CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Parts C & D Fraud, Waste, and Abuse Training and General Compliance Training

Developed by the Centers for Medicare & Medicaid Services

Issued: February, 2013

Important Notice

This training module consists of two parts: (1) Medicare Parts C & D Fraud, Waste, and Abuse (FWA) Training and (2) Medicare Parts C & D General Compliance Training. All persons who provide health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. This module *may* be used to satisfy both requirements.

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1) Fraud, Waste, and Abuse Training

2) General Compliance Training

CENTERS FOR MEDICARE & MEDICAID SERVICES

Part 1: Medicare Parts C and D Fraud, Waste, and Abuse Training

Developed by the Centers for Medicare & Medicaid Services

FWA Training Exception - Notice

There is one exception to the FWA training and education requirement. Regulations effective June 7, 2010 implemented a “deeming” exception which exempts FDRs who are enrolled in Medicare Parts A or B from annual FWA training and education. Therefore, if an entity or an individual is enrolled in Medicare Parts A or B, the FWA training and education requirement has already been satisfied. If you are unsure if this “deeming” exception applies to you please contact your sponsor for more information.

Why Do I Need Training?

Every year *millions* of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

Including <u>YOU</u>.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

<u>YOU</u> are part of the solution.

Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse
- Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
- Provide information on how to report fraud, waste, and abuse
- Provide information on laws pertaining to fraud, waste, and abuse

Requirements

The Social Security Act and CMS regulations and guidance govern the Medicare program, including parts C and D.

- Part C and Part D sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
- Sponsors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Where Do I Fit In?

As a person who provides health or administrative services to a Part C or Part D enrollee you are either:

- Part C or D Sponsor Employee
- First Tier Entity
  - Examples: PBM, a Claims Processing Company, contracted Sales Agent
- Downstream Entity
  - Example: Pharmacy
- Related Entity
  - Example: Entity that has a common ownership or control of a Part C/D Sponsor

What are my responsibilities?

You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Part C or Part D requirements, including adopting and implementing an effective compliance program.
- **SECOND** you have a duty to the Medicare Program to report any violations of laws that you may be aware of.
- **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.

An Effective Compliance Program

- Is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste and abuse.

- Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Prevention

How Do I Prevent Fraud, Waste, and Abuse?

- Make sure you are up to date with laws, regulations, policies.
- Ensure you coordinate with other payers.
- Ensure data/billing is both accurate and timely.
- Verify information provided to you.
- Be on the lookout for suspicious activity.

Policies and Procedures

Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Make sure you are familiar with your entity's policies and procedures.

Detection

Understanding Fraud, Waste and Abuse

In order to detect fraud, waste, and abuse

you need to know the **Law**

Criminal FRAUD

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.

18 United States Code §1347

What Does That Mean?

Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse

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

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

Differences Between Fraud, Waste, and Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

Report Fraud, Waste, and Abuse

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your compliance department or your sponsor's compliance department . Your sponsor's compliance department area will investigate and make the proper determination.

Indicators of Potential Fraud, Waste, and Abuse

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

Indicators of Potential Fraud, Waste, and Abuse

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your role as a sponsor, pharmacy, or other entity involved in the Part C and/or Part D programs.

Key Indicators: Potential Beneficiary Issues

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

Key Indicators: Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?

Key Indicators: Potential Provider Issues

- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill the sponsor for services not provided?

Key Indicators: Potential Pharmacy Issues

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Are generics provided when the prescription requires that brand be dispensed?

Key Indicators: Potential Pharmacy Issues

- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?

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 AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?

Key Indicators: Potential Manufacturer Issues

- Does the manufacturer promote off label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a federal health care program?

Key Indicators: Potential Sponsor Issues

- Does the sponsor offer cash inducements for beneficiaries to join the plan?
- Does the sponsor lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?
- Does the sponsor use unlicensed agents?
- Does the sponsor encourage/support inappropriate risk adjustment submissions?

How Do I Report Fraud, Waste, or Abuse?

Reporting Fraud, Waste, and Abuse

Everyone is required to report suspected instances of fraud, waste, and Abuse. Your sponsor's Code of Conduct and Ethics should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.

Reporting Fraud, Waste, and Abuse

Every MA-PD and PDP sponsor is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities. Each sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting. Review your sponsor's materials for the ways to report fraud, waste, and abuse.

When in doubt, call the MA-PD or PDP fraud, waste, and abuse Hotline or the Compliance Department.

Correction

Correction

Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government money and ensures you are in compliance with CMS' requirements.

How Do I Correct Issues?

Once issues have been identified, a plan to correct the issue needs to be developed. Consult your compliance officer or your sponsor's compliance officer to find out the process for the corrective action plan development.

The actual plan is going to vary, depending on the specific circumstances.

Laws You Need to Know About

Laws

The following slides provide very high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

Civil Fraud
Civil False Claims Act

Prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it's true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733

Civil False Claims Act Damages and Penalties

The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

Criminal Fraud Penalties

If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code §1347

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 (which includes the Medicare program).

42 United States Code §1320a-7b(b)

Anti-Kickback Statute Penalties

Fine of up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment.

Stark Statute (Physician Self-Referral Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn

Stark Statute Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with Stark are not payable. Up to a **$15,000** fine for each service provided. Up to **a $100,000** fine for entering into an arrangement or scheme.

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 Office of Inspector General.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

HIPAA

Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

Consequences

Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs

Scenario #1

A person comes to your pharmacy to drop 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?

Scenario #1

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

Scenario #1 Answer

Answer: C

Call the prescriber to verify

If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the sponsor's compliance hotline. The sponsor will provide next steps.

Scenario #2

Your job is to submit risk diagnosis to CMS for purposes of payment. As part of this job you are to verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the sponsor's process and to adjust/add risk diagnosis codes for certain individuals.

What do you do?

Scenario #2

A. Do what is asked of your immediate supervisor
B. Report the incident to the compliance department (via compliance hotline or other mechanism)
C. Discuss concerns with immediate supervisor
D. Contact law enforcement

Scenario #2 Answer

Answer: B

Report the incident to the compliance department (via compliance hotline or other mechanism)

The compliance department is responsible for investigating and taking appropriate action. Your sponsor/supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.

Scenario #3

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider ("Doe Diagnostics") has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics' claims far exceed any other provider that you reviewed.

What do you do?

Scenario #3

A. Call Doe Diagnostics and request additional information for the claims
B. Consult with your immediate supervisor for next steps
C. Contact the compliance department
D. Reject the claims
E. Pay the claims

Scenario # 3 Answer

Answers B or C

Consult with your immediate supervisor for next steps

or

Contact the compliance department

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance department have occurred, including whether additional documentation is necessary.

Scenario #4

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

Scenario #4

A. Call the local law enforcement
B. Perform another review
C. Contact your compliance department
D. Discuss your concerns with your supervisor
E. Follow your pharmacies procedures

Scenario #4 Answer

Answer E

Follow your pharmacies procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.

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CONGRATULATIONS!

You have completed the Centers for Medicare & Medicaid Services Parts C & D Fraud, Waste and Abuse Training

<TYPE YOUR NAME HERE>

<Insert Today's Date>

NOTICE

This concludes the Medicare Parts C & D Fraud, Waste and Abuse training. Please select the next slide to take the Medicare Parts C & D Compliance Training.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Part 2: Medicare Parts C & D Compliance Training

Developed by the Centers for Medicare & Medicaid Services

IMPORTANT NOTICE

This training module will assist Medicare Parts C and D plan Sponsors in satisfying the Compliance training requirements of the Compliance Program regulations at 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi) and in Section 50.3 of the Compliance Program Guidelines found in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

While Sponsors may choose to use this module to satisfy compliance training requirements, completion of this training in and of itself does not ensure that a Sponsor has an "effective Compliance Program." Sponsors are responsible for ensuring the establishment and implementation of an effective Compliance Program in accordance with CMS regulations and program guidelines.

Why Do *I* Need Training?

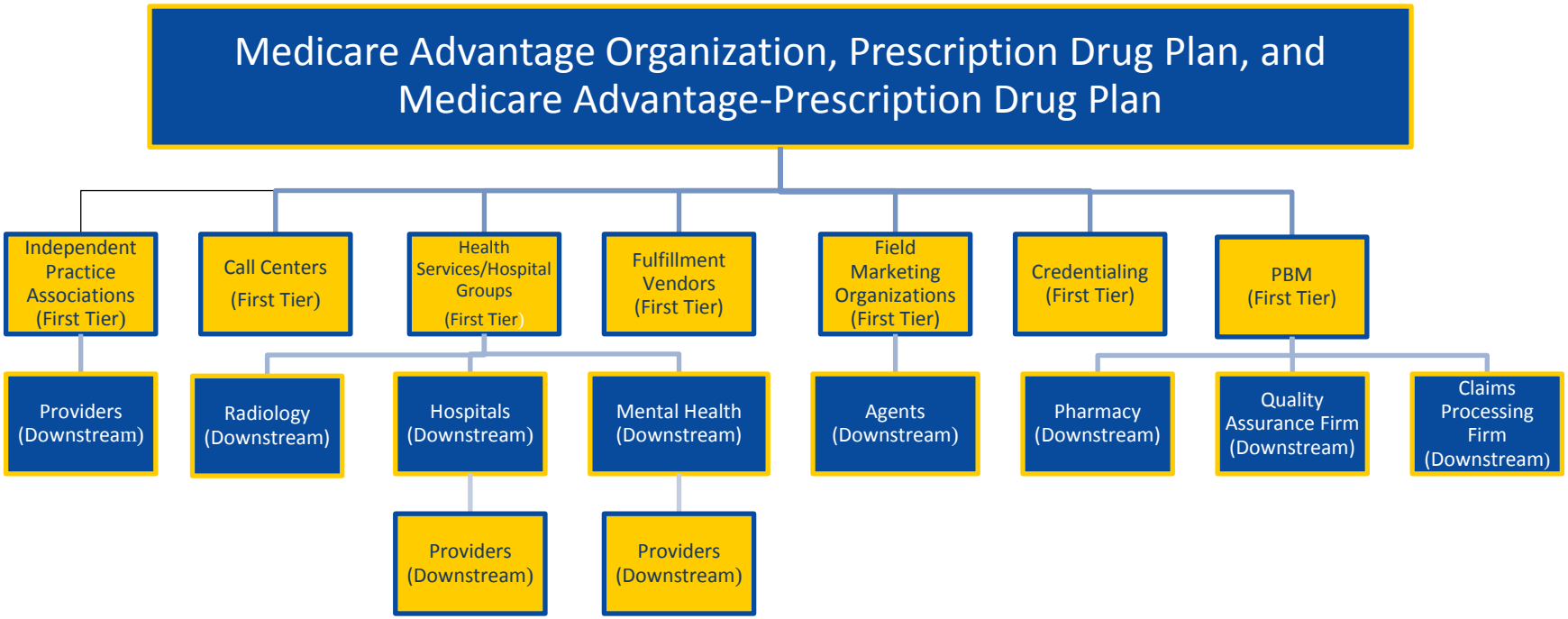
Compliance is EVERYONE'S responsibility!

As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare program, or the Medicare trust fund.

Training Objectives

- To understand the organization's commitment to ethical business behavior
- To understand how a compliance program operates
- To gain awareness of how compliance violations should be reported

Where Do I Fit in the Medicare Program?



Background

- CMS requires Medicare Advantage, Medicare Advantage-Prescription Drug, and Prescription Drug Plan Sponsors ("Sponsors") to implement an effective compliance program.

- An effective compliance program should:

Compliance

A culture of compliance within an organization:

- Prevents noncompliance
- Detects noncompliance
- Corrects noncompliance

Compliance Program Requirements

At a minimum, a compliance program must include the 7 core requirements:

1. Written Policies, Procedures and Standards of Conduct;
2. Compliance Officer, Compliance Committee and High Level Oversight;
3. Effective Training and Education;
4. Effective Lines of Communication;
5. Well Publicized Disciplinary Standards;
6. Effective System for Routine Monitoring and Identification of Compliance Risks; and
7. Procedures and System for Prompt Response to Compliance Issues

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual ("IOM"), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9

Compliance Training

- CMS expects that all Sponsors will apply their training requirements and "effective lines of communication" to the entities with which they partner.

- Having "effective lines of communication" means that employees of the organization and the partnering entities have several avenues through which to report compliance concerns.

Ethics – Do the Right Thing!

Act Fairly and Honestly

Comply with the letter and spirit of the law

As a part of the Medicare program, it is important that you conduct yourself in an ethical and legal manner.

It's about doing the right thing!

Adhere to high ethical standards in all that you do

Report suspected violations

How Do I Know What is Expected of Me?

Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which an organization operates.

Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations.

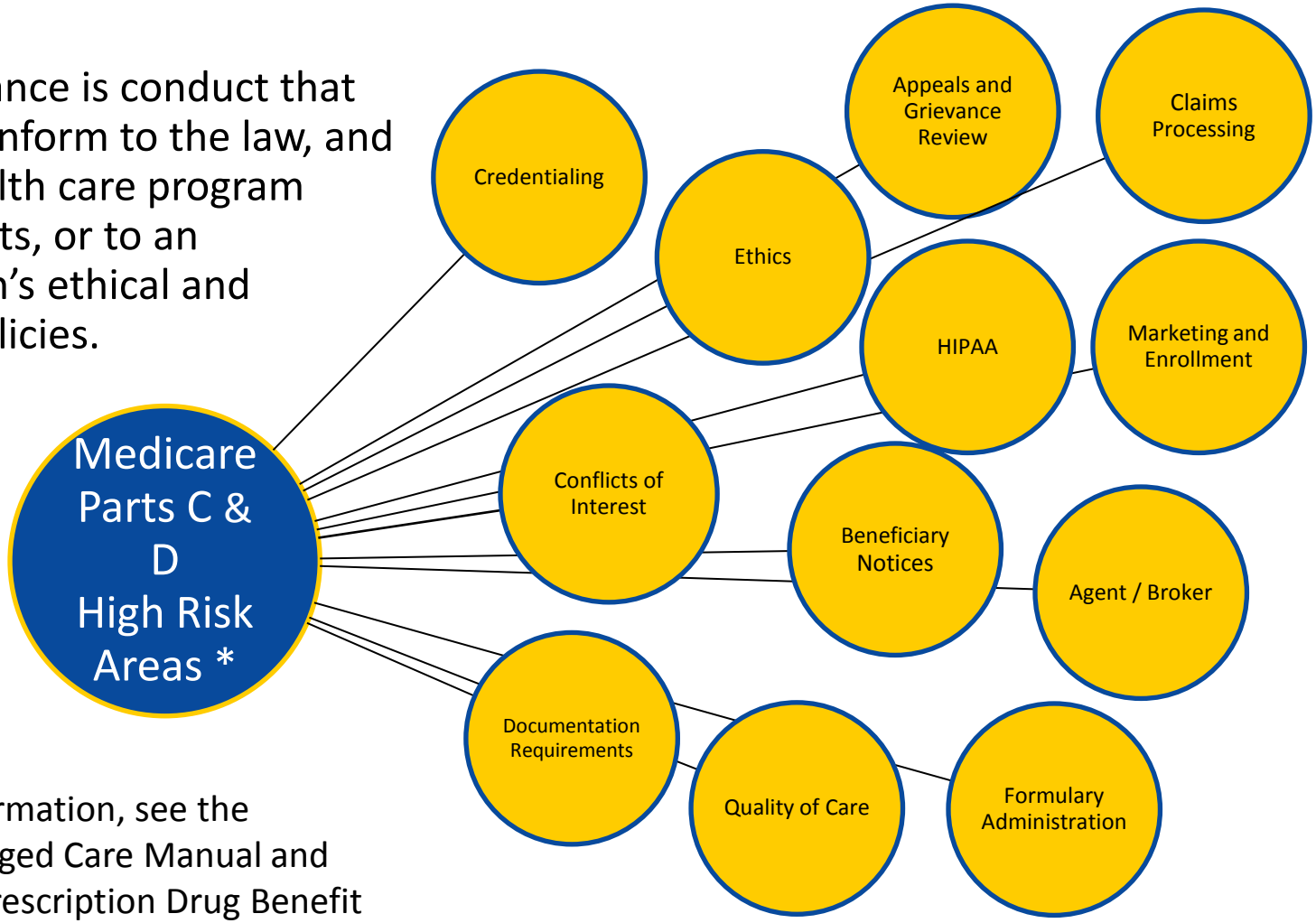
How Do I Know What is Expected of Me (cont.)?

Everyone is required to report violations of Standards of Conduct and suspected noncompliance.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report.

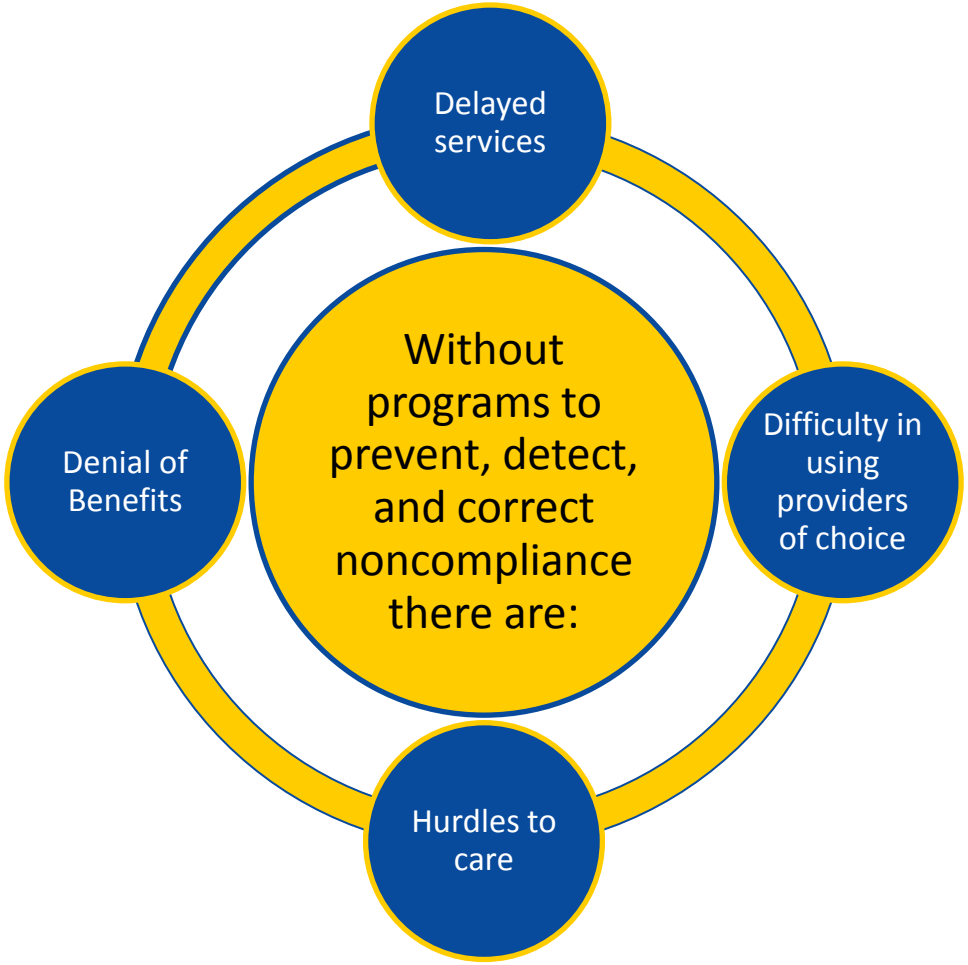
What Is Noncompliance?

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



* For more information, see the Medicare Managed Care Manual and the Medicare Prescription Drug Benefit Manual on http://www.cms.gov

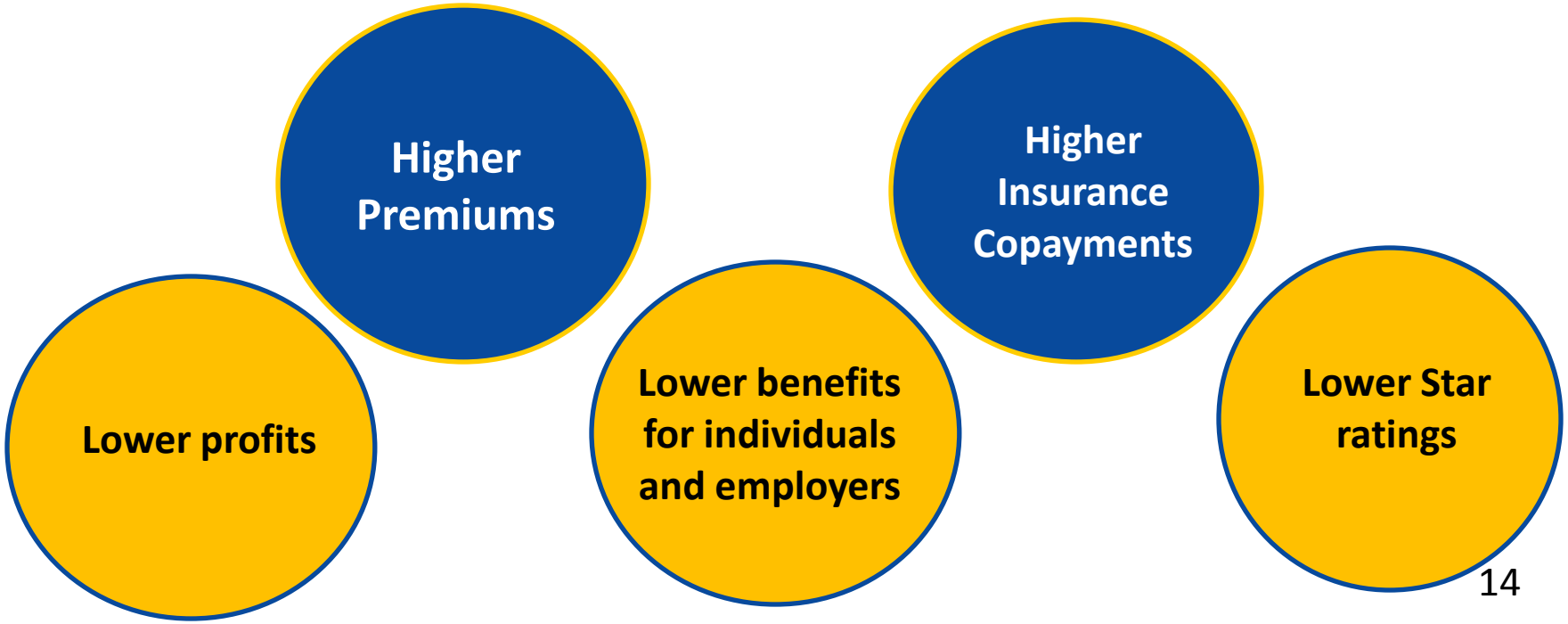
Noncompliance Harms Enrollees



Noncompliance Costs Money

Non Compliance affects EVERYBODY!

Without programs to prevent, detect, and correct noncompliance you risk:



I'm Afraid to Report Noncompliance

There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.

Each Sponsor must offer reporting methods that are:

Confidential

Anonymous

Non-Retaliatory

How Can I Report Potential Noncompliance?

Employees of an MA, MA-PD, or PDP Sponsor

- Call the Medicare Compliance Officer
- Make a report through the Website
- Call the Compliance Hotline

FDR Employees

- Talk to a Manager or Supervisor
- Call Your Ethics/Compliance Help Line
- Report through the Sponsor

Beneficiaries

- Call the Sponsor's compliance hotline
- Make a report through Sponsor's website
- Call 1-800-Medicare

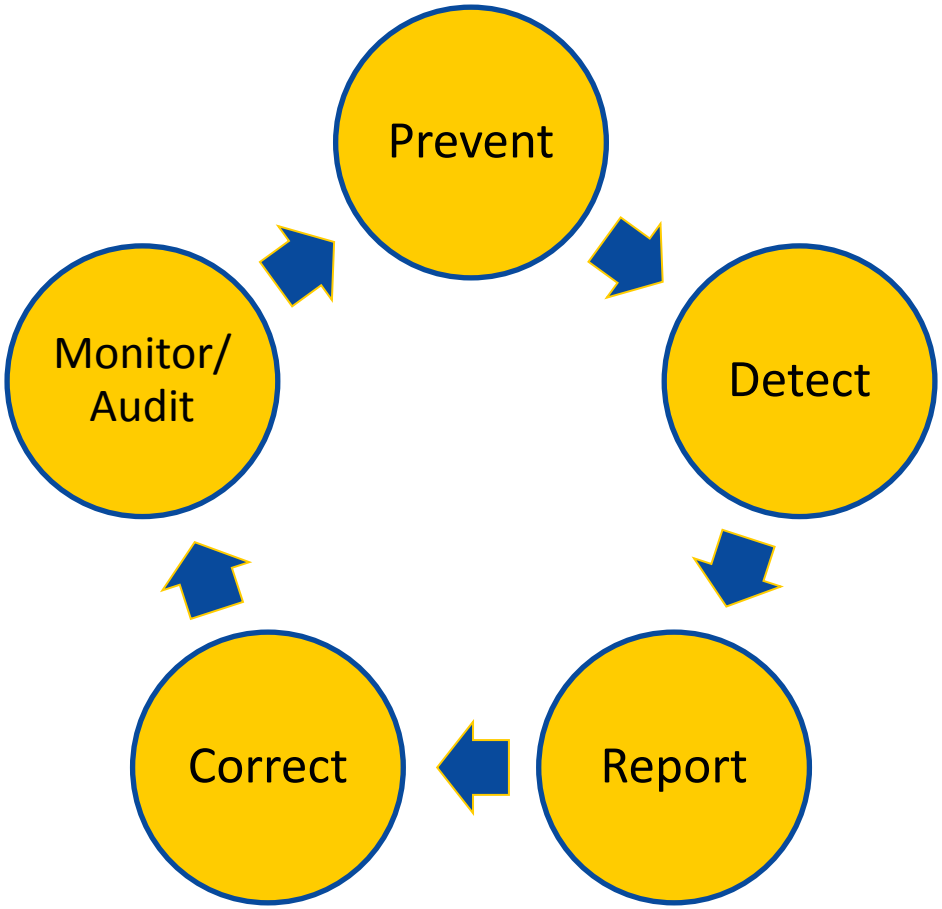
What Happens Next?

Correcting Noncompliance

- Avoids the recurrence of the same noncompliance
  - Promotes efficiency and effective internal controls
    - Protects enrollees
      - Ensures ongoing compliance with CMS requirements

How Do I Know the Noncompliance Won't Happen Again?

- Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.
- Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.
- Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures



Know the Consequences of Noncompliance

Your organization is required to have disciplinary standards in place for non-compliant behavior. Those who engage in non-Compliant behavior may be subject to any of the following:

Compliance is EVERYONE'S Responsibility!!

PREVENT

- Operate within your organization's ethical expectations to PREVENT noncompliance!

DETECT & REPORT

- If you DETECT potential noncompliance, REPORT it!

CORRECT

- CORRECT noncompliance to protect beneficiaries and to save money!

Scenario 1

You have discovered an unattended email address or fax machine in your office which receives beneficiary appeals requests.

You suspect that no one is processing the appeals. What should you do?

Scenario 1

A) Contact Law Enforcement
B) Nothing
C) Contact your Compliance Department
D) Wait to confirm someone is processing the appeals before taking further action
E) Contact your supervisor

Scenario 1

The correct answer is: C – Contact your Compliance Department.

Suspected or actual noncompliance should be reported immediately upon discovery. It is best to report anything that is suspected rather than wait and let the situation play out.

Your Sponsor's compliance department will have properly trained individuals who can investigate the situation and then, as needed, take steps to correct the situation according to the Sponsor's Standards of Conduct and Policies and Procedures.

Scenario 2

A sales agent, employed by the Sponsor's first-tier or downstream entity, has submitted an application for processing and has requested two things:

i) the enrollment date be back-dated by one month

ii) all monthly premiums for the beneficiary be waived

What should you do?

Scenario 2

A) Refuse to change the date or waive the premiums, but decide not to mention the request to a supervisor or the compliance department

B) Make the requested changes because the sales agent is responsible for determining the beneficiary's start date and monthly premiums

C) Tell the sales agent you will take care of it, but then process the application properly (without the requested revisions). You will not file a report because you don't want the sales agent to retaliate against you

D) Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.

E) Contact law enforcement and CMS to report the sales agent's behavior.

Scenario 2

The correct answer is: D - Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.

The enrollment application should be processed in compliance with CMS regulations and guidance. If you are unclear about the appropriate procedure, then you can ask your supervisor or the compliance department for additional, job-specific training.

Your supervisor and the compliance department should be made aware of the sales agent's request so that proper retraining and any necessary disciplinary action can be taken to ensure that this behavior does not continue. *No one*, including the sales agent, your supervisor, or the Compliance Department, can retaliate against you for a report of noncompliance made in good faith.

Scenario 3

You work for an MA-PD Sponsor. Last month, while reviewing a monthly report from CMS, you identified multiple enrollees for which the Sponsor is being paid, who are not enrolled in the plan.

You spoke to your supervisor, Tom, who said not to worry about it. This month, you have identified the same enrollees on the report again.

What do you do?

Scenario 3

A) Decide not to worry about it as your supervisor, Tom, had instructed. You notified him last month and now it's his responsibility.

B) Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting. To be safe, you submit a report through your Compliance Department's anonymous tip line so that you cannot be identified.

C) Wait until next month to see if the same enrollees are on the report again, figuring it may take a few months for CMS to reconcile its records. If they are, then you will say something to Tom again.

D) Contact law enforcement and CMS to report the discrepancy.

E) Ask Tom about the discrepancies again.

Scenario 3

The correct answer is: B - Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting. To be safe, you submit a report through your Compliance Department's anonymous tip line so that you cannot be identified.

There can be no retaliation for reports of noncompliance made in good faith. To help promote reporting, Sponsors should have easy-to-use, confidential reporting mechanisms available to its employees 24 hours a day, 7 days a week.

It is best to report any suspected noncompliance to the Compliance Department promptly to ensure that the Sponsor remains in compliance with CMS requirements. Do the right thing! Compliance is everyone's responsibility.

What Governs Compliance?

- **Social Security Act:**
  - Title 18
- **Code of Federal Regulations*:**
  - 42 CFR Parts 422 (Part C) and 423 (Part D)
- **CMS Guidance:**
  - Manuals
  - HPMS Memos
- **CMS Contracts:**
  - Private entities apply and contracts are renewed/non-renewed each year
- **Other Sources:**
  - OIG/DOJ (fraud, waste and abuse (FWA))
  - HHS (HIPAA privacy)
- **State Laws:**
  - Licensure
  - Financial Solvency
  - Sales Agents

** 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)*

Additional Resources

- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
  - Title XVIII of the Social Security Act
  - Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
  - Civil False Claims Act (31 U.S.C. §§ 3729-3733)
  - Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
  - Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
  - Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)
  - Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)
  - OIG Compliance Program Guidance for the Healthcare Industry: http://oig.hhs.gov/compliance/compliance-guidance/index.asp

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CONGRATULATIONS!

You have completed the Centers for Medicare & Medicaid Services Parts C & D Compliance Training

<TYPE YOUR NAME HERE>

<Insert Today's Date>