feel unwelcome.

If you feel singled out unfairly, or feel you are being picked on, form a plan to stop the bullying. Never escalate the bullying. Shouting counter insults or yelling back might end up making the situation worse. Use a calm and collected tone of voice and tell the person to stop. Keep a record of the bullying including specific times, dates and locations. Ask co-workers if they will serve as witnesses to bullying incidents. Set up a meeting with your supervisor or human resources representative. Bring your written evidence, your witnesses, and present your case in a calm manner. If the bullying continues, you have the right to go to higher management.

Select all of the actions you should take if you are being bullied.

***Form a plan to stop the bullying**
Shout counter insults/yell back
***Use a calm/collected tone of voice and tell the person to stop**
Only share your concern with a co-worker
***Keep a record of the bullying**
***Present your case to your supervisor or human resources representative**

Lesson 10: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Your organization wants to gain a competitive edge over the competition and therefore differentiate their service from the others. You play a vital role in gaining this edge! To the customer you may be their primary point of contact and every word and mannerism you convey speaks for the organization. Your fast response, smile, energy, and focus on empathizing with their concerns will improve customer satisfaction, reduce costs and increase profits. If you have any questions about customer service, contact the appropriate personnel within your organization for guidance and assistance.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. Which of the following actions can help develop a good customer relationship?
    a. Display a stern expression.
    b. Provide a friendly greeting.
    c. Multitask while listening to the customer so you can get more accomplished.
    d. Use words such as “Can I” and “Yup”.

2. Good customer service will improve:
    a. Customer satisfaction
    b. Customer cooperation
    c. Outcomes
    d. All of the above

3. Which of the following actions does not help you display a positive attitude?

    a. Pausing, taking a deep breath and thinking before you speak
    b. Saying positive words to yourself
    c. Being flexible/adapting to new challenges
    d. Sharing negative thoughts about your job with your customers

4. Sharing negative thoughts about your job with the customer can:
    a. Lead to doubt
    b. Cause anxiety
    c. Create a negative experience
    d. All of the above

5. Active listening takes:
    a. Focus
    b. Energy
    c. Attention
    d. All of the above

6. You can remove physical barriers to active listening by:
    a. Turning off screens that could distract you.
    b. Avoiding mind drift and making assumptions
    c. Using nonverbal encouragers such as head nods.
    d. Using verbal encouragers such as hmm, oh, ah.

7. You can remove internal barriers to active listening by:

a. Turning off screens that could distract you.
b. Avoiding mind drift and making assumptions.
c. Using nonverbal encouragers such as head nods.
d. Using verbal encouragers such as hmm, oh, ah.

8. Good customer service includes:
a. Fighting with the customer.
b. Making excuses.
c. Prematurely ending a conversation.
d. Active listening.

9. Bullying can come from:
a. Team members
b. Supervisors
c. Management
d. All of the above

Pool 2 (4 or 2 questions)

TRUE/FALSE

10. A customer can be both internal and external to the organization.

11. Customer service experiences can change the perception a customer has on an entire organization.

12. Customer service is an important factor in making your organization the healthcare facility of choice for the people in your service area.

13. Customers are savvy enough to take their business elsewhere if they are not receiving the service and attention they seek.

14. Making a strong, positive first impression will help you develop a good customer relationship.

15. Good customer service begins with a positive attitude.

16. Hearing is the same as listening.

17. Active listening allows for greater productivity with fewer mistakes.

18. Customer service events can only control your attitude if you allow it.

19. Managers spend at least 75 percent of their time resolving workplace conflicts.

20. If someone is bullying you it is best to shout counter insults or yell back.

Customer Service – Clinics

Lesson 1: Objectives

At the end of the course, participants will be able to:

- Better meet customer expectations;
- Make a strong, positive first impression;
- Display a positive attitude and engage in active listening;
- Handle a stressful customer service encounter; and
- Address workplace conflict including bullying.

Introduction

Customer service is the act of taking care of the customer's needs by providing professional, helpful, quality service and assistance before, during, and after the customer's expectations are met. A customer can be both internal and external to the organization. This can include patients, visitors, team members, medical staff, volunteers, and more.

Customer service is something most people don't consider or appreciate until there is a problem. Customer service experiences can change the entire perception a customer has on an individual or even the entire organization that an employee represents. It can be an important factor in making your organization the healthcare facility of choice for the people in your service area. Good customer service will improve customer satisfaction and cooperation and improve outcomes.

Lesson 2: Meeting Customer Expectations

Customers expect certain things when they walk into a healthcare facility, and the facilities with the highest level of customer satisfaction know how to identify these expectations and meet them.

Some of the most common expectations that customers have for healthcare facilities are similar to other businesses. These include fast, efficient and accurate service, friendly and helpful staff, prompt responses to questions, trained team members that can handle their immediate questions without being transferred or placed on hold, and attentiveness to a customer's problems or complaints. The best way to determine how well you met your customers' expectations is to simply ask the question. Your organization may also provide a formal customer satisfaction survey. The goal of both is to discover ways to improve your customers' experiences. Remember, customers are savvy enough to take their business elsewhere if they are not receiving the service and attention they seek.

Lesson 3: Meeting and Greeting

Your customer will make early decisions about you and perhaps the organization based upon your appearance, attitude, body language, facial expressions, what you say and especially tone of voice. Making a strong, positive first impression will help you develop a good customer relationship. Be sure to make eye contact, display a nice warm smile, provide a friendly greeting, give the customer your undivided attention and listen to their needs and questions with empathy and compassion. The words you use will set your organization apart as well. Using words such as “May I” instead of “Can I”, and “Yes” instead of “Yup” as well as avoiding absolute extremes such as “every”, “all”, “never” and “always” will help.

Select all of the actions that can help develop a good customer relationship.

***Make eye contact**
Display a stern expression
***Provide a friendly greeting**
Multitask while listening to the customer so you can get more accomplished
***Listen to the customer’s needs/questions with empathy/compassion**
Use words such as “Can I” and “Yup”
Use absolute extremes such as “every”, “all”, “never” and “always”

Lesson 4: Positive Attitude

Good customer service begins with a positive attitude. It is not just what a person says; it is how they say it and how they behave while they are saying it. Your tone of voice and behavior speaks loudly to those we serve. It reinforces your competence and commitment to providing excellent, quality care towards the task at hand.

To display a positive attitude pause, take a deep breath and think before you speak. Self-talk can also have a dramatic affect both positively and negatively. You have a choice about what you say to yourself. Positive words include “I can do it”. Negative words limit our potential and are self-defeating. Choose to be positive. Be flexible and adapt to new challenges. Providing customer service is not easy but with making good choices about one’s thoughts, anything is possible.

Sharing negative thoughts about your job, the organization, or other team members with the customer leads to doubt, anxiety and a negative experience for the people we serve. Avoid sharing these thoughts as many times we invite the type of behavior that we show to others.

Quiz Question:

Which of the following actions does not help you display a positive attitude?

A. Pausing, taking a deep breath and thinking before you speak
B. Saying positive words to yourself
C. Being flexible/adapting to new challenges
D. *Sharing negative thoughts about your job with your customers

Lesson 5: Active Listening

Hearing is not the same as listening. Active listening displays a concerned attitude, enhanced understanding and better customer satisfaction. It allows for greater productivity with fewer mistakes. Information that the customer provides is vital. You may even want to take notes. Active listening takes focus, energy, and attention. To do this you must recognize and remove physical barriers (such as turning off screens that could distract you), minimize internal barriers (such as allowing your mind to drift or make assumptions), use nonverbal encouragers (such as eye contact and head nods), and verbal encouragers (such as hmm, oh, ah…) to show that you are paying attention, ask open-ended questions, listen with purpose, and recap your understanding of the issue. Everyone can overcome these obstacles. Remember, listening is not passive, it is active. Stay alert and be energetic about listening, if not you may miss important information.

Quiz Question:

Fill in the blanks with the word options provided:

Active listening displays a concerned **attitude**, enhanced **understanding** and better customer **satisfaction**. It allows for greater **productivity** with fewer **mistakes**.

Lesson 6: Handling Customer Service Stress

Many people allow events to shape how they feel and what they do. However, events can only control your attitude if you allow it. When providing customer service, it is important to not allow stressful events to govern your attitude. If you are unprepared and unfocused when providing customer service, you may be caught off guard and perceive the event as a threat. Your natural reaction will be to respond to the threat either by fighting or running (also known as the fight or flight stress response). Most of the customer service events that you experience at work are not life threatening and therefore you must change your perception of the encounter. Good customer service does not include fighting with the customer or running away by making excuses or prematurely ending a conversation.

Your primary role in a stressful customer service encounter is to keep the situation under control and prevent things from getting worse. Always take into consideration the customer's frame of mind at the time of the event. Disarm a difficult customer with a greeting and an invitation to help. Smile even if the event takes place over the phone. Respond by conveying the truth and invite the customer in a two-way discussion with

words like “I understand, I see, or I hear what you are saying, etc.”. You are not in control of every event but you are in control of your own behavior and response to these events. There is no place for anger in customer service. Choose to stay calm. Be prepared. Pause, take a deep breath, slow down your pace of speech, allow the customer to vent, take notes, listen actively, be emphatic, think rationally and focus on what you can control. Remember, the real problem is whatever is causing the customer to behave that way, not the customer’s behavior. The root cause of the behavior must be fixed in order to meet the customers’ expectations.

Quiz Question:

Avoid allowing stressful events to govern your attitude.

***True** or False

Lesson 7: Internal Customer Service

We often think of the importance of customer service in regard to individuals who visit our organization such as patients and visitors. However, those you serve internally should be provided the same consideration. While all of the principles previously discussed can be applied, there are additional concerns when servicing those who work for the organization.

Lesson 8: Workplace Conflict

Workplace conflict is a normal and natural part of any workplace and can occur when there is a disagreement or opposition of interests or ideas. It has been estimated that managers spend at least 25 percent of their time resolving workplace conflicts. By learning to constructively resolve conflict, we can turn a destructive situation into an opportunity for creativity and enhanced work performance.

There are many causes of conflict in a work setting including ineffective communication, differences in values and interests, scarce resources, personality clashes, and poor performance. Sometimes what we are trying to communicate gets lost in translation despite our best intentions. These conflicts can be resolved through active listening, asking the appropriate questions, and making sure both parties are understood. The failure to accept or understand one another’s differing values can lead to conflict. The way a person views or addresses a situation is not wrong just because it does not match your own. You may have differing interests as well. Sometimes an individual’s personal goals can be at odds with your goals or even the organization’s goals. This conflict can be addressed by finding a common ground and negotiating goals that work for everyone. Scarce resources can make employees feel they have to compete for available resources in order to do their job. This can be alleviated by teaching prioritization of time and resources, as well as ways to negotiate with one another. Personality clashes can cause conflict. All organizations are made up of different

personalities and team members must strive to understand and accept each other's approach to work and problem-solving. Conflict can also occur when team members are not contributing their share of effort or not performing at the expected level of quality. This can cause extra work and frustration for others. This issue can be resolved by their manager through coaching, feedback and evaluation.

Arriving at a positive resolution to conflict is always the ultimate goal. In resolving conflict, it is important that you clearly state the cause of the conflict and why and how you recommend it being resolved. It is best to address conflict face-to-face and stick to the issue at hand. Sometimes our emotions may interfere with arriving at a resolution. If this happens, take a time-out and continue resolving the conflict at another designated time. Avoiding conflict is often the easiest way to deal with it; however, it does not make it go away. By actively resolving conflict when it occurs, you can create a more positive work environment for everyone.

Lesson 9: Workplace Bullying

Workplace bullying refers to any repeated, intentional behavior directed at an employee with the purpose of degrading, humiliating, embarrassing, or otherwise undermining their performance. Bullying can come from team members, supervisors, or management, and is a problem for workers at all levels. By learning to recognize and address workplace bullying behavior, you can help to create a healthier, more productive environment for yourself and your co-workers.

Bullying is more than a simple misunderstanding or personal disagreement. Workplace bullying may include shouting, whether in private, in front of team members, or in front of customers, name calling, belittling or disrespectful comments, excessive monitoring, criticizing, or nitpicking someone's work, deliberately overloading someone with work, undermining someone's work by setting them up to fail, and excluding someone from staff room conversations and making them feel unwelcome.

If you feel singled out unfairly, or feel you are being picked on, form a plan to stop the bullying. Never escalate the bullying. Shouting counter insults or yelling back might end up making the situation worse. Use a calm and collected tone of voice and tell the person to stop. Keep a record of the bullying including specific times, dates and locations. Ask co-workers if they will serve as witnesses to bullying incidents. Set up a meeting with your supervisor or human resources representative. Bring your written evidence, your witnesses, and present your case in a calm manner. If the bullying continues, you have the right to go to higher management.

Select all of the actions you should take if you are being bullied.

***Form a plan to stop the bullying**
Shout counter insults/yell back
***Use a calm/collected tone of voice and tell the person to stop**
Only share your concern with a co-worker

***Keep a record of the bullying**
***Present your case to your supervisor or human resources representative**

Lesson 10: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Your organization wants to gain a competitive edge over the competition and therefore differentiate their service from the others. You play a vital role in gaining this edge! To the customer you may be their primary point of contact and every word and mannerism you convey speaks for the organization. Your fast response, smile, energy, and focus on empathizing with their concerns will improve customer satisfaction, reduce costs and increase profits. If you have any questions about customer service, contact the appropriate personnel within your organization for guidance and assistance.

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Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

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    b. Provide a friendly greeting.
    c. Multitask while listening to the customer so you can get more accomplished.
    d. Use words such as “Can I” and “Yup”.

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    a. Customer satisfaction
    b. Customer cooperation
    c. Outcomes
    d. All of the above

3. Which of the following actions does not help you display a positive attitude?

    a. Pausing, taking a deep breath and thinking before you speak
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b. Making excuses.
c. Prematurely ending a conversation.
d. Active listening.

9. Bullying can come from:
a. Team members
b. Supervisors
c. Management
d. All of the above

Pool 2 (4 or 2 questions)

TRUE/FALSE

10. A customer can be both internal and external to the organization.

11. Customer service experiences can change the perception a customer has on an entire organization.

12. Customer service is an important factor in making your organization the healthcare facility of choice for the people in your service area.

13. Customers are savvy enough to take their business elsewhere if they are not receiving the service and attention they seek.

14. Making a strong, positive first impression will help you develop a good customer relationship.

15. Good customer service begins with a positive attitude.

16. Hearing is the same as listening.

17. Active listening allows for greater productivity with fewer mistakes.

18. Customer service events can only control your attitude if you allow it.

19. Managers spend at least 75 percent of their time resolving workplace conflicts.

20. If someone is bullying you it is best to shout counter insults or yell back.

EMTALA

Lesson 1: Objectives

At the completion of this course, you will be able to:

- Identify the requirements of the Emergency Medical Treatment and Labor Act (EMTALA);
- Discuss the importance of preventing an unnecessary delay in examination and treatment;
- Identify that the hospital must have a physician on-call list; and
- Recognize that there are penalties for violating EMTALA.

Introduction

The Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping law, went into effect in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Congress passed this federal law to ensure that individuals with *emergency medical conditions* were not denied essential lifesaving services. EMTALA applies to any hospital that accepts payment under the Medicare program for services provided to beneficiaries of that program.

Lesson 2: Signage

An EMTALA sign must be posted in any emergency department or place likely to be noticed by all individuals entering the emergency department, as well as those waiting for examination and treatment in other areas. The sign must include an individual's rights with respect to examination and treatment for emergency medical conditions and women in labor, whether the hospital participates in the Medicaid program, and other items specified by the Secretary of Health and Human Services.

Lesson 3: Medical Screening Examination

When an individual *comes to the emergency department* and requests an examination for a medical condition, the *hospital*, within its capabilities, must provide an appropriate medical screening examination by a *qualified individual* to determine, with reasonable clinical confidence, whether or not an emergency medical condition exists, regardless of the individual's ability to pay and whether or not they are eligible for Medicare benefits. A medical screening examination must be provided to every individual including women in labor, their unborn child, and newly born infants protected by the Born-Alive Infant Protection Act when they *come to the emergency department* and request an examination for a medical condition. This request may be made on the individual's behalf. A medical screening examination is an ongoing process that usually begins with triage. Triage involves the clinical assessment of the individual's presenting signs and

symptoms, in order to prioritize when the individual will be seen by a physician, provider, or other qualified medical personnel. The medical screening examination must be appropriate to the individual's signs and symptoms and may involve a wide spectrum of actions, from a simple examination to a more complex examination that involves diagnostic testing. The medical screening examination must be the same examination that the hospital would perform on any individual coming to the hospital's *dedicated emergency department* with those signs and symptoms, regardless of the individual's ability to pay for medical care.

Once a medical screening examination has been performed and a physician or other qualified medical personnel has determined that the patient does not have an emergency medical condition, the hospital has no further obligations under EMTALA. The emergency department may then refer the patient to a fast track or non-emergent care facility, another hospital clinic, or the patient's own physician for further treatment. If a pregnant patient presents with complaints of active labor and it is determined that she is not in active labor, the physician or other qualified medical personnel should complete a certificate of false labor.

Quiz Question:

Drag and drop the words to their places to describe the hospital's responsibilities.

When an individual comes to the emergency department and requests an examination for a medical condition, the hospital, within its capabilities, must provide ***an appropriate medical screening examination*** by a ***qualified individual*** to determine, with reasonable clinical confidence, whether or not ***an emergency medical condition exists***, regardless of the individual's ability to pay and whether or not they are eligible for Medicare benefits.

Lesson 4: Treatment and Transfer

If an emergency medical condition is determined to exist, the hospital must provide *stabilizing* treatment within its capabilities to minimize the risk to the individual's (including a born-alive infant's) health and, in the case of a woman in *labor*, the health of the unborn child; or *transfer* the individual to another medical facility. The receiving facility must have available space and qualified personnel for the treatment of the individual and agree to accept the transfer of the individual and provide appropriate medical treatment. The transferring hospital must send to the receiving facility copies of all *medical records.* Other records not yet available or readily available must be sent as soon as possible after the transfer. The transfer must involve qualified personnel and appropriate equipment, as warranted by the patient's condition. A hospital that has specialized capabilities or facilities may not refuse to accept from a referring hospital an appropriate transfer of an individual who requires such specialized capabilities or

facilities if the receiving hospital has the *capacity* to treat the individual. This applies to any hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

A hospital may only transfer an individual with an unstable emergency medical condition when it is appropriate and the individual (or a legally responsible person acting on the individual's behalf) requests the transfer after being informed of the hospital's obligations and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that the individual is aware of the risks and benefits of the transfer. A physician must sign a certification indicating that the medical benefits expected from the receipt of treatment at another medical facility outweigh the risks from being transferred. If a physician is not physically present at the time an individual is transferred a qualified medical person can sign the certification after consultation with the physician and the physician can countersign in a timely manner. Medical records must be retained for five years from date of transfer and can be kept in paper or electronic format.

Special exceptions are given to transfers during a national emergency and the relocation or direction of individuals to an alternate location for medical screening in accordance with a State emergency or pandemic preparedness plan. In addition, your organization may have diversion policies for times when it does not have available space or qualified personnel to accept additional patients. When the hospital admits the individual as an *inpatient* for further treatment or stabilization its obligations under EMTALA end.

Quiz Question:

Select the correct word from the dropdown to describe the hospital's responsibilities.

If an emergency medical condition is determined to exist, the hospital must provide ***stabilizing** treatment within its capabilities to minimize the risk to the individual's health and, in the case of a woman in labor, the health of the unborn child; or ***transfer** the individual to another medical facility.

Lesson 5: Delay in Examination or Treatment

A hospital may not delay providing an appropriate medical screening examination or further medical examination and treatment in order to find out the individual's method of payment or insurance status. The hospital may not seek, or ask an individual to seek, authorization from their insurance company for screening or stabilization services to be furnished by a hospital, physician, or non-physician practitioner until after an appropriate medical screening examination has been provided and the patient has been stabilized. An emergency physician or non-physician practitioner may contact the individual's

physician to seek advice regarding the individual's medical history and needs as long as this consultation does not inappropriately delay services. Hospitals may follow reasonable registration processes as long as it does not delay examination or treatment.

Quiz Question:

It is appropriate for the hospital to delay providing a medical screening examination:

a. In order to find out the individual's method of payment.

b. In order to find out the individual's insurance status.

c. In order to seek authorization from the individual's insurance company for services to be furnished by the hospital.

d. *None of the above.

Lesson 6: Refusal to Consent to Examination, Treatment, or Transfer

If an individual (or a person acting on the individual's behalf) does not consent to further examination, treatment, or the transfer to another medical facility, the medical record must contain a description of the examination, treatment, and/or the proposed transfer that was refused. The hospital must take all reasonable steps to secure the individual's written informed refusal. This document must indicate that the person had been informed of the risks and benefits of the examination, treatment, and/or transfer and indicate the reason for the individual's refusal.

Lesson 7: Availability of On-Call Physicians

A hospital must maintain a list of physicians who are on-call after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Follow your organization's policies and procedures regarding situations in which a particular specialty is not available or the on-call physician cannot respond, the availability of services if the hospital permits on-call physicians to schedule elective surgery during on-call time or have simultaneous on-call duties, and the hospital's participation in a formal *community call plan*.

Lesson 8: Penalties for Violations

The hospital is obligated to report the receipt of patients whom it has reason to believe may have been transferred inappropriately. The report must be made within 72 hours of occurrence. In cases where a medical opinion is necessary to determine a physician's or hospital's liability under EMTALA, the Centers for Medicare and Medicaid Services (CMS) will request the appropriate Quality Improvement Organization to review the alleged violation. If it is determined that a hospital failed to fulfill its EMTALA obligations they may be subject to termination of its Medicare provider agreement, which would result in loss of all Medicare and Medicaid payments. The hospital may also face civil monetary penalties.

Quiz Question:

If a hospital fails to fulfill its EMTALA obligations, it may be subject to:

a. Loss of all Medicare payments.

b. Loss of all Medicaid payments.

c. Civil monetary penalties.

d. *All of the above.

Lesson 9: Central Log

The hospital must keep a central log on each individual who comes to the emergency department, seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged. The central log includes, directly or by reference, patient logs from other areas of the hospital that may be considered dedicated emergency departments, such as pediatrics and labor and delivery departments where a patient might present for emergency services or receive a medical screening examination instead of in the "traditional" emergency department. The hospital may keep its central log in an electronic format.

Lesson 10: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Your organization is committed to the rights of their patients including the right to essential lifesaving services required under EMTALA. And it takes your help! If you

have any questions about EMTALA, including reporting a violation, contact the appropriate personnel within your organization for guidance and assistance.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. "Comes to the emergency department" means the individual:

    a. Has presented at a hospital's dedicated emergency department.
    b. Has presented on hospital property.
    c. Is in a ground or air ambulance, owned and operated by the hospital, to be examined and treated at the hospital's dedicated emergency department.
    d. Is in a ground or air ambulance, non-hospital-owned, on hospital property for examination and treatment at the hospital's dedicated emergency department.
    e. All of the above.

2. It is appropriate for the hospital to delay providing a medical screening examination:

    a. To find out the individual's method of payment.
    b. To find out the individual's insurance status.
    c. To obtain authorization from the individual's insurance company for services to be provided by the hospital.
    d. None of the above.

3. If a hospital fails to meet its EMTALA obligations it may be subject to:

    a. Loss of all Medicare payments.
    b. Loss of all Medicaid payments.
    c. Civil monetary penalties.
    d. All of the above.

4. Once it has been determined that the patient does not have an emergency medical condition, the emergency department may then refer the patient to:

    a. A fast track or non-emergent care facility.
    b. Another hospital clinic.
    c. The patient's own physician.
    d. All of the above.

5. A receiving facility must have:

    a. Available space.

b. Qualified personnel for the treatment of the individual.
c. Agreed to accept the transfer.
d. Agreed to provide appropriate medical treatment.
e. All of the above.

6. A request for transfer must:

a. Be in writing.
b. Indicate the reasons for the request.
c. Indicate that the individual is aware of the risks and benefits of transfer.
d. All of the above.

7. The acronym EMTALA means:

a. Emergency Management Triage and Life Act.
b. Emergency Medical Treatment and Labor Act.
c. Emergency Medicine To Allow Life Act.
d. Emergency Medication To Accompany Living Adults.

Pool 2 (4 or 2 questions)

TRUE/FALSE

8. A hospital may not transfer an individual with an unstable emergency medical condition.

9. Congress passed antidumping requirements to ensure that individuals with emergency medical conditions are not denied essential lifesaving services.

10. A medical screening examination is an ongoing process that usually begins at discharge.

11. Triage involves the clinical assessment of the individual's presenting signs and symptoms in order to prioritize when he or she will be seen by a physician or other qualified medical personnel.

12. The medical screening examination is performed based upon the individual's ability to pay for medical care.

13. The transferring hospital must send to the receiving facility all medical records, related to the emergency condition, available at the time of the transfer.

14. A physician (or other qualified medical person) must sign a certification indicating that at the medical benefits expected from the receipt of treatment at another medical facility outweigh the risks from being transferred.

15. Hospitals must not register patients because it delays treatment.

16. When a patient refuses a transfer the hospital must take all reasonable steps to secure the individual's written informed refusal.

17. A hospital must maintain a list of physicians who are on-call for duty to provide treatment to stabilize an individual with an emergency medical condition.

FACTA Red Flags – Identity Theft Prevention

Lesson 1: Objectives

Upon completion of this course, you will be able to:

- Detect and appropriately respond to Red Flags to prevent and mitigate identity theft.

Introduction

The Fair and Accurate Credit Transactions Act of 2003 (FACT Act or FACTA) requires that financial institutions and creditors have a written Identity Theft Prevention Program to detect, prevent, and mitigate identity theft in connection with the opening of an account or any existing account. Identity theft is fraud that is committed or attempted using a person's identifying information without authority. Any account which permits multiple payments or transactions and is primarily for personal, family, or household purposes, or in which there is a reasonably foreseeable risk from identity theft to customers or to the safety and soundness of an organization must be protected. The organization must identify patterns, practices, and specific activities that indicate the possible existence of identity theft, referred to as Red Flags, and train their employees on the detection and response to these Red Flags. Although FACTA applies specifically to financial institutions and creditors, every organization that handles customer accounts should be aware of the Red Flags that apply to its business.

Your organization provides oversight of its Identity Theft Prevention Program including the review of compliance reports, approval of changes, and oversight of service provider agreements, as applicable.

Lesson 2: Identity Theft Prevention Program

There are four basic elements of an Identity Theft Prevention Program: the identification of relevant Red Flags, detection of Red Flags, response to Red Flags to prevent and mitigate identity theft, and periodic updating.

Identification and Detection of Red Flags

In identifying relevant Red Flags for its accounts, an organization considers the types of accounts it offers or maintains, the methods it provides to open and access accounts, and its previous experiences with identity theft. Organizations also incorporate Red Flags from a variety of sources such as previous incidences of identity theft; methods of identity theft that change its risks; and supervisory guidance. Red Flags may also be identified through warnings received by consumer reporting agencies; the presentation

of suspicious documents or personal identifying information; the unusual use of an account; or a notice from customers, victims of identity theft, law enforcement authorities, or other persons regarding possible identity theft. Each of these Red Flags will be explained in more detail in the following sections. You should be familiar with the Red Flags that are applicable to your organization so you can detect and respond appropriately when obtaining identifying information about, and verifying the identity of, a person opening an account or authenticating customers, monitoring transactions, and verifying the validity of change of address requests for existing accounts.

Alerts, notifications, or other warnings from a consumer reporting agency may indicate a Red Flag. For example,

- A fraud or active duty alert.
- A notice of credit freeze, address discrepancy, or an inconsistent pattern of activity when compared with the history and usual pattern of activity of a customer, such as:
    - A recent and significant increase in the volume of inquiries;
    - An unusual number of recently established credit relationships;
    - A material change in the use of credit; or
    - An account that was closed for cause or identified for abuse of account privileges.

The presentation of suspicious documents may indicate a Red Flag. For example,

- Documents provided for identification appear to have been altered or forged.
- The photograph or physical description on the identification is not consistent with the appearance of the customer.
- Other information on the identification is not consistent with information provided by the customer or with information that is on file with the organization, such as a signature card or check.
- An application appears to have been altered or forged or gives the appearance of having been destroyed and reassembled.

The presentation of suspicious personal identifying information by the customer may indicate a Red Flag. For example,

- Personal identifying information provided is not consistent with external information sources. For example, the address does not match the address on the consumer report; or the Social Security number has not been issued or is listed on the Social Security Administration’s Death Master File.

- Personal identifying information provided is not consistent with other information provided by the customer. For example, there is a lack of correlation between the Social Security number range and date of birth.
- Personal identifying information provided is associated with known fraudulent activity. For example, the address or phone number on the application is the same as the address or phone number provided on a fraudulent application.
- Personal identifying information provided is of a type commonly associated with fraudulent activity, such as a fictitious address, a mail drop, or a prison; or an invalid phone number or one that is associated with a pager or answering service.
- The Social Security number provided is the same as that submitted by other persons opening an account or other customers.
- The address or telephone number provided is the same as or similar to the address or telephone number submitted by an unusually large number of other persons opening accounts or other customers.
- The person opening the account or the customer fails to provide all required personal identifying information on an application or in response to notification that the application is incomplete.
- Personal identifying information provided is not consistent with information that is on file with the organization.
- The person opening the account or the customer cannot answer challenge questions or provide authenticating information beyond that which generally would be available from a wallet or consumer report.

The unusual use of, or other suspicious activity related to, an account may indicate a Red Flag. For example,

- Shortly following a notice of a change of address for an account, the organization receives a request for a new, additional, or replacement card or cell phone, or for the addition of authorized users on the account.
- A new revolving credit account is used in a manner commonly associated with known patterns of fraud. For example:
    - The majority of available credit is used for cash advances or merchandise that is easily convertible to cash; or
    - The customer fails to make the first payment or makes an initial payment but no subsequent payments.
- An account is used in a manner that is not consistent with established patterns of activity on the account. There is, for example,
    - A nonpayment when there is no history of late or missed payments;
    - A material increase in the use of available credit;
    - A material change in purchasing or spending patterns;

    - A material change in electronic fund transfer patterns in connection with a deposit account; or
    - A material change in telephone call patterns in connection with a cellular phone account.
- An account that has been inactive for a reasonably lengthy period of time is used.
- Mail sent to the customer is returned repeatedly as undeliverable although transactions continue to be conducted in connection with the customer's account.
- The organization is notified that the customer is not receiving paper account statements.
- The organization is notified of unauthorized charges or transactions in connection with a customer's account.

Quiz Question:

Match the Red Flag to its example:

Alerts, notifications, or other warnings from a consumer reporting agency = *A notice of an inconsistent pattern of activity when compared with the history and usual pattern of activity of a customer.

The presentation of suspicious documents = *Documents provided for identification appear to have been altered or forged.

The presentation of suspicious personal identifying information by the customer = *The Social Security number provided is the same as that submitted by other persons opening an account or other customers.

The unusual use of, or other suspicious activity related to, an account = *An account that has been inactive for a reasonably lengthy period of time is used.

Lesson 3: Responding to Red Flags

It is critical that you respond appropriately to a detected Red Flag in order to prevent or mitigate identity theft. Your response should be in proportion with the risk of identity theft. Appropriate responses may include:

- Monitoring an account for evidence of identity theft;
- Contacting the customer;
- Changing any passwords, security codes, or other security devices that permit access to an account;
- Reopening an account with a new account number;

- Not opening a new account;
- Closing an existing account;
- Not attempting to collect on an account or not selling an account to a debt collector;
- Notifying law enforcement; or
- Determining that no response is needed under the circumstances.

Quiz Question:

Select **all** of the responses that may be appropriate when a Red Flag is detected:

a. ***Monitoring an account for evidence of identity theft.**
b. ***Contacting the customer.**
c. ***Changing any passwords, security codes, or other security devices that permit access to an account.**
d. ***Reopening an account with a new account number.**
e. ***Not opening a new account.**
f. ***Closing an existing account.**
g. ***Not attempting to collect on an account or not selling an account to a debt collector.**
h. ***Notifying law enforcement.**
i. ***Determining that no response is needed under the circumstances.**

Lesson 4: Additional FACTA Requirements

FACTA requires credit and debit card issuers validate a change of address request when there is a request for additional or replacement cards within a short period of time from the original request. In these cases, a new card may not be issued unless the organization notifies the cardholder of the change of address request at the cardholder's former address or by any other agreed upon means of communication, and provides to the cardholder a reasonable means of promptly reporting an incorrect address change.

FACTA also requires organizations that request consumer reports have policies and procedures regarding a notice of address discrepancy by the consumer reporting agency and methods to determine whether the report belongs to the correct consumer. Methods may include comparing the information in the consumer report with the information the organization obtains and uses to verify the consumer's identity in accordance with Customer Information Program requirements; maintains in its own records, such as applications, change of address notifications, other customer account

records; or obtains from third-party sources. The organization may also verify the information in the consumer report with the consumer. The organization must give the consumer reporting agency an address for the consumer that the organization has reasonably confirmed is accurate.

Lesson 5: Updating the Identity Theft Prevention Program

Organizations should update its Identity Theft Prevention Program periodically to reflect changes in risks to customers or to the safety and soundness of the organization from identity theft, based on factors such as:

- The experiences of the organization with identity theft;
- Changes in methods of identity theft;
- Changes in methods to detect, prevent, and mitigate identity theft;
- Changes in the types of accounts that the organization offers or maintains; and
- Changes in the business arrangements of the organization.

Lesson 6: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Employees must be able to detect and appropriately respond to Red Flags to prevent and mitigate identity theft. If you have any questions, contact the appropriate personnel within your organization.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. The four basic elements of an Identity Theft Prevention Program include:

    a. The identification and detection of Red Flags.
    b. The response to Red Flags.
    c. Periodic updating.
    d. All of the above.

2. In identifying relevant Red Flags, an organization considers:

    a. The types of accounts it offers or maintains.
    b. The methods it provides to open and access accounts.
    c. Its previous experiences with identity theft.
    d. All of the above.

3. Organizations incorporate Red Flags from a variety of sources such as:

    a. Previous incidences of identity theft.
    b. Methods of identity theft that change its risks.
    c. Supervisory guidance.
    d. All of the above.

4. Which of the following may indicate a Red Flag?

    a. Documents provided for identification appear to have been altered or forged.
    b. The photograph on the identification is not consistent with the appearance of the customer.
    c. The application appears to have been destroyed and reassembled.
    d. All of the above.

5. Which of the following may indicate a Red Flag?

    a. The person opening the account cannot answer challenge questions beyond that which generally would be available from a wallet or consumer report.

b. Personal identifying information provided is consistent with other information provided by the customer.
c. Personal identifying information provided is consistent with external information sources.
d. Personal identifying information provided is consistent with information that is on file with the organization.

6. Which of the following is an inappropriate response to a detected Red Flag?

a. Not opening a new account.
b. Verbally accusing the customer of identity theft.
c. Closing an existing account.
d. Determining that no response is needed under the circumstances.

Pool 2 (4 or 2 questions)

TRUE/FALSE

7. Identity theft is fraud that is committed or attempted using a person's identifying information without authority.

8. Red Flags are patterns, practices, and specific activities that indicate the possible existence of identity theft.

9. FACTA requires that financial institutions and creditors detect, prevent, and mitigate identity theft in connection with the opening of an account or any existing account.

10. Red Flags may be identified through warnings received by consumer reporting agencies.

11. Red Flags may be identified through the presentation of suspicious documents.

12. Red Flags may be identified through the presentation of suspicious personal identifying information by the customer.

13. Red Flags may be identified through the unusual use of an account.

14. Red Flags may be identified through a notice from a customer regarding possible identity theft.

HIPAA

Lesson 1: Objectives

After completion of this course, you will be able to:

- Describe the HIPAA Privacy Rule, including the permitted uses and disclosures of protected health information by covered entities and business associates, uses and disclosures that require individual authorization, the privacy practices notice, and administrative requirements;
- Describe the HIPAA Security Rule, including a risk analysis and the maintenance of administrative, physical, and technical safeguards;
- Identify the role of the Office for Civil Rights in enforcement and penalties for noncompliance; and
- Describe the Breach Notification Rule.

Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To meet this requirement, HHS created what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule set up national standards for the use and disclosure of protected health information (PHI), by covered entities, as well as standards for providing individuals with rights to understand and control how their health information is used. The Security Rule set up national standards for the protection of an individual's health information that is created, received, maintained or transmitted, in electronic form.

The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law in 2009 to promote the adoption and meaningful use of health information technology. The HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information by strengthening the enforcement of the HIPAA rules and requiring HIPAA covered entities and their business associates to provide notification following a breach of unsecured PHI.

Lesson 2: The Privacy Rule

The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this "protected health information (PHI)". PHI includes information related to the individual's past, present, or future physical or mental health or condition; the health care provided; or the past, present, or future payment for health care; and identifies the individual. PHI includes many common identifiers such as name, address, and birth date.

De-identified information is PHI stripped of identifiers in a manner that results in information that is no longer protected by the Privacy Rule. There are two de-identification methods: formal determination by a qualified expert or the removal of 18 specified identifiers, also known as the safe harbor method.

Quiz Question:

Drag the correct words from the word bank to define Protected Health Information (PHI).

PHI includes information related to the individual's past, present, or future ***physical or mental health or condition**; the health care ***provided**; or the past, present, or future **payment** for health care; and ***identifies** the individual.

Lesson 3: Covered Entities and Business Associates

The Privacy Rule applies to "covered entities" such as health plans, health care clearinghouses, and health care providers. Health plans are individual and group plans that provide or pay the cost of medical care, including health, dental, and vision insurers. Health care clearinghouses process nonstandard information into a standard or vice versa, such as billing services. Health care providers include all providers of services (such as hospitals) and providers of medical and health services (such as physicians) and any other person or organization that delivers, bills, or is paid for health care. Every health care provider who electronically transmits health information in connection with certain transactions (such as claims, benefit eligibility questions, and referral authorization requests) is a covered entity.

A business associate is a person or organization that performs certain functions on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of PHI. When "business associate" services are used an agreement must be obtained which addresses safeguards for PHI. If the business associate delegates or outsources services or functions to a subcontractor, that subcontractor becomes a business associate if they need to access, use, or disclose PHI to perform their services. Entities that store PHI, either electronic or in hard copy, are also business associates even if they don't access, use, or disclose that information, however entities that merely transport PHI are not business associates.

Quiz Question:

Match the following covered entity with their description:

Health plans = *Individual and group plans that provide or pay the cost of medical care.

Health care clearinghouses = *Process nonstandard information into a standard or vice versa.

Health care providers = *All providers of services and providers of medical and health services and any other person or organization that delivers, bills, or is paid for health care.

Lesson 4: Uses and Disclosures of PHI

A covered entity is permitted to use and disclose PHI, without an individual's authorization, to the individual who is the subject of the information; for treatment, payment and health care operations; with opportunity to agree or object; with incident to an otherwise permitted use or disclosure; for limited data set; and for public interest and benefit activities.

Treatment, Payment, and Health Care Operations

Treatment is the delivery, coordination, or management of health care for an individual by health care providers. Payment includes, but is not limited to, activities of a health care provider to obtain payment or be reimbursed for providing health care. Health care operations include, but are not limited to, quality assessment and improvement activities. An exception to this rule applies to psychotherapy notes, which in fact require individual authorization for use or disclosure.

Opportunity to Agree or Object

A health care provider may rely on an individual's informal permission to list in its facility directory the individual's name, condition, religion, and location in the facility; to disclose to family members or others PHI directly relevant to that person's involvement in the individual's care or payment for care; to notify family members or others of the individual's location, condition, or death; and to notify entities authorized by law to assist in disaster relief efforts.

Incidental Use and Disclosure

Use or disclosure of information that occurs as a result of an otherwise permitted use or disclosure is allowed as long as the covered entity has adopted reasonable safeguards and the information being shared was limited to the "minimum necessary" to accomplish the intended purpose.

Limited Data Set

Limited data set is PHI from which certain direct identifiers of individuals and their relatives, household members, and employers have been removed.

Public Interest and Benefit Activities

The Privacy Rule permits use and disclosure of PHI for the following purposes:

- as required by law
- for public health authorities to collect or receive information for preventing or controlling disease, injury, or disability and receive reports of child abuse and neglect; entities subject to U.S Food and Drug Administration (FDA) regulation; individuals who may have contracted or been exposed to a communicable disease; for information concerning a work-related illness or injury or workplace related medical surveillance; for proof of immunization of a student or prospective student to a school that is required by State or other law to have such proof prior to admission and the entity receives and documents the agreement to the disclosure from either a parent, guardian, or the individual (as applicable).
- to government authorities regarding victims of abuse, neglect, or domestic violence
- to health oversight agencies
- in a judicial or administrative proceeding
- to law enforcement officials
- to funeral directors, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions
- to facilitate the donation and transplantation of organs, eyes, and tissue
- for research purposes
- to prevent or lessen a serious and imminent threat to a person or the public
- for government functions
- to comply with workers' compensation laws

A covered entity must obtain the individual's written authorization for any other use or disclosure of PHI, including the marketing and sale of PHI. Individual authorization must be received before using PHI for marketing communications that encourage recipients to purchase or use a product or service. This is also required if the covered entity receives payment from a third party whose services are being marketed, unless it falls under an exclusion such as communications promoting good health or providing information about government programs.

Covered entities are prohibited from receiving direct or indirect financial compensation in exchange for the sale of PHI unless they receive individual authorization. All authorizations must be in plain language and contain specific information regarding what is to be disclosed or used, the person disclosing and receiving the information, expiration, the right to revoke, and other data.

Genetic Information

In accordance with the Genetic Information Nondiscrimination Act of 2008 (GINA) genetic information is health information and group health plans, health insurance issuers, and issuers of Medicare supplemental policies are which prohibited from using or disclosing genetic information for underwriting purposes.

Quiz Question:

A covered entity is permitted to use and disclose PHI, without an individual's authorization: (Select all that apply)

a. ***To the individual who is the subject of the information.**
b. ***For treatment, payment, and health care operations.**
c. ***With opportunity to agree or object.**
d. ***With incident to an otherwise permitted use or disclosure.**
e. ***For limited data set.**
f. ***For public interest and benefit activities.**
g. For marketing of PHI.
h. For sale of PHI.
i. For the disclosure of psychotherapy notes.

Lesson 5: Privacy Practices Notice

Each covered entity must provide a notice of its privacy practices. The notice must describe the ways in which the entity may use and disclose PHI. The notice must also describe the individuals' rights, including the right to review their PHI, obtain a copy of or electronic access to their PHI, or change information that is inaccurate or incomplete in their designated record set; the right to a list of disclosures; the right to request that a covered entity restrict the use or disclosure of PHI, including the disclosure to a group health plan of a service or item that the individual has paid in full and out of pocket; the right to request an alternative means or location for receiving communications; and the right to complain to HHS and to the entity if it is believed a right has been violated. Individuals must also be informed that they will be notified of a breach of unsecured PHI; that written authorization is required for uses or disclosures for marketing purposes, the sale of PHI, as well as for the disclosure of psychotherapy notes; that the use or disclosure of PHI that is genetic information for underwriting purposes is prohibited; and they may opt-out of fundraising communications. In an emergency treatment situation, the health care provider may present the notice as soon as it is reasonable to do so.

A health care provider must also make a good faith effort to obtain written acknowledgement of the receipt of the privacy practices notice and document the reason for any failure to obtain the acknowledgement. Health care providers are not required to obtain a written acknowledgment from individuals in an emergency treatment situation.

Quiz Question:

An individual has the right: (Select all that apply)

a. ***To review their PHI, obtain a copy of or electronic access to their PHI, or change information that is inaccurate or incomplete in their designated record set.**
b. ***To a list of disclosures.**
c. ***To request that a covered entity restrict the use or disclosure of PHI.**

d. ***To request an alternative means or location for receiving communications.**
e. ***To complain to HHS and to the entity if it is believed a right has been violated.**

Lesson 6: Administrative Requirements

A covered entity must meet the following administrative requirements:

- develop, implement, and enforce privacy policies and procedures
- designate a privacy official responsible for developing and implementing its policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on its privacy practices
- train all workforce members on its policies and procedures and take action against those who violate it
- lessen any harmful effect caused by use or disclosure of PHI by its workforce
- maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent deliberate or accidental use or disclosure of PHI and limit its incidental use and disclosure
- establish procedures for individuals to complain about its compliance with its privacy policies and procedures, including to the Secretary of HHS
- avoid retaliation against a person for exercising their rights, assisting in an investigation by HHS or another appropriate authority, or opposing an act or practice that the person believes in good faith violates the Privacy Rule
- maintain until six years after the date of their creation or last effective date, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions and activities that the Privacy Rule requires to be documented

Lesson 7: The Security Rule

The Security Rule requires covered entities and business associates to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronic protected health information (e-PHI). Covered entities and business associates must ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain, or transmit; identify and protect against anticipated threats to the security or integrity of the information; protect against anticipated, unpermitted uses or disclosures; and ensure compliance by their workforce.

Quiz Question:

The Security Rule requires covered entities and business associates to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronic protected health information.

***True** or False

Lesson 8: Risk Analysis and Management

The Security Rule requires covered entities and business associates perform a risk analysis as part of their security management processes. The risk analysis process includes, but is not limited to, the evaluation of the likelihood and impact of potential risks to e-PHI; implementation of security measures to address the risks identified in the risk analysis; documentation of the chosen security measures with rationale; and maintenance of continuous, reasonable, and appropriate security protections. Risk analysis is an ongoing process, in which a covered entity or business associate regularly reviews its records to track access to e-PHI and detect security incidents, evaluates the effectiveness of security measures put in place, and reevaluates potential risks to e-PHI.

Lesson 9: Administrative, Physical, and Technical Safeguards

A covered entity or business associate must maintain the following administrative, physical, and technical safeguards for protecting e-PHI.

Administrative Safeguards

A covered entity or business associate must:

- designate a security official who is responsible for developing, implementing, and enforcing its security policies and procedures
- authorize access to e-PHI only when appropriate based on the user or recipient's role and terminate access when the employment of a workforce member ends
- provide for appropriate authorization and supervision of workforce members who work with e-PHI
- train all workforce members regarding its security policies and procedures and take action against workforce members who violate them
- perform a periodic assessment of how well its security policies and procedures meet the requirements of the Security Rule
- maintain until six years after the date of creation or last effective date, security policies and procedures and records of required actions, activities, or assessments
- periodically review and update its documentation in response to environmental or organizational changes that affect the security of e-PHI

Physical Safeguards

A covered entity or business associate must:

- limit physical access to its facilities while ensuring that authorized access is allowed
- specify proper use of and access to workstations and electronic media

- implement policies and procedures regarding the transfer, removal, disposal, and re-use of electronic media

Technical Safeguards

A covered entity or business associate must:

- allow only authorized persons to access e-PHI
- implement hardware, software, and/or procedural mechanisms to record and examine access and other activity in information systems that contain or use e-PHI
- ensure that e-PHI is not improperly altered or destroyed
- guard against unauthorized access to e-PHI that is being transmitted over an electronic network

Quiz Question:

What are the three safeguards for protecting e-PHI?

a. ***Administrative, Physical, Technical.**
b. Safety, Health, Occupational.
c. Accountability, Portability, Timing.
d. Compliance, Testing, Observation.

Lesson 10: Enforcement and Penalties for Noncompliance

The HHS, Office for Civil Rights is responsible for administering and enforcing the HIPAA Privacy Rule and HIPAA Security Rule and may conduct random audits and investigate complaints and breach reports. Covered entities and business associates that fail to comply with the HIPAA rules may be subject to civil money penalties. The HITECH Act significantly increased the penalty amounts the HHS Secretary may demand for violations, up to $1.5 million per year for each violation and encourages quick corrective action by the covered entity or business associate.

Quiz Question:

The Office for Civil Rights is responsible for administering and enforcing the HIPAA rules.

***True** or False

Lesson 11: Breach Notification Rule

In addition to enforcing new civil money penalty amounts for HIPAA rule violations, the HITECH Act requires covered entities and their business associates to provide notification following a breach of unsecured PHI (discovered on or after September 23,

2009), to the affected individual(s), the HHS Secretary, and, in certain circumstances, the media. PHI that is used or disclosed in violation of the Privacy Rule requires breach notification unless one of the following three exceptions apply: unintentional access or disclosure by employees authorized to access PHI and acting in good faith within the scope of that authority, inadvertent disclosure between employees authorized to access PHI, and/or instances in which it is reasonable to believe the disclosed PHI has not actually been viewed or retained applies. The covered entity or business associate may also conduct a risk assessment to determine if there is a low-probability that the PHI has been compromised by considering the following factors: the nature and extent of the PHI involved, the unauthorized person who used the PHI or to whom the PHI was disclosed, whether the PHI was actually acquired or viewed, and the extent to which the risk to the PHI has been lessened. Unsecured PHI is information that has not been rendered unusable, unreadable, or indecipherable through the use of a technology or methodology such as encryption and destruction. If electronic PHI is encrypted it is considered to be secured under the Breach Notification Rule.

Quiz Question:

Electronic PHI that is encrypted is secured.

***True** or False

Lesson 12: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Your organization is committed to protecting the privacy and security of PHI. And it takes your help! If you have any questions regarding the HIPAA Privacy Rule, HIPAA Security Rule or Breach Notification Rule, contact the appropriate personnel within your organization for guidance and assistance.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. A covered entity must obtain the individual's written authorization to use or disclose:
    a. PHI for treatment, payment, and health care operations.
    b. PHI to the individual who is the subject of the information.
    c. Psychotherapy notes.
    d. PHI for public interest and benefit activities.

2. An individual has the right:
    a. To obtain a copy of or electronic access to their PHI.
    b. To a list of disclosures.
    c. To request an alternative means or location for receiving communications.
    d. To request that a covered entity restrict the use or disclosure to PHI.
    e. All of the above.

3. The Security Rule set up national standards for the protection of an individual's health information that is:
    a. Transmitted in electronic form.
    b. Received in electronic form.
    c. Maintained in electronic form.
    d. All of the above.

4. The HITECH Act:
    a. Addresses the privacy and security concerns associated with the electronic transmission of health information.
    b. Strengthens the enforcement of the HIPAA rules.
    c. Requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured PHI.
    d. All of the above.

5. PHI is an acronym for:
    a. Protected Health Information.
    b. Personal Health Information.
    c. Permitted Health Information.
    d. Primary Health Information.

6. Which of the following is not a protected identifier?
    a. Name.
    b. Favorite color.
    c. Address.

d. Birth date.

7. Individuals must be informed of which of the following:
   a. A breach of unsecured PHI.
   b. The use and disclosure of PHI that is genetic information for underwriting purposes is prohibited.
   c. They may opt-out of fundraising communications.
   d. All of the above.

8. Written authorization is required for:
   a. Uses or disclosures of PHI for marketing purposes.
   b. Sale of PHI.
   c. Disclosure of psychotherapy notes.
   d. All of the above.

Pool 2 (4 or 2 questions)

TRUE/FALSE

9. Hospitals are “covered entities” and therefore must comply with the Privacy Rule.

10. Covered entities must ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain, or transmit.

11. The Office for Civil Rights is responsible for administering and enforcing the HIPAA rules.

12. The Security Rule set up national standards for the use and disclosure of PHI.

13. The HITECH Act was signed into law to promote the adoption and meaningful use of health information technology.

14. Only the Emergency Department must provide a notice of its privacy practices.

15. Covered entities that fail to comply with the HIPAA rules may be subject to civil money penalties.

16. De-identified information is PHI stripped of identifiers in a manner that results in information that is no longer protected by the Privacy Rule.

17. Entities that transport PHI, but do not access, use, or disclose the information are business associates.

18. The use or disclosure of genetic information for underwriting purposes is prohibited.

19. Individual authorization must be received before using PHI for marketing.

20. Individual authorization must be received before the sale of PHI.

Medicare Fraud & Abuse: Prevent, Detect, Report

Slide 1: Title

Medicare Fraud & Abuse: Prevent, Detect, Report

Slide 2: Introduction

The Medicare Fraud & Abuse: Prevent, Detect, Report course is brought to you by the Medicare Learning Network®.

Slide 3: Introduction cont.

Welcome to the Medicare Fraud & Abuse: Prevent, Detect, Report Course!

This course educates health care professionals about how to prevent, detect, and report Medicare fraud & abuse.

Although there is no precise measure of health care fraud, those who exploit Federal health care programs can cost taxpayers billions of dollars while putting beneficiaries' health and welfare at risk. The impact of these losses and risks magnifies as Medicare continues to serve a growing number of beneficiaries.

The Federal government aggressively cracks down on fraud & abuse, but it needs your help. All health care professionals must do their part to prevent fraud & abuse.

Please note: The information in this course focuses on the Medicare FFS Program (also known as Original Medicare). Many of the laws discussed apply to all Federal health care programs (including Medicaid and Medicare Parts C and D). See Job Aid C for information on fraud & abuse in Medicaid and Medicare Parts C & D.

Slide 4: Introduction cont.

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

Slide 5: Introduction cont.

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
- 2,712 Exclusions

NOTE: All statistics cover FY 2018 unless otherwise noted.

Slide 6: Introduction cont.

After completing this course, you should correctly:

- Identify what Medicare considers fraud & abuse
- Identify Medicare fraud & abuse provisions and penalties
- Recognize Medicare fraud & abuse prevention methods
- Recognize entities that detect Medicare fraud & abuse
- Recognize how to report Medicare fraud & abuse

Slide 7: Introduction cont.

This course consists of five lessons:

- Lesson 1: Medicare Fraud & Abuse explains fraud & abuse basics
- Lesson 2: Medicare Fraud & Abuse Laws and Penalties outlines the laws and sanctions used to fight fraud & abuse
- Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors describes methods to prevent Medicare fraud & abuse
- Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies identifies the entities charged with detecting Medicare fraud & abuse
- Lesson 5: Report Suspected Medicare Fraud & Abuse describes how to report suspected Medicare fraud & abuse, how to self-disclose violations, and the rewards available for reporting fraud & abuse

Slide 8: Lesson 1: Medicare Fraud & Abuse

This lesson introduces the basic Medicare fraud & abuse concepts and what you must know to detect it within your organization. Fraud is a crime with serious consequences, including exclusion from Federal health care programs, fines, and prison. It should take about 10 minutes to complete this lesson.

In this lesson, you'll learn about:

- Medicare fraud
- Medicare abuse

This lesson includes Medicare fraud & abuse examples.

In 2018, the Federal government won or negotiated over $2.3 billion in health care fraud judgements and settlements.

Slide 9: Lesson 1: Medicare Fraud & Abuse cont.

After completing this lesson, you should correctly:
- Identify Medicare fraud basics
- Identify Medicare abuse basics
- Recognize Medicare fraud & abuse instances

Slide 10: Lesson 1: Medicare Fraud & Abuse cont.

A Serious Problem Requiring Your Attention

Health care fraud can cost taxpayers billions of dollars. The dollars lost to Medicare fraud & abuse increase the strain on the Medicare Trust Fund. The impact of these losses and risks magnifies as Medicare continues to serve a growing number of people.

Schemes and fraudulent billing practices not only cost taxpayers, they endanger the health and welfare of beneficiaries. For example, dozens of patients got medically unnecessary cardiac pacemakers implanted because of a cardiologist-involved scam. The doctor convinced his patients to get the pacemakers by telling them they would die, even though they had a non-fatal diagnosis. Thanks to anti-fraud efforts and education, law enforcement caught and prosecuted the doctor. He was sentenced to 42 months in prison and ordered to pay over $300,000 in fines and restitution.

Slide 11: Lesson 1: Medicare Fraud & Abuse cont.

To combat fraud & abuse, 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 the Medicare Program.

Click video for more information.

Slide 12: Lesson 1: Medicare Fraud & Abuse cont.

What is Medicare Fraud?

- Knowingly submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain a Federal health care payment (in other words, fraud includes obtaining something of value through misrepresentation or concealment of material facts)

- Knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health services.

Slide 13: Lesson 1: Medicare Fraud & Abuse cont.

Examples of actions that may constitute Medicare fraud include:

- Knowingly billing services not given or supplies not provided, including billing Medicare appointments patients fail to keep
- Knowingly altering claim forms, medical records, or receipts to get a higher payment
- Paying for referrals of Federal health care program beneficiaries

To learn about real cases of Medicare fraud and its consequences, see the case studies in Job Aid A.

Slide 14: Lesson 1: Medicare Fraud & Abuse cont.

Fraud in Practice

Anyone can commit Medicare fraud, including people you know.

Medicare fraud extends beyond medical professionals. Corporations and organized crime networks commit Medicare fraud, unlawfully getting millions of Medicare Program dollars.

A major pharmaceutical manufacturer pled guilty to misbranding and paid $600 million to resolve criminal and civil liability from promoting a certain drug. Part of the settlement resolved allegations the company misled doctors about the drug's safety and success and instructed them to miscode claims to ensure Federal health care payments. The company also allegedly paid doctors kickbacks.

In another case, the government charged 73 defendants when investigators uncovered an organized crime ring's scheme that allegedly involved more than $163 million in fraudulent billings and identity theft impacting thousands of beneficiaries and doctors.

Slide 15: Lesson 1: Medicare Fraud & Abuse cont.

Fraud Examples

A hospital paid $8 million to settle allegations it knowingly kept patients hospitalized, beyond the time considered medically necessary, to increase its Medicare payments and maintain its classification as a long-term acute care facility.

A Durable Medical Equipment (DME) business owner served 70 months in prison and paid $1.9 million in restitution after pleading guilty to conspiracy to commit health care fraud and aggravated identity theft. The DME company owner created several different companies and submitted more than 1,500 false and fraudulent claims to Medicare for unnecessary medical equipment.

An oncologist and his wife paid $3.1 million to resolve allegations they jointly defrauded Medicare and other Federal health care programs by overbilling medications and services and billing medications and services not provided.

A court sentenced a home health provider to 168 months in prison for his role as one of the owners of a home health agency that submitted about $45 million in false claims to Medicare. Almost all his insulin claims billed twice-daily injections to purportedly homebound diabetic patients. The investigation revealed most patients were not homebound or insulin-dependent diabetics.

Slide 16: Lesson 1: Medicare Fraud & Abuse cont.

What is Medicare Abuse?

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice inconsistent with providing patients medically necessary services, meeting professionally recognized standards, and charging fair prices.

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

Slide 17: Lesson 1: Medicare Fraud & Abuse cont.

Examples of actions that may constitute Medicare abuse include:

- Billing unnecessary medical services
- Charging excessively for services or supplies
- Misusing claim codes, such as upcoding or unbundling codes

To learn about real Medicare abuse cases and its consequences, see the case studies in Job Aid B.

Slide 18: Lesson 1: Medicare Fraud & Abuse cont.

Program Integrity

Program Integrity includes a range of activities to target the various causes of improper payments beyond fraud & abuse.

- Mistakes result in errors: such as incorrect coding
- Inefficiencies result in waste: such as ordering excessive diagnostic tests

- Bending the rules results in abuse: such as improper billing practices (like upcoding)
- Intentional deceptions result in fraud: such as billing for services or supplies that were not provided

NOTE: The types of improper payments are examples for educational purposes. Providers who engage in these practices may be subject to administrative, civil, or criminal liability.

Slide 19: Lesson 1: Medicare Fraud & Abuse cont.

Lesson 1: Summary

- Fraud & abuse drain billions of dollars from the Medicare Program each year and put beneficiaries' health and welfare at risk by exposing them to unnecessary services, taking money away from care, and increasing costs.
- Fraud & abuse jeopardize quality health care and services and threaten the integrity of the Medicare Program by fostering the misconception that Medicare means easy money.
- Fraud & abuse cost you as a health care provider and taxpayer. Fraud & abuse result in waste and unintentionally financing criminal activities.
- Fraud includes, but is not limited to, knowingly submitting false statements or making misrepresentations of material facts to get a Federal health care payment for which no entitlement would otherwise exist.
- Abuse describes practices that, either directly or indirectly, result in unnecessary Medicare Program costs.

Slide 20: Lesson 1: Medicare Fraud & Abuse cont.

Review Question 1

If you knowingly submit a false statement of material fact to get a Medicare payment when no entitlement would otherwise exist for someone other than yourself, you did not commit Medicare fraud.

A. True
B. False

Correct Answer – B

Slide 21: Lesson 1: Medicare Fraud & Abuse cont.

Review Question 2

Medicare abuse describes practices that directly or indirectly result in unnecessary Medicare Program costs.

A. True
B. False

Correct Answer – A

Slide 22: Lesson 1: Medicare Fraud & Abuse cont.

Review Question 3

A physician regularly bills Medicare X-rays never provided to beneficiaries. This is considered Medicare _____.

A. Mistakes
B. Inefficiencies
C. Abuse
D. Fraud

Correct Answer – D

Slide 23: Lesson 1: Medicare Fraud & Abuse cont.

You've completed Lesson 1: Medicare Fraud & Abuse

Now that you've learned about Medicare fraud & abuse, let's look at relevant Medicare fraud & abuse laws. Lesson 2 explains provisions and penalties used to fight and punish fraud & abuse and preserve Medicare Program integrity.

Slide 24: Lesson 2: Medicare Fraud & Abuse Laws and Penalties

In this lesson, you'll learn about laws the Centers for Medicare & Medicaid Services (CMS) and its partners use to address fraud & abuse. Knowledge of fraud & abuse laws helps you partner in preventing these activities, which drains billions of dollars from the Medicare Program, endangers its integrity, drives up health care costs, and compromises beneficiary health care services. This lesson should take you about 35 minutes to complete.

In this lesson, you'll learn about:

- Federal laws governing fraud & abuse
- Penalties for fraud & abuse

Slide 25: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

After completing this lesson, you should correctly

- Identify these fraud & abuse Federal laws:
    - Federal Civil False Claims Act (FCA)

    - Anti-Kickback Statute (AKS)
    - Physician Self-Referral Law (Stark Law)
    - Criminal Health Care Fraud Statute
    - Exclusion Statute
    - Civil Monetary Penalties Law (CMPL)
  - Recognize civil and criminal fraud penalties

Use Job Aid F as a resource for the laws discussed in this lesson.

Slide 26: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Medicare Fraud & Abuse Laws

The FCA, AKS, Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statue, Social Security Act, which includes the Exclusion Statute, and CMPL, are the main laws that address Medicare fraud & abuse and specify the criminal, civil, and administrative penalties the government imposes on those committing fraud & abuse. Violations may result in:

- Medicare-paid claims recoupment
- Civil Monetary Penalties (CMPs)
- Exclusion from Federal health care programs participation
- Criminal and civil liability

These laws prohibit Medicare Part C and Part D and Medicaid fraud & abuse.

Let's take a closer look at Medicare fraud & abuse laws.

Slide 27: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

False Claims Act

The FCA (31 United States Code [U.S.C.] Sections 3729-3733) protects the Federal government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal government. The terms "knowing" and "knowingly" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim.

There is also a criminal FCA (18 U.S.C. Section 287) . Criminal penalties for submitting false claims may include prison, fines, or both.

Example: A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than provided.

Click video for more information about the FCA.

Slide 28: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Anti-Kickback Statue

The AKS (42 U.S.C. Section 1320a-7b(b))makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program. Remuneration includes anything of value such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultations.

Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participating in Federal health care programs.

Example: A provider gets cash or below-fair-market-value rent for medical office space in exchange for referrals.

The Code of Federal Regulations (CFR) at 42 CFR Section 1001.952 sets the safe harbor regulations and describes various payments and business practices that may satisfy regulatory requirements and may not violate AKS. Go to the Safe Harbor Regulations webpage for more information.

Click video for more information about the AKS.

Slide 29: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (Stark Law) (42 U.S.C. Section 1395nn) prohibits a physician from referring certain "designated health services“ (for example, clinical laboratory services, physical therapy, and home health services), payable by Medicare or Medicaid, to an entity where the physician (or an immediate family member) has an ownership/investment interest or has a compensation arrangement, unless an exception applies.

Penalties for physicians who violate the Stark Law include fines, repayment of claims, and potential exclusion from participation in Federal health care programs.

Example: 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.

Review the Code List for Certain Designated Health Services (DHS) webpage and request an advisory opinion if you have questions on specific scenarios.

Click video for more information about the Stark Law.

Slide 30: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie about the delivery of, or payment for, health care benefits, items, or services to either:

- Defraud any health care benefit program
- Get (by means of false or fraudulent pretenses, representations, or promises) the money or property owned by, or under the custody or control of, a health care benefit program

Example: Several doctors and medical clinics conspired to defraud the Medicare Program by submitting claims for medically unnecessary power wheelchairs.

Penalties for violating the Criminal Health Care Fraud Statute may include fines, prison, or both.

Now, let's review Medicare fraud & abuse penalties for violating the FCA, AKS, Stark Law, or the Criminal Fraud Statute.

Slide 31: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Medicare Fraud & Abuse Penalties

Beyond paying restitution to CMS for money acquired fraudulently, Medicare fraud & abuse penalties may include exclusions, CMPs, and sometimes criminal sanctions—including fines and prison—against health care providers and suppliers who violate the FCA, AKS, Physician Self- Referral Law (Stark Law), or Criminal Health Care Fraud Statute.

Now, let's look at Medicare Program exclusions and how they affect providers.

Slide 32: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion Statute

The Exclusion Statute (42 U.S.C. Section 1320a-7) requires the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) to exclude health care providers and suppliers convicted of certain offenses from participating in Federal health care programs. OIG may also impose permissive exclusions on several other grounds.

Visit the OIG Exclusions Program webpage for more information.

Click video for more information about the Exclusion Statute.

Slide 33: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion Statute: Referrals

Excluded providers may not participate in Federal health care programs for a designated period but may refer a patient to a non-excluded provider if the excluded provider does not furnish, order, or prescribe services for the referred patient. In this case, the non-excluded provider must treat the patient and independently bill Federal health care programs for items or services provided. Covered items or services from a non-excluded provider to a Federal health care program beneficiary are payable, even when an excluded provider referred the patient.

Slide 34: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Mandatory Exclusion

For certain offenses, the OIG must impose an exclusion. Mandatory exclusions stay in effect for a minimum of 5 years; however, aggravating factors may lead to an even longer or permanent exclusion. Providers and suppliers face mandatory exclusions if convicted of these offenses:

- Medicare or Medicaid fraud and criminal offenses related to the delivery of items or services under a Federal or State health care program
- Criminal offenses related to patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct connected to the delivery of a health care item or service
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances

Slide 35: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Permissive Exclusion

The OIG may impose exclusions for offenses not under a mandatory exclusion. Permissive exclusions vary in length.

The OIG may issue permissive exclusions for various actions.

For a complete list of permissive exclusions, review 42 U.S.C. Section 3120a-7.

Slide 36: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Permissive Exclusion Examples

- Misdemeanor health care fraud convictions other than Medicare or Medicaid fraud

- Misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances
- Revocation, suspension, or health care license surrender for reasons of professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard service
- Convictions for obstructing an investigation or audit
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

Slide 37: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

OIG List of Excluded Individuals/Entities

The OIG List of Excluded Individuals/Entities (LEIE) publicly lists individuals and entities currently excluded from participation in all Federal health care programs. Providers and contracting entities must check the program exclusion status of individuals and entities in the LEIE before entering employment or contractual relationships.

Health care providers that knowingly hire an excluded party are subject to potential FCA liability and CMPs. Medicare will not pay for services by an excluded party, with certain exceptions. Prior to hiring an individual, purchasing supplies, or contracting with an entity (and periodically thereafter), health care providers should use the OIG LEIE to check program exclusion status.

Slide 38: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Search the List of Excluded Individuals/Entities

The LEIE is accessible through a searchable online database. It identifies parties excluded from Medicare reimbursement. The list includes information about the provider's specialty, exclusion type, and exclusion date.

Access the LEIE on the OIG website.

Using the Exclusions Database: Click video for information on searching the LEIE.

Slide 39: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

General Services Administration’s System for Award Management

The General Services Administration (GSA) consolidated several Federal procurement systems into one new system—the 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
- Disqualified from getting Federal contracts or certain subcontracts
- Excluded
- Suspended

OIG compliance guidance encourages health care providers to check the SAM prior to hiring an individual, purchasing durable medical equipment (DME), supplies, or contracting with an entity (and periodically thereafter). Read the GSA fact sheet How do I search for an exclusion? for detailed instructions.

Remember, health care providers should check the LEIE and the SAM before making employment and contract decisions. You cannot get Federal payment or compensation for services provided by individuals and organizations listed on the LEIE and the SAM.

Now, let's look closer at the exclusion payment denial.

Slide 40: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion: Denial of Payment

An OIG exclusion means Federal health care programs do not pay for items or services given, ordered, or prescribed by an excluded individual or entity. Federal health care programs also make no payment to the excluded individual, anyone who employs or contracts with the excluded individual, and a hospital or other provider where the excluded individual provides services.

The exclusion applies regardless of who submits the claims for payment and applies to all administrative and management services given by the excluded individual.

For example, Federal health care programs do not make payment if:

- 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 gets
- The excluded nurse violates their exclusion thereby causing the hospital to submit claims for items or services they provide

During an exclusion period, the excluded individual or entity may face additional penalties for submitting or causing the submission of claims to a Federal health care program. The excluded individual or entity is susceptible to CMP liability as well as reinstatement denial to the Federal health care programs, including Medicare. Exceptions to payment denial apply in specific situations.

Slide 41: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion: Denial of Payment Exceptions

If a beneficiary submits claims for items or services given, ordered, or prescribed by an excluded individual or entity in any capacity after the effective date of the exclusion:

- Medicare pays the first claim submitted by the beneficiary and immediately gives the beneficiary notice of the exclusion
- Medicare makes no payment for the beneficiary items or services given more than 15 days after the date of the notice or after the effective date of the exclusion, whichever is later

The same process applies when labs or DME suppliers submit item or service claims ordered or prescribed by an excluded individual or entity.

There are also exceptions for certain inpatient hospital, skilled nursing facility, home health, and emergency services detailed in the Medicare Program Integrity Manual. Chapter 4, Section 4.19.2.6.

Slide 42: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion: Reinstatement

Reinstating excluded entities and individuals is not automatic once the specified exclusion period ends. Those who want to participate in all Federal health care programs must apply for reinstatement and get authorized notice from the OIG they granted reinstatement. If the OIG denies reinstatement, the excluded party is eligible to re-apply after 1 year.

Now, let's look at CMPs.

Slide 43: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Civil Monetary Penalties

CMPs apply to a variety of health care fraud violations, and assessment of the CMP depends on the type of violation. The CMP authorizes penalties up to $100,000 (in 2018) per violation, and assessments of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received. Violations that justify CMPs include:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or is false and fraudulent
- Violating the AKS
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs

CMP Inflation Adjustment

Each year, the Federal government adjusts all CMPs for inflation. The adjusted amounts apply to civil penalties assessed after August 1, 2016, and violations after November 2, 2015. Refer to 45 CFR 102.3 for the yearly inflation adjustments.

Now, let's look at civil prosecutions and penalties.

Click video for an example of where CMPs applied in a kickback scheme.

Slide 44: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Civil Prosecutions and Penalties

Depending on the severity of the violation, a civil suit or settlement may include any combination of the following:

- A CMP for each item or service in non-compliance (or higher amounts where applicable by statute)
- Payment up to 3 times the amount claimed for each item or service instead of damages sustained by the Federal government
- Exclusion from all Federal health care programs for a specified period
- An OIG Corporate Integrity Agreement (CIA), which requires an individual or entity to carry out a compliance program (including, for example, hiring a compliance officer, developing written standards and policies, carrying out an employee training program, and conducting annual audits and reviews)

In addition to civil prosecutions and penalties, law enforcement may prosecute health care fraud and pursue criminal convictions. Under the Affordable Care Act, the U.S. Sentencing Commission may add offense levels for health care fraud crimes with more than $1 million in losses. It is also a crime to obstruct fraud investigations.

Stay updated on the latest enforcement actions on the OIG Criminal and Civil Enforcement webpage.

Slide 45: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Lesson 2: Summary

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

- FCA: The FCA imposes civil liability on a person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim.

- Anti-Kickback Statute: The AKS prohibits knowingly and willfully offering, paying, soliciting, or getting remuneration in exchange for Federal health care program business referrals.
- Physician Self-Referral Law (Stark Law): The Physician Self-Referral Law (Stark Law) prohibits physicians from referring Medicare beneficiaries for designated health services to an entity where the physician (or an immediate family member) has an ownership/investment interest or a compensation arrangement, unless an exception applies.
- Criminal Health Care Fraud Statute: The Criminal Health Care Fraud Statute 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 to get (by means of false or fraudulent pretenses, representations, or promises) the money or property owned by, or under the custody or control of, a health care benefit program.

Slide 46: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

- Exclusion Statute: The Exclusion Statute 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.
- 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 got.

Providers and contracting entities must check for program exclusion status prior to entering employment or contractual relationships using the OIG LEIE. OIG recommends checking SAM as well.

Civil and criminal prosecutions can result in a variety of fines, exclusion, CIAs, and even prison in criminal cases.

Slide 47: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Review Question 1

The Federal fraud & abuse laws are the False Claims Act (FCA), the Anti-Kickback Statute, the Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statute, Social Security Act, and the Civil Monetary Penalties Law (CMPL).

A. True
B. False

Correct Answer – A

Slide 48: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Review Question 2

Which of the following is NOT a possible penalty for Medicare fraud or abuse?

A. Exclusion from participating in all Federal health care programs
B. Imprisonment in criminal cases
C. Civil Monetary Penalties (CMPs) up to $500,000 per violation

Correct Answer – C

Slide 49: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

You've completed Lesson 2: Medicare Fraud & Abuse Laws and Penalties.

Now that you've learned about Medicare fraud & abuse basic laws and penalties, let's look at preventing Medicare fraud & abuse.

Slide 50: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors

In this lesson, you'll learn how physician relationships with payers, other providers, and vendors can prevent Medicare fraud & abuse. It should take about 15 minutes to complete.

In this lesson, you'll learn about:

- How you can help prevent Medicare fraud & abuse
- How compliance with Medicare laws, regulations, and policies prevent fraud & abuse
- Continuing education available on Medicare laws, regulations, and polices about fraud & abuse prevention

Slide 51: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

After completing this lesson, you should correctly:

- Identify ways your relationships with payers, other providers, and vendors prevent fraud & abuse
- Identify ways to comply with Medicare laws, regulations, and policies to prevent fraud & abuse
- Identify continuing education available on Medicare laws, regulations, and policies

Slide 52: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Relationships with Payers, Other Providers, and Vendors

The U.S. health care system relies on third party payers to pay most medical bills on behalf of patients. These payers understand Federal fraud & abuse laws apply when the government covers items or services provided to Medicare and Medicaid beneficiaries. This lesson focuses on:

- Physician Relationships with Payers
- Physician Relationships with Other Providers
- Physician Relationships with Vendors
- Continuing Medical Education on Medicare laws, regulations, and policies

Slide 53: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

You Can Help Prevent Medicare Fraud & Abuse

As a health care provider, you play a vital role in the fight against Medicare fraud & abuse. Help prevent Medicare fraud & abuse by:

- Checking the List of Excluded Individuals/Entities (LEIE) and System for Award Management (SAM) before making hiring and contracting decisions
- Providing only medically necessary, high quality Medicare beneficiary services
- Accurately coding and billing Medicare services
- Maintaining accurate and complete Medicare beneficiary medical records
- Understanding and complying with the Anti-Kickback Statute and Physician Self-Referral Law (Stark Law) when making investments or doing business with vendors

Slide 54: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Fraud & abuse also exist in Medicare Part C, Part D, and Medicaid, especially involving "dual eligibles."

For more information, see Job Aid C and Job Aid D.

Now let's look at physicians' relationships with payers related to accurate coding, billing, documentation, investments, and physician recruitment.

Click video, which focuses on fraud in Medicare Part D.

Slide 55: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Accurate Coding and Billing

As a physician, payers trust you to provide medically necessary, cost-effective, quality care. When you submit claims for Medicare services, you certify you earned the payment and complied with billing requirements. If you knew, or should have known, you submitted a false claim, this is an illegal attempt to collect payment. Examples of improper claims include:

- Billing codes that reflect a more severe illness than existed or a more expensive treatment than provided
- Billing medically unnecessary services
- Billing services not provided
- Billing services performed by an improperly supervised or unqualified employee
- Billing services performed by an employee excluded from participation in Federal health care programs
- Billing services of such low quality they are virtually worthless
- Billing separately for services already included in a global fee, like billing an Evaluation and Management (E/M) service the day after surgery

Slide 56: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Documentation

Maintain accurate and complete records of the services you provide. Make sure your documentation supports your claims for payment. Good documentation practices help ensure your patients get appropriate care and allow other providers to rely on your records for patients' medical histories.

The Medicare Program may review beneficiaries' medical records. Good documentation helps address any challenges raised about the integrity of your claims. You may have heard the saying regarding malpractice litigation: "If you didn't document it, it's the same as if you didn't do it." The same can be said for Medicare billing.

Slide 57: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Medicare pays for many physician services using E/M codes. These codes identify the level of service and pay new patient codes at a higher level than established patients. Billing an established patient follow-up visit using a higher-level E/M code is upcoding.

Another example of E/M upcoding is misusing modifier -25, which allows additional payment for a significant, separately identifiable E/M service provided on the same day of a procedure or other service. Upcoding occurs when a provider uses modifier -25 to claim payment for a medically unnecessary E/M service, an E/M service not distinctly separate from the procedure provided, or an E/M service not above and beyond the care usually associated with the procedure.

Slide 58: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Investments in Health Care Business Ventures

Some physicians who invest in business ventures with outside parties (for instance, imaging centers, laboratories, equipment vendors, or physical therapy clinics) refer more patients for services provided by those parties than physicians who do not invest. These business relationships may improperly influence or distort physician decision-making and result in improper patient-steering to a therapy or service where a physician has a financial interest.

Excessive and medically unnecessary referrals waste Federal government resources and can expose Medicare beneficiaries to harmful, unnecessary services. Many of these investment relationships have legal risks under the AKS and Stark Law.

If a health care business invites you to invest and might be a place where you would refer your patient, investigate the relationship thoroughly before proceeding.

Slide 59: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Recruitment

Hospitals and other health systems may provide a physician-recruitment incentive to induce providers or practices to join their medical staff. Often, such recruitment efforts fill a legitimate "clinical gap" in a medically underserved area where attracting physicians may be difficult without financial incentives.

Some hospitals, however, may offer incentives which cross the line into an illegal arrangement with legal consequences for the provider and the hospital.

A hospital may pay a provider a fair market-value salary as an employee or pay them a fair market value for specific services they provide to the hospital as an independent contractor. The hospital may not offer money, free or below-market rent for a medical office, or engage in similar activities designed to influence referral decisions.

Now let's look at physician relationships with vendors related to transparency and conflict of interest.

Slide 60: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Relationships with Vendors

Many drug and biologic companies provide free product samples to physicians. It is legal to give these samples to patients free of charge, but it is illegal to sell the samples. The Federal government prosecutes physicians for billing Medicare for free samples. Implement reliable systems to safely store free samples and ensure they remain separate from your commercial stock.

Some pharmaceutical and device companies use sham consulting agreements and other arrangements to buy physician loyalty.

If you have opportunities to work as a consultant for the drug or device industry, evaluate the link between the services you provide and the compensation you get. Test the appropriateness of any proposed relationship by asking yourself:

- Does the company really need your specific expertise or input?
- Does the company's monetary compensation represent a fair, appropriate, and commercially reasonable exchange for your services?
- Is it possible the company is paying for your loyalty, so you prescribe or use its products?

Slide 61: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Federal Open Payments Program

The Federal Open Payments Program is a national disclosure program that promotes health care transparency by making financial relationships between health care providers and drug and medical device companies available to the public. The Open Payments data includes payments and other transfers of value such as gifts, honoraria, consulting fees, research grants, travel reimbursements, and other payments drug or device companies provide to physicians and teaching hospitals. The data also includes ownership and investment interests held by physicians or their immediate family members in reporting entities.

Data from a given year must be reported by drug and device companies by March 31 of the following year. CMS posts Open Payments data on or by June 30 each year. The public data is accessible via the Open Payments Search Tool. CMS closely monitors this process to ensure reported data integrity.

Visit Open Payments for more information.

Slide 62: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Conflict-of-Interest Disclosures

Rules about disclosing and managing conflicts of interest come from a variety of sources, including grant funders, such as States, universities, and the National Institutes

of Health (NIH), and from the U.S. Food and Drug Administration (FDA) when you submit data to support marketing approval for new drugs, devices, or biologics.

If you are uncertain whether a conflict exists, ask yourself if you would want the arrangement to appear in the news.

Slide 63: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Education on Medicare Laws, Regulations, and Policies

The Medicare Learning Network® (MLN) offers a variety of health care training and educational materials explaining Medicare policy. The MLN delivers planned and coordinated provider education through various media, including MLN Matters® Articles, fact sheets and booklets, web-based training courses, videos, and podcasts. Visit the MLN for a list of educational products.

The MLN Provider Compliance webpage contains educational products informing Medicare Fee-For-Service (FFS) Providers how to avoid common Medicare Program billing errors and other improper activities.

The OIG Compliance webpage provides education, compliance guidance, advisory opinions, and training resources.

Medicare Administrative Contractor (MAC) Provider Outreach and Education (POE) Programs offer providers and suppliers education on the fundamentals of the Medicare Program.

Slide 64: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Lesson 3: Summary

You play a vital role in detecting fraud. Your actions can help protect the Medicare Trust Fund. Be sure to review:

- Your relationships with payers related to accurate coding, billing, and documentation
- Your relationships with other providers related to investments and recruitment
- Your relationships with vendors related to transparency and conflict of interest
- Training available related to Medicare laws, regulations, and policies

Slide 65: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Review Question 1

You can help prevent Medicare fraud & abuse by _____.

A. Providing only medically necessary, high quality services to Medicare beneficiaries
B. Properly documenting all services provided to Medicare beneficiaries
C. Correctly billing and coding services provided to Medicare beneficiaries
D. All of the above

Correct Answer – D

Slide 66: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Review Question 2

The Medicare Learning Network provides a variety of _____ for health care professionals.

A. Coding Rules
B. Training and educational products
C. Regulations
D. Enrollment forms

Correct Answer – B

Slide 67: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

You've completed Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors

Now that you've learned how your relationships with payers, other providers, and vendors prevent fraud & abuse, let's look at Medicare anti-fraud partnerships and agencies.

Slide 68: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies

In this lesson, you'll learn about the entities and methods used to detect fraud & abuse. It should take about 15 minutes to complete this lesson.

In this lesson, you will learn about:

- Efforts by the Centers for Medicare & Medicaid Services (CMS) to detect fraud & abuse in the Medicare program
- Data analysis, the Fraud Prevention System (FPS), and the Integrated Data Repository (IDR)
- Entities that conduct pre-payment and/or post-payment claims review to detect Medicare fraud & abuse

- Entities that investigate suspected Medicare fraud & abuse

The return on investment from 2016-2018 was $4.00 for every $1.00 dollar spent on fighting health care fraud & abuse.

Slide 69: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

After completing this lesson, you should correctly:
- Recognize efforts by CMS to detect fraud & abuse in the Medicare program
- Recognize entities conducting pre-payment and/or post-payment claims review
- Recognize entities investigating suspected Medicare fraud & abuse

Slide 70: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Health Care Fraud Prevention Partnership

The Health Care Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership including 132 partners from the Federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations. Their goal is to identify and reduce fraud, waste, and abuse across the health care sector through collaboration, data and information sharing, and cross-payer research studies. The HFPP also performs sophisticated industry-wide analytics to detect and predict fraud schemes.

Slide 71: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

The Centers for Medicare & Medicaid Services

CMS is the Federal agency within the Department of Health and Human Services (HHS) that administers the Medicare and Medicaid programs.

CMS works with individuals, entities, and law enforcement agencies to prevent fraud & abuse including:
- Accreditation Organizations
- Medicare beneficiaries and caregivers
- Physicians, suppliers, and other health care providers
- Office of Inspector General (OIG)
- Federal Bureau of Investigation (FBI)
- Contractors

Let’s review the contractors that assist with CMS efforts to prevent and detect fraud.

Slide 72: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Claim-Reviewing Entities

CMS authorizes several different contractors to conduct pre-payment and/or post-payment review of claims. These include:

- Comprehensive Error Rate Testing (CERT) Contractors
- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractors (UPICs)

If one of these entities contacts you, respond within the specified timeframe and with all requested documentation supporting the claim service(s) medical necessity. This ensures accurate payment of the claim(s) under review and prevents payment recoupment for claims correctly paid. Contact your MAC to find contact information for your review contractors.

Slide 73: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Comprehensive Error Rate Testing Program

The CERT Program produces a national Medicare Fee-For-Service (FFS) error rate. CERT randomly selects a statistically valid, random sample of Medicare FFS claims and reviews those claims' and related medical records' compliance with Medicare coverage, payment, coding, and billing rules.

To accurately measure the MACs' performance and gain insight into error causes, CMS calculates a national Medicare FFS paid claims error rate and an improper payment rate by claim type and publishes the results of these reviews annually.

Slide 74: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

For example, here are the improper payment rate and projected improper payment amounts by claim type for Fiscal Year (FY) 2018. If you see your provider type on this list, refer to Job Aid D for tips on avoiding fraud & abuse.

Service Type	Improper Payment Rate	Improper Payment Amount
Inpatient Hospitals	4.29%	$4.96B
Durable Medical Equipment	35.54%	$2.59B
Physician/Lab/Ambulance	10.68%	$10.47B
Non-Inpatient Hospital Facilities	8.07%	$13.60B
Overall	8.12%	$31.62B

Slide 75: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

CERT Program FFS Improper Payment Rate

The Medicare FFS Improper Payment Rate is a good indicator of how Medicare FFS claims errors impact the Medicare Trust Fund. CMS and MACs educate providers and suppliers on CERT-identified high-risk areas.

For more information, visit the CERT Documentation Contractor website. The CERT Outreach and Education Task Force provides consistent, accurate provider outreach and education to help reduce the improper payment rate.

Slide 76: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Medicare Administrative Contractors

CMS, MACs, and other claim review contractors identify suspected billing problems through error rates produced by the CERT Program, vulnerabilities identified through the Recovery Audit Program, analysis of claims data, and evaluation of other information (for example, complaints).

CMS, MACs, and other claim review contractors target Medical Review (MR) activities on problem areas based on the severity of the problem. The SMRC conducts nationwide MR as directed by CMS. This includes identifying underpayments and overpayments.

MR may occur before or after the MAC makes a payment on the claim. MACs may review one or multiple claims at the same time.

Some providers may go through probed reviews or placed on Progressive Corrective Action (PCA) plans depending on the extent of their billing errors.

Slide 77: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Medicare FFS Recovery Audit Program

Medicare FFS Recovery Audit Contractors (RACs) conduct post-payment claim reviews to detect improper underpayments and overpayments. RACs may target claim reviews by service. Each RAC website publishes its targeted services. Visit the Recovery Audit Program webpage for more information, including Medicare Parts A and B Recovery Auditors contact information.

Also review the Quarterly Provider Compliance Newsletter for common Medicare FFS Recovery Audit and CERT findings and tips for avoiding issues.

Slide 78: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Parts C and D Recovery Audit Program

CMS created the Parts C and D Recovery Audit Program to identify and correct past improper payments to Medicare providers. CMS also implemented procedures to help MACs prevent future improper payments. Communication about audit results and trends leads to continuous process improvement, more accurate payments, and helps plan sponsors correct issues in a timely manner.

CMS designated one Recovery Auditor to review payments for Medicare Part D. CMS will start the Recovery Audit Program for Medicare Part C payments in the future. Visit the Parts C and D Recovery Audit Program webpage for more information.

Now that you've learned about the entities that review claims, let's discuss entities that provide analytical support to CMS to detect fraud & abuse activities.

Slide 79: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Analytical Entities

Within CMS, the Center for Program Integrity (CPI) promotes Medicare integrity through audits, policy reviews, and identifying and monitoring program vulnerabilities. CPI oversees CMS' collaboration with key stakeholders on detecting, deterring, monitoring, and combating fraud & abuse issues.

In 2010, HHS and CMS launched the Fraud Prevention System (FPS), a state of-the-art predictive analytics technology that runs Medicare FFS claims predictive algorithms and other analytics prior to payment to detect potentially suspicious claims and patterns that may constitute fraud & abuse.

Slide 80: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Fraud Prevention System

The FPS uses sophisticated analytics to prevent and detect fraud & abuse in the Medicare FFS Program. It provides a comprehensive view of Medicare FFS provider and beneficiary activities to identify and analyze provider networks, billing patterns, beneficiary usage patterns, and patterns representing a high risk of fraudulent activity.

The FPS is fully integrated with the Medicare FFS claims processing system and uses other data sources, such as the Integrated Data Repository (IDR).

Slide 81: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Examples of these fraudulent activities:

- A home health agency in Florida billed services never provided. Due to the FPS, CMS placed the home health agency on pre-payment review and payment suspension, referred the agency to law enforcement, and ultimately revoked the agency's Medicare enrollment.
- In Texas, the FPS identified an ambulance company submitting claims for non-covered services and services not given. Medicare revoked the ambulance company's enrollment.
- The FPS identified an Arizona medical clinic with questionable billing practices, such as billing excessive units of service per beneficiary per visit. The physicians delivered repeated and unnecessary neuropathy treatments to beneficiaries. CMS revoked the medical clinic's Medicare enrollment.

Slide 82: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Integrated Data Repository

The IDR creates an integrated data environment from Medicare and Medicaid claims, beneficiaries, providers, Medicare Advantage (MA) plans, Part D Prescription Drug Events (PDEs), and other data.

The IDR provides greater information sharing, broader and easier access, enhanced data integration, increased security and privacy, and strengthened query and analytic capability by building a unified data repository for reporting and analytics.

Now let's review the entities that help CMS investigate fraud & abuse activities.

Slide 83: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Investigating Entities

The following entities review claims and more extensively investigate specific health care providers:

- Unified Program Integrity Contractors (UPICs)
- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Federal Bureau of Investigation (FBI)

These entities work with the claim reviewing entities and CMS to protect the Medicare Program against fraud & abuse.

Medicare Advantage (MA) plans also investigate Medicare Part C fraud & abuse. Prescription Drug Plans (PDPs) investigate Medicare Part D fraud & abuse. Medicare Drug Integrity Contractors (MEDICs) investigate Medicare Part C and Part D fraud & abuse.

Slide 84: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Unified Program Integrity Contractors

UPICs identify suspected fraud & abuse cases and refer them to the OIG. UPICs may also act to minimize potential losses to the Medicare Trust Fund and protect Medicare beneficiaries from potential adverse effects. Appropriate action varies from case to case. For example, when a provider's employee files a complaint, the UPIC immediately advises the OIG.

For more information, go to the Medicare Program Integrity Manual. Chapter 4.

Slide 85: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Office of Inspector General

The OIG protects the integrity of HHS programs, including Medicare, and the health and welfare of its beneficiaries. The OIG carries out its duties through a nationwide network of audits, investigations, inspections, and other related functions. The OIG can exclude individuals and entities who engaged in fraud or abuse from participation in all Federal

health care programs and impose Civil Monetary Penalties (CMPs) for certain Federal health care program misconduct.

Click video for a snapshot of the OIG's work.

Slide 86: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Department of Justice

The DOJ investigates and prosecutes fraud & abuse in Federal government programs. The DOJ's investigators partner with the OIG; the FBI; and other Federal, State, and local law enforcement offices through HEAT to investigate and prosecute Medicare fraud & abuse. DOJ attorneys, through the U.S. Attorney's Offices, handle the civil and criminal prosecutions.

Slide 87: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Health Care Fraud Prevention and Enforcement Action Team

The DOJ and HHS established HEAT to build and strengthen existing programs to combat Medicare fraud while investing new resources and technology to prevent fraud & abuse. HEAT investigators use new state-of-the-art technology to fight fraud with unprecedented speed and efficiency.

Slide 88: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Medicare Fraud Strike Force

The DOJ-HHS Medicare Fraud Strike Force also fights fraud. Each Medicare Fraud Strike Force team combines the FBI's investigative and analytical resources with HHS-OIG's Criminal Division's Fraud Section and the U.S. Attorney's Offices prosecutorial resources.

Strike Force Statistics since Inception:

- Cases Filed: 1,750
- Defendants Charged: 3,800
- Defendants Billed Medicare: $15 billion

Slide 89: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Lesson 4: Summary

- Medicare fraud & abuse data helps guide claims reviewers and investigators to high-risk fraud & abuse areas.
- MACs and UPICs conduct pre-payment claims reviews.
- MACs, the SMRC, UPICs, CERT Contractors, and RAC Auditors conduct post-payment claims reviews.
- UPICs, OIG, DOJ, and HEAT investigate Medicare fraud & abuse.

Slide 90: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Review Question 1

Which of the following entities conduct claims Medical Review (MR)?

A. Medicare Administrative Contractors (MACs)
B. Comprehensive Error Rate Testing (CERT) Contractors
C. Recovery Audit Program Recovery Auditors
D. All of the above

Correct Answer – D

Slide 91: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Review Question 2

Which of the following entities investigate health care providers suspected of Medicare fraud & abuse?

A. Office of Inspector General (OIG)
B. Department of Justice (DOJ)
C. Unified Program Integrity Contractors (UPICs)
D. B and C
E. A, B, and C

Correct Answer – E

Slide 92: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

You've completed Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies

Now that you've learned about the basic concepts of Medicare fraud & abuse detection, let's look at how to report Medicare fraud & abuse.

Slide 93: Lesson 5: Report Suspected Medicare Fraud & Abuse

In this lesson, you'll learn about reporting fraud & abuse. It should take about 5 minutes to complete. In this lesson, you'll learn about:

- How you can report suspected Medicare fraud & abuse
- How you can self-disclose Medicare fraud & abuse
- The Medicare Incentive Reward Program (IRP)

Slide 94: Lesson 5: Report Suspected Medicare Fraud & Abuse

After completing this lesson, you should correctly:

- Recognize how to report suspected Medicare fraud & abuse
- Recognize how to self-disclose Medicare fraud & abuse

Slide 95: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

How to Report Suspected Medicare Fraud & Abuse: IOG

The Office of Inspector General (OIG) maintains a hotline and webpage that accepts and reviews tips from all sources, such as Medicare and Medicaid beneficiaries and providers. You can report suspected fraud & abuse anonymously by phone (OIG Hotline), email, fax, mail, and on the OIG website. The OIG collects no information that could trace the complaint to you; however, lack of contact information may prevent a comprehensive review of the complaint. OIG encourages you to provide contact information for follow-up.

Use Job Aid E to report fraud & abuse to the appropriate authorities.

Click video for a snapshot of the OIG's work.

Slide 96: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

How to Report Suspected Medicare Fraud & Abuse: MAC

For questions about Medicare billing procedures, billing errors, or questionable billing practices, contact your Medicare Administrative Contractor (MAC).

Slide 97: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

What to do if you Suspect you have Problematic Relationships or Inappropriate Billing Practices:

- Stop submitting problematic bills
- Seek legal counsel
- Determine money collected in error from patients and from Federal health care programs and report and return refunds
- Cease involvement in a problematic investment

- Get out of the problematic relationship(s)
- Consider self-disclosing the issues

Slide 98: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

How to Self-Disclose Medicare Fraud & Abuse to the OIG

Providers who wish to voluntarily disclose evidence of potential fraud, where it may trigger Civil Monetary Penalties (CMPs), may do so under the OIG Provider Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to minimize the costs and disruptions associated with a government-directed investigation and civil or administrative litigation.

The OIG works cooperatively with forthcoming, thorough, and transparent providers in their disclosures to resolve these matters. While the OIG does not speak for the Department of Justice (DOJ) or other agencies, the OIG consults with these agencies, as appropriate, regarding SDP issues resolution.

Visit the OIG Self-Disclosure Information webpage for more information or to complete your self-disclosure online.

Slide 99: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

How to Self-Disclose Actual or Potential Violations of the Physician Self-Referral Law (Stark Law)

For Physician Self-Referral Law (Stark Law) actual or potential violations, Centers for Medicare & Medicaid Services (CMS) Self-Referral Disclosure Protocol (SRDP) allows health care providers and suppliers to self-disclose them through a separate OIG process.

The physician cannot use the SRDP to get a CMS determination as to whether an actual or potential violation of the Physician Self-Referral Law (Stark Law) occurred. Providers and suppliers should submit their overpayment liability exposure to the SRDP to resolve the conduct they identify.

Under certain circumstances, CMS can reduce the amount due. However, fraud & abuse self-disclosure does not protect health care providers from sanctions and prosecutions.

Slide 100: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

Medicare Incentive Reward Program

CMS established the Medicare IRP to encourage reporting suspected fraud & abuse.

The IRP rewards information on Medicare fraud & abuse or other punishable activities. The information must lead to a minimum Medicare recovery of $100 from individuals and entities CMS determines committed fraud.

For more information, go to the Medicare Program Integrity Manual, Chapter 4, Section 4.9.

Slide 101: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

Lesson 5: Summary

You may report suspected Medicare fraud & abuse by phone, email, fax, mail, and on the OIG website.

You may self-disclose fraud & abuse to the OIG using the Provider SDP. You may self-disclose actual or potential violations of the Physician Self-Referral Law (Stark Law) to CMS using the Medicare SRDP.

The Medicare IRP provides rewards for Medicare fraud & abuse information or other punishable activities.

Slide 102: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

Review Question 1

You may report suspected fraud & abuse anonymously by phone, email, fax, mail, and on the Office of Inspector General (OIG) website.

A. True
B. False

Correct Answer – A

Slide 103: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

Review Question 2

Health care providers who self-disclose fraud & abuse violations are protected from sanctions and prosecutions.

A. True
B. False

Correct Answer – B

Slide 104: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

You've completed Lesson 5: Report Suspected Medicare Fraud & Abuse.

Next you will be presented with the Job Aids mentioned throughout the course. Then you will be given a brief 10 question Post-Test to assess your knowledge. The Post-Test should take about 10 minutes.

Successfully completing the course includes finishing all lessons and scoring 70 percent or higher on the Post-Test.

Slide 105: Job Aids

Job Aid A

Case Examples of Medicare Fraud

To learn about more real Medicare fraud & abuse cases and their consequences, visit the Office of Inspector General (OIG) Criminal and Civil Enforcement webpage.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier

Violation of the Anti-Kickback Statute: A Durable Medical Equipment supplier paid $30 million and entered a Corporate Integrity Agreement (CIA) to settle allegations they paid illegal kickbacks to induce spinal surgeons to use the company's products. A subsidiary of the DME supplier paid kickbacks to spinal surgeons through sham consulting agreements, sham royalty arrangements, sham research grants, travel, and entertainment.

Home Health Agency (HHA)

Violation of the Criminal Health Care Fraud Conspiracy Statute and the Anti-Kickback Statute: Nine defendants got a combined 16 years and 2 months in prison and paid more than $5.8 million in restitution for their roles in an HHA fraud scheme. The president of the HHA and co-conspirators allegedly offered and paid kickbacks and bribes to patient recruiters in return for referring beneficiaries to the HHA to serve as patients. Beneficiaries also got kickbacks for agreeing to serve as HHA patients. The HHA received $9.5 million in reimbursements from these false claims.

Hospital or Other Health Care Facilities

Violation of the Civil False Claims Act (FCA): A clinic paid $656,000 to resolve allegations it violated the FCA and overcharged Medicare. The clinic allegedly performed certain blood tests (lipid panel tests and a cholesterol test) without any intervening review to determine the medical necessity of the second test.

Violation of the Physician Self-Referral Law (Stark Law): A hospital executive director personally paid $64,000 for allegedly causing Medicare Claims submission in violation of the Physician Self-Referral Law (Stark Law). During the relevant time, the hospital

executive director also served as the hospital's compliance officer and the court found him personally liable for the hospital's alleged violations.

Exclusion Statute and Civil Monetary Penalties Law: A long-term care facility paid $170,000 for allegedly violating the Civil Monetary Penalties Law by employing an individual the facility knew or should have known was excluded from Federal health care programs participation.

Exclusion Statute and Civil Monetary Penalties Law: Two hospitals paid $243,819 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged the hospitals knew or should have known they employed five individuals excluded from Federal health care programs participation.

Pharmacist/Pharmacy

Exclusion Statute and Civil Monetary Penalties (CMP) Law: A national drugstore chain paid nearly $1 million to settle allegations it billed Federal health care programs for prescriptions filled by an excluded pharmacist. For nearly 4 years, two stores allegedly submitted Medicare and TRICARE claims for medications filled by a pharmacist listed on the Federal health care programs List of Excluded Individuals/Entities (LEIE). The $969,230 settlement represented a recovery of double damages for all claims paid by Medicare and TRICARE for prescriptions the pharmacist filled at the stores.

Physical Therapist

Fraudulent Billing and the CMP Law: A physical therapist paid $122,474 for allegedly violating the CMP Law when the therapist improperly billed Medicare for physical therapy services not properly supervised by a licensed physical therapist.

Physicians

Violation of the Anti-Kickback Statute: A doctor pled guilty and got a prison sentence for accepting cash kickbacks for beneficiary information used to submit Medicare and Medicaid DME claims.

Violation of the Physician Self-Referral Law (Stark Law): A physician paid the Federal government $203,000 to settle allegations he violated the physician self-referral prohibition in the Physician Self-Referral Law (Stark Law) by routinely referring Medicare beneficiaries to an oxygen supply company he owned.

Exclusion Statute: A physician paid $65,000 and got a Notice of Exclusion barring the physician's participation in all Federal health care programs for 3 years. The physician solicited and got consulting payments from a medical device manufacturer for using the manufacturer's orthopedic hip and knee products.

CMP Law: A doctor paid $650,000 for allegedly violating the CMP Law provisions applicable to kickbacks. The doctor allegedly solicited and got consulting payments from two medical device manufacturers for using their orthopedic hip and knee products.

Fraudulent Billing: A psychiatrist paid a $400,000 fine and was permanently excluded from Federal health care programs participation. The psychiatrist misrepresented his 15 minutes or less medication checks as 30- 60 minutes of patient face-to-face therapy sessions. The psychiatrist also misrepresented he provided therapy sessions when a non-licensed individual conducted the sessions.

Misuse of Provider and Prescription Numbers: A physician paid $50,000 in restitution to the Federal government. On his provider number application, the physician falsely indicated he ran his own practice when, in fact, a neurophysiologist owned and operated the practice and paid the physician's salary.

Liability Resolved Under OIG Provider Self-Disclosure Protocol: A neurosurgery practice paid $10,000 to resolve liability for employing an individual excluded from Federal health care programs participation.

Job Aid B

Case Examples of Medicare Abuse

To learn about more real Medicare fraud & abuse cases and their consequences, visit the Office of Inspector General (OIG) Criminal and Civil Enforcement webpage.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier

Medically Unnecessary Services: A DMEPOS supplier got a Group 2 standard power wheelchair $5,049 payment. The power wheelchair documentation did not support medical necessity according to the applicable National Coverage Determination (NCD) and Local Coverage Determination (LCD). Neither the diagnoses nor the face-to-face physician's evaluation supported the inability to self-propel. The DMEPOS supplier provided no other valid documentation why a power mobility device was reasonable and necessary. Medicare recouped the entire payment.

Medically Unnecessary Services: A DMEPOS supplier got $231 monthly payments for an oxygen concentrator and a portable gaseous unit. When asked for supporting documentation, the supplier provided an incomplete Certificate of Medical Necessity (CMN) dated 4 months after the claim's adjudication date. On the CMN, no responses appeared for the following inquiries: (1) the results of the oxygen saturation test, (2) whether the beneficiary was an inpatient during testing, and (3) the oxygen-flow rate. This record did not meet the LCD for oxygen and oxygen equipment medical necessity criteria. Medicare recouped the entire payment.

Hospital or Other Health Care Facilities

No Documentation: A provider received a $520 payment for a colonoscopy. After reviewers made several attempts to get the record, the provider sent a letter that stated, "Patient was not seen on this date of service." The Medicare Administrative Contractor (MAC) recouped the entire payment.

Insufficient Documentation: A hospital got an inpatient hospital stay $2,767 payment. After reviewers made multiple attempts to get the documentation, the hospital submitted an initial history and physical, and a brief discharge summary. Insufficient documentation did not support the services billed. The recouped the entire payment.

Medically Unnecessary Services: A provider got a $146 payment for outpatient diagnostic tests. Repeated requests for evidence showing the treating physician's intent to order the specific diagnostic tests did not support medical necessity. Medicare recouped the entire payment.

Medically Unnecessary Services: A hospital received a 1-day inpatient $4,699 hospital stay payment. The hospital admitted the beneficiary with abdominal pain and hospitalized the patient for less than 12 hours. The beneficiary failed to meet inpatient admission medical necessity criteria. The hospital, however, could have treated the beneficiary on an outpatient observation status. The MAC recouped the entire payment.

Incorrect Coding: A provider got a transthoracic echocardiography with contrast, with real time exercise stress test $741 payment. Documentation of the transthoracic echocardiography revealed the provider performed the diagnostic study without using contrast material. This coding error resulted in a $14 provider overpayment. Medicare recouped it.

Hospital or Other Health Care

Violation of the Civil False Claims Act (FCA): A clinic paid $656,000 to resolve allegations it violated the FCA and overcharged Medicare. The clinic allegedly performed certain blood tests (lipid panel tests and a cholesterol test) without any intervening review to determine the medical necessity of the second test.

Violation of the Physician Self-Referral Law (Stark Law): A hospital executive director personally paid $64,000 for allegedly causing Medicare Claims submission in violation of the Physician Self-Referral Law (Stark Law). During the relevant time, the hospital executive director also served as the hospital's compliance officer and the court found him personally liable for the hospital's alleged violations.

Exclusion Statute and Civil Monetary Penalties Law: A long-term care facility paid $170,000 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged the hospitals knew or should have known they employed five individuals excluded from Federal health care programs participation.

Physical Therapist

Insufficient Documentation: A MAC paid $136 for physical therapy visits. The physical therapy records included no order, ordering physician-signed plan of care, or treatment notes. The MAC recouped the entire payment.

Physician

No Documentation: A physician got a $183 hospital visit payment. After multiple attempts to get the record, the physician sent a letter that stated, "No record for time period found." The MAC recouped the entire payment.

Job Aid C

Fraud & Abuse in Medicare Part C and Part D, and Medicaid

Medicare Part C

Medicare Part C, or Medicare Advantage (MA), is a Medicare beneficiary health plan choice. MA is 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.

MA plans must cover all services Medicare covers except hospice care. MA plans provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Medicare Part D

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Insurance companies or other Medicare-approved companies provide prescription drug coverage to individuals who live in a plan's service area.

Fraud, Waste, and Abuse in Medicare Part C and Part D

Medicare Part C and Part D contractors and plans play a vital part in preventing, detecting, and reporting Medicare fraud & abuse. MA plans and PDPs must follow certain requirements and report suspected fraud & abuse. Part C and Part D contractors must have an effective compliance program that includes measures to prevent, detect, and correct Medicare non-compliance, fraud, and abuse. Contractors also must have effective fraud & abuse training.

Medicare Part C and Part D Indicators of Fraud & Abuse

The following details types of entities and the key indicators for each:

Beneficiary

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

Provider

- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Are the provider's prescriptions appropriate for the beneficiary's health condition (medically necessary)?
- Is the provider prescribing a higher quantity of medication than the medically necessary amount for the condition?
- Is the provider giving medically unnecessary beneficiary services?
- Is the provider's beneficiary diagnosis supported in the medical record?
- Does the provider bill the MA plan or PDP sponsor for services not provided?

Pharmacy

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are prescriptions altered (changing quantities or Dispense As Written [DAW])?
- Are proper provisions made if the pharmacist cannot fill the entire prescription (no additional dispensing fees for split prescriptions)?
- Are generic drugs provided when the prescription requires brand name drugs?
- Are Pharmacy Benefit Managers (PBM) getting bills for prescriptions not filled or picked up?
- Are drugs diverted? (Are drugs meant for nursing homes, hospices, and other entities sent elsewhere?)

Wholesaler

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

Manufacturer

- Does the manufacturer promote off-label drug use?
- Does the manufacturer provide samples, knowing the entity bills them to a Federal health care program?

MA Plan/PDP Sponsor

- Does the sponsor have an easily accessible employee and beneficiary plan to report potential fraud, abuse, or other misconduct?
- Does the sponsor provide Medicare Part C and Part D fraud & abuse fliers, letters, and Explanations of Benefits (EOBs) beneficiary education?
- Does the sponsor accept anonymous and confidential reports? (MA plans and PDPs cannot retaliate against those who report potential misconduct.)
- Does the sponsor promptly respond to and correct potential or actual fraud & abuse? (The MA or PDP compliance officer must engage in this process to ensure appropriate documentation and fraud & abuse investigations tracking, including the investigations and corrective actions.)
- Does the sponsor offer beneficiary cash inducements to join the plan?
- Does the sponsor lead the beneficiary to believe the cost of benefits is one price, only for the beneficiary to find out the actual cost exceeds that price?
- Does the sponsor use unlicensed agents?
- Does the sponsor encourage/support inappropriate risk adjustment submissions?

Medicaid

Medicaid is a joint Federal and State health care program that helps some people with low incomes and limited resources with medical costs. Medicaid programs vary from state to state. The term “dual eligibles" refers to individuals entitled to, or enrolled in, Medicare Part A or Part B, and eligible for Medicaid. Federal and the respective state fraud & abuse laws apply to the Medicaid Program and protect Medicaid beneficiaries and dual eligibles.

Go to the Medicaid Program Integrity Education webpage for toolkits and resources.

Medicaid Indicators of Fraud & Abuse

There Are Many Types of Medicaid Fraud describes various fraud indicators using provider and beneficiary examples.

Report Suspected Fraud & Abuse

MA plans and PDPs cannot retaliate against those who report potential misconduct. To report suspected fraud & abuse to the Office of Inspector General (OIG), use the contact information below:

Forms.OIG.HHS.gov/HotlineOperations/index.aspx
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
Mail: U.S. Department of Health and Human Services
Attn: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026

Additionally, Medicaid beneficiaries and providers may contact their Medicaid State Agency: the National Association of Medicaid Fraud Control Units (NAMFCU) lists State Medicaid Fraud Control Units.

Medicare beneficiaries may call 1-877-7SafeRx (1-877-772-3379) or 1-800-MEDICARE (1-800-633-4227) for Medicare Managed Care or Prescription Drug Plan options.

Job Aid D

Tips for Avoiding Medicare Fraud & Abuse

To help you prevent Medicare fraud & abuse, these tips on vulnerabilities appear according to provider type. For additional guidance on compliance, visit the OIG Compliance webpage. For additional guidance on recognizing fraud & abuse, visit the CMS Fraud Prevention Toolkit webpage.

All Provider Types Vulnerabilities

- All Services
  - Tips

    The Office of Inspector General (OIG) "spotlights" certain services vulnerable to fraud & abuse and all recent material added to the website, including the latest reports, advisory opinions, enforcement actions, and other OIG news, in one easy-to-access spot.

  - Resources

    OIG Eye on Oversight
    OIG What’s New

- Computed Tomography (CT) Scans
  - Tips

    Check the order from the ordering practitioner to make sure it is signed and keep a copy. Document a performed CT scan in your medical record.

    Keep a copy of the CT scan radiologist report or interpreting physician.

    If you get a documentation request from a claim review contractor, submit:
    - The order
    - The ordering practitioner's progress notes

        - The medical record entry
        - The interpreting physician's CT scan report

    - Resources
      Medicare Imaging Services Coverage

- Evaluation and Management (E/M) Services
    - Tips

      Ensure you bill the correct service code level provided.

      Correctly use the appropriate pulmonary diagnostic, therapeutic, or monitoring procedures modifier on the same date of an E/M service.

      Follow payment guidelines for E/M services provided during the global surgery period. Correctly bill for services provided to patients in swing beds.

    - Resources

      Evaluation and Management Services Guide

      Global Surgery

      Swing Bed Services

- Signature Requirements
    - Tips

      Ensure the ordering practitioner authenticates services ordered or provided and adequately documented.

      Ensure handwritten or electronic (stamped signatures are only allowed for limited exceptions) signatures.

      Ensure legible signatures.

    - Resources

      Complying with Medicare Signature Requirements

      Complying with Documentation Requirements for Laboratory Services

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Vulnerabilities

- Diabetes Supplies
  - Tips

    Ensure the physician signs and dates the glucose testing supplies order describing the dispensed items.

    Ensure the medical record contains the beneficiary's test log results or other documentation (such as, diagnosis and treatment regimen) supporting frequency.

    Ensure documentation reflects the reason the beneficiary is testing above policy limits.

    Ensure you document the beneficiary's diagnosis.

    Medicare policy states the supply allowance for supplies used with a therapeutic CGM system encompasses all items necessary for the use of the device and includes, but is not limited to: CGM sensor, CGM transmitter, home BGM, related BGM supplies (test strips, lancets, lancing device, calibration solutions) and batteries. Supplies or accessories billed separately will be denied as unbundling.

  - Resources

    Provider Compliance Tips for Diabetic Test Strips

    Provider Compliance Tips for Glucose Monitors

    Recovery Auditor Finding: Blood Glucose Monitor Device Bundling

- Parenteral Nutrition
  - Tips

    Document the reason enteral nutrition is needed.

    Document the reason the parenteral nutrition is needed.

    Verify the physician wrote a detailed enteral nutrition and pump order, signed and dated by the treating physician, and available upon request.

  - Resources

    Provider Compliance Tips for Parenteral Nutrition

- Infusion Pumps, Accessories, and Drugs
  - Tips

Ensure billing staff know the billing infusion pumps, accessories, and drugs requirements.

- Resources

  MLN Matters Special Edition Article SE1609, Medicare Policy Clarified for Prolonged Drug and Biological Infusions Started Incident to a Physician's Service Using an External Pump

- Nebulizers and Related Drugs
  - Tips

    Medicare requires that claims for nebulizer machines and related drugs be reasonable and necessary. Local Coverage Determinations issued by Medicare contractors that process Durable Medical Equipment (DME) and supply claims, include utilization guidelines and documentation requirements.

  - Resources

    Provider Compliance Tips for Nebulizers and Related Drugs

- Oxygen Therapy Supplies
  - Tips

    Ensure physician visit or evaluation documentation before the initial or recertification date. Ensure the original blood, gas, or saturation test results documentation.

    Ensure documentation indicates beneficiary oxygen needs and home uses.

    Ensure documentation shows continued equipment need or use.

    For portable oxygen, ensure documentation demonstrates the beneficiary is mobile within the home.

  - Resources

    Provider Compliance Tips for Ordering Oxygen Supplies and Equipment

- Positive Airway Pressure (PAP) Devices
  - Tips

Ensure documentation exists of the treating physician's initial face-to-face clinical evaluation conducted before the sleep study to assess Obstructive Sleep Apnea (OSA).

Ensure Medicare-covered sleep study documentation supporting PAP device medical necessity.

Ensure the treating physician signs and dates the order describing the dispensed items.

Ensure the treating physician's face-to-face re-evaluation documentation within the proper time frame.

- Resources

Provider Compliance Tips for Positive Airway Pressure (PAP) Devices and Accessories Including Continuous Positive Airway Pressure (CPAP)

- Power Mobility Devices (PMDs)
  - Tips

Ensure you correctly document PMDs and medical necessity.

  - Resources

Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements

Inclusion of Power Mobility Device Codes in the Prior Authorization Program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items

Inpatient and Outpatient Provider Vulnerabilities

- Cardiac Pacemakers
  - Tips

For dual-chamber pacemakers, ensure documentation supports the medical need for a dual-chamber pacemaker rather than a single-chamber pacemaker.

Ensure beneficiaries identified for dual-chamber pacemakers do not have a clear contraindication, such as chronic atrial fibrillation.

- Resources

  Medicare Billing for Cardiac Device Credits

- Hospice Care
  - Tips

    Ensure all Medicare coverage requirements are met, including plan-of-care guidelines.

    Bill hospice patient services appropriately.

  - Resources

    Provider Compliance Tips for Hospital Based Hospice

    Hospice Payment System

- Inpatient Hospital Services
  - Tips

    Ensure inpatient admissions are medically necessary, reasonable, and appropriate for the beneficiary's diagnosis and condition at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the medical care and must get services of such intensity that they can be given safely and effectively only on an inpatient basis.

    Ensure the claim diagnosis codes are correct by waiting to assign diagnosis codes until you have the complete medical record.

    Appropriately bill pre-admission diagnostic testing services.

  - Resources

    Comprehensive Error Rate Testing (Cert): Observation And Inpatient Hospital Care

    Recovery Auditor Finding – A Reminder: Durable Medical Equipment (DME) Suppliers Billing For DME For Beneficiaries In A Medicare Inpatient Stay

    Guidance for Medicare Administrative Contractors (MACs) Processing Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIO) Two-Midnight (2MN) Short Stay Review (SSR) Determinations

- Inpatient Rehabilitation Services
  - Tips

    Ensure properly documented and coded services.

    Ensure appropriate, complete, and legible.

  - Resources

    Provider Compliance Tips for Inpatient Rehabilitation Facility (IRF) – Inpatient

    Rehabilitation Hospitals and Inpatient Rehabilitation Units

- Laboratory Services
  - Tips

    Ensure the treating physician orders all diagnostic X-ray tests, diagnostic lab tests, and other diagnostic tests.

    In progress notes, clearly indicate all ordered tests.

  - Resources

    Complying with Documentation Requirement for Laboratory Services

- Outpatient Rehabilitation Therapy Services
  - Tips

    Ensure the plan of care is completed.

    Ensure appropriate, present, complete, legible, and dated signatures. Ensure documented modality times.

    Ensure completed plan of care certifications and recertifications.

  - Resources

    Therapy Services

- Outpatient Services
  - Tips

    Include the appropriate billing for multiple diagnostic services on the same day modifier.

Ensure you bill the correct services or procedures code.

Ensure you bill the correct number of units.

Ensure you properly document all services and procedures.

- Resources

Provider Compliance Tips For Ordering Hospital Outpatient Services

- Skilled Nursing Facilities (SNF)
  - Tips

Ensure your services meet quality of care requirements.

Provide adequate discharge planning.

  - Resources

SNF Billing Reference

Provider Compliance Tips For Ordering Hospital Outpatient Services

Physician Vulnerabilities

- All Physician Services
  - Tips

Ensure Federal law compliance that combat fraud & abuse.

Ensure you provide beneficiaries appropriate quality medical care.

Ensure you can identify "red flags" that could lead to potential law enforcement liability and administrative actions.

  - Resources

Medicare Fraud & Abuse: Prevent, Detect, Report

- Chiropractic
  - Tips

Ensure you properly code and bill maintenance therapy.

Ensure you properly and correctly document services.

- Resources

  Chiropractic Services

  Medicare Documentation Job Aid for Doctors of Chiropractic

- Correct Coding
  - Tips

    Ensure you correctly code the Place of Service (POS)

    Ensure you do not upcode services (services billed at a higher reimbursement level than the beneficiary service provided).

  - Resources

    Proper Coding for Specimen Validity Testing Billed in Combination with Drug Testing

- Open Payments
  - Tips

    Voluntarily track payments and value transfers made to you by pharmaceutical and medical device manufacturers, and be aware these value/payments and ownerships investment interests in pharmaceutical, medical device, or group purchasing organizations transfers held by you or your immediate family are reported to the Centers for Medicare & Medicaid Services (CMS) and published on a publicly searchable website.

    Voluntarily register with CMS to get industry-submitted notifications and information.

    Voluntarily review attributed data for accuracy before public posting and dispute potentially inaccurate data.

  - Resources

    OPEN PAYMENTS Physicians and Teaching Hospitals Webpage

- Podiatry
  - Tips

    Ensure you do not bill routine foot care, unless an exception applies.

Job Aid E

How to Report Fraud & Abuse

Medicare Beneficiary

For any complaints:
Centers for Medicare & Medicaid Services (CMS) Hotline:
1-800-MEDICARE (1-800-633-4227) or TTY 1-800-486-2048

OR

For Medicare Managed Care or Prescription Drugs:
1-877-7SafeRx (1-877-772-3379) or 1-800-MEDICARE (1-800-633-4227)

Office of Inspector General (OIG) Hotline
Phone: 1-800-HHS-TIPS (1-800-447-8477)
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
TTY: 1-800-377-4950
Web: Forms.oig.hhs.gov/HotlineOperations/index.aspx

Mail: U.S. Department of Health and Human Services
Attn: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

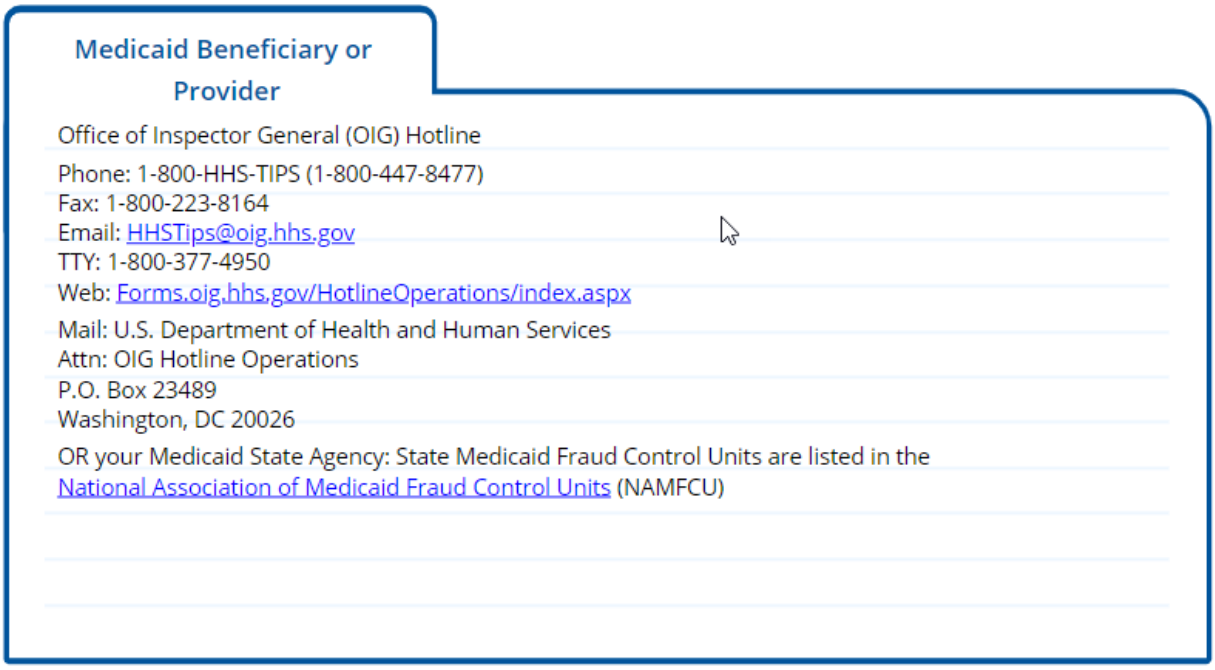
For Medicare Part C (Managed Care) or Part D (Prescription Drug Plans) complaints:
1-877-7SafeRx (1-877-772-3379)

Medicare Provider

Office of Inspector General (OIG) Hotline

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
Web: Forms.oig.hhs.gov/HotlineOperations/index.aspx
Mail: U.S. Department of Health and Human Services
Attn: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

OR your Medicare Administrative Contractor (MAC)



Job Aid F

Medicare Fraud & Abuse: Prevent, Detect, Report Booklet

Learn fraud and abuse definitions, laws, how to report suspected fraud, and physician business relationships that may raise concerns.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

Test Questions (10 questions Post-Test)

MULTIPLE CHOICE

1. The Federal laws that address fraud & abuse include _____.
    a. False Claims Act (FCA)
    b. Anti-Kickback Statute
    c. Physician Self-Referral Law (Stark Law)
    d. Civil Monetary Penalties Law (CMPL)
    e. All of the above

2. Health care providers can prevent fraud & abuse in the Medicare Program by _____.
    a. Not selling free samples from vendors
    b. Carefully reviewing business ventures to avoid violating the Anti-Kickback Statute
    c. Reviewing training and educational materials on Medicare policy on the Medicare Learning Network ® (MLN)
    d. All of the above

3. A chiropractor, in an intentional attempt to falsely get Medicare Program money, billed medically unnecessary services and falsified the beneficiary's Medicare claim diagnosis. Depending on the facts and circumstances, she most likely committed _____.

    a. A violation of the Anti-Kickback Statute
    b. A violation of the Physician Self-Referral Law (Stark Law)
    c. Medicare fraud or abuse because she knowingly submitted false Medicare Program claims

4. You may report suspected fraud & abuse anonymously to the Office of Inspector General (OIG) via _____.

    a. Phone or fax
    b. Email or mail
    c. OIG website
    d. All of the above

5. You can help prevent Medicare fraud & abuse by _____.

    a. Checking the Office of Inspector General List of Excluded Individuals/Entities (LEIE) before entering employment or contractual relationships with individuals or entities.

b. Providing Medicare beneficiaries only medically necessary, high-quality services
c. Properly documenting all Medicare beneficiary services provided
d. All of the above

6. Possible Medicare fraud & abuse penalties include _____.

a. Imprisonment in criminal cases
b. Civil Monetary Penalties (CMPs) up to $100,000 (in 2018) per violation and assessments of up to 3 times the amount claimed for the item, service, or remuneration offered, paid, solicited, or received
c. Exclusion from participation in all Federal health care programs
d. A, B, and C
e. A and C

7. Select the true statement.

a. Medicare Administrative Contractors (MACs), Comprehensive Error Rate Testing (CERT) Contractors, and the Office of Inspector General (OIG) review only claims and do not investigate health care providers suspected of Medicare fraud & abuse.
b. MACs, CERT Contractors, and the OIG investigate only health care providers suspected of Medicare fraud & abuse and do not review claims.
c. MACs, CERT Contractors, and Recovery Audit Program Recovery Auditors review only claims and generally do not investigate health care providers suspected of Medicare fraud & abuse.
d. MACs, CERT Contractors, and Recovery Audit Program Recovery Auditors investigate only health care providers suspected of Medicare fraud & abuse and do not review claims.

TRUE/FALSE

8. You can help prevent Medicare fraud & abuse by properly and thoroughly documenting all services provided to Medicare beneficiaries.

9. Medicare abuse includes any practice inconsistent with the goals of providing patients with all requested services, meeting professionally recognized standards, and charging fair prices.

10. Health care providers use the Self-Referral Disclosure Protocol (SRDP) to report all suspected fraud & abuse.

Pain Management

Lesson 1: Objectives

At the completion of this course, you will be able to:

- Recall the number of individuals with chronic pain in the United States;
- Describe what is included in a pain treatment plan;
- Identify tools that can be used to evaluate for pain;
- Describe pharmacological and non-pharmacological therapies;
- Monitor for adverse effects;
- Recognize pain management barriers;
- Identify special populations of individuals with pain; and
- Describe the importance of pain management education at discharge.

Introduction

According to the Centers for Disease Control and Prevention (the CDC), 50 million adults in the United States have chronic daily pain, with close to 20 million experiencing pain that interferes with daily life or work activities. Chronic pain is pain that is ongoing and usually lasts longer than six months. Acute pain is mild and lasts just a moment, or it might be severe and last for weeks or months. The assessment and management of pain, including safe opioid prescribing, is a priority for your healthcare organization.

Lesson 2: Screening, Assessment, and Reassessment

An individual is given a thorough initial evaluation, including assessment of both the medical and biopsychosocial factors causing or contributing to their pain. Based upon this, the healthcare provider, with the involvement of the individual, develops a patient-centered pain treatment plan that includes realistic expectations and measurable goals, objectives used to evaluate treatment progress, and education on pain management, treatment options, and safe use of medications when prescribed. A plan that consists of using treatments from one or more clinical disciplines can reduce pain severity, improve mood and overall quality of life, and increase function.

During screenings and assessment, the individual's identified needs and pain management goals should be discussed, and the appropriate tools used. For adults, adolescents, and children that can self-report, pain assessment tools include Numerical Rating Scales, Verbal Rating Scales, Visual Analog Scales, and the Faces Pain Scale. For individuals unable to self-report, tools include the Critical-Care Pain Observation Tool and the Behavioral Pain Scale. For children aged 3-18 years, as well as older persons who are cognitively impaired, the Face, Legs, Activity, Cry, Consolability (FLACC) tool may be used. Behavioral and physiologic variables of heart rate and oxygen saturation may be used to assess acute pain in infants, as well as the Neonatal/Infant Pain Scale (NIPS).

Reassessment should be completed in a timely manner to determine the response to an intervention, progress towards pain management goals, side effects of treatment, and risk factors of adverse events.

The misidentification and under-treatment of pain continues to occur in healthcare organizations. When an individual presents for other medical issues, pain may be overlooked or missed. Consult your organization's policies and procedures for screening, assessment, and reassessment guidelines.

Quiz Question:

Match the pain tool image to the appropriate population for its use:

Numerical Rating Scales – ***adults, adolescents, and children that can self-report**
Critical-Care Pain Observation Tool - ***individuals unable to self-report**
Face, Legs, Activity, Cry, Consolability Tool - ***children aged 3-18 years and older persons who are cognitively impaired**
Neonatal/Infant Pain Scale - ***infants**

LESSON 3: Pain Management Therapy

Treatment strategies for pain may include non-pharmacologic, pharmacologic, or a combination of approaches. Referrals may be required for individuals who present with complex pain management needs.

Pharmacological Therapy

Pharmacological therapy is medical care that involves the use of medications. The selection of the most appropriate medication-based treatment involves a careful analysis of risks and benefits.

- Non-opioid medications that are commonly used for pain relief include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), antidepressants, anticonvulsants, musculoskeletal agents, biologics, topical analgesics, and anxiolytics.
- Opioids are a controlled substance group of medications that provide pain relief for a variety of conditions. Common prescription opioid medications include hydromorphone, hydrocodone, codeine, oxycodone, methodone, and morphine. Although effective for moderate to severe acute pain, the effectiveness of opioids beyond three months has not been determined. Opioid medications can be associated with significant side effects, including constipation, sedation, nausea, vomiting, irritability, itching of the skin, and respiratory depression. Even when used as directed, opioids contribute to overdose or lead to development of substance use disorder in some individuals. The high potential for misuse of opioids have led to alarming trends across the United States, including record numbers of people developing opioid use disorders, overdosing on opioids, and dying from overdoses. Initiation of opioid therapy should be at a low dose and then increased to find the lowest dose required to control the pain or improve function and

quality of life and then be adjusted as needed. Opioid treatment should be maintained for a period no longer than necessary for adequate pain control. The availability of naloxone as well as education for the individual and their family about naloxone can lessen the risks of overdose. The healthcare provider may require written treatment agreements with individuals with chronic pain who are prescribed opioids. Prescription drug monitoring programs can support safe prescribing and dispensing practices and help curb opioid prescription by detecting patterns that can alert clinicians to individuals who may be at risk of a substance use disorder. Your organization has identified opioid treatment programs that can be used for referrals.

Non-pharmacological Therapy

While evidence for some non-pharmacologic modalities is mixed and/or limited, they may serve as a complementary approach for pain management and potentially reduce the need for opioid medications in some circumstances. Non-pharmacological therapy may include:

- Restorative therapies including therapeutic exercise, transcutaneous electric nerve stimulation (TENS), massage therapy, traction, cold and heat therapy, therapeutic ultrasound, and bracing;
- Interventional procedures including trigger point injections, facet joint nerve block, and spinal cord stimulator;
- Behavioral health approaches including cognitive behavioral therapy, acceptance and commitment therapy, mindfulness-based stress reduction, emotional awareness and expression therapy, and self-regulatory or psychophysiological approaches; and
- Complementary and integrative health including acupuncture, massage, manipulative therapies, yoga, tai chi, and spirituality.

Quiz Question:

Place the appropriate description under Pharmacological Therapy or Non-Pharmacological Therapy.

Pharmacological Therapy	**Non-Pharmacological Therapy**
***Non-opioid medications**	***Restorative therapies**
***Opioids**	***Interventional procedures**
	***Behavioral health approaches**
	***Complementary and integrative health**

LESSON 4: Adverse Effects

Healthcare providers administering pain medication are not only responsible for the correct medication, route, time, person, dosage, and documentation, but also an evaluation for adverse effects. Some adverse effects are predictable. The healthcare

provider can eliminate or lessen these effects through anticipation and careful observation.

- Narcotic medications, such as opioids, have a sedating effect. Individuals can become overly sedated and suffer respiratory depression or arrest, which can be fatal.
- Stool softeners and laxatives may be used for constipation.
- Be aware of diseases that can lead to drug accumulation.
- Evaluate the individual's age, weight, and activity level and consider dosage adjustments.
- Be cautious in the administration of more than one medication via more than one route since interaction among multiple medications can have significant clinical and symptomatic effects.

Quiz Question:

Healthcare providers administering pain medication are responsible for the evaluation of adverse effects.

***True** or False

LESSON 5: Barriers to Pain Management

Both the individual and the healthcare provider may have barriers to pain management which can minimize the success of the treatment plan.

Healthcare provider barriers may include:

- Inadequate assessment of pain;
- Fear of creating addiction to pain medication;
- Fear of creating adverse effects; and
- Fear that the individual will develop tolerance.

Individual barriers may include:

- Perception of weakness or of not being a "good" person if they report pain;
- Assumption that the disease must be getting worse if more pain is experienced;
- Fear of becoming addicted to pain medication;
- Cost of pain medication or lack of insurance coverage;
- Limited access to care; and
- Stigma.

Quiz Question:

An individual may not report pain for fear of becoming addicted to pain medication.

***True** or False

LESSON 6: Special Populations

Chronic pain can affect children and adolescents. These pain conditions can be from congenital diseases, chronic non-congenital diseases, or primary chronic pain conditions.

Chronic pain is one of the most common, costly, and incapacitating conditions in older adults. Managing pain in these adults can be complex because of age-related physiologic changes, medical and mental health issues, the use of multiple medications, increases in pain thresholds, decreases in pain tolerance, and the increase risk of side effects from medication treatment.

Millions of Americans experience cancer pain. Cancer survivors can continue to experience persistent pain as a result of treatment.

Studies suggest that women experience more pain then men, have greater sensitivities to painful stimuli, and report experiencing more intense pain.

Managing pain in pregnant women is challenging because the treatment can affect the pregnant mother and the developing fetus.

Sickle Cell Disease, a group of inherited disorders characterized by complex acute and chronic symptoms, including pain, disproportionately affects minority populations, particularly African Americans. Pain is unique in that it occurs throughout the individual's lifespan, from infancy to adulthood, and develops directly from the disease.

Considerable evidence exists regarding health inequalities in racial and ethnic minority populations, particularly in the occurrence, treatment, progression, and outcomes of pain-related conditions.

Individuals in the military can experience combat-related injuries in addition to conditions such as post-traumatic stress disorder and traumatic brain injury. Among Veterans, pain conditions are associated with an increased risk of suicide.

LESSON 7: Non-Clinical Personnel Assistance

Any staff member in the healthcare organization can and should assist with pain management. Non-clinical staff can:

- Acknowledge the individual's complaint and inquire about their pain level using a pain scale;
- Report the complaint to the individual's nurse immediately; and

- Assist in making the individual more comfortable through repositioning, distraction or other non-pharmacological therapies as appropriate.

Pain management is a priority and should not be ignored by any staff member. A staff member must not tell the individual that he or she cannot help; must not advise that they speak with the nurse instead; and must not complete his/her immediate task before reporting the pain.

Quiz Question:

Who can assist with pain control?

a. Only the physician.
b. Only the physician and nursing staff.
c. ***All individuals associated with the individual.**
d. Only the nursing staff.

LESSON 8: Discharge

Upon discharge, education must be provided on the pain management plan of care, side effects of treatment, activities of daily living that might increase pain or reduce effectiveness of treatment, as well as strategies to address these issues, and the safe use, storage, and disposal of opioids when prescribed. Education can be emphasized through various means, including discussion, informational materials, and web resources.

LESSON 9: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Individuals may not be pain free, but healthcare providers can help them meet their expectations and goals, evaluate treatment progress and provide education. If you have any questions regarding pain management, contact the appropriate personnel within your organization for guidance and assistance.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. Who can assist an individual with pain control?
    a. Only the physician.
    b. Only the physician and nursing staff.
    c. All staff associated with the individual.
    d. Only the nursing staff.

2. Which of the following is considered non-pharmacological therapy?
    a. Massage therapy.
    b. Cognitive behavioral therapy.
    c. Acupuncture.
    d. All of the above.

3. What assessment tools should be used in evaluating pain levels?
    a. Nursing experience.
    b. Physician knowledge.
    c. Pain scales.
    d. Family intervention.

4. The Numeric Rating Scale for pain should be considered for:
    a. Adults.
    b. Impaired adults.
    c. Infants.
    d. Small children.

5. The FACES Pain Scale should be considered for:
    a. Adults.
    b. School age children.
    c. Infants.
    d. Adolescents.

6. The Face, Legs, Activity, Cry and Consolability (FLACC) Tool for pain should be considered for:
    a. Adults.
    b. School age children.
    c. Infants.
    d. Adolescents.

Pool 2 (4 or 2 questions)

TRUE/FALSE

7. An individual may not report pain for fear of becoming addicted to pain medication.

8. Healthcare providers administering pain medication are responsible for the evaluation of adverse effects.

9. Pharmacological Therapy is medical care that involves the use of medications.

10. If an individual is experiencing pain, they will always report it.

11. Pain management is a priority and should not be ignored by any staff member.

12. An individual may not report pain because of the cost of pain medication.

13. Treatment strategies for pain may include non-pharmacologic, pharmacologic, or a combination of approaches.

14. Opioids contribute to overdose or lead to development of substance use disorder in some individuals.

15. Opioid treatment should be maintained for a period no longer than necessary for adequate pain control.

16. Narcotic medications may have a sedating effect.

Sexual Harassment

This course offers education for both employees and supervisors. Students select their role within an organization at the beginning of the course to receive education specific to their needs.

(NOTE: You may wish to add-on your organization's anti-harassment policy and complaint procedure.)

Lesson 1: Objectives

At the completion of this course, you will be able to:

- Define, prevent, and report sexual harassment and
- Identify how your organization responds to and corrects harassment.

Introduction

Although harassment is against the law and violates Title VII of the Civil Rights Act of 1964, it remains a problem in American workplaces. Harassment involves discriminatory (or unfair) treatment towards an individual on the basis of race, color, sex (including pregnancy, gender identity, and sexual orientation), religion, national origin, age (40 or older), disability, genetic information, or towards an individual who has complained about discrimination, filed a charge of discrimination or participated in an employment discrimination investigation or lawsuit. It is against the law for an employer to hire, fire, or alter other aspects of an individual's employment, such as compensation, terms, conditions and privileges, based on discriminatory reasons. The U.S. Equal Employment Opportunity Commission (EEOC) enforces these federal laws and has the authority to investigate and file charges of discrimination.

In 1980 sexual harassment became a violation of Title VII of the Civil Rights Act and criteria was established for determining when unwelcome conduct of a sexual nature signified sexual harassment, circumstances under which an employer may be held liable (or responsible) and steps an employer should take to prevent sexual harassment. Title VII applies to employers with 15 or more employees, including local, state and federal governments, employment agencies and labor organizations. Individuals who work for smaller employers are usually protected by similar state anti-discrimination laws.

Quiz Question:

Sexual harassment is a violation of Title VII of the Civil Rights Act.

***True** or False

Lesson 2: Sexual Harassment Defined

Sexual attraction may often play a role in the day-to-day social exchange between employees. Federal law does not prohibit simple teasing, offhand comments, or isolated incidents. The law does, however, prohibit sexual harassment which includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when this conduct openly or secretly is a term or condition of an individual's employment, used as a basis for employment decisions, unreasonably interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment.

Sexual harassment can occur in a variety of circumstances. The harasser can be the victim's supervisor, a supervisor in another area, a co-worker, or even a person outside of the organization, such as a client or customer. Both the victim and the harasser can be either a woman or a man, and the victim and harasser can be the same sex. The victim does not have to be the person harassed but can be anyone affected by the offensive conduct.

Quiz Question:

Place each action under whether it is OR is not prohibited under Federal Law.

Federal Law Prohibits
***Unwelcome sexual advances**
***Requests for sexual favors**
***Verbal conduct of a sexual nature that is used as a term of employment**
***Physical conduct of a sexual nature that is used as a basis for employment decisions**
***Verbal conduct of a sexual nature that interferes with an individual's work performance**
***Physical conduct of a sexual nature that creates an intimidating working environment**

Federal Law Does Not Prohibit
***Simple teasing**
***Offhand comments**
***Isolated incidents**

Lesson 3: Prevention of Sexual Harassment for Employees

Prevention is the best tool to eliminate sexual harassment in the workplace. Your organization takes all steps necessary to prevent sexual harassment including the enforcement of its anti-harassment policy, anti-retaliation policy and complaint procedure or grievance system. Sexual harassment will not be tolerated. Remember, sexual harassment is determined by the perception of the victim. Therefore, be cautious because you may not always know whether or not something you do or say is considered harassing and you may end up in court defending yourself, paying high attorneys' fees and, if found guilty, a large amount of money out of your own pocket.

Lesson 4: Reporting and Correction of Sexual Harassment for Employees

If you become a victim of sexual harassment you are encouraged to inform the harasser directly that the conduct is unwelcome and must stop. Communicating your feelings of discomfort can prevent what is inappropriate, yet innocent, behavior from becoming harassing and overly offensive. You should also promptly use your organization's complaint procedure or grievance system before the harassment becomes severe or frequent. Telling a co-worker about a harassing situation is not sufficient notice to your employer of the problem.

When your organization receives a complaint or otherwise learns of possible sexual harassment in the workplace, it will investigate promptly and thoroughly so that it can be determined whether inappropriate sexual conduct occurred. Your organization will look at the nature of the conduct and the context in which the alleged incidents took place. A determination will be made from the facts, on a case by case basis. Confidentiality during the investigation is ensured as much as possible.

Your organization will take immediate and appropriate corrective action by doing whatever is necessary to end the harassment, make you whole by restoring lost employment benefits or opportunities, and prevent the misconduct from recurring. Disciplinary action against the offending supervisor or co-worker, ranging from reprimand to termination, may be necessary. The corrective action will reflect the severity of the conduct. Once the investigation is complete, all parties will be informed of the results and whether corrective action was taken, however the employee who made the complaint will usually not be told the details of the disciplinary actions. Your organization will also make follow-up inquiries to ensure the harassment has not resumed and you and other witnesses have not suffered retaliation (or revenge). If you are a victim of retaliation, you must report this immediately. Retaliation will be subject to discipline, up to and including termination.

Quiz Question:

When your organization receives a complaint or otherwise learns of possible sexual harassment in the workplace, it takes the appropriate steps. Place the steps in order.

1. *Investigate promptly and thoroughly
2. *Take immediate and appropriate corrective action
3. *Inform all parties of the results and whether corrective action was taken
4. *Make follow-up inquiries to ensure the harassment has not resume and no one has suffered retaliation

Lesson 5: Prevention of Sexual Harassment for Supervisors

Your organization is committed to the prevention and correction of sexual harassment including the enforcement of its anti-harassment policy, anti-retaliation policy and

complaint procedure or grievance system. Prevention is the best tool for the elimination of sexual harassment. Your organization takes all steps necessary to prevent sexual harassment from occurring, such as affirmatively raising the subject, expressing strong disapproval, developing appropriate sanctions, informing employees of their right to raise and how to raise the issue of harassment under title VII, and developing methods to sensitize all concerned. Your organization's policies should contain, at a minimum, a clear explanation of prohibited conduct; assurance that employees who make complaints of harassment or provide information related to such complaints will be protected against retaliation; a clearly described complaint process that provides a prompt, thorough, and impartial investigation and is designed to encourage victims to come forward and report harassment before it becomes severe or frequent and offers accessible avenues to complain including individuals outside an employee's chain of command and details the time frames for filing charges with the EEOC or state fair employment practice agencies; assurance that the employer will protect the confidentiality of harassment complaints to the extent possible; and assurance that the employer will take immediate and appropriate corrective action when it determines that harassment has occurred.

Quiz Question:

Your organization takes all steps necessary to prevent sexual harassment from occurring. Select the correct word from the dropdown to describe each step.

affirmatively *__raising__ the subject
expressing *__strong__ disapproval
developing appropriate *__sanctions__
informing employees of their right to raise the issue of harassment under *__Title VII__
developing *__methods__ to sensitize all concerned

Lesson 6: Reporting and Correction of Sexual Harassment for Supervisors

As a supervisor or manager, you must understand your responsibilities under the organization's anti-harassment policy, anti-retaliation policy and complaint procedure or grievance system, including documentation requirements. You must address or report to appropriate personnel complaints of harassment regardless of whether you are officially designated to take complaints and regardless of whether a complaint was framed in a way that follows the organization's complaint procedure. Furthermore, management must correct harassment regardless of whether an employee files an internal complaint if the conduct is clearly unwelcome. If an employee informs you as their supervisor of an alleged harassment but asks to keep the matter confidential and take no action, your inaction could lead to employer liability. While it may seem reasonable to let the employee determine whether to pursue a complaint, the employer must exercise its duty to prevent and correct harassment. One of the biggest mistakes you as a supervisor can make is to ignore or improperly respond to sexual harassment.

Remedial or corrective measures are designed to stop harassment, correct its effects on the employee, and ensure that the harassment does not recur. These measures may include the restoration of leave taken because of the harassment; removal of negative evaluation(s) from the employee's personnel file that arose from the harassment; reinstatement; apology by the harasser; monitoring the treatment of the employee to ensure that he or she is not subjected to retaliation by the harasser or others in the workplace because of the complaint; and correction of any other harm caused by the harassment.

Quiz Question:

Remedial measures are designed to:

a. stop the harassment
b. correct the harassment's effect on the employee
c. ensure that the harassment does not recur
d. ***all of the above**

Lesson 7: Employer Liability

Employers are subject to vicarious liability for unlawful harassment by its supervisors. An individual qualifies as an employee's "supervisor" if he or she has authority to undertake or recommend tangible employment decisions such as hiring, firing, promoting, and demoting or has authority to direct the employee's daily work activities. In some circumstances, an employer may be subject to vicarious liability for harassment by a supervisor who does not have actual authority over the employee. An employer is always liable for harassment by a supervisor that ended in a tangible employment action. If the harassment did not end in a tangible employment action, the employer may be able to avoid liability or limit damages if it exercised reasonable care to prevent and promptly correct any harassing behavior, and the employee unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer or to avoid harm otherwise.

In addition to costly lawsuits, sexual harassment harms business operations and can cause lost productivity time due to absenteeism, turnover and employee dissatisfaction. The employer's reputation in the community may suffer as well resulting in the loss of business opportunities and good job applicants.

Quiz Question:

An employer is always liable for harassment by a supervisor that ended in a tangible employment action.

***True** or False

Lesson 8: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Your organization is committed to the prevention and correction of sexual harassment. And it takes your help! If you have any questions about sexual harassment, including your organization's anti-harassment policy, anti-retaliation policy, complaint procedure or grievance system, contact the appropriate personnel for guidance and assistance.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. Sexual harassment includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when the conduct:
   a. Affects an individual's employment.
   b. Interferes with an individual's work performance.
   c. Creates an intimidating, hostile, or offensive work environment.
   d. All of the above.

2. It is appropriate to fire an individual based on:
   a. Race.
   b. Sex.
   c. Age.
   d. None of the above.

3. _____ is the best tool to eliminate sexual harassment in the workplace.
   a. Protection
   b. Prevention
   c. Firing
   d. Promoting

4. It is against the law for an employer to _____ based on discriminatory reasons.
   a. Hire
   b. Fire
   c. Alter other aspects of an individual's employment such as compensation
   d. All of the above

5. The harasser can be:
   a. The victim's supervisor.
   b. A supervisor in another area.
   c. A co-worker.
   d. All of the above.

6. Which statement below is FALSE in regards to sexual harassment?
   a. Both the victim and the harasser can be either a woman or a man.
   b. The victim and harasser can be the same sex.
   c. The victim must be the person that was directly harassed.
   d. The harasser can be the victim's supervisor.

Pool 2 (4 or 2 questions)

TRUE/FALSE

7. Sexual harassment is a violation of Title VII of the Civil Rights Act.

8. Telling a co-worker about a harassing situation is sufficient notice to your employer of the problem.

9. Harassment remains a problem in American workplaces.

10. It is lawful for an employer to hire, fire, or alter other aspects of an individual's employment based on discriminatory reasons.

11. Federal law does not prohibit simple teasing, offhand comments, or isolated incidents.

12. If you become a victim of sexual harassment you should inform the harasser directly that the conduct is unwelcome and must stop.

13. Retaliation can be subject to discipline, up to and including termination.

14. The victim of sexual harassment can be anyone affected by the offensive conduct.

15. Sexual harassment will not be tolerated.

16. When your organization receives a complaint or otherwise learns of possible sexual harassment in the workplace, it must investigate promptly and thoroughly.

Workplace Diversity

Lesson 1: Objectives

At the completion of this course, you will be able to:

- Describe characteristics protected by anti-discrimination laws;
- Define harassment; and
- Identify how your organization responds to and corrects harassment and discrimination.

Introduction

Healthcare organizations are more diverse than ever. Men and women of all race, color, religion and national origin are working together. Healthcare employees must embrace the diversity of their organization and give others the respect and dignity they deserve. Every human being is of equal worth, entitled to the same privileges and opportunities. It is illegal to discriminate or treat an individual unfairly based on race, color, sex, religion, national origin, age, disability, genetic information, pregnancy, or opposition to job discrimination or participation in an investigation or complaint process (referred to as protected activity).

Lesson 2: Harassment

Harassment is unwelcome conduct that is based on race, color, sex, religion, national origin, age, disability, genetic information, or pregnancy. Harassment becomes unlawful when the offensive conduct becomes a condition of continued employment or the conduct creates a work environment that a reasonable person would consider intimidating, hostile, or abusive. Offensive conduct may include, but is not limited to, offensive jokes, slurs, name calling, physical assaults or threats, intimidation, mockery, insults, offensive pictures, and interference with work performance.

Anti-discrimination laws also prohibit harassment against individuals in retaliation for filing a discrimination charge, testifying, or participating in an investigation, proceeding, or lawsuit under these laws; or opposing employment practices that they believe discriminate against individuals, in violation of these laws.

Sexual harassment is also unlawful and includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature.

The harasser can be the victim's supervisor, a supervisor in another area, a co-worker, or a non-employee. The victim does not have to be the person harassed but can be anyone affected by the offensive conduct. If you become a victim of harassment, inform the harasser directly that the conduct is unwelcome and must stop.

Quiz Question:

A harasser can be which of the following?

a. the victim's supervisor
b. a supervisor in another area
c. a co-worker
d. a non-employee
e. ***All of the above**

Lesson 3: Race and Color Discrimination

Race discrimination involves treating an individual unfavorably because they are of a certain race or because of personal characteristics associated with their race. Color discrimination involves treating an individual unfavorably because of their skin color complexion. Race and color discrimination also involves treating an individual unfavorably because they are married to (or associated with) a person of a certain race or color or have a connection with a race-based organization or group or an organization or group that is generally associated with people of a certain color.

Quiz Question:

It is inappropriate to use derogatory terms when referring to an employee of a different race than you.

***True** or False

Lesson 4: Sex-Based Discrimination

Sex discrimination involves treating an individual unfavorably because of their sex or their connection with an organization or group that is generally associated with people of a certain sex. The Equal Pay Act requires that men and women in the same workplace be given equal pay for equal work. The jobs must be substantially equal as determined by job content (not job titles). All forms of pay are covered by this law.

Quiz Question:

It is inappropriate to use belittling terms when referring to an employee of a different sex than you.

***True** or False

Lesson 5: Religious Discrimination

Religious discrimination involves treating an individual unfavorably because of their religious beliefs, because they are married to (or associated with) an individual of a particular religion or have a connection with a religious organization or group. The law protects not only people who belong to traditional, organized religions, such as

Buddhism, Christianity, Hinduism, Islam, and Judaism, but others who have sincerely held religious, ethical or moral beliefs. An employer must reasonably accommodate an employee's religious beliefs or practices, unless doing so would cause more than a minimal burden on business operations. This applies not only to schedule changes or leave for religious observances, but also to such things as dress or grooming practices. An employee cannot be forced to participate (or not participate) in a religious activity as a condition of employment. Workplace or job segregation based on religion is prohibited, such as assigning an employee to a non-customer contact position because of actual or feared customer preference.

Quiz Question:

It is inappropriate to tell jokes that focus on religion.

***True** or False

Lesson 6: National Origin and Citizenship Discrimination

National origin discrimination involves treating an individual unfavorably because they are from a particular country or part of the world, appear to be of a certain ethnic background (even if they are not), are married to (or associated with) a person of a certain national origin, have a connection with an ethnic organization or group or because of ethnicity or accent. An employee is only required to speak fluent English if it is necessary to perform their job effectively, however a foreign accent cannot seriously interfere with job performance.

The Immigration Reform and Control Act of 1986 prohibits discrimination based upon an individual's citizenship or immigration status. It is illegal for employers to hire only U.S. citizens or lawful permanent residents unless required to do so by law, regulation or government contract.

Quiz Question:

It is inappropriate to mimic the accent of an employee of a particular national origin.

***True** or False

Lesson 7: Age Discrimination

Age discrimination involves treating an individual less favorably because of their age. The Age Discrimination in Employment Act prohibits discrimination against people who are age 40 or older. Some states have additional laws that protect younger workers from age discrimination.

Quiz Question:

It is inappropriate to use age-related terms or phrases when referring to other employees.

*True or False

Lesson 8: Disability Discrimination

Disability discrimination occurs when an employer covered by the Americans with Disabilities Act (ADA) or the Rehabilitation Act treats a qualified individual with a disability (as defined by the law) unfavorably because they have a disability, have a history of disability, or is believed to have a physical or mental impairment that is not transitory and minor. An employer must provide reasonable accommodation to an employee with a disability, unless doing so would cause undue hardship. A reasonable accommodation is any change in the work environment to help a person with a disability apply for a job, perform the duties of a job, or enjoy the benefits and privileges of employment. The law also protects people from discrimination based on their relationship with a person with a disability. While the federal anti-discrimination laws don't require an employer to accommodate an employee who must care for a disabled family member, the Family and Medical Leave Act (FMLA) may require an employer to take such steps.

Quiz Question:

It is inappropriate to joke about an employee's mental condition.

*True or False

Lesson 9: Genetic Information Discrimination

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination against employees because of genetic information. GINA prohibits the use of genetic information, including the individual's genetic tests and the genetic tests of an individual's family members, as well as family medical history, in making employment decisions, restricts employers from requesting, requiring, or purchasing genetic information, and strictly limits the disclosure of genetic information.

Quiz Question:

It is inappropriate to disclose an employee's medical condition to others.

*True or False

Lesson 10: Pregnancy Discrimination

The Pregnancy Discrimination Act prohibits unfavorable treatment of a woman because of pregnancy, childbirth, or a medical condition related to pregnancy or childbirth. If a woman is temporarily unable to perform her job due to a medical condition related to pregnancy or childbirth, the employer must treat her the same as any other temporarily disabled employee. Pregnant employees may have additional

rights under FMLA. Nursing mothers may have additional rights under the Fair Labor Standards Act. Impairments resulting from pregnancy may be disabilities under the ADA.

Quiz Question:

Pregnancy discrimination involves treating a woman unfavorably because of:

a. Pregnancy.
b. Childbirth.
c. A medical condition related to pregnancy or childbirth.
d. *All of the above.

Lesson 11: Reporting and Correction of Discrimination

If you become a victim of discrimination or harassment, you should promptly consult your organization's anti-discrimination or anti-harassment policy and follow the complaint procedure. When your organization receives a complaint, it must investigate promptly and thoroughly. Confidentiality during the investigation is ensured as much as possible. Your organization will take immediate and appropriate corrective action. Disciplinary action against the offending individual, ranging from reprimand to discharge, may be necessary. The corrective action will reflect the severity of the conduct. Your organization will also make follow-up inquiries to ensure the discrimination has not resumed and you and other witnesses have not suffered retaliation.

In addition to costly lawsuits, discrimination harms business operations and can cause lost productivity time due to absenteeism, turnover and employee dissatisfaction. The employer's reputation in the community may suffer as well resulting in the loss of business opportunities and good job applicants.

Lesson 12: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Employees must treat each other with courtesy and respect, regardless of their differences. If you have any questions about your organization's anti-discrimination policy and complaint procedure, contact the appropriate personnel for guidance and assistance.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. It is appropriate to treat an individual unfairly based on:
    a. Race.
    b. Sex.
    c. Age.
    d. None of the above.

2. Which discrimination involves treating an individual unfavorably because they have a connection with the NAACP (National Association for the Advancement of Colored People)?
    a. Age.
    b. Race.
    c. Sex.
    d. Religious.

3. Which Act requires that men and women in the same workplace be given equal pay for equal work?
    a. Immigration Reform and Control Act of 1986.
    b. Age Discrimination in Employment Act.
    c. Americans with Disabilities Act.
    d. Equal Pay Act.

4. Which discrimination involves treating an individual unfavorably because they are married to a Christian?
    a. National origin.
    b. Disability.
    c. Genetic information.
    d. Religious.

5. Which discrimination involves treating an individual unfavorably because they are from a particular country or part of the world?
    a. Pregnancy.
    b. Age.
    c. National origin.
    d. Religious.

6. The Age Discrimination in Employment Act prohibits discrimination against people who are what age?
    a. 20 or older.
    b. 30 or older.

c. 40 or older.
d. 50 or older.

7. Disability discrimination occurs when an individual is treated unfavorably because:
   a. They have a disability.
   b. They had a disability in the past.
   c. They are believed to have a physical or mental impairment.
   d. All of the above.

8. Pregnancy discrimination involves treating a woman unfavorably because of:
   a. Pregnancy.
   b. Childbirth.
   c. A medical condition related to pregnancy or childbirth.
   d. All of the above.

Pool 2 (4 or 2 questions)

TRUE/FALSE

9. It is appropriate to use slang or derogatory terms when referring to an individual of a different race than you.

10. It is appropriate to use belittling terms when referring to an individual of a different sex than you.

11. It is appropriate to tell jokes that focus on religion.

12. It is appropriate to mimic the accent of an individual of a particular national origin.

13. It is appropriate to joke about an employee's *believed* mental impairment.

14. It is appropriate for an employer to disclose genetic information about their employees.

15. Sexual harassment will not be tolerated.

16. When your organization receives a complaint or otherwise learns of possible discrimination in the workplace, it must investigate promptly and thoroughly.

Workplace Violence Prevention

Lesson 1: Objectives

At the end of the course, participants will be able to:

- ❖ Define workplace violence;
- ❖ List risk factors associated with violence in healthcare organizations;
- ❖ Identify workplace violence prevention measures;
- ❖ Detail how to keep safe when encountering verbal or physical violence or the potential for violence;
- ❖ Define lateral violence and its negative effects; and
- ❖ Describe the importance of reporting all incidences of workplace violence.

Introduction

Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. Workplace violence ranks among the top four causes of death in the workplace and is a major concern for employers and employees. Health care workers face significant risks of workplace violence. The rate of serious workplace violence incidents is more than four times greater in healthcare than in private industry. In fact, health care accounts for nearly as many serious violent injuries as all other industries combined. Many more assaults or threats go unreported. Forms of violence to health care workers include biting, kicking, punching, pushing, pinching, shoving, scratching, spitting, name calling, intimidating, threatening, yelling, harassing, stalking, beating, choking, stabbing and killing. Possible sources of violence include patients/residents, visitors, intruders, and even coworkers.

Lesson 2: Risk Factors

While no specific diagnosis or type of patient/resident predicts future violence, studies show that inpatient and acute psychiatric services, geriatric long-term care settings, high volume urban emergency departments and residential and day social services present the highest risks. Risk factors for health care workers include:

- Individuals in pain, who have been given a devastating prognosis, or whose disease is progressing;
- Individuals in unfamiliar surroundings;
- Working directly with people who have a history of violence, abuse drugs or alcohol, gang members, and relatives of patients/residents or clients;
- Individuals with altered mental status or mental illness;
- Patients in police custody;
- Transporting patients/residents and clients;
- Working alone in a facility or in a patient’s home;

- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident;
- Poorly lit corridors, rooms, parking lots and other areas;
- Lack of means of emergency communication;
- Presence of firearms, knives and other weapons among patients/residents and their families and friends;
- Working in neighborhoods with high crime rates;
- Lack of policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients/residents, clients, visitors, or staff;
- Working when understaffed—especially during mealtimes and visiting hours;
- High worker turnover;
- Inadequate security and mental health personnel on site;
- Long waits and overcrowded, uncomfortable waiting rooms;
- Unrestricted movement of the public within the facility; and the
- Perception that violence is tolerated, and victims will not be able to report the incident to police and/or press charges.

LESSON 3: Workplace Violence Prevention

Workplace violence comes at a high cost. In addition to the cost of workers compensation, increased insurance premiums, and lawsuits, workplace violence results in low staff morale and high worker turnover.

Your organization has a comprehensive workplace violence prevention program. The program has full support of management and includes worker involvement. Your organization has performed an assessment to identify existing and potential hazards that may lead to incidents of workplace violence and has committed to preventing or controlling these hazards. Recordkeeping and ongoing evaluation help determine the program's effectiveness and identify any deficiencies or changes that should be made. All staff members are informed of potential hazards and taught how to protect themselves and their coworkers.

LESSON 4: Keep Yourself Safe

Health care workers must be alert and ready to act when they encounter verbal or physical violence, or the potential for violence. Your response to defensive behavior is often the key to avoiding a physical confrontation with someone who has lost control of their behavior.

- Be empathic and nonjudgmental – Do not judge or discount someone's feelings.
- Respect personal space - If possible, stand 1.5 to three feet away from the person. If you must enter someone's personal space, explain your actions so the person feels less confused and frightened.

- Use nonthreatening nonverbals – Be aware of your gestures, facial expressions, movements, and tone of voice.
- Avoid overreacting - Remain calm, rational, and professional.
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- Choose wisely what you insist upon – Decide which rules are negotiable and which are not.
- Allow silence for reflection – Give the person a chance to reflect on what's happening, and how he or she needs to proceed. And,
- Allow time for decisions - Give the person a few moments to think through what you've said.

Quiz Question:

Select all of the appropriate responses to defensive behavior.

Discount the individual's feelings
Be judgmental
***Stand 1.5 to 3 feet away from the person**
Put your hands in a fist
***Remain calm**
Defend yourself when asked challenging questions
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LESSON 5: Lateral Violence

Lateral violence is the deliberate and harmful behavior demonstrated in the workplace by one employee to another. Lateral violence is a significant problem in the nursing profession and includes name calling, threatening body language, fault finding, negative criticism, gossip, shouting, blaming, put-downs, rolling of the eyes, unfair assignments, refusing to work with certain people, sabotage and exclusion. Lateral violence negatively impacts both the work environment and the nurse's ability to deliver care. This violence has also caused many nurses to leave their profession. Nurses are encouraged to resolve personal and/or professional pain, build therapeutic relationships, and promote positive work environments. As nurses promote health in their patients/residents, they must also promote health in themselves and one another.

Quiz Question:

Select all of the ways lateral violence can impact the work environment.

***Negatively impacts the work environment**
***Negatively impacts the nurse's ability to deliver care**
***Causes many nurses to leave their profession**
Builds therapeutic relationships
Promotes positive work environments

LESSON 6: Reporting

Violence against health care workers is grossly underreported. Many healthcare workers feel a professional and ethical duty to "do no harm" to patients/residents. Some will put their own safety and health at risk to help a patient/resident and consider violence to be "part of the job." Healthcare workers also recognize that many injuries caused by patients/residents are unintentional and accept them as routine or unavoidable. Workplace violence is never acceptable. When violence occurs report it! Notify leadership, security, and, if needed, law enforcement.

Quiz Question:

Workplace violence is never acceptable.

***True** or False

LESSON 7: Joint Commission Requirements

(NOTE: This lesson may be removed for your organization.)

Intimidating and unprofessional behaviors can foster medical errors, contribute to poor patient/resident satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, healthcare organizations must address the problem of behaviors that threaten the performance of the health care team including workplace violence. Take a stand: No more violence to health care workers!

LESSON 8: Conclusion

(NOTE: You may wish to display the contact information for the appropriate personnel within your organization.)

Violence in the healthcare arena has reached an astonishing level. It is the responsibility of employees, employers, and corporate and government agencies to

provide protection for all healthcare staff. If you have questions regarding violence prevention programs at your organization, contact the appropriate personnel for guidance and assistance.

Test Questions (10 questions Pre-Test or 5 questions Post-Test)

Pool 1 (6 or 3 questions)

MULTIPLE CHOICE

1. Workplace violence occurs at the work site and is any act or threat of:
    a. Physical violence.
    b. Harassment.
    c. Intimidation.
    d. All of the above.

2. Workplace violence comes at a high cost to the organization through:
    a. Workers compensation settlements.
    b. Increased insurance premiums.
    c. Lawsuits.
    d. All of the above.

3. A potentially violent situation may be de-escalated by:
    a. Staying calm.
    b. Being empathetic.
    c. Respecting personal space.
    d. All of the above.

4. A potentially violent situation may be escalated by:
    a. Putting your hands in a fist.
    b. Offering choices and consequences.
    c. Giving the person a chance to reflect on what's happening.
    d. Giving the person a few moments to think through what you've said.

5. Lateral violence can impact the work environment in which of the following ways?
    a. Builds therapeutic relationships.
    b. Promotes positive work environments.
    c. Negatively impacts the nurse's ability to deliver care.
    d. Encourages the nurse to stay in their current profession.

6. As a victim of lateral violence, you should:
    a. Use the PASS technique.
    b. Talk about the incident with your coworkers.
    c. Report the incident to your supervisor.
    d. Threaten the offender.

Pool 2 (4 or 2 questions)

TRUE/FALSE

7. Violence in the workplace is a financial burden for the healthcare organization.

8. An increasing number of healthcare staff are being subjected to violent situations.

9. Every employee in a healthcare organization has the right to a safe and healthy work environment.

10. Health care workers face significant risks of workplace violence.

11. Workplace violence only occurs in the emergency department.

12. Lateral violence includes incidents between coworkers in which psychological injury is inflicted.

13. Workplace violence results in low staff morale and high worker turnover.

14. Violence against health care workers is grossly underreported.

Workplace Violence Prevention - Clinics

Lesson 1: Objectives

At the end of the course, participants will be able to:

- ❖ Define workplace violence;
- ❖ List risk factors associated with violence in healthcare organizations;
- ❖ Identify workplace violence prevention measures;
- ❖ Detail how to keep safe when encountering verbal or physical violence or the potential for violence;
- ❖ Define lateral violence and its negative effects; and
- ❖ Describe the importance of reporting all incidences of workplace violence.

Introduction

Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. Workplace violence ranks among the top four causes of death in the workplace and is a major concern for employers and employees. Health care workers face significant risks of workplace violence. The rate of serious workplace violence incidents is more than four times greater in healthcare than in private industry. In fact, health care accounts for nearly as many serious violent injuries as all other industries combined. Many more assaults or threats go unreported. Forms of violence to health care workers include biting, kicking, punching, pushing, pinching, shoving, scratching, spitting, name calling, intimidating, threatening, yelling, harassing, stalking, beating, choking, stabbing and killing. Possible sources of violence include patients, visitors, intruders, and even coworkers.

Lesson 2: Risk Factors

While no specific diagnosis or type of patient predicts future violence, studies show that inpatient and acute psychiatric services, geriatric long-term care settings, high volume urban emergency departments and residential and day social services present the highest risks. Risk factors for health care workers include:

- Individuals in pain, who have been given a devastating prognosis, or whose disease is progressing;
- Individuals in unfamiliar surroundings;
- Working directly with people who have a history of violence, abuse drugs or alcohol, gang members, and relatives of patients or clients;
- Individuals with altered mental status or mental illness;
- Patients in police custody;
- Transporting patients and clients;
- Working alone in a facility or in a patient’s home;

- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident;
- Poorly lit corridors, rooms, parking lots and other areas;
- Lack of means of emergency communication;
- Presence of firearms, knives and other weapons among patients and their families and friends;
- Working in neighborhoods with high crime rates;
- Lack of policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff;
- Working when understaffed—especially during mealtimes and visiting hours;
- High worker turnover;
- Inadequate security and mental health personnel on site;
- Long waits and overcrowded, uncomfortable waiting rooms;
- Unrestricted movement of the public within the facility; and the
- Perception that violence is tolerated, and victims will not be able to report the incident to police and/or press charges.

LESSON 3: Workplace Violence Prevention

Workplace violence comes at a high cost. In addition to the cost of workers compensation, increased insurance premiums, and lawsuits, workplace violence results in low staff morale and high worker turnover.

Your organization has a comprehensive workplace violence prevention program. The program has full support of management and includes worker involvement. Your organization has performed an assessment to identify existing and potential hazards that may lead to incidents of workplace violence and has committed to preventing or controlling these hazards. Recordkeeping and ongoing evaluation help determine the program's effectiveness and identify any deficiencies or changes that should be made. All staff members are informed of potential hazards and taught how to protect themselves and their coworkers.

LESSON 4: Keep Yourself Safe

Health care workers must be alert and ready to act when they encounter verbal or physical violence, or the potential for violence. Your response to defensive behavior is often the key to avoiding a physical confrontation with someone who has lost control of their behavior.

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