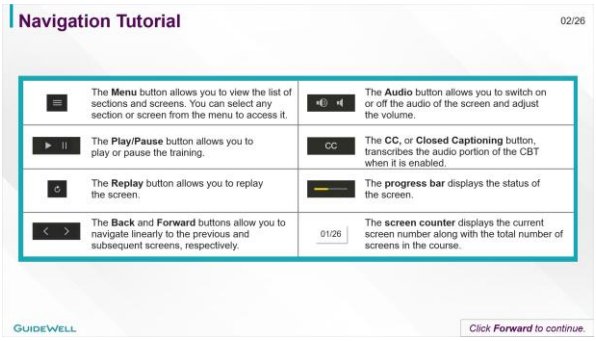

**Notes:**

Welcome to the Fraud, Waste, and Abuse Training course.

Click the **Launch** button to begin.




**Notes:**

Please take a moment to review the navigation instructions displayed on your screen.

Please ensure that you are using the Chrome browser to view this course. If not, please exit and restart in the Chrome browser. It's also important to close other applications while taking this course.

Click the forward button when you're ready to continue.


**Notes:**

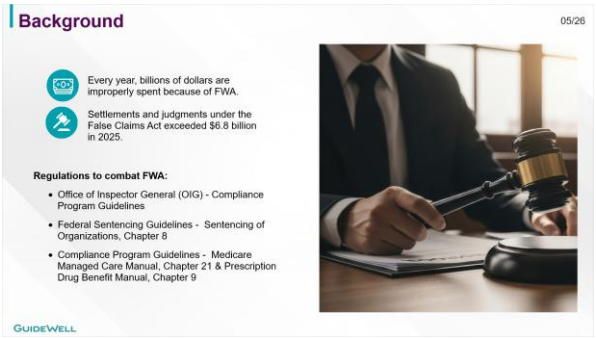
The purpose of this training is to educate you on the critical issue of fraud, waste, and abuse (FWA) in health care, and equip you with the knowledge to prevent, detect, and report potential FWA violations as a GuideWell employee or contractor.

Additionally, the Centers for Medicare and Medicaid Services (CMS) requires all our employees, our governing body, and our First-Tier, Downstream, and Related Entities (FDRs) to receive training about FWA.

To successfully complete this training, you will need to access and view every page of the course; score 100% in the course assessment and complete the attestation statement. This will ensure that you have a thorough understanding of the material and can apply it to your work.


**Notes:**

After completing this course, you will be able to define FWA; identify instances of FWA in health care programs; understand major laws and regulations related to FWA; report potential FWA violations; and recognize how to identify, prevent, and correct FWA.




**Notes:**

Every year, billions of dollars are improperly spent because of fraud, waste, and abuse (FWA). This is a critical issue across the healthcare industry, impacting the individuals and communities we serve. In fact, for the most recent fiscal year ending on September 30, 2025, False Claims Act settlements and judgments exceeded $6.8 billion, the highest amount in a single year in the history of the False Claims Act.

These significant financial losses underscore the importance of combating FWA. To address this issue, several regulations and guidelines have been established. These include the Office of Inspector General (OIG) Compliance Program Guidelines, the Federal Sentencing Guidelines (Sentencing of Organizations, Chapter 8), and the Compliance Program Guidelines in the Medicare Managed Care Manual (Chapter 21) and the Prescription Drug Benefit Manual (Chapter 9).

Next, let’s define the terms fraud, waste, and abuse.


**Notes:**

Understanding the terms fraud, waste, and abuse is crucial. These three concepts are often used interchangeably, but they have distinct meanings and implications.

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.

Waste, on the other hand, refers to the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the health care benefit program. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

And finally, abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the health care benefit program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

The key difference between fraud, waste, and abuse lies in the intent and knowledge behind the action. Fraud involves intentional deception with knowledge of wrongdoing, whereas waste and abuse may result from improper payments or unnecessary costs, but without the same level of intent and knowledge.

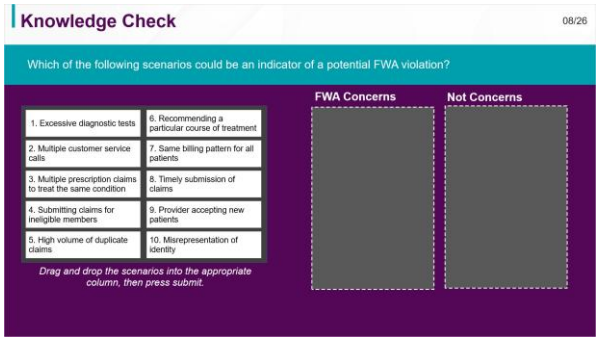
Next, let's review some examples of fraud, waste, and abuse.

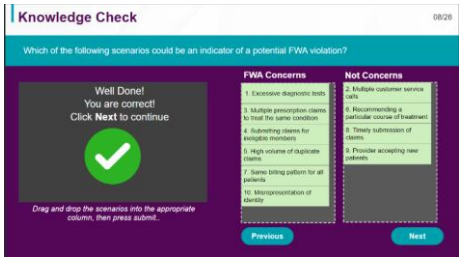

**Notes:**

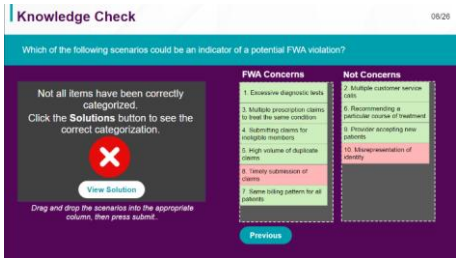
Actions that may constitute health care fraud include: knowingly billing for services not furnished or supplies not provided; knowingly billing for nonexistent prescriptions; knowingly altering claim forms, medical records, or receipts to receive a higher payment; knowingly encouraging or supporting inaccurate risk adjustment submissions at the plan sponsor level; or knowingly enrolling someone without their knowledge or consent.

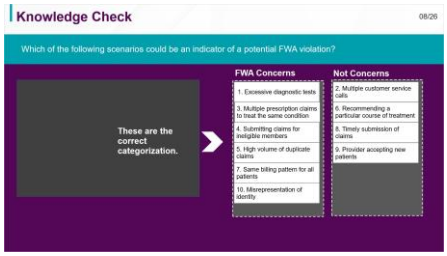
Whereas examples of waste may include: conducting excessive office visits or writing excessive prescriptions; prescribing more medications than necessary for treating a specific condition; or ordering excessive laboratory tests.

And finally, examples of actions that may constitute abuse include: billing for unnecessary medical services; billing for brand name drugs when generics are dispensed; billing for a more expensive procedure or service than was provided, also known as upcoding; or accidentally or consistently using incorrect billing codes that result in higher reimbursement, also known as miscoding.




**Notes:**

Let’s apply what you’ve just learned about FWA in a knowledge check.

Which of the following scenarios could be an indicator of a potential FWA violation?

Sort the following scenarios by dragging them into the appropriate column, and then press “Submit”.

- Excessive diagnostic tests
- Multiple customer service calls
- Multiple prescription claims to treat the same condition
- Submitting claims for ineligible members
- High volume of duplicate claims
- Recommending a particular course of treatment
- Same billing pattern for all patients
- Timely submission of claims
- Provider accepting new patients

- Misrepresentation of identity

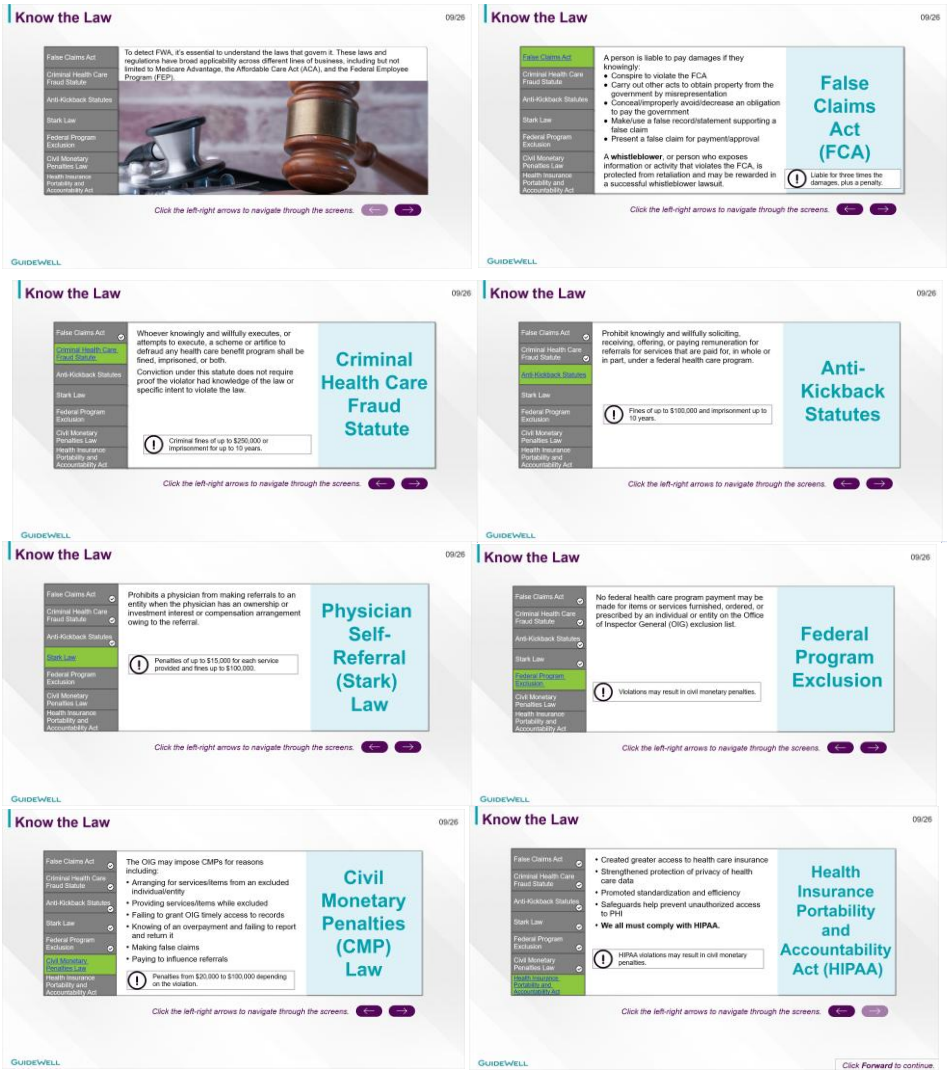
Well Done! You are correct! Click Next to continue.

or

Sorry, not all items have been correctly categorized. Click the View Solution button to see the correct categorization.

or

These are the correct categorizations. Click Next to continue.




**Notes:**

To detect FWA, it's essential to understand the laws that govern it. These laws and regulations have broad applicability across different lines of business, including but not limited to Medicare Advantage, the Affordable Care Act (ACA), and the Federal Employee Program (FEP). Click the right arrow to continue.

The **False Claims Act**, or the FCA, makes a person liable to pay damages to the government if they knowingly conspire to violate the FCA, carry out other acts to obtain property from the government by misrepresentation, or conceal or improperly avoid or decrease an obligation to pay the government, make or use a false record or statement supporting a false claim, or present a false claim for payment or approval.

Any person who knowingly submits a false claim to the government is liable for three times the government's

**Commented [MK1]:** Should we update Anti-Kickback Statutes to singular form **Anti-Kickback Statute** so that it is consistent with how it is referred to on OIG web?

If yes, slide will also need to edit Prohibit to **Prohibits**

**Commented [SN2R1]:** No, this was changed based on feedback from Legal since there are multiple anti-kickback statutes.

damages caused by the violation, plus a penalty.

The whistleblower provision of the FCA protects individuals who expose information or activity that is deemed illegal, dishonest, or violates professional or clinical standards. They may also be rewarded a percentage of the money collected in a successful lawsuit.

You can read more about the law by clicking the link in the green box or click the right arrow to continue.

The **Criminal Health Care Fraud Statute** states that anyone who knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program shall be fined, or imprisoned, or both. Conviction under the statute does not require proof the violator knew the law or had specific intent to violate the law.

People who knowingly make a false claim may be subject to criminal fines of up to $250,000 or imprisonment for up to 10 years. If the violations resulted in death, the individual may be imprisoned for any term of years, or life.

You can read more about the law by clicking the link in the green box or click the right arrow to continue.

The **Anti-Kickback Statutes** prohibit knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid for, in whole or in part, under a federal health care program (including the Medicare program).

Commented [MK3]: Related to comment above

Commented [SN4R3]: Not changing based on previous response.

Damages and penalties may be punishable by a fine of up to $100,000 and imprisonment up to 10 years.

You can read more about the law by clicking the link in the green box or click the right arrow to continue.

The **Stark Law**, also referred to as the Physician Self-Referral law, prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of the physician's family) has an ownership or investment interest or compensation arrangement as a result of the referral. Medicare claims tainted by an arrangement that does not comply with the Stark Law are not payable.

A penalty of up to $15,000 can be imposed for each service provided. There may also be a fine up to $100,000 for entering into an unlawful arrangement or scheme.

You can read more about the law by clicking the link in the green box or click the right arrow to continue.

**Federal program exclusion** is governed by the Office of Inspector General (OIG), which has the authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and

Entities (LEIE). 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. Violations may result in civil monetary penalties.

You can read more about the law by clicking the link in the green box or click the right arrow to continue.

Under the **Civil Monetary Penalties (CMP) law**, the OIG may impose a fine, known as a **civil monetary penalty,** 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 an overpayment and failing to report and return it, making false claims, or paying to influence referrals.

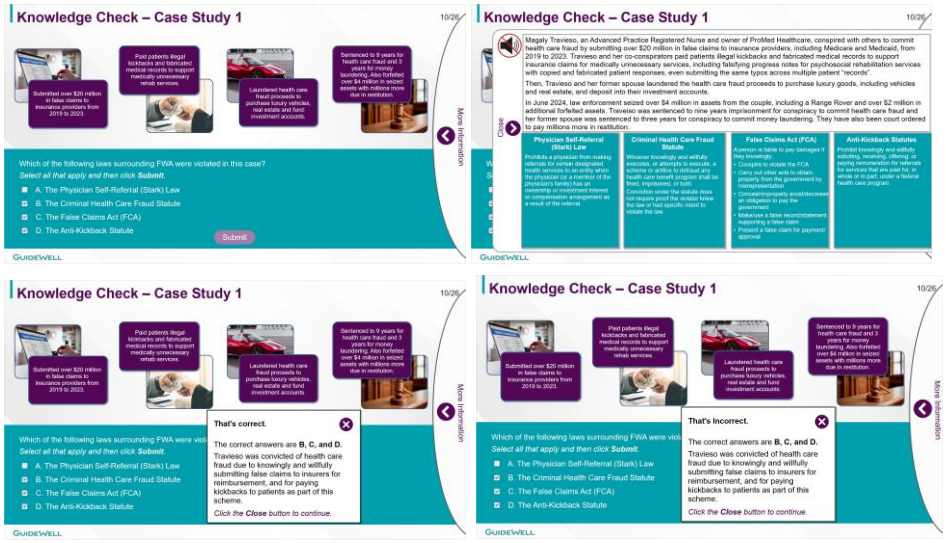
The penalties can be between $20,000 to $100,000 depending on the specific violation. Violators are also subject to three times the amount claimed for each service or item or of remuneration offered, paid, solicited, or received.

You can read more about the law by clicking the link in the green box or click the right arrow to continue.

The **Health Insurance Portability and Accountability Act**, commonly referred to as HIPAA, created greater access to health care insurance, strengthened health care data privacy protections, and promoted standardization and efficiency of the health care industry. HIPAA safeguards also help prevent unauthorized access to protected health information. As individuals with access to protected health information, we must all comply with HIPAA.

HIPAA violations may result in civil monetary penalties, or criminal penalties in some cases.

You can read more about the law by clicking the link in the green box or click the **Forward** button to continue.




**Notes:**

Next, let's review a couple of news stories covering health care violations and match them to the associated laws governing FWA.

In our first story, Magaly Travieso, an Advanced Practice Registered Nurse and owner of ProMed Healthcare, conspired with others to commit health care fraud by submitting over $20 million in false claims to insurance providers, including Medicare and Medicaid, from 2019 to 2023. Travieso and her co-conspirators paid patients illegal kickbacks and fabricated medical records to support insurance claims for medically unnecessary services, including falsifying progress notes for psychosocial rehabilitation services with copied and fabricated patient responses, even submitting the same typos across multiple patient "records".

Then, Travieso and her former spouse laundered the health care fraud proceeds to purchase luxury goods, including vehicles and real estate, and deposit into their investment accounts.

In June 2024, law enforcement seized over $4 million in assets from the couple, including a Range Rover and over $2 million in additional forfeited assets. Traveiso was sentenced to nine years imprisonment for conspiracy to commit health care fraud and her former spouse was sentenced to three years for conspiracy to commit money laundering. They have also been court ordered to pay millions more in restitution.

Which of the following laws surrounding FWA were violated in this case?

A. The Physician Self-Referral (Stark) Law
B. The Criminal Health Care Fraud Statute
C. The False Claims Act (FCA)
D. The Anti-Kickback Statute

Select all that apply and then click Submit.

You may click the "More Information" icon to the right of the screen at any time to review the scenario or refresh yourself with the laws.

That's correct.

The correct answers are B, C, and D.

Travieso was convicted of health care fraud due to knowingly and willfully submitting false claims to insurers for reimbursement, and for paying kickbacks to patients as part of this scheme.

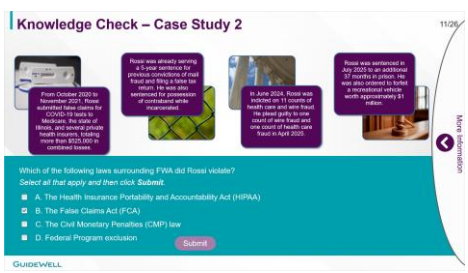
Click the Close button to continue.

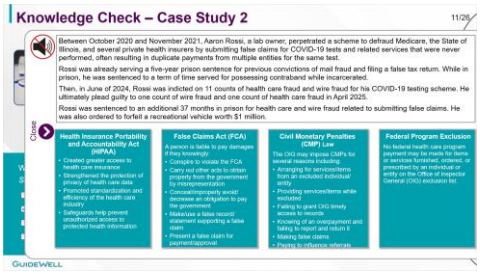
That's Incorrect.

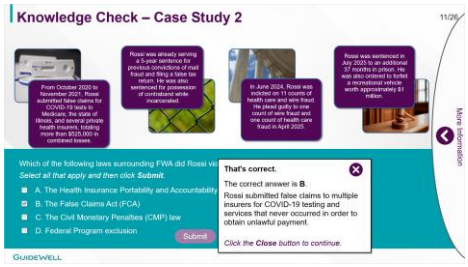
The correct answers are B, C, and D.

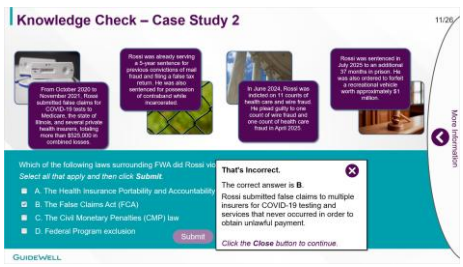
Travieso was convicted of health care fraud due to knowingly and willfully submitting false claims to insurers for reimbursement, and for paying kickbacks to patients as part of this scheme.

Click the Close button to continue.




**Notes:**

Between October 2020 and November 2021, Aaron Rossi, a lab owner, perpetrated a scheme to defraud Medicare, the State of Illinois, and several private health insurers by submitting false claims for COVID-19 tests and related services that were never performed, often resulting in duplicate payments from multiple entities for the same test.

Rossi was already serving a five-year prison sentence for previous convictions of mail fraud and filing a false tax return. While in prison, he was sentenced to a term of time served for possessing contraband while incarcerated.

Then, in June of 2024, Rossi was indicted on 11 counts of health care fraud and wire fraud for his COVID-19 testing scheme. He ultimately plead guilty to one count of wire fraud and one count of health care fraud in April 2025.

Rossi was sentenced to an additional 37 months in prison for health care and wire fraud related to submitting false claims. He was also ordered to forfeit a recreational vehicle worth $1 million.

Which of the following laws surrounding FWA did Rossi violate?

A. The Health Insurance Portability and Accountability Act (HIPAA)
B. The False Claims Act (FCA)
C. The Civil Monetary Penalties (CMP) law
D. Federal Program exclusion

Select all that apply and then click Submit.

You may click the "More Information" icon to the right of the screen at any time to review the scenario or refresh yourself with the laws.

**That's correct.**

The correct answer is **B**.

Rossi submitted false claims to multiple insurers for COVID-19 testing and services that never occurred in order to obtain unlawful payment.

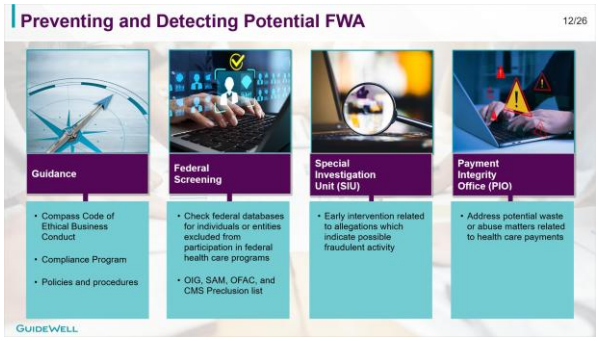
Click the **Close** button to continue.

**That's Incorrect.**

The correct answer is **B**.

Rossi submitted false claims to multiple insurers for COVID-19 testing and services that never occurred in order to obtain unlawful payment.

Click the **Close** button to continue.



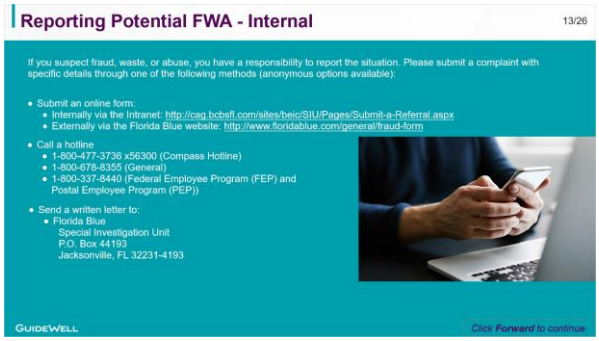

**Notes:**

Now that you understand the definitions and rules surrounding FWA, let’s explore the processes GuideWell has in place to prevent and detect potential instances of FWA.

Our company has established guidelines to prevent and detect FWA within our organizations through the Compass Code of Ethical Business Conduct, our Compliance Program, and through our written policies and procedures.

We check federal databases, including the Office of Inspector General (OIG) list, System for Award Management (SAM), Office of Foreign Assets Control (OFAC), and the CMS Preclusion List, to ensure that our employees, contractors, and anyone who provides items or services to federal health care programs, or directs or prescribes services, aren't excluded from participating in federal health care programs, as required by law, to prevent improper payments.

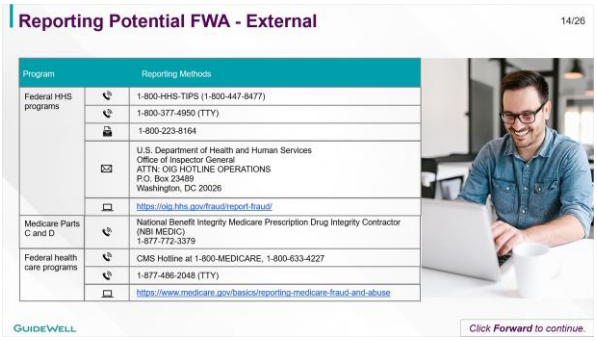
We have established a Special Investigation Unit, the SIU, within our organization, dedicated to preventing, identifying, and reporting potential situations of FWA. SIU aligns its strategy around early intervention related to allegations which indicate possible fraudulent activity. It partners closely with the Payment Integrity Office (PIO) to address potential waste or abuse matters related to health care payments. Please see the Corporate Policy website for more information on FWA.




**Notes:**

If you suspect FWA, you have a responsibility to report the situation. Please submit a complaint with specific details through one of the following methods. You may also submit a complaint anonymously. You may: submit an online complaint form; call the applicable fraud hotline; or write to GuideWell's Special Investigation Unit at the address displayed on your screen.

Click the Forward button to continue.




**Notes:**

Sometimes, it may be necessary for GuideWell to report fraudulent conduct outside of the organization to the OIG, the U.S. Department of Justice, or CMS. Individuals or entities that wish to voluntarily disclose self-discovered potential fraud to the OIG may do so under the Self-Disclosure Protocol. Self-disclosure gives people the opportunity to avoid the costs and disruptions associated with a government-directed investigation and civil or administrative proceedings.

When reporting suspected FWA, you should include contact information for the source of the information, suspects, and witnesses; details of the alleged FWA; identification of the specific Medicare rules allegedly violated; and the suspect's history of compliance, education, training, and communication with your organization or other entities.

To report suspected cases of FWA in Health and Human Services (HHS) programs, use the online OIG Hotline form. You may also call, mail, or fax HHS using the information provided on your screen.

For Medicare Parts C and D, contact the National Benefit Integrity Medicare Prescription Drug Integrity Contractor, also known as the NBI MEDIC.

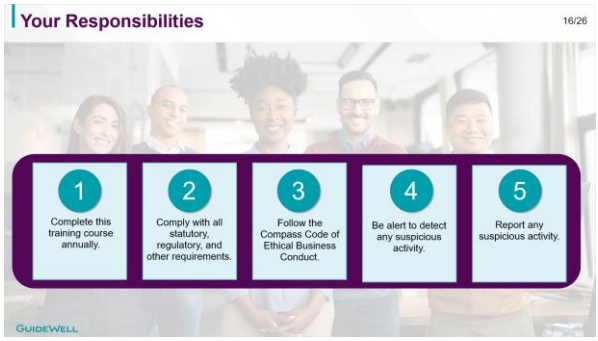
For all other federal health care programs, contact the CMS Hotline or use the form on the Medicare beneficiary website.

Click the **Forward** button to continue.


**Notes:**

FWA is investigated immediately (within two weeks) after the incident is reported to the appropriate area (SIU/Compliance).

The investigations may include, but are not limited to, the following actions and/or corrective controls: initiating recovery of monies or stopping checks as applicable; flagging providers for the prepay hold rule or placing contract controls on members, as necessary; considering providers for deactivation; making recommendations for operational controls to prevent future reoccurrences; referring documented cases internally to the Network area and/or Legal Affairs as appropriate; and referring documented cases, highly suggestive of health care fraud, to the proper law enforcement or other regulatory authorities (e.g., NBI MEDIC).




**Notes:**

You play a vital role in preventing, detecting, and reporting FWA. To do this, you must:

1. Complete this training course annually to stay up to date on FWA rules and regulations;
2. Comply with all statutory, regulatory, and other requirements applicable to the line of business you support.
3. Follow the Compass Code of Ethical Business Conduct that articulates your and GuideWell's commitment to standards of conduct and ethical rules of behavior;
4. Use the knowledge you've gained during this course to be alert to suspicious activity in your day-to-day work;
5. And finally, report any suspected or actual FWA violations of which you may be aware via the reporting mechanisms outlined in this training.


**Notes:**

Here is a recap of what you learned:

Fraud is intentionally submitting false information to any health care program to get money or a benefit.

Waste and abuse include practices that directly or indirectly result in unnecessary costs to health care programs.

In order to understand how to detect FWA, you need to know the False Claims Act (FCA); the Criminal Health Care Fraud Statute; the Anti-Kickback Statutes; the Stark Law (Physician Self-Referral Law); the Civil Monetary Penalties (CMP) Law; exclusion from all federal health care programs requirements; and the Health Insurance Portability and Accountability Act (HIPAA).

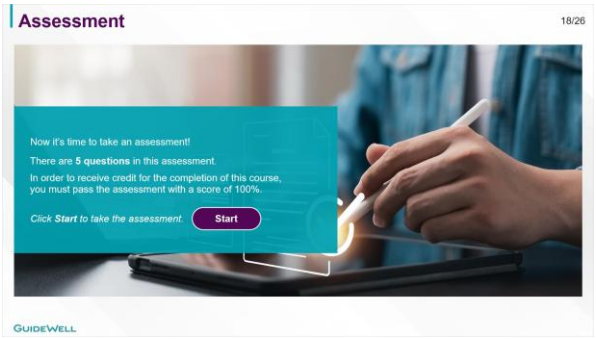
You should be alert to suspicious activity.

And, if you suspect fraud, waste, or abuse, you have a responsibility to report the situation by submitting an online fraud and abuse report form, emailing the Special Investigation Unit (SIU), calling the GuideWell fraud hotline, or writing to GuideWell's SIU.

When you are ready, click the forward button to begin the assessment.

**Commented [MK5]:** Suggest edit to singular form Anti-Kickback Statute

**Commented [SN6R5]:** Not changing, see previous comment.

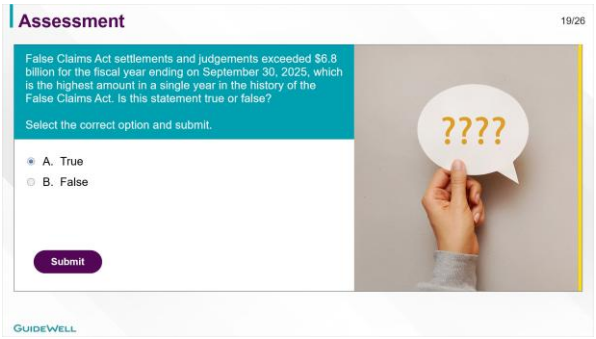



**Notes:**

Now it’s time to take an assessment!

There are five questions in this assessment. In order to receive credit for the completion of this course, you must pass the assessment with a score of 100%.

Click the Start button to take the assessment.



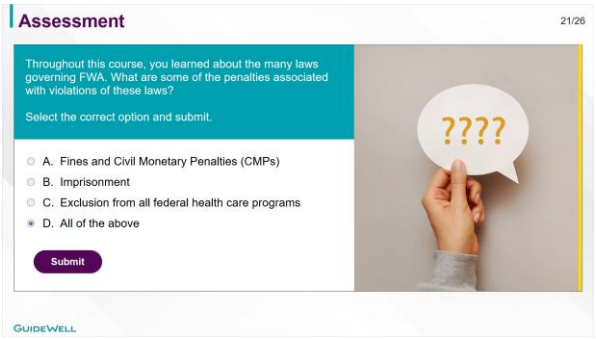

**Notes:**

Question 1. False Claims Act settlements and judgements exceeded $6.8 billion for the fiscal year ending on September 30, 2025, which is the highest amount in a single year in the history of the False Claims Act. Is this statement true or false?

A. True

B. False

Select the correct option and submit.




**Notes:**

Question 2: Throughout this course, you learned about the many laws governing FWA. What are some of the penalties associated with violations of these laws?

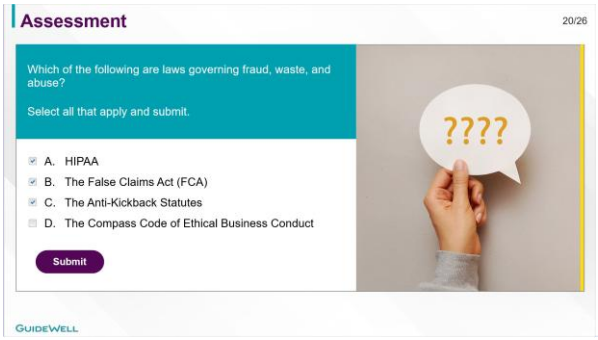
A. Fines and Civil Monetary Penalties (CMPs)

B. Imprisonment

C. Exclusion from all federal health care programs

D. All of the above

Select the correct option and submit.




**Notes:**

Question 3: Which of the following are laws governing FWA?

A. HIPAA

B. The False Claims Act (FCA)

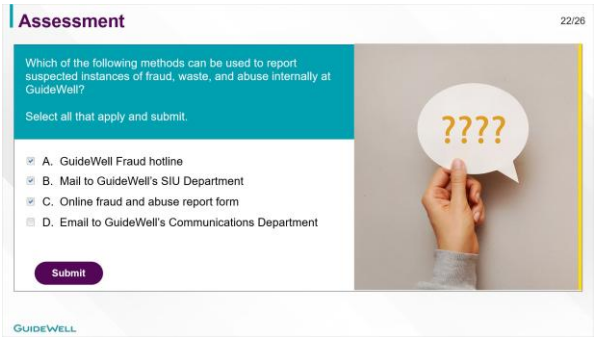
C. The Anti-Kickback Statutes

D. The Compass Code of Ethical Business Conduct

Select all that apply and submit.

**Commented [MK7]:** Suggest edit to singular form Anti-Kickback Statute

**Commented [SN8R7]:** Not changing, see previous comment.




**Notes:**

Question 4: Which of the following methods can be used to report suspected instances of FWA internally at GuideWell?

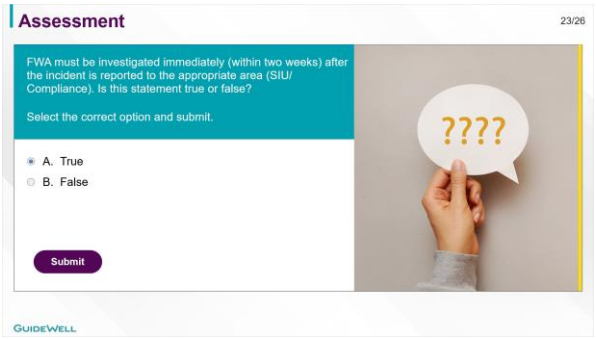
A. GuideWell Fraud hotline

B. Mail to GuideWell's SIU Department

C. Online fraud and abuse report form

D. Email to GuideWell's Communications Department

Select all that apply and submit.



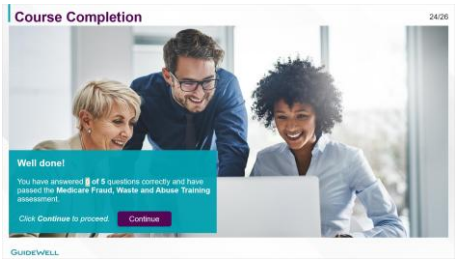

**Notes:**

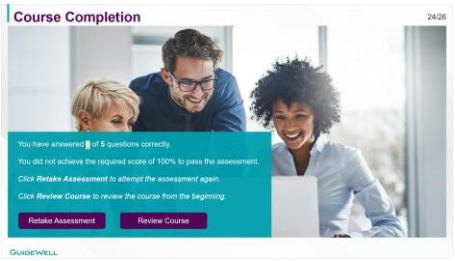
Question 5: FWA must be investigated immediately (within two weeks) after the incident is reported to the appropriate area (SIU/Compliance). Is this statement true or false?

A. True

B. False

Select the correct option and submit.




**Notes:**

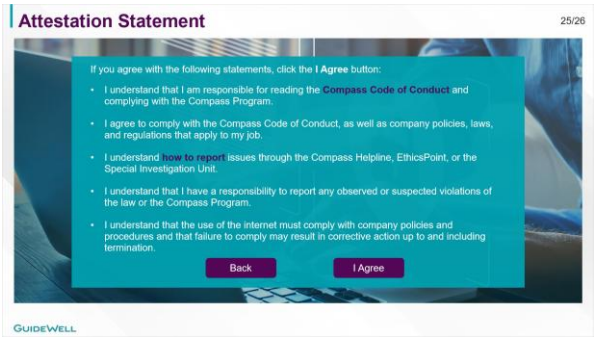
Well done!

You have passed the assessment.

Click Continue to proceed.

You did not achieve the required score of 100% to pass the assessment.

Click Retake Assessment to attempt the assessment again. Alternatively, click Review Course to review the course from the beginning and then retake the assessment.




**Notes:**

If you agree with the following statements, click the **I Agree** button.

- I understand that I am responsible for reading the Compass Code of Conduct and complying with the Compass Program.
- I agree to comply with the Compass Code of Conduct, as well as company policies, laws, and regulations that apply to my job.
- I understand how to report issues through the Compass Helpline, EthicsPoint, or the Special Investigation Unit.
- I understand that I have a responsibility to report any observed or suspected violations of the law or the Compass Program.
- And, I understand that the use of the Internet must comply with company policies and procedures and that failure to comply may result in corrective action up to and including termination.


**Notes:**

This completes the Fraud, Waste and Abuse Training course. In order to receive credit for completion, you must have: accessed and viewed every page within the course; passed the assessment; and completed the Attestation Statement.

You may now close the browser to exit.