Fraud, Waste, and Abuse Training

HEALTH NETWORK ONE

Agenda

- Background
- Training Objective
- What is Fraud, Waste and Abuse?
- Applicable laws and regulations
- Your Role in the Fight Against FWA
- How to Report FWA?
- Special Investigation Unit (SIU)

Introduction

- This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their fraud, waste, and abuse (FWA) training requirements in the regulations and sub- regulatory guidance at:
  - 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
  - 42 CFR Section 423.504(b)(4)(vi)(C)
  - CMS-4182-F, Medicare Program Contract Year 2019 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs
  - Section 50.3.2 of the Compliance Program Guidelines (Chapter 9 of the "Medicare Prescription Drug Benefit).
  - Manual" and Chapter 21 of the "Medicare Managed Care Manual")
- Sponsors and their FDRs are responsible for providing additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

- Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training for preventing, detecting, and correcting FWA.

- FWA training must occur within 90 days of initial hire and at least annually thereafter. More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website.

Learn more about Medicare Part C

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

State/Regional Laws and Contract Provisions

- We abide by all local laws that relate to our business and are in effect in the areas where we operate.

- Our contracts may also have provisions that could exceed state/federal laws. If so, we will adopt and operate under the highest standard applicable to a function in order to meet all requirements.

Acronyms

Acronym	Title Text
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
EPLS	Excluded Parties List System
FCA	False Claims Act
FDRs	First-tier, Downstream, and Related Entities
FWA	Fraud, Waste, and Abuse
LEIE	List of Excluded Individuals and Entities
MA	Medicare Advantage
NPI	National Provider Identifier
OIG	Office of Inspector General

Objectives

At the end of this training, you will be able to:

- Recognize FWA in the Medicare Program.
- Identify the major laws and regulations pertaining to FWA.
- Recognize potential consequences and penalties associated with violations.
- Identify methods of preventing FWA.
- Identify how to report FWA.
- Recognize how to correct FWA.

Why do I need training?

- Every year billions of dollars are improperly spent because of FWA. It affects everyone – including you. This training will help you detect, correct, and prevent FWA. You are part of the solution.

- Combating FWA is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

Why do I need this training?

Any individual who has in effect an agreement to participate in Medicare and provide services to Medicare enrollees, is responsible of complying with CMS regulatory requirements, including detect, prevent, correct and report any situation of potential fraud, waste and abuse. This training will provide guidance on how to report any suspected situation, what is considered fraud, waste and abuse and the applicable laws.

CMS regulation established that a provider is a Downstream entity.

- **Downstream entity** – means any party that enters into an acceptable written arrangement below the level of the arrangement between an MA organization (and contract applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

What is FWA?

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program. Obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

- The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to $250,000.

- In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

What is FWA? (Continued)

Waste

- Includes overusing 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 by 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.

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

Examples of FWA

Fraud

- Knowingly billing for services of higher complexity than services actually provided or documented in patient medical records.
- Knowingly billing for services or supplies not provided, including falsifying records to show the service was delivered.
- Knowingly ordering medically unnecessary patient items or services.
- Billing Medicare for appointments that the patient failed to keep.
- Billing for non-existent prescriptions
- Paying for federal health care program patient referrals.

Abuse

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

Waste

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

Differences Among Fraud, Waste, and Abuse

There are differences among fraud, waste, and abuse.

- One of the primary differences is intent and knowledge.
- **Fraud** requires intent to obtain payment and the knowledge that the actions are wrong.
- **Waste and Abuse** may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program, but does not require the same intent and knowledge.

Applicable Federal Laws

- False Claims Law (False Claim Act or FCA)
- Anti-bribery Statute (Anti-Kickback Statute)
- Stark Statute (Physician Self-Referral Law)
- Criminal Statute of Fraud in Health Services (Criminal Health Care Fraud Statute)
- Beneficiary Incentives Law (Beneficiary Inducement Law)

False Claims Act (FCA)

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

Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty. For more information, refer to 31 United States Code (U.S.C.) Sections 3729-3733 on the Internet.

Example: A Medicare Part C Plan in Florida

Hired an outside company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from the Centers for Medicare &Medicaid Services (CMS); was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported; Failed to report the unsupported diagnosis codes to Medicare; and agreed to pay $22.6 million to settle FCA allegations.

Civil False Claims Act

- A **whistleblower** is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.
- **Protected:** Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- **Rewarded:** Persons who bring a successful whistleblower lawsuit receive at least 15 percent but not more than 30 percent of the money collected.

Protections (applicable only to events related to federal funds):

- Employers cannot retaliate against employees:
- An employer cannot threaten or enact any negative employment consequences.

Remedies:

- Job reinstatement
- Double lost wage payment
- Payment for other damages

Qui Tam Lawsuits

- The False Claims Act provides for qui tam lawsuits.
- A company employee or a former company employee sues an organization or individual on behalf of the federal government.
  - If successful, the whistleblower can receive a share of the total award.

Many highly successful qui tam convictions rewarded the assisting individuals with millions.

Anti-Kickback Statute

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

Damages and Penalties

Violations are punishable by:

- A fine of up to $25,000;
- Imprisonment for up to 5 years; or both.
- For more information, refer to the Social Security Act (the Act), Section 1128B(b) on the Internet.

Example: From 2012 through 2015, a physician operating a pain management practice in Rhode Island Conspired to solicit and receive kickbacks for prescribing a highly addictive version of the opioid Fentanyl. Reported patients had breakthrough cancer pain to secure insurance payments. Received $188,000 in speaker fee kickbacks from the drug manufacturer. Admitted the kickback scheme cost Medicare and other payers more than $750,000. The Physician must pay more than **$750,000** restitution and is awaiting sentencing.

Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest; or
- A compensation arrangement (exceptions apply).

Damages and Penalties

- Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable.
- A penalty of around $24,250 may be imposed for each service provided.
- There may also be around a $161,000 fine for entering into an unlawful arrangement or scheme.
- For more information, visit the Physician Self-Referral webpage on the CMS website and refer to the Act, Section 1877 on the Internet.

Example: Hospital ordered to pay more than $3.2 million

A California hospital was ordered to pay more than $3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician groups outside the fair market value standards or that were improperly documented are exceptions.

Criminal Health Care Fraud Statute

The Health Care Fraud Statute states that any person who knowingly and intentionally executes or attempts to execute a scheme to defraud any health benefit penalized, could face imprisonment from a term not to exceed 10 years, or both (penalties and prison).

Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law. For more information, refer to 18 U.S.C. Section 1346-1347 on the Internet.

Criminal Health Care Fraud
Persons who knowingly make a false claim may be subject to:
- Criminal fines up to $250,000
- Imprisonment for up to 20 year

Example: The owner of multiple Durable Medical Equipment (DME) companies in New York

Falsely represented themselves as one of a nonprofit health maintenance organization's (that administered a Medicare Advantage plan) authorized vendors; Provided no DME to any beneficiaries as claimed; Submitted almost $1 Million in false claims to the nonprofit; $300,000 was paid; Pleased guilty to one count of conspiracy to commit health care fraud.

Beneficiary Inducement Law

It makes it illegal to offer exchange or remuneration with which the person knows or should know that it could influence a beneficiary when selecting a particular provider, professional, or supplier. This includes:

- Offer payments or gifts to influence affiliates to receive a consultation or treatment;
- Eliminate copayments and deductibles to induce members to receive services from a provider;
- Gifts offered to beneficiaries cannot exceed a monetary value of $15 individually, or $75 per year per beneficiary. Under no circumstances may cash or gift cards be given to recipients.

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose Civil penalties for a number of reasons, including:

- Arranging for services or items from an excluded individual or entity;
- Providing services or items while excluded;
- Knowing of an overpayment and failing to report and return it.
- Failing to grant OIG timely access to records;
- Making false claims; or
- Paying to influence referrals.

Damages and Penalties
The penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three times the amount: Claimed for each service or item; or of remuneration offered, paid, solicited, or received.

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

Conflict of Interest

A conflict of interest happens when a health care professional with responsibility to others is influenced (consciously or unconsciously) by financial, personal or other factors that involve self interest.

- As our employees/contractors, you should report any perceived conflict of interest to your supervisor.
- He/she will re-assign the case or project to another staff member, as appropriate.

Exclusion

- No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG.
- The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE). You can access the LEIE on the Internet.
- The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management website.
- When looking for excluded individuals or entities, make sure to check both the LEIE and the EPLS since the lists are not the same. For more information, refer to 42 U.S.C. Section 1320a-7 and 42 Code of Federal Regulations Section 1001.1901 on the Internet.

LEIE Link: https://exclusions.oig.hhs.gov

Exclusion (Continued)

Important: All Medicare Advantage organizations (Medical Plans), providers and contracting entities must review the exclusion status of all their employees, contractors or associates before hiring or contracting and monthly thereafter.

Such reviews should be conducted against the following exclusion lists:

- https://exclusions.oig.hhs.gov
- https://www.sam.gov

Example: A pharmaceutical company pleads guilty for failure to file required reports
A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the Food and Drug Administration concerning oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. At the time the non-convicted executive was excluded, there was evidence he was involved in misconduct leading to the company's conviction.

CMS Preclusion List

The individual or entity will be excluded from participating in the provision of Medicare health services. No payments can be made for services rendered, ordered or prescribed by individuals or entities that have been excluded by CMS as of April 1, 2019.

This listing is issued by CMS on a monthly basis beginning January 1, 2019 and is only accessible to Medicare contractors — 42 CFR § 422.222 (Preclusion list)

Health Insurance Portability and Accountability (HIPAA)

- HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and
- Promoted standardization and efficiency in the health care industry.
- HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.
- For more information, visit HIPAA webpage — https://www.hhs.gov/hipaa

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

Example: Former hospital employee pleaded guilty to criminal HIPAA charges after obtaining PHI.
A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

What should I do?

Prevent, Detect and Correct any actual or suspected situation of Fraud, Abuse and Waste is the responsibility of all employees, delegated entities, providers, suppliers and consultants, so you must:

- Provide only high quality, medically necessary services;
- Document transactions and services appropriately;
- Bill, code and process services and claims correctly;
- Check the exclusion lists as required by CMS;
- Comply with policies and procedures;
- Establish systems for a prompt response and initiation of investigations of potential situations o fraud, abuse, waste and / or non-compliance.

How can you report FWA?

- ACTing ethically at all times.
- Reporting any suspected or actual non-compliance, Fraud, Waste and Abuse activity.
- Providing accurate information (including in the billing process).
- Stay informed of policies and procedures, Code of Conduct, Compliance Program, state and federal laws, regulations and guidelines.
- Participate and complete satisfactorily all regulatory and specialized and/or fraud, abuse and waste trainings to raise awareness of Medicare, our line of business, or other compliance requirements related to your job function.

What are your responsibilities?

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

- **FIRST**, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
- **SECOND**, you have a duty to the Medicare Program to report any compliance concerns, and suspected or actual violations 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.

How do you Prevent and Detect FWA?

- Look for suspicious activity.
- Conduct yourself in an ethical manner.
- Ensure accurate and timely data/billing.
- Ensure you coordinate with other payers.
- Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance.
- Verify all received information.

How do we correct incidents of FWA?

Once an incident of fraud, abuse or waste has been detected, it must be corrected promptly. Correcting the problem helps prevent further money loss and ensures compliance with CMS requirements. For this purpose, investigations are carried out to identify the scope of the incident and outline an action plan that includes:

- Design of corrective actions to deal with the incident in question, according to the investigation carried out;
- Adaptation of corrective actions to specifically address the identified FWA incident, including deadlines for the implementation of said actions;
- Documentation of corrective actions taken;
- Monitoring of the implementation of corrective actions to ensure that there is no recurrence of the situation.

Corrective Action Examples

Corrective actions may include:

- Adopting new prepayment edits or document review requirements.
- Conducting mandated training.
- Providing educational materials.
- Revising policies or procedures.
- Sending warning letters.
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment.
- Terminating an employee or provider.

Consequences for Non-Compliance

If an employee is found non-compliant:

The Compliance Officer of the Organization is notified and appropriate action will be taken:

- Mandatory re-training required by law.
- Based on the incident's severity disciplinary action or termination.

Federal authorities may be notified for potential criminal prosecution.

Report FWA

Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state this obligation.

Sponsors may not retaliate against you for making a good faith effort in reporting.

Do not be concerned about whether it is fraud, waste, or abuse.

Report any potential FWA concerns to your compliance department or your Sponsor's compliance department. Your Sponsor's compliance department area will investigate and make the proper determination. Often, Sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain an FWA Hotline.

Our FWA Hotline: **(866) 321-5550**

Details to include when reporting FWA

When reporting suspected FWA, you should include:

- Contact information for the source of the information, suspects, and witnesses.
- Alleged FWA details.
- Alleged Medicare rules violated.
- The suspect's history of compliance, education, training, and communication with your organization or other entities.

Where to report FWA (within our Organization)

You can report directly:

- Your Supervisor
- In person to the Special Investigative Unit (SIU) of the Compliance Department, to include the Compliance Officer.
- By calling the organization's FWA hotline at **(866) 321-5550.**
- Via email to SIU@healthnetworkone.com
- By sending a fax to **(866) 276-3667**

Your questions and concerns will be kept confidential, as permitted by law. You also don't have to give your name if you wish to remain anonymous.

Health System One Contact Information

Fraud, Waste, and Abuse Hotline:

(866)-321-5550 (Toll-Free). You can also file an anonymous report, if you want.

Mail your report to:

Marjorie Dorcely
Special Investigative Unit (SIU)
2001 S. Andrews Avenue, Fort Lauderdale, FL 33316

Fax your report to:
Attention: Marjorie Dorcely

(866)-276-3667 - *This is a dedicated Compliance line*

E-Mail your report to: SIU@healthnetworkone.com

Report FWA

If you report to the Compliance Office, you cannot face retaliation for:

- Reporting suspected fraud in good faith.
- Actively providing information for an internal investigation.

If retaliation does occur, the False Claims Act provides protections to the employee. However, if you are found to have participated in the alleged misconduct, these protections do not apply!

You can report these violations directly to Health System One, the State or Federal Government, or to the affected Health Plan(s).

Health Plan/State	Contact	Phone	Fax	Email	Mail Address
Amerigroup	Special Investigative Unit (SIU)	866-847-8247 800-600-4441		Medicaidfraudinvestigations@amerigroup.com	Special Investigative Unit (SIU) Amerigroup Community Care 4425 Corporation Lane Virginia Beach, VA 23462
Coventry/ Aetna	Compliance Department	888-891-8910		www.aetna.alterline.com	Aetna Compliance Department P.O. Box 370205 W. Hartford, CT 06137
Humana	Special Investigative Unit (SIU)	800-614-4126 877-5-THE-KEY		SIUReferrals@Humana.com www.ethicshelpline.com	Humana Special Investigative Unit (SIU) 1100 Employers Blvd Green Bay, WI 54344
State of Hawaii	OHANA Health Plan	1-866-685-8664			
Hawaii Department of Human Services	Medicaid Recipient Fraud Medicaid Provider Fraud	808-587-8444			

You can report these violations directly to Health System One, the State or Federal Government, or to the affected Health Plan(s).

Health Plan/State	Contact	Phone	Fax	Email	Mail Address
Community Care Plan	Compliance Officer	954-265-5855 954-622-3489 855-843-1106		CCP.Compliance@ccpcares.org CCP.SIU@ccpcares.org www.lighthouse-services.com/ccpcares	
Molina Healthcare	Compliance Officer	866-606-3889		Molinahealthcare.alertline.com	
Florida Blue	Special Investigations Unit (SIU)	800-678-8355		specinvestunit@bcbsfl.com	Florida Blue Special Investigations Unit P.O. Box 44193 Jacksonville, FL 32231
CarePlus/ Humana	Special Investigative Unit (SIU)	800-614-4126 877-5-THE-KEY	920-339-3673	SIUReferrals@Humana.com www.ethicshelpline.com	Humana Special Investigative Unit (SIU) 1100 Employers Blvd Green Bay, WI 54344
SAnta Fe (AvMed)	Compliance Department	(877)-286-3889 (844)-263-2376		http:/ www.mycompliancereport.com	Santa Fe Healthcare Corporate (AvMed) Comlinace Porgram PO Box 749 Gainesbille, FL 32602-0749

You can report these violations directly to Health System One, the State or Federal Government, or to the affected Health Plan(s).

Health Plan/State	Contact	Phone	Fax	Email	Mail Address
WellCare	Hotline	866-685-8664			
Devoted Health Plan	**CCO:** Shannon O'Kane	855-292-7485		Compliance@devoted.com Sokane@devoted.com	
Simply Healthcare	Special Investigations Unit (SIU)	866-847-8247		medicaresiu@anthem.com	9250 W. Flagler Street STE. 600 Miami, FL 33174-3460
MCS	Elizabeth Rousell	877-627-0004 787-758-2500 Ext. 2071		MCSCompliance@medicalcardsystem.com Elizabeth.Roussel@medicalcardsystem.com	
Doctors Health Plan	**FWA Manager:** Nelson Gaviria **Compliance Officer:** Mayra Campuzano	833-342-7911 833-500-3427	786-628-2600	Reportfraud@doctorshcp.com Ngaviria@doctorshcp.com Mcampuzano@doctorshcp.com	Doctors HealthCare Plans, INC Attention: FWA Unit 2020 Ponce de Leon Blvd., PH 1 Coral Gables, FL 33134
MMM of Puerto Rico	Liza Rivera	877-307-1211 844-256-3953		www.mmmpr.ethicspoint.com www.psg.ethicspoint.com	MMM Holdings, LLC P.O. Box P.O. Box 71114 San Juan, PR 00936-8014

You can report these violations directly to Health System One, the State or Federal Government, or to the affected Health Plan(s).

Health Plan/State	Contact	Phone	Fax	Email	Mail Address
Triple S Advantage TSA	Jenny D Cárdenas	787-277-6633 787-620-1919 Ext. 4183		tsacompliance@sssapr.com fraude@ssspr.com	
State of Georgia	Department of Community Health Office of Inspector General	800-533-0686		oiganonymous@dch.ga.gov	Department of Community Health Office of Inspector General 2 Peachtree Street, NW 5th FL Atlanta, GA 30303
State of Florida	Office of Medicaid Program Program Integrity of The Inspector General	888-419-3456 Provider Fraud 866-966-7226 Member Fraud 866-762-2237			
State of New Jersey	Medicaid Fraud Division	1-888-937-2835	609-826-4849		Office of the State Comptroller Medicaid Fraud Division P.O. Box 025 Trenton, NJ 08625
AmeriHealth Caritas	Vivian Anderson Kira Lucrezi	866-833-9718		vanderson@amerihealthcaritas.com klucrezi@amerihealthcaritas.com FraudTip@amerihealthcaritas.com	
SOLIS Health Plan	Fraud Hotline	833-720-0006 833-896-3762			
Ultimate Health Plan	Compliance Team	1-888-937-2835		Investigatefwa@ulthp.com compliancehotline@ulthp.com	

Where to report FWA (Outside the organization)

HHS Office of Inspector General:

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Fax: 1-800-223-8164

E-Mail: HHSTips@oig.hhs.gov

Online: https://oig.hhs.gov/fraud/report-fraud/

For Medicare Parts C and D:

Investigations Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRx (1-877-772-3379)

For all other Federal Health Care Programs:

CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

Medicare Beneficiary Website:

https://www.medicare.gov/basics/reporting-medicare-fraud-and-abuse

Medicaid Program:

PRMFCU: PRMFCU@justicia.pr.gov, 787-721-2900 ext. 1560/1561
All other Federal health care programs: CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

Important Contact Information State/Local Regulators

Florida Medicaid:

Medicaid Program Integrity – Hotline 888-419-3456
Office of the Attorney General - 866-966-7226

New Jersey Medicaid:

NJ Department of Human Services - New Jersey Medicaid Fraud Division
Toll-Free Number: 888-937-2835

Georgia Medicaid:

Office of Inspector General Special Investigations Unit
Toll-Free Number: 800-533-0686
oiganonymous@dch.ga.gov | reportMedicaidFraud@dch.ga.gov

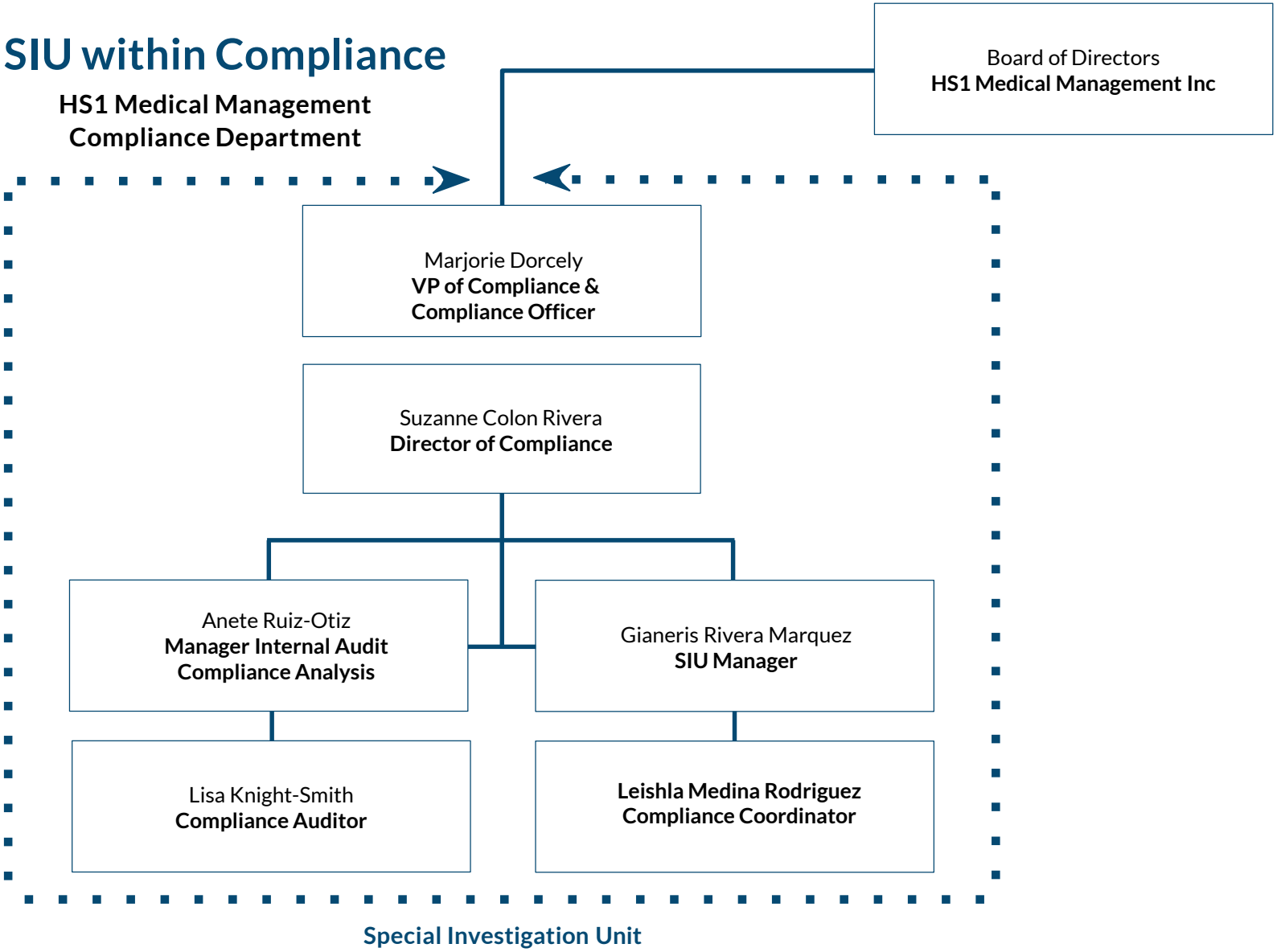
Commonwealth of Puerto Rico:

Programa Medicaid Phone Number: 787-641-4224
Email: fraudemedicaid@salud.pr.gov

Failure to report fraud can lead to:

- Disciplinary action
- Mandatory re-training
- Your termination
- Potential exclusion from the organization or from participation as a provider.

SIU within Compliance



Important Contact Information for our Organization

Mail your report to:

Marjorie Dorcely
Special Investigative Unit (SIU)
2001 S. Andrews Avenue, Fort Lauderdale, FL 33316

Fax your report to:
Attention: Marjorie Dorcely

(866)-276-3667 - *This is a dedicated Compliance line*

Organization FWA Hotline:

866-321-5550 (Toll-Free)
You can also file an anonymous report, if you want.

E-Mail your report to: SIU@healthnetworkone.com

Reporting FWA Incidents within the Organization

- Must follow up on your reports in a reasonably timely manner.
- If you report a fraud-related incident to the organization, you can ask the Compliance Staff (SIU) for updates on the progress of the investigation.

Applicable Laws for Reference

Job Aid: Applicable Laws for Reference

- Anti-Kickback Statute 42 USC Section 1320A-7b(b).
- Civil False Claims Act 31 USC Sections 3729–3733.
- Civil Monetary Penalties Law 42 USC Section 1320a-7a.
- Criminal False Claims Act 18 USC Section 287.
- Exclusion 42 USC Section 1320a-7.
- Health Care Fraud Statute 18 USC Section 1347.
- Physician Self-Referral Law 42 USC Section 1395nn.

Resources

Linked Text/Image	Hyperlink URL
42 USC Section 1320A-7b(b)	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7b.pdf
31 USC Sections 3729–3733	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title31/pdf/USCODE-2016-title31-subtitleIII-chap37-subchapIII.pdf
42 USC Section 1320a-7a	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7a.pdf
18 USC Section 287	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap15-sec287.pdf
42 USC Section 1320a-7	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7.pdf
18 USC Section 1347	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1347.pdf
42 USC Section 1395nn	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXVIII-partE-sec1395nn.pdf

Resources (Continued)

Resource	Website
Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training	https://oig.hhs.gov/compliance/provider-compliance-training/
OIG's Provider Self-Disclosure Protocol	https://oig.hhs.gov/compliance/self-disclosure-info/self-disclosure-protocol/
Physician Self-Referral	https://www.cms.gov/medicare/regulations-guidance/physician-self-referral
Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians	https://oig.hhs.gov/compliance/physician-education/
Safe Harbor Regulations	https://oig.hhs.gov/compliance/safe-harbor-regulations

Where to report FWA

HHS Office of Inspector General:

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Fax: 1-800-223-8164

E-Mail: HHSTips@oig.hhs.gov

Online: https://oig.hhs.gov/fraud/report-fraud/

For Medicare Parts C and D:

Investigations Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRx (1-877-772-3379)

For all other Federal Health Care Programs:

CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048


HEALTH NETWORK ONE