UnitedHealth Group
General Compliance
and Fraud, Waste and Abuse
New Hire Training
UnitedHealth Group takes an aggressive approach to preventing, detecting and correcting health care fraud, waste and abuse. In order to support our efforts and to fulfill the company’s regulatory requirements, this course ensures you have the information you need.

Before you get started with the course, I'd like to test your knowledge on health care fraud.
Which of the following do you think is true? (Choose one)

- An anonymous tip to an insurance company's investigations department led to the arrest and fraud conviction of a Michigan plastic surgeon.

- In 2018, the United States Department of Justice (DOJ) recovered 2.5 billion from health care fraud schemes.

- The National Health Care Anti-fraud Association (NHCAA) estimates that conservatively 3% of all health care spending ($68 billion) is lost to health care fraud. This loss results in higher premiums, higher costs to provide care, and possible compromise in quality of care.

- Health care costs have been one of the fastest growing costs to organizations recently.
Was it difficult to pick just one of the statements as true? That is because ALL of the statements are true.

Health care fraud impacts everyone. As a UnitedHealth Group employee, it's your right and responsibility to recognize and report any and all suspected misconduct. You also should be aware of the enforcement tools that aid in deterring potential health care fraud, waste and abuse.

This course will provide you with the information you need to help you meet these expectations.
Behind me are elevators. You will use an elevator to explore four floors of this building. On each floor you will perform various activities to help you in combating health care fraud, waste and abuse.

After you've completed the activities on each floor, you will test your knowledge by completing an assessment.
Floor 1 – Meet the Expert: On this floor, you will have the opportunity to ask a health care fraud expert questions as well as analyze situations and determine if they are suspicious or not suspicious.

Floor 2 – Employee Scenarios: On this floor, you will help employees determine if there is potential health care fraud, waste or abuse in a given situation.

Floor 3 – Employee Questions: On this floor, you will help employees answer questions regarding reporting potential health care-related fraud, waste and abuse.

Floor 4 – Enforcement Tools: On this floor, you will explore various objects to view health care laws and regulations in the headlines.

Floor 5 – Course Assessment: Once you complete all the activities, this floor will allow you to take the assessment for this course.
In order to be effective in helping reduce health care fraud, waste and abuse, you need to be able to identify suspicious activity or activity that is potentially fraud, waste or abuse.

On this floor, you will have an opportunity to ask me questions regarding health care fraud, waste and abuse as well as analyze situations that you may face in the workplace.
How does UnitedHealth Group define health care fraud?

Fraud
Fraud is the intentional misrepresentation or concealing of facts to obtain something of value. The complete definition has three primary components:

- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit

This definition applies to all persons and all entities. However, there are special rules around intentional misrepresentations to government programs such as Medicare & Medicaid, or TRICARE.
Ask the Health Care Fraud Expert

How do I recognize waste in the health care system?

Waste

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the health care system.
Ask the Health Care Fraud Expert

How do I recognize abuse in the health care system?

Abuse

Abuse includes actions that may, directly or indirectly, result in:

- unnecessary costs to the health care system,
- improper payment,
- payment for services that fail to meet professionally recognized standards of care, or
- services that are medically unnecessary.
What if I can’t tell the difference between health care fraud, waste or abuse?

What if I can't tell the difference?

That's ok. Differentiating between health care fraud, waste and abuse can be difficult and oftentimes cannot be determined without further investigation.

Your role is to watch for and identify situations that may have the potential for fraud, waste or abuse or needs further review. Most importantly, your role is to report it so that we respond accordingly.
Analyze

Being able to recognize suspicious activity is essential in preventing health care fraud, waste and abuse.

In this activity, I'm going to present you with three scenarios. It's your job to determine if the scenario is suspicious or not suspicious.

**Suspicious** - A situation that makes you question if there is something wrong or that is different from what you would normally expect from a process or activity.

**Not Suspicious** - A situation that generally follows what you would normally expect from the process or activity.
Analyze - Questions

Member allows a non-member to use their member card for health services.

○ Suspicious    ○ Not Suspicious    ○ Not Sure

Customer service representative receives a call from a provider about a reimbursement she is expecting. The representative notices that this provider has an abnormally high claim/reimbursement volume.

○ Suspicious    ○ Not Suspicious    ○ Not Sure

Dr. Longmire submitted a claim with an invalid CPT code.

○ Suspicious    ○ Not Suspicious    ○ Not Sure
Member allows a non-member to use their member card for health services.

- **Suspicious**
  - Not Suspicious
  - Not Sure

This scenario describes a potential health care fraud situation. Any situation that is suspicious should be reported. You'll cover how to report suspicious activity on the 3rd floor.
Customer service representative receives a call from a provider about a reimbursement she is expecting. The representative notices that this provider has an abnormally high claim/reimbursement volume.

- **Suspicious**
  - Not Suspicious
  - Not Sure

This scenario describes a potential waste or abuse situation. Any situation that is suspicious should be reported. You'll cover how to report suspicious activity on the 3rd floor.
Dr. Longmire submitted a claim with an invalid CPT code.

- Suspicious
- Not Suspicious
- Not Sure

There are times when something that looks like potential health care fraud, waste and abuse is really an error made by providers, members, vendors, employees or contractors.

Errors are unintentional mistakes that require action and should be corrected by following the applicable policies for your department or business. However, providers or claimants who seem to develop a pattern of mistakes or errors may need further attention. In those situations, remember to report any suspicions so that the company can investigate and respond appropriately.
Good work on analyzing and identifying the suspicious situations.

Remember, you don’t need to determine if the situation contains health care fraud, waste or abuse, but rather to identify if the situation needs further review and, most importantly, report it so that we respond accordingly. You’ll review reporting on the 3rd floor.
Floor 1 – Meet the Expert: On this floor, you will have the opportunity to ask a health care fraud expert questions as well as analyze situations and determine if they are suspicious or not suspicious.

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Floor 5 – Course Assessment: Once you complete all the activities, this floor will allow you to take the assessment for this course.
In the workplace, you may face situations in which you will need to determine if there is a potential for health care fraud, waste or abuse.

In this activity, three individuals will present you with scenarios. You will need to determine if there is a potential for health care fraud, waste or abuse.
1st Scenario – Part 1

As part of a provider audit, I reviewed claims from a dermatology clinic over a two week period. During my review, I noticed several claims that were originally denied because the services provided were administered by an unlicensed staff member at the clinic. In each instance, the same claim was resubmitted with a licensed staff member as the provider of the service and the claims were subsequently paid.

Should I be concerned that this could be potential health care fraud, waste or abuse?

○ Potential FWA ○ No Concern

The correct answer is Potential FWA.
1st Scenario – Part 2

What clues led you to that conclusion?

- Several claims were submitted for services performed by an unlicensed staff member as the provider

- Those same claims were resubmitted under a different staff member who is licensed at the clinic

- A random provider audit was conducted on the dermatology clinic
What clues led you to that conclusion?

• Several claims were submitted for services performed by an unlicensed staff member as the provider

• Those same claims were resubmitted under a different staff member who is licensed at the clinic
  
  o A random provider audit was conducted on the dermatology clinic

These clues are typical of potential provider fraud or abuse. Other activities that are indicative of potential provider fraud and abuse include:

➢ Submitting bills or claims for treatment or services that were never provided
➢ Falsifying the date of service to correspond with a member’s coverage period
➢ Billing for non-covered services using incorrect codes in order to have the services covered

*Please note: These are not the only examples of potential provider fraud and abuse.*
I received an anonymous call that a member, Doris Smith, is using her medical transportation benefits to go to hair appointments and run other non-medical related errands and not for their intended purpose - to take her to medical appointments. In analyzing her claim history, I noticed there are claims for the medical transportation but there are no corresponding provider claims on the same days.

Should I be concerned that this could be potential health care fraud, waste or abuse?

○ Potential FWA ○ No Concern

The correct answer is Potential FWA.
What clues led you to that conclusion?

- An anonymous call was made reporting Doris Smith for inappropriate use of the medical transportation benefit
- Transportation benefits are not available for medical appointments
- The transportation benefit does not have corresponding medical appointments on the same days
What clues led you to that conclusion?

• An anonymous call was made reporting Doris Smith for inappropriate use of the medical transportation benefit
  
  o Transportation benefits are not available for medical appointments

• The transportation benefit does not have corresponding medical appointments on the same days

These clues are typical of potential member or patient fraud or abuse. Other activities that are indicative of potential member or patient fraud and abuse include:

➢ Stockpiling prescriptions and selling goods unlawfully
➢ Concealing information about additional coverage in order to lower out-of-pocket payments or receive inappropriate reimbursement from multiple plans
➢ Identity theft
➢ Doctor shopping

*Please note: These are not the only examples of potential member or patient fraud and abuse.
3rd Scenario – Part 1

I received a call from the daughter of a Medicare patient with a question regarding an Explanation of Benefits (EOB) her mother received. The EOB indicated multiple nurse home care visits the daughter believes had not occurred. I reviewed the patient claim history and discovered the patient was in an out of state hospital during one of the home care visits.

Should I be concerned that this could be potential health care fraud, waste or abuse?

- Potential FWA
- No Concern

The correct answer is Potential FWA.
What clues led you to that conclusion?

- EOB indicated multiple home care visits from a nurse the daughter believed had not occurred
- A claim for a hospital visit shows she was in the hospital during one of the home care visits by the nurse
- The daughter of the Medicare patient called with a question regarding the EOB
What clues led you to that conclusion?

- EOB indicated multiple home care visits from a nurse the daughter believed had not occurred

- A claim for a hospital visit shows she was in the hospital during one of the home care visits by the nurse
  
  - The daughter of the Medicare patient called with a question regarding the EOB

These clues are typical of potential employee fraud or abuse. Other activities that are indicative of potential employee fraud and abuse include:

- Falsifying or recording untrue information in patient records
- Identity theft
- Using a member’s ID number to obtain prescriptions, services, supplies, etc.

*Please note: These are not the only examples of potential employee fraud and abuse.*
Nice work on helping the employees!

In this activity, you not only determined if there was a potential for fraud, waste and abuse, you were introduced to various types of health care fraud, waste and abuse.

We will review several different types of health care fraud, waste and abuse next.
Types of health care fraud and abuse

Provider fraud and abuse
Activities that are indicative of potential provider fraud and abuse include:

- Submitting bills or claims for treatment or services that were never provided
- Falsifying the date of service to correspond with a member’s coverage period
- Billing for non-covered services using incorrect codes in an attempt to have the services covered

*Please note: These are not the only examples of potential provider fraud and abuse.

Sales Agent fraud and abuse
Activities that are indicative of potential sales agent fraud and abuse include:

- Enrolling a member by forging a signature on an application for benefits
- Coaching individuals to fill out their insurance enrollment information with false or misleading information
- Using a nonexistent company to enroll a group of individuals
- Falsifying the geographic location of a group in order to obtain insurance or lower premium rates

*Please note: These are not the only examples of potential sales agent fraud and abuse.
Types of health care fraud and abuse

Pharmacy fraud and abuse

Activities that are indicative of potential pharmacy fraud and abuse include:

- Inappropriate pharmacy billing
  - Billing for medication that was never dispensed
  - Billing for brand name drugs, but dispensing generics
  - Billing for medication not requested and delivering via the mail
- Prescription drug shorting
  - Intentionally providing less than the prescribed quantity and not informing the patient
- Prescription forging or altering
  - Increasing the quantity of tablets or number of refills without the provider’s permission
  - Substituting more expensive brand name drugs in place of generic drugs

*Please note: These are not the only examples of potential pharmacy fraud and abuse.*
Types of health care fraud and abuse

Member or Patient fraud and abuse

Activities that are indicative of potential member or patient fraud and abuse include:

• Stockpiling prescriptions and selling goods unlawfully
• Concealing information about additional coverage in order to lower out-of-pocket payments or receive inappropriate reimbursement from multiple plans
• Identity theft
• Doctor shopping
  • Seeing multiple providers in an attempt to obtain multiple prescriptions. Usually includes deception and can be driven by addiction, drug diversion for profit, or both

*Please note: These are not the only examples of potential member or patient fraud and abuse.*
Employee fraud and abuse

Activities that are indicative of potential employee fraud and abuse include:

- Falsifying or recording untrue information in patient records
  - Note: If the patient that had their records falsified was being served through a government program, billing for services related to these documented visits could violate the U.S. False Claims Act.
- Identity theft
- Using a member’s ID number to obtain prescriptions, services, supplies, etc.

*Please note: These are not the only examples of potential employee fraud and abuse.*
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Reporting suspicious situations is key in helping to reduce fraud, waste and abuse in the health care system.

The employees on this floor need some help, you will answer their questions regarding reporting potential fraud, waste and abuse.
I'm creating a list of resources that I can use to report suspicious activities. What resources should I add to my list?

The correct answers are:

- Health Care Fraud Tip Line at 1-866-242-7727
- Compliance & Ethics HelpCenter 1-800-455-4521
- Her manager
- Her business segment Compliance Officer

1st Scenario
To report health care fraud, waste and abuse contact:
• Health Care Fraud Tip Line at 1-866-242-7727 or Online > Health Care Fraud Tip Portal.

Note: If your business area has specific instructions for reporting potential health care fraud, follow that procedure.
• **OptumRx** - OptumRx customer service representatives should use the online RxWeb audit referral form for reporting potential pharmacy fraud.
• **UnitedHealthOne** - UnitedHealthOne employees should use UnitedHealthOne’s Fraud Hotline at (866) 283-7354 for reporting potential fraud.

Additional reporting resources include:
• Your manager
• Your business segment Compliance Officer
• Your business segment Legal department
• The Compliance & Ethics HelpCenter (available 24 hours a day, 7 days a week)
  • 1-800-455-4521 (U.S.) or find your country’s dialing instructions from the online HelpCenter portal
  • [www.uhghelpcenter.ethicspoint.com](http://www.uhghelpcenter.ethicspoint.com)
• UnitedHealth Group Compliance & Ethics at 952-936-7463 or ethicsoffice@uhg.com

*UnitedHealth Group prohibits any form of retaliation against employees who report good faith concerns of unethical conduct or violation of law, regulation or company policy.*
I know that another employee was made aware of a potential health care fraud situation. Can't I just let the other person report the situation?

What advice would you give Bruce?

- Sure. As long as one person reports the situation you're ok.

- No. You must report the situation. We are all responsible for and expected to report any suspected misconduct, including suspected violations of policies or procedures, federal or state laws and as required by the UnitedHealth Group Reporting Misconduct policy.
2nd Scenario - Answers

The correct answer is No. You must report the situation.

You must report the situation even if another individual is aware of the situation.

UnitedHealth Group is also committed to maintaining an effective compliance program that includes measures to prevent, detect and correct health care fraud, waste and abuse.

The full text of the UnitedHealth Group Reporting Misconduct policy can be found within the online eGRC Policy Center.
UnitedHealth Group's compliance programs are designed to ensure that we meet all legal, regulatory and business requirements, both domestic and international. They reflect our commitment to reduce the potential for non-compliance with these requirements.

Our compliance programs follow the seven core elements of an effective compliance program:

- **High Level Oversight**
  Designated leaders responsible for oversight of the development and implementation of an effective compliance program, including an engaged compliance committee of senior management leaders.

- **Policies & Procedures**
  Policies, procedures and other operating guidelines, like the UnitedHealth Group Code of Conduct.

- **Education & Training**
  Regular and effective education and training about compliance expectations, such as this course.

- **Monitoring & Auditing**
  Systematic checks for compliance with requirements through monitoring and auditing.

- **Effective Communication**
  Ongoing communication and awareness between leadership and employees about compliance expectations, including systems and processes to receive and respond to compliance questions or reports of potential non-compliance.

- **Enforcement & Discipline**
  Ensure appropriate and consistent disciplinary action for non-compliance as well as enforcement of non-retaliation policies. The UnitedHealth Group Non-Retaliation policy can be found on the Hub within the Policies menu under Workplace Policies.

- **Responding to Violations**
  Take the reasonable steps necessary to promptly respond to and prevent further non-compliance or misconduct, including corrective action as needed.
I’m worried that if I report a situation, I may lose my job or be treated differently. Could this happen?

What advice would you give Tamika? (Select all that apply.)

- There are laws and policies that protect you from harassment, demotion, or wrongful termination if you report in good faith.

- It could happen. Just make sure no one finds out you reported the situation.

- UnitedHealth Group has policies that prohibit any form of retaliation against employees who report good faith concerns of unethical conduct or violations of law, regulation or company policy.
3rd Scenario - Answers

The correct answers are:

• There are laws and policies that protect you from harassment, demotion, or wrongful termination if you report in good faith.

• UnitedHealth Group has policies that prohibit any form of retaliation against employees who report good faith concerns of unethical conduct or violations of law, regulation or company policy.

You shouldn't be concerned with retaliation.

UnitedHealth Group prohibits retaliation for persons who report or raise concerns in good faith. Protections are provided to persons who report good faith concerns through the False Claims Act and UnitedHealth Group Non-Retaliation policy.

The False Claims Act protects good faith reporters from retaliation, including the following:

• Harassment
• Demotion
• Wrongful termination

UnitedHealth Group prohibits any form of retaliation against employees who report good faith concerns of unethical conduct or provide information or participate in investigations of such conduct. This includes reports of potential violations of law, regulation or company policy.

The UnitedHealth Group Non-Retaliation policy can be found on the Hub within the Policies menu under Workplace Policies.
Remember, when in doubt, route your concern through any of the appropriate company reporting resources.

Even if another individual is aware of the situation; it is still your responsibility to report.

Don't hesitate to report. UnitedHealth Group expressly prohibits retaliation against employees who, in good faith, report or participate in the investigation of compliance concerns.
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Health care fraud, waste and abuse is on the rise. To combat this steady increase of cases, fraud prevention and enforcement efforts are increasing.

On this floor, you will explore recent headlines to see how enforcement tools are used to address fraud, waste and abuse situations.
Enforcement Tools - The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The nature of our jobs in health care often requires us to have some level of access to member-protected information, such as Social Security Number, address, date of birth, diagnosis, etc.

This access requires that we be highly focused on protecting that information.

One example of the relationship between privacy and health care fraud, waste and abuse is medical identity theft. The use of personal information to commit medical or health care identity theft is a fast growing issue.

Medical identify theft mainly happens in one of two ways:
• Others obtain medical goods and services like drugs and costly services, using someone else’s personal information.
• Personal information such as someone’s name and identification is used to bill for procedures that were never done or for supplies that were never received.

Remember HIPAA fraud, waste and abuse provisions apply to all health care benefit programs - not just Medicare and Medicaid.
Title II of HIPAA includes provisions related to the prevention of health care fraud and abuse including:

- The creation of the Fraud, Abuse and Control program for coordination of state and federal health care fraud investigation and enforcement activities.

- The expansion of the Exclusion Authority so that any health care fraud conviction, even if the fraud is not related to a government program, results in mandatory exclusion from participation in the Medicare or Medicaid programs.

- The creation of new criminal provisions that expanded what actions could be considered ‘health care fraud’ and strengthened the tools available to prosecute violations at the federal level. These new provisions made it a federal crime to defraud health care benefit programs - any benefit program - not just Medicare or Medicaid.
The Center for Medicare and Medicaid Services - Data Use Agreement

As part our Medicare contracts with the Centers for Medicare and Medicaid Services (CMS), UnitedHealthcare and Optum are required to attest annually that:

• UnitedHealthcare and Optum will only use CMS data and their systems for the administration of the Medicare managed care and/or outpatient prescription drug benefit programs; and
• we will follow UnitedHealth Group privacy and security policies to ensure data is protected at all times.

What does this mean?

Simply stated, our data use agreement with CMS means that we have committed to following UnitedHealth Group privacy and security policies such as not sharing passwords, using the minimum amount of information necessary to complete our jobs, and ensuring that confidential data is protected and secure at all times.
Federal and state anti-kickback statutes make it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a federal or state health care program. In addition to kickbacks, some of the state level statutes prohibit fee-splitting, patient brokering and self-referrals.

The intent of anti-kickback statutes is to ensure referrals for health care services are based on medical need or benefit and not based on financial or other types of incentives.

Violations may result in a felony conviction, with penalties including imprisonment and fines. In addition, civil penalties can involve fines and exclusion from government health care programs.

For more information about anti-kickback statutes, see the UnitedHealth Group policy, “Anti-Kickback,” located on the online eGRC Policy Center.
U.S. Stark Law

The U.S. Stark Law, which focuses on physician self-referrals, is related to anti-kickback statutes; both are intended to prevent health care providers from inappropriately profiting from referrals.

This means a physician generally may not refer a patient for certain designated services to an entity where the physician has an ownership or financial arrangement if the service is covered by government programs such as Medicare or Medicaid.

Violations may result in a denial for payment for the prohibited transaction; require the refund of payments received, civil penalties and exclusion from government health care programs.
Enforcement Tools – U.S. Federal and State False Claims Acts

The U.S. Federal False Claims Act prohibits any person from knowingly presenting or causing the presentation of a false or fraudulent claim for payment to the federal government.

The Act creates liability for anyone, person or company, who knowingly submits, uses, or causes to be submitted a false or fraudulent claim or uses a false record, statement, or claim to obtain payment from the government.

Knowingly or known means that a person has actual knowledge; acts in purposeful or 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 knowledge.

Claim is broadly defined to include any submission that results or could result in payment.

“Government” includes any organization under contract with the government to administer health care benefits - for example, state agencies or managed care organizations such as Medicare Advantage or Part D plans and Medicaid managed care plans.
Enforcement Tools – U.S. Federal and State False Claims Acts (cont.)

In addition to the Federal False Claims Act, a number of U.S. states have also enacted False Claims Acts to discourage fraud against state government programs. Medicaid program claims and related submissions are subject to both the Federal False Claims Act and the False Claims Act in that state.

The U.S. Health Care Reform Law of 2010 (Patient Protection and Affordable Care Act) expanded the False Claims Act to add liability for reverse false claims. Under the reverse false claims provisions, overpayments or any funds received or retained under a federal program (like Medicare, Medicaid or TRICARE, etc.) to which a person or organization is not entitled must be reported within 60 days of identification. The Affordable Care Act also expanded the range of health plan business subject to the FCA and compliance must now be a significant concern in “non-government” lines of business.

Violations of the False Claims Act can result in liability for repayment of up to three times the original dollar amount that the government was defrauded and potential civil penalties for each false claim.

For more information on the Federal and State False Claims Acts, see the UnitedHealth Group policy “False Claims Act Compliance” located on the online eGRC Policy center.

The False Claims Act provides protections that protect good faith reporters from retaliation, including the following:

- Harassment
- Demotion
- Wrongful termination

UnitedHealth Group prohibits any form of retaliation against employees who report good faith concerns of unethical conduct or provide information or participate in investigations of such conduct. This includes reports of potential violations of law, regulation and company policy.

The UnitedHealth Group Non-Retaliation policy can be found on the Hub within the Policies menu under Workplace Policies.

The UnitedHealth Group Reporting Misconduct policy can be found within the online eGRC Policy Center.
Enforcement Tools – U.S. Federal Health Care Fraud Statute

In addition to the laws that address the protection of government dollars, the Federal Health Care Fraud Statute applies to all health care benefit programs - not just programs funded by the government.

The Federal Health Care Fraud Statute makes it a crime to defraud any health care benefit program. The Health Care Reform Law of 2010 (Patient Protection and Affordable Care Act) updated the Health Care Fraud Statute so that now, proof of actual knowledge or intent to violate the statute is not required.

Violations may result in a felony conviction, with potential penalties including imprisonment and fines.
Hospice Facility Pays $12 Million to Resolve False Claims Act Allegations

The Federal False Claims Act prohibits any person from knowingly presenting or causing the presentation of a fraudulent claim for payment.

Several states have also enacted false claims laws modeled after the federal False Claims Act.

**ARTICLE:** A hospice facility along with a related entity and their parent corporation have agreed to pay $12 million to resolve allegations that they violated the False Claims Act by submitting or causing the submission of false claims of Arizona patients who did not need end of life care or for whom the hospice billed at a higher reimbursement rate than it was entitled. Allegations also included not implementing an adequate compliance program that might have addressed these problems.

The Program Applicability of each U.S. states’ False Claims Act can be found in the following pages.
<table>
<thead>
<tr>
<th>State</th>
<th>Program Applicability:</th>
<th>District of Columbia</th>
<th>New Jersey</th>
<th>Tennessee*</th>
</tr>
</thead>
</table>
| Minnesota*    | Broad range of state-funded programs (including Medicaid) | Broad range of state-funded programs (including Medicaid) | Broad range of state-funded programs (including Medicaid) | Separate laws:  
• Medicaid False Claims Act  
• Civil False Claims Act |
| District of Columbia | Program Applicability: | Broad range of state-funded programs (including Medicaid) | Broad range of state-funded programs (including Medicaid) | Separate laws:  
• Medicaid False Claims Act  
• Civil False Claims Act |
| New Jersey    | Broad range of state-funded programs (including Medicaid) | Broad range of state-funded programs (including Medicaid) | Broad range of state-funded programs (including Medicaid) | Separate laws:  
• Medicaid False Claims Act  
• Civil False Claims Act |
| Tennessee*    | Broad range of state-funded programs (including Medicaid) | Broad range of state-funded programs (including Medicaid) | Broad range of state-funded programs (including Medicaid) | Separate laws:  
• Medicaid False Claims Act  
• Civil False Claims Act |
| Iowa*         | Program Applicability: | Broad range of state-funded programs (including Medicaid) | Broad range of state-funded programs (including Medicaid) | Separate laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act |
| Washington*   | Program Applicability: | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act |
| Florida       | Program Applicability: | Broad range of state-funded programs (including Medicaid) | Separates Laws:  
• Medicaid Fraud Control Act (MFCA)  
• Civil Statute for False Claims to help the state combat fraud and recover losses | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act |
| Kansas        | Program Applicability: | Separates Laws:  
• Medicaid Fraud Control Act (MFCA)  
• Civil Statute for False Claims to help the state combat fraud and recover losses | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act |
| Hawaii*       | Program Applicability: | Broad range of state-funded programs (including Medicaid) | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act |
| Nevada        | Program Applicability: | Broad range of state-funded programs (including Medicaid) | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act | Separates Laws:  
• Medicaid Fraud False Claims Act (MFCA)  
• Health Care False Claims Act |
<p>| Texas*        | Medicaid &amp; other State Health care funds only | Broad range of state-funded programs (including Medicaid) | Medicaid &amp; other State Health care funds only | Medicaid &amp; other State Health care funds only |
| Delaware*     | Program Applicability: | Broad range of state-funded programs (including Medicaid) | Medicaid &amp; other State Health care funds only | Medicaid &amp; other State Health care funds only |
| New Mexico    | Program Applicability: | Medicaid &amp; other State Health care funds only | Medicaid &amp; other State Health care funds only | Medicaid &amp; other State Health care funds only |
| California*   | Program Applicability: | Medicaid &amp; other State Health care funds only | Medicaid &amp; other State Health care funds only | Medicaid &amp; other State Health care funds only |</p>
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<th>State</th>
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<td>Connecticut*</td>
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<td>Louisiana</td>
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<td>Maryland</td>
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Pharma to pay $11.4 Million in Anti-Kickback Case

The Anti-Kickback Statute makes it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a Federal health care program.

The intent of anti-kickback statutes is to ensure referrals for health care services are based on medical need or benefit and not based on financial or other types of incentives.

**ARTICLE:** An $11.4 million settlement resolved a lawsuit against a specialty pharmaceutical company. The company is accused of promoting its drugs by paying kickbacks, such as event tickets, to doctors to induce them to write prescriptions for pharmaceutical company’s products, including prescriptions for patients covered by Medicare and other federal health insurance programs.

Physician assistant found guilty in $18.9M Medicare Fraud

Did you know that HIPAA not only protects health information but also contains provisions to combat fraud, waste and abuse? The following is an example of the fraud provisions within the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) in action.

**ARTICLE:** A physician assistant who worked at fraudulent medical clinics used the stolen identities of doctors to write prescriptions for medically unnecessary durable medical equipment (DME) and diagnostic tests has been convicted of conspiracy, health care fraud, and aggravated identity theft charges in connection with a $18.9 million Medicare fraud scheme.

Sleep Disorder Treatment Organization Agrees To Pay $15.3M

Under the Federal False Claims Act, reporters are protected from retaliation including: harassment, demotion, and wrongful termination.

**ARTICLE:** A former employee of the organization brought the charges to the attention of the government and filed suit under the False Claims Act claiming the clinic inappropriately billed government health care programs including Medicare, the Railroad Retirement Medicare Program, and the military health care program TRICARE- for sleep diagnostic services. The suit contended that false claims were submitted for payment to Medicare and TRICARE because services were performed by technicians with the company that lacked the required credentials and certifications. Under federal program requirements, tests must be conducted by technicians who are licensed or certified by a state or national credentialing body as sleep test technicians.

http://www.jameshoyer.com/american-sleep-medicine-to-pay-15-3-million/
In this section you learned more about enforcement tools used to address health care fraud, waste and abuse.

Remember, it's important that you report potential issues so the organization can respond promptly.
Floor 1 – Meet the Expert: On this floor, you will have the opportunity to ask a health care fraud expert questions as well as analyze situations and determine if they are suspicious or not suspicious.

Floor 2 – Employee Scenarios: On this floor, you will help employees determine if there is potential health care fraud, waste or abuse in a given situation.

Floor 3 – Employee Questions: On this floor, you will help employees answer questions regarding reporting potential health care-related fraud, waste and abuse.

Floor 4 – Enforcement Tools: On this floor, you will explore various objects to view health care laws and regulations in the headlines.

Floor 5 – Course Assessment: Once you complete all the activities, this floor will allow you to take the assessment for this course.
Now that you've completed the activities on each floor, it's time to test your knowledge on the material.

The assessment contains 15 questions.
True or False: HIPAA contains provisions to combat health care fraud, waste and abuse.

- True
- False

The correct answer is... True.

HIPAA contains provisions to combat health care fraud, waste and abuse in addition to protecting individual personal information. One way in which this manifests itself is through medical identity theft, which is on the rise.
Question #2

UnitedHealth Group employees and applicable contractors are trained annually on health care fraud, waste and abuse prevention and awareness because: (Select all that apply.)

- We are all on the front line to combat health care fraud, waste and abuse.
- UnitedHealth Group takes an aggressive approach to prevent, detect and correct health care fraud, waste and abuse.
- Annual training supports the organizations efforts to fulfill regulatory requirements.

All of the answers are correct.

Annual training supports the organizations efforts to fulfill regulatory requirements. We all play a role in combating fraud, waste and abuse.
Question #3

True or False: All UnitedHealth Group employees and contractors are responsible for and expected to report any suspected misconduct, including suspected violations of policies or procedures, and federal or state laws.

- True
- False

The correct answer is...True.

As required by the UnitedHealth Group Reporting Misconduct policy all employees and contractors are responsible for and expected to report any suspected misconduct, including suspected violations of policies or procedures, and federal or state laws.
Question #4

Reporters are protected from retaliation under which of the below? (Select all that apply.)

- UnitedHealth Group Non-Retaliation Policy
- Federal Transportation Laws
- U.S. False Claims Act
- Stark Law

The correct answers are...UnitedHealth Group Non-Retaliation Policy and U.S. False Claims Act.
Question #5

What if you can’t tell if a situation is potential health care fraud, waste and abuse?

- Report the situation to an appropriate company resource
- Do Nothing
- Investigate the situation on your own

The correct answer is....Report the situation to an appropriate company resource.

Differentiating between health care fraud, waste and abuse can be difficult and oftentimes cannot be determined without further investigation. Therefore your role is not to determine if a situation is fraud, waste or abuse, but rather to identify if the situation needs further review and, most importantly, report it so that we respond accordingly.
Question #6

True or False: States can also enact false claims laws modeled after the federal False Claims Act.

- True
- False

The correct answer is... True.

In addition to the Federal False Claims Act, a number of states have also enacted False Claims Acts to discourage health care fraud against state government programs. Medicaid program claims and related submissions are subject to both the Federal False Claims Act and the False Claims Act in that state.
Question #7

Under the U.S. False Claims Act, which of the following activities are reporters protected against? (Select all that apply.)

- Harassment
- Demotion
- Wrongful termination

The correct answers are...Harassment, Demotion and Wrongful termination.
Question #8

A nurse employed by company XYZ has been documenting notes within the company system for five patients indicating regular visits over the past three months. Robert, the nurse’s manager, performs an audit on the nurse’s performance and the audit indicates that none of the patients had been seen by the nurse. This type of behavior is:

- Suspicious, and is an example of potential employee fraud.
- Suspicious, and is an example of potential member fraud.
- Not suspicious. There must be an error in the billing.

The correct answer is...Suspicious, and is an example of potential employee fraud.

In this scenario the falsification of records has potentially occurred. If the patients that had their records falsified were being served through a government program the documented visits could violate the U.S False Claims Act.
Question #9

Whom should you contact if you have a health care fraud, waste and abuse concern? (Select all that apply.)

- Health Care Fraud Tip Line
- IT Help Desk
- HRdirect
- Compliance & Ethics HelpCenter

The correct answers are the...Health Care Fraud Tip Line and Compliance & Ethics HelpCenter.

Both of these resources are appropriate places to report health care fraud, waste and abuse concerns. Your business may also have specific fraud reporting procedures.
Question #10

Kono has a backache after gardening all weekend. She decides to go to her doctor to make sure everything is okay. After a brief examination, Kono’s doctor decides to send her to a specialist and order an MRI, despite the fact that Kono indicated that the pain is only mild and that she was gardening over the weekend. An MRI is not typically the first step to address mild back pain. This type of behavior is:

- Suspicious, and is an example of potential health care fraud.
- Suspicious, and is an example of potential waste or abuse.
- Not suspicious. There must be an error in the billing.

The correct answer is...Suspicious, and is an example of potential waste and abuse.

In those situations, remember to report any suspicions so that the company can investigate and respond appropriately.

In most cases, waste and abuse are not caused by careless actions but rather the misuse of resources.
Charlotte is a customer care representative at our company. She receives a call from a member who is confused over an explanation of benefits she recently received. The member indicates that she does not recognize the name of the physician listed on the explanation of benefits and mentions she was on vacation at the date of service. Charlotte looks at the claim in the system, and it appears to be a legitimate claim.

What are some of the clues Charlotte should consider when determining whether or not to report the situation?  *(Select all that apply.)*

- The member doesn't recognize the name of the physician on her explanation of benefits.
- The member was on vacation during the date of service.
- The member called confused over an explanation of benefits.

The correct answers are... The member doesn’t recognize the name of the physician on her explanation of benefits and the member was on vacation during the date of service.

Remember, anytime you have the suspicion of potential health care fraud it needs to be reported to appropriate company resources.
Question #12

The complete definition of health care fraud has which component(s)?

- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- Knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit
- All of the above

The correct answer is... All of the above.

The complete definition of health care fraud has the following components:
- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- Knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit
Question #13

A member of our health plan was identified as having high utilization of services and was selected for further review to identify possible interventions to assist the member with additional services to benefit their condition. The case manager, Bonita, reviewing the member files notices that the member has recently had frequent emergency room visits in a short period of time and those visits are at different hospitals.

What are some of the clues Bonita should consider when determining whether or not to report the situation? (Select all that apply.)

- A member of our health plan was identified as having high utilization of services
- The member is eligible to receive additional services to benefit their condition
- The member has recently had frequent emergency room visits in a short period of time and those visits are at different hospitals.

See next page for answer.
Question #13 - Answer

What are some of the clues Bonita should consider when determining whether or not to report the situation? *(Select all that apply.)*

- A member of our health plan was identified as having high utilization of services
- The member is eligible to receive additional services to benefit their condition
- The member has recently had frequent emergency room visits in a short period of time and those visits are at different hospitals.

The correct answers are... *A member of our health plan was identified as having high utilization of services and The member has recently had frequent emergency room visits in a short period of time and those visits are at different hospitals.*

The pattern of behavior seems suspicious and needs to be reviewed further. Remember, anytime you have the suspicion of potential health care fraud it needs to be reported to appropriate Company resources.
Question #14

Sahid, a customer care representative, receives a phone call from a new member who just received a welcome packet. The new member is confused over how she was enrolled in the health plan. The new member states that she does not remember signing any applications or meeting with a sales agent.

Should Sahid be concerned if this could be potential health care fraud, waste or abuse?

- Yes
- No

The correct answer is... Yes, potential health care fraud waste or abuse.

One of the clues is the member does not remember signing any applications or meeting with a sales agent. Anytime a member reports this type of suspicious behavior it needs to be investigated by the appropriate company resources.
Question #15

The intent of the Anti-Kickback Statute is to? (Select all that apply.)

- Ensure referrals for health care services are based on medical need or benefit.
- Ensure referrals for health care services are not based on financial or other types of incentives.
- Prohibit any person from knowingly presenting or causing the presentation of a fraudulent claim for payment.

The correct answers are...Ensure referrals for health care services are based on medical need or benefit and ensure referrals for health care services are not based on financial or other types of incentives.

The Anti-Kickback Statute makes it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a Federal health care program.
Attestation of Compliance

UHG Fraud, Waste and Abuse New Hire Training 2020

Attestation of Compliance

We are all responsible for and expected to report any suspected misconduct, including suspected violations of company policies or procedures and federal or state laws.

I attest that I have completed this course, understand the information presented and acknowledge that I am required to follow reporting guidelines as outlined in the course.

Name (please print) __________________________________________ Employee/Contractor Number ____________________________

Signature __________________________________________ Date of Completion ____________________________

Please mail or email and scan signed form to:
UnitedHealth Group Compliance
9900 Bren Road East
MN008-T615
Minnetonka, MN  55343
Email: uhgcompliancetraining@uhg.com

Ref# 353516-560873