2012-2013
Compliance Expectations & Fraud, Waste and Abuse Training Materials for First Tier, Downstream and Related Entities
UnitedHealthcare Medicare Plans

**Medicare Advantage**
- AARP® MedicareComplete®
- UnitedHealthcare® MedicareComplete®
- UnitedHealthcare® Group Medicare Advantage
- UnitedHealthcare® MedicareDirect™
- UnitedHealthcare® Nursing Home Plan
- UnitedHealthcare® Chronic Complete
- UnitedHealthcare Dual Complete™
- Care Improvement Plus
- Erickson Advantage®
- Medica Healthcare Plans
- Physicians Health Choice™
- Preferred Care Partners
- Sierra Spectrum®
- Senior Dimensions®

**Part D**
- AARP® MedicareRx
- UnitedHealthcare® MedicareRx for Groups
Overview

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage Organizations (MAO) and Part D Plan sponsors to have effective compliance programs which include:

• Communicating general compliance information and distributing Standards of Conduct.

• Establishing effective lines of communication.

• Conducting effective fraud, waste and abuse training.

• Reviewing for exclusion and debarment from Federal health care programs.

These requirements apply to both the MAO/Plan sponsor – and first tier, downstream, and related entities—employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing bodies and downstream entities or subcontractors.
Overview (continued)

In regulations effective June 7, 2010, CMS implemented a “deeming” exception which exempts first tier, downstream, and related entities that are enrolled in Medicare Parts A or B from the annual fraud, waste and abuse training and education requirements.

• To qualify for deemed status, you/your organization must meet certification requirements via enrollment in Medicare Parts A or B or accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

• If you or your organization qualifies for deemed status, please retain records or evidence of your certification. You may be asked to provide documentation for audit purposes.

• If you/your organization has already completed fraud, waste and abuse training – whether through your own program or with another health plan sponsor – AND that training meets CMS requirements. UnitedHealthcare accepts documentation of that training in lieu of the administration of the training material.

• UnitedHealthcare also accepts documentation confirming completion of the CMS Medicare Learning Network (MLN) fraud, waste and abuse training and education module.
If you do not or your organization does not qualify for deemed status, training is required by December 31 and annually thereafter.

Please note that there is no deemed status for the Standards of Conduct distribution, nor the reviews for exclusion and debarment from Federal health care programs.

Please maintain records of all training – including dates, methods of training, materials used for training, identification of trained employees via sign-in sheets or other methods, etc. – as well as records for Standards of Conduct distribution and all exclusion and debarment review activity.

Documentation demonstrating completion of compliance requirements at the first tier, downstream and related entity employee level must be retained for a minimum of 10 years and made available upon request to UnitedHealthcare, CMS, or agents acting on behalf of CMS.

UnitedHealthcare, CMS, or agents of CMS may request such records to verify that the required activity occurred.
Overview (continued)

If you have or your organization has contracted with other entities or persons to provide health care and/or administrative services on behalf of your patients covered by UnitedHealthcare Medicare Advantage or Part D plans or the services you have contracted to provide for UnitedHealthcare, you must provide this training material to your subcontractor for training. Please ensure that the subcontractor, or other entity they may have contracted with to perform services, maintains records confirming training.

All contracted entities should have policies and procedures to prevent, detect, and correct fraud, waste, and abuse – including effective training, reviews for excluded or debarred status, reporting mechanisms, and methods to respond to detected offenses.
Overview (continued)

Contracted Entity Definitions

**First Tier:** Any party that enters into a written agreement with a plan sponsor to provide administrative or health care services for a Medicare-eligible individual under Medicare Advantage or Part D programs.

Examples include, but are not limited to: pharmacy benefit manager (PBM), contracted hospitals or providers.

**Downstream:** Any party that enters into a written agreement below the level of the arrangement between a sponsor and a first tier entity for the provision of administrative or health care services for a Medicare-eligible individual under Medicare Advantage or Part D programs.

Examples include, but are not limited to: pharmacies, claims processing firms, billing agencies.

**Related:** Any entity that is related to the sponsor by common ownership or control and 1) performs some of the sponsor’s management of functions under a contract of delegation, 2) furnishes services to Medicare enrollees under an oral or written agreement, or 3) leases real property or sells materials to the sponsor at a cost of more than $2500 during a contract period.
Course Outline

• Compliance Expectations:
  • CMS – Role and Definition
  • Seven Elements of an Effective Compliance Program
  • Standards of Conduct Distribution
  • Effective Lines of Communication
  • Effective Training and Communication
  • Reviews for exclusion and debarment from Federal health care programs.

• CMS Medicare Learning Network Fraud, Waste and Abuse Training Module Option

• UnitedHealthcare Fraud, Waste and Abuse Training Materials
  • Definitions
  • Pertinent Laws and Regulations
  • Examples of Fraud, Waste and Abuse
  • Reporting Obligation and Mechanisms

• Additional Resources

• Training Quiz and Self Assessment
Compliance Expectations
The Centers for Medicare & Medicaid Services (CMS) is a government agency within the U.S. Department of Health and Human Services.

• CMS is responsible for oversight of the Medicare program – including health plan sponsors of programs such as Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), and Prescription Drug Plans (PDP).

• The main or central office for CMS is located in Baltimore, MD. CMS also has regional offices in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, MO, New York, Philadelphia, San Francisco, and Seattle.

• CMS publishes guidance on complying with the rules and regulations of MA, MAPD and PDP plans through the Medicare Managed Care Manual and the Prescription Drug Benefit Manual. First tier, downstream and related entities should refer to and be familiar with these materials to ensure compliance with the Medicare requirements related to their delegated functions.

See ‘Additional Resources’ at the end of this presentation for a link to the CMS Medicare Managed Care Manual and Prescription Drug Benefit Manual.
Seven Elements of an Effective Compliance Program

Federal law requires Medicare Advantage and Part D plan sponsors to implement and maintain an effective compliance program that incorporates measures to detect, prevent, and correct fraud, waste and abuse.

The Health & Human Services (HHS) Office of Inspector General (OIG) has identified seven core elements of a compliance program:

1. **Written Standards of Conduct** – An organization’s Code of Conduct, policies, procedures and other written operating guidelines.

2. **High Level Oversight** – Designation of a leader(s), including an established compliance committee, responsible for implementing and monitoring the compliance program.

3. **Effective Training and Education** – Development and implementation of regular and effective training programs.
Seven Elements of an Effective Compliance Program

4. Effective Lines of Communication – Ongoing communication to raise awareness about compliance expectations, including a system to receive, record and respond to compliance questions or reports of potential non-compliance either directly or anonymously.

5. Enforcement and Disciplinary Guidelines – Policies that consistently enforce standards, including enforcement of non-retaliation standards.

6. Auditing and Monitoring – Systematic checks for compliance through auditing and monitoring activities.

7. Response to Identified Issues – Procedures for responding to detected offenses via the reasonable steps necessary to promptly respond to and prevent further non-compliance or misconduct – including corrective action as needed.

Additional information on CMS requirements and recommendations for compliance programs and addressing fraud, waste and abuse is available within Chapter 9 of the CMS Prescription Drug Benefit Manual and Chapter 21 of the CMS Medicare Managed Care Manual. See ‘Additional Resources’ at the end of this presentation for a link.
Standards of Conduct Distribution

As part of the UnitedHealthcare compliance program, the standards of conduct that govern and provide guidelines for ethical behavior are set forth in the UnitedHealth Group Code of Conduct.


- UnitedHealthcare must make you aware of and make available to you our Code of Conduct.
- First tier, downstream and related entities working on our Medicare Advantage and Part D programs (including contracted providers) must distribute either our Code of Conduct to their employees – OR – distribute your own comparable Standards of Conduct that meet CMS expectations.

To address this requirement, please review the UnitedHealth Group Code of Conduct, available at unitedhealthgroup.com > About > Ethics & Integrity, and provide this – OR – your own comparable standards of conduct to your employees / subcontractors.
Effective Lines of Communication

Medicare Advantage Organizations and Part D Plan Sponsors must establish and implement effective lines of communication that allow confidential and anonymous good faith reporting of potential compliance issues that are accessible to all.

To report suspected non-compliance to UnitedHealthcare, please contact:

- Your UnitedHealthcare account manager or business contact
- The Provider Service contact number (listed at the end of this presentation)
- The UnitedHealth Group Compliance & Ethics HelpCenter - 800-455-4521

UnitedHealthcare expects all first tier, downstream, and related entities to also establish effective lines of communication that allow their employees to ask questions, request compliance support, or report suspected non-compliance or potential fraud, waste and abuse.

UnitedHealthcare expressly prohibits retaliation against employees or contractors who, in good faith, report or participate in the investigation of compliance concerns.
Effective Training & Education

Medicare Advantage Organizations and Part D Plan Sponsors are required to establish, implement and provide effective training and education, including both general compliance training and fraud, waste and abuse training.

UnitedHealthcare requires completion of fraud, waste and abuse training and education upon hire and annually thereafter by all first tier, downstream, and related entity employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body members and downstream entities or subcontractors.

- Documentation demonstrating completion of training at the first tier, downstream, and related entity employee level must be retained for a minimum of 10 years and be available upon request to UnitedHealthcare, CMS, or agents acting on behalf of CMS.

UnitedHealthcare is required to communicate general compliance information to its first tier, downstream and related entities. First tier, downstream and related entities should communicate this information to their employees and subcontractors.

Please also refer to related materials you receive from UnitedHealthcare for additional general compliance information, including:

- Provider manuals, newsletters, contracts and associated agreements, online communication materials, fax blasts and Informational mailings or emails.
Exclusion and Debarment
Review Requirements

Payment related to Medicare or Medicaid benefit programs must not be made for items or services furnished or prescribed by an excluded provider, person, or entity.

Our first tier, downstream and related entities must review federal exclusion lists at the time of hire/contracting and MONTHLY thereafter to ensure that none are excluded from participating in Federal health care programs.

Review for excluded status is required for any:

- First tier, downstream and related entity employee (including temporary workers and volunteers), CEO, senior administrator or manager, governing body member, downstream entity or subcontractor.

Please retain all documentation confirming the review activity was conducted and the results of the review.

If you identify an excluded party or entity employed or contracted by your organization, you must report this to UnitedHealthcare through either your UnitedHealthcare Account Manager, business contact or the UnitedHealth Group Compliance & Ethics HelpCenter at 800-455-4521.
Exclusion and Debarment Review Requirements

For more information on these requirements and for access to the publicly accessible excluded party online databases, please see the following links:


General Services Administration (GSA)’s list of parties excluded from Federal procurement and non-procurement programs at System for Award Management (SAM): [http://www.sam.gov.com](http://www.sam.gov.com)
CMS Medicare Learning Network
Fraud, Waste and Abuse
Training Module Option
CMS MLN FWA Training Module

As announced in the 05/08/2012 CMS HPMS memo, ‘Fraud, Waste and Abuse Training and Education Guidance’, CMS has developed a web-based, standardized fraud, waste and abuse training module that can be used by first tier, downstream and related entities to satisfy fraud, waste and abuse training and education requirements.

Using CMS’ training and education module is optional however this training meets CMS’ fraud, waste and abuse training requirements and UnitedHealthcare will accept its use by first tier and downstream entities.

- The module is available through the CMS Medicare Learning Network at [http://www.cms.gov/MLNProducts](http://www.cms.gov/MLNProducts)
- From the MLN Products page follow this path:
  - Click Provider Compliance (link listed within the left side navigation panel)
  - Under Downloads, choose Medicare Parts C and D Fraud, Waste and Abuse Training zip file
  - To access the training module which is provided in both PDF and PowerPoint formats, choose Open or Save.

Documentation demonstrating completion of training at the employee level must be retained for at least 10 years and be available upon request to UnitedHealthcare, CMS, or agents acting on behalf of CMS.
UnitedHealthcare
Fraud, Waste and Abuse
Training Materials
Fraud, Waste and Abuse Defined

**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. *(18 U.S.C. § 1347)*

**Waste** is over-utilization 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 misuse of resources.

**Abuse** includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare 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. It can’t be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.)*

Fraud, Waste and Abuse Policies

First tier, downstream and related entities must establish and implement policies and procedures to address fraud, waste and abuse.

Examples of policies include but are not limited to:

- Policies providing guidance to employees on how to request compliance assistance or report suspected non-compliance or potential fraud, waste and abuse.

- Policies expressly prohibiting retaliation against employees who, in good faith, report or participate in the investigation of compliance concerns.

- Procedures to conduct timely and reasonable inquiries to detected offenses, including corrective actions as necessary.
Pertinent Laws and Regulations

False Claims Act

The Federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have enacted false claims laws as well.

• A “claim” is broadly defined to include any submissions that results, or could result, in payment.

• Under the False Claims Act, ‘knowing’ or ‘known’ means that a person:
  • Has actual knowledge
  • Acts in deliberate ignorance of truth or falsity or Acts in reckless disregard of truth or falsity

  Proof of specific intent to defraud is not required to fall within the definition of “knowing” or “known”.

• Claims submitted to the government include claims submitted to intermediaries such as state agencies, managed care organizations and other subcontractors under contract with the government to administer health care benefits.
Pertinent Laws and Regulations

False Claims Act (continued)

Liability can also be created by improper retention of an overpayment.
- The Patient Protection and Affordable Care Act of 2010 (PPACA) expanded a provision of the False Claims Act referred to as a reverse false claim.
- Overpayments or any funds received or retained under Medicare or Medicaid that a person or organization is not entitled to must be reported and returned within 60 days of identification.

Whistleblower and Whistleblower Protections:
- The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. or state governments to file suit on behalf of the government against the person or business that committed the fraud.
- Individuals who file such suits are known as ‘whistleblowers’. The federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing or participating in a whistleblower action.

UnitedHealthcare expressly prohibits retaliation against employees – including employees of first tier, downstream and related entities – who, in good faith, report or participate in the investigation of compliance concerns.
Pertinent Laws and Regulations

False Claims Act (continued)

Examples include:

- A physician who submits a bill to Medicare for medical services not provided.

- A government contractor who submits records that he/she knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

- An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare Plan Sponsor.
Pertinent Laws and Regulations

Anti-Kickback Statute

The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit or receive something of value to induce or reward business referrals under Federal health care programs.

The Anti-Kickback law is intended to ensure that referrals for health care services are based on medical need and not financial or other types of incentives to individuals or groups.

The Health Care Reform law has added a provision to the Anti-Kickback statute where “knowingly and willfully” does not mean the individual had the intent to specifically violate the statute. In addition, violations of the Anti-Kickback statute can now be considered a false and fraudulent claim under the False Claims Act.
Pertinent Laws and Regulations

Anti-Kickback Statute (continued)

Examples include:

- A frequent flyer campaign in which a physician may be given airline frequent flier mileage rewards for questionnaires completed for new patients put on a drug company's product.
- Free laboratory testing offered to health care providers, their families and their employees to induce referrals.

In addition to criminal penalties, violation of the Federal Anti-Kickback statute could result in civil monetary penalties and exclusion from federal health care programs, including Medicare and Medicaid programs.
Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI) as well as provisions related to prevention of health care fraud and abuse.

HIPAA Privacy
- The Privacy Rule outlines specific protections for use and disclosure of PHI. It also grants rights to members.

HIPAA Security
- The Security Rule outlines specific protections and safeguards for electronic PHI.

If you become aware of a potential breach or inappropriate disclosure of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.
Pertinent Laws and Regulations

HIPAA

Examples of HIPAA provisions related to the prevention of health care fraud and abuse:

• Creation of the Fraud Abuse and Control Program for coordination of state and federal health care fraud investigation and enforcement activities.

• Expansion of the exclusion authority so that any health care fraud conviction, even if the fraud is not related to Medicare or Medicaid, results in mandatory exclusion from participation in the Medicare or Medicaid programs.

• Creation of a new series of federal crimes, together referred to as “health care fraud,” which make it a federal crime to defraud health care benefit programs – any benefit program, not just Medicare or Medicaid.
Pertinent Laws and Regulations

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 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 in connection with the delivery of or payment for health care benefits, items or services.

Proof of actual knowledge or specific intent to violate the law is not required. Penalties for violating the Criminal Health Care Fraud statute may include fines, imprisonment, or both.
Examples of Member Fraud, Waste and Abuse

Consumer or Member Fraud, Waste and Abuse:

**Doctor Shopping** – Consumer or other individual consults with a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale.

**Prescription Diversion and Inappropriate Use** – Consumers obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and give or sell this medication to someone else. Also can include the inappropriate consumption or distribution of a consumer’s medications by a caregiver or anyone else.

**Identity Theft or Medical Identity Theft** – A person uses another person’s Medicare card to obtain services or prescriptions – OR – another person’s information is used to bill for procedures never done or for supplies never received.
Examples of Pharmacy Fraud, Waste and Abuse

Pharmacy Fraud, Waste and Abuse:

**Prescription Drug Switching** – The pharmacy or pharmacy benefit manager (PBM) receives a payment to switch a consumer from one drug to another or influences the prescriber to switch the patient to a different drug.

**Prescription Drug Shorting or Splitting** – A pharmacy or PBM’s mail order pharmacy intentionally provides less than the prescribed quantity and does not inform the patient or make arrangements to provide the balance, but bills for the fully-prescribed amount. The pharmacy splits the original prescription to receive additional dispensing fees.

**Inappropriate billing practices such as:**

- Billing for brand when generics are dispensed
- Billing for non-covered prescriptions as covered items
- Billing for prescriptions that are never picked up
Examples of Prescriber Fraud, Waste and Abuse

Prescriber Fraud, Waste and Abuse:

**Script Mills** – Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale and might include improper payments to the provider.

**Illegal Remuneration Schemes** – Prescriber is offered, paid, solicits or receives unlawful remuneration (payment or items of value) to induce or reward the prescriber to write prescriptions for drugs or products.

**Prescription Drug Switching** – Drug switching involves offers of cash payments or other benefits to a prescriber to induce them to prescribe certain medications rather than others.
Examples of Sales Agent Fraud, Waste and Abuse

Sales Agent Fraud, Waste and Abuse:

**Marketing Schemes** –

- Enrollment of a consumer in a Medicare Plan without the consumer’s knowledge or consent.
- Offering consumers a cash payment or other reward as encouragement to enroll in a Medicare, Medicaid, or health care benefit plan.
- Selling or marketing insurance without a license.
- Using consumer information supplied through a third-party (another agent, friend, etc.) to market Medicare plans.
- Agents splitting commissions or agent referral fees.
- Misrepresenting themselves as a representative of the government (Medicare/Social Security/Federal Government).
Reporting Obligation and Mechanisms

If you identify or are made aware of potential misconduct or a suspected fraud, waste or abuse situation, it is your right and responsibility to report it.

Network providers can call the main phone number associated with the secure website(s) where they transact administrative activities for their patients or call your local network contact.

Callers are encouraged to provide contact information should additional information be needed. However, you may report anonymously and retaliation is strictly prohibited if a report is made in good faith.
Reporting Obligation and Mechanisms

Contracted network providers can call the main phone number associated with the secure website(s) where they transact administrative activities for their patients.

Callers are encouraged to provide contact information should additional information be needed. However, you may report anonymously and retaliation is strictly prohibited if a report is made in good faith.

Contracted vendors or delegates may call the UnitedHealthcare Medicare Vendor Fraud Hotline: 877-401-9430
Resources

CMS’ Prescription Drug Benefit Manual – Chapter 9

CMS’ Medicare Managed Care Manual – Chapter 21
http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html

CMS’ Prescription Drug Benefit Manual
http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html

CMS’ Medicare Managed Care Manual

Code of Federal Regulations (see 42 CFR 422.503 and 42 CFR 423.504)

Office of the Inspector General – Fraud Information
http://oig.hhs.gov/fraud/

Medicare Learning Network (MLN) Fraud & Abuse Job Aid
Quiz and Self Assessment

Please answer the following questions and then check your answers on the next slide. If you cannot answer these questions correctly without referring to the answers, please review the training materials:

1. Which of the following is NOT an essential element of an effective compliance program?
   1. Written Standards of Conduct
   2. High Level Oversight
   3. Effective Lines of Communication
   4. Conference Calls

2. True or False? The Centers for Medicare & Medicaid Services (CMS) is the part of the Federal government that oversees the Medicare program.

3. True or False? If I identify or am made aware of potential misconduct or a suspected fraud, waste or abuse situation, I should keep this information to myself and not tell anyone else.
1. **(D) CONFERENCE CALLS.** Conference calls are not an essential element of an effective compliance program.

   The government has identified these elements as part of an effective compliance program:
   1. Written Standards of Conduct
   2. High Level Oversight
   3. Effective Compliance Training
   4. Effective Lines of Communication
   5. Disciplinary Mechanisms
   6. Monitoring and Auditing
   7. Procedures for Responding to Detected Offenses

2. **TRUE.** CMS is an entity within the U.S. Department of Health and Human Services that is responsible for oversight of the Medicare Program, including health plans such as Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), and Prescription Drug Plan (PDP).

3. **FALSE.** If you identify or are made aware of potential misconduct or a suspected fraud, waste or abuse situation, it is your right and responsibility to report it.
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