

2022 Specialized Anti-Healthcare Fraud Training Detection and Prevention

1. Navigation

1.1 Objectives

Anti-Fraud and Abuse Awareness Detection and Prevention



This course examines the most common types of fraud and abuse indicators in health care and describes current trends identified by law enforcement and monitoring organizations like the National Health Care Anti-Fraud Association (NHCAA), the Office of the Inspector General (OIG) and the Federal Bureau of Investigation (FBI).

First, we will review the Course Objectives.

For help with navigating this course, click the **Help** button on the upper right area of the screen at any time for instructions.

This course does not contain audio.

Notes:

1.2 Untitled Slide

Objective 1

Why is this course important?

State regulations require that health care insurance personnel receive annual continuing education related to fraud, waste and abuse.

UnitedHealth Group is committed to addressing the problem of fraud, waste and abuse by stressing continuous awareness and providing the most current information available. In support of this effort and to fulfill the company's regulatory requirements, this course ensures you have the information you need to do your part.



Course Objectives

Regulatory Compliance Statement

1 2 3

Untitled Layer 1 (Slide Layer)

strategy to identify and protect against fraudulent activity.

The anti-fraud plan elements shall include, but are not be limited to, all of the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; internal procedure for referring suspected fraud and required reporting to the appropriate regulatory agency(ies).

This course is part of an annual anti-fraud training series designed in accordance with these statutes and specifically these California Codes of Regulations:

- The "Insurance Frauds Prevention Act" or "(IFPA)" - California Insurance Code section 1871-1879.8
- California Code of Regulations, Title 10, Chapter 5, Subchapter 9 Insurance Fraud, Article 2 Special Investigative Unit Regulations Section 2698.30-45, inclusive
 - SIU Annual Report - CA Code of Regulations, Title 10, § 2698.40
 - Referrals - CA Code of Regulations, Title 10, § 2698.37 (a) and (b)
- California Health & Safety Code §1348
 - Annual Fraud Report - CA Health & Safety Code Section 1348[c]

1.3 Untitled Slide

Objective 2

What will I learn about in this course?

The topics covered in this course represent the common fraud, waste, and abuse indicators you may encounter in the course of your daily work, including processing claims for payment. You will learn when they are likely to occur.

- Abusive or Fraudulent Referrals
- Overcharging and Overpayments
- Excessive Charges
- Overutilization
- Unnecessary Services or Supplies
- Services Not Rendered
- Medical Coding – upcoding or inappropriate coding
- Common Fraudulent Coding, Billing Schemes
- Hospital inpatient or outpatient billing
- Fraudulent applications for coverage



Course Objectives



1.4 Untitled Slide

Objective 3

How can I prevent fraud, waste and abuse?

You are in a unique, front-line position to identify patterns associated with fraud, waste and abuse and help prevent improper payments.

Reporting any unusual circumstances or patterns of payment that are out of the ordinary is your responsibility as outlined in the UnitedHealth Group **Code of Conduct**.

Completing this course and the assessment with a score of 80% or better will show that you understand these topics and that you are prepared to do your part.




Course Objectives



1.5 Introduction

Introduction

2022 Healthcare Fraud Outlook



The Department of Health and Human Services (HHS) Office of Inspector General (OIG) published its **Work Plan** that furnishes guidance to providers and suppliers on the agency's enforcement priorities for the upcoming year.

Notes:

2. Module 1 Referrals

2.1 Referrals

1 Referrals

Section 1: The Laws


In this section, we will review the Anti-Kickback and Stark self-referral laws and the financial relationships allowed between providers who service patients receiving benefits from government health care programs.

Anti-Kickback Statute

Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal/State health care program business.

The Stark Law

Prohibits a physician from referring Medicare or Medicaid patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies.



Notes:

2.2 Anti-Kickback

1 Referrals

What is a Kickback?

For Federal/State health care programs, paying or rewarding someone for referring patients and/or business is a crime. Those who offer to pay a kickback, as well as for those who receive the kickback, can be charged under the Anti-Kickback Statute.



- Hospitals pay physicians for patient referrals.
- Service providers pay physicians for referrals.
- Drug or medical device companies pay/reward physicians to prescribe their products.
- Physicians routinely waive co-payments that are required by Medicare and Medicaid programs.
- Service providers disguise referral fees as salaries and pay referring physicians for services that are never rendered or in excess of fair market value.
- Large hospitals or groups offer reduced rent to providers for using service companies they own.

[Click Here for Emerging Kickback Fraud Trends](#)

Kickback Trends (Slide Layer)

1 Referrals

What is a Kickback?

For Federal/State health care programs, paying or rewarding someone for referring patients and/or business is a crime. Those who offer to pay a kickback, as well as for those who receive the kickback, can be charged under the Anti-Kickback Statute.

Emerging Trends/Schemes

Here is an area, reported by the Department of Justice (DOJ), where kickback schemes are currently being seen:

Cancer Genetic Tests and DME/Telemedicine -

Independent clinical laboratories and marketing companies offering and paying illegal kickbacks and bribes to telemedicine companies in exchange for doctors' orders for expensive medically unnecessary cancer genetic tests and durable medical equipment.


A Few Examples

- Hospitals pay physicians for patient referrals.
- Service providers pay physicians for referrals.
- Drug or medical device companies pay/reward physicians to prescribe their products.
- Physicians routinely waive co-payments that are required by Medicare and Medicaid programs.
- Service providers disguise referral fees as salaries and pay referring physicians for services that are never rendered or in excess of fair market value.
- Large hospitals or groups offer reduced rent to providers for using service companies they own.

2.3 Referral Case 1

1 Referrals

Examples of Recent Fraud Cases



Let's review three actual cases reported by the Department of Justice.
Use the scroll-bar to see additional information.

Arthrex Agrees to Pay \$16 Million to Resolve Kickback Allegations


Arthrex Inc. (Arthrex), a Florida-based orthopedic device company, has agreed to pay \$16 million to resolve allegations that Arthrex paid a Colorado-based orthopedic surgeon millions of dollars under the guise of royalty payments. While Arthrex's agreement with the surgeon purported to compensate the surgeon for contributing to the development of certain orthopedic products, the government contends that Arthrex made the payments to induce the surgeon's use and recommendation of Arthrex products. As a result, the government alleges that Arthrex violated the Anti-Kickback Statute and, in turn, the FCA.

Source:
<https://www.iustice.gov/usao-ma/pr/arthrex-agrees-pay-16-million->

2.4 Referral Case 2

1 Referrals

Examples of Recent Fraud Cases



Let's review three actual cases reported by the Department of Justice.
Use the scroll-bar to see additional information.

Pain Clinic Owners Convicted of Unlawfully Distributing Opioids and Multimillion-Dollar Health Care Fraud

A federal jury convicted a Tennessee physician and his wife of conspiracy to unlawfully distribute controlled substances and conspiracy to commit health care fraud, along with various substantive counts related to the same. They were also convicted of conspiring to defraud the United States and receiving kickbacks. Evidence at trial showed that the clinic provided pre-signed prescriptions to thousands of patients a month, including prescriptions written outside the usual course of professional practice without a legitimate medical purpose. The couple also solicited and received unlawful payments for referring fraudulent or unnecessary services to patients.

Notes:

2.5 Referral Case 3

1 Referrals

Examples of Recent Fraud Cases



Let's review three actual cases reported by the Department of Justice.
Use the scroll-bar to see additional information.

Anesthesia providers and outpatient surgery centers pay more than \$28 million to resolve kickback and False Claims Act allegations

Three anesthesia providers and several Georgia outpatient surgery centers, as well as their physician-owners and an administrator, agreed to pay more than \$28 million to resolve allegations that they entered into kickback arrangements by paying and receiving payments for medications, supplies, equipment and labor as well as free staffing in exchange for the referral of patients. The Government alleges that these arrangements violated the Anti-Kickback Statute and caused the submission of false claims in violation of the False Claims Act.

Source:


2.6 Stark Law

1 Referrals

Stark Law

Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the physician self-referral law and commonly referred to as the "Stark Law":

- Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare or Medicaid to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.
- Prohibits the entity from presenting or causing to be presented claims to Medicare or Medicaid (or billing another individual, entity, or third party payer) for those referred services.
- Establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.



[Click Here to view Designated Health Services](#)

DHS (Slide Layer)

1 Referrals

Stark Law

Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the physician referral law and commonly referred to as the "Law":

- Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare or Medicaid to an entity with which she (or an immediate family member) has a relationship (ownership, investment, or compensation), unless an exception applies.
- Prohibits the entity from presenting or causing to be presented claims to Medicare or Medicaid (or another individual, entity, or third party) that pay for those referred services.
- Establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

Designated Health Services

- Laboratory services
- Physical therapy services
- Occupational therapy services
- Outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

3. Module 2 Services

3.1 Services & Billing Fraud

1 Referrals 2 Services

Section 2: Service Related Fraud and Abuse

In this section, we will examine how health care services, and the billing processes for services, are sometimes manipulated to commit fraud and abuse.


Types of Fraud and Abuse Related To Services

Provider fraud involves not only doctors, but nursing homes, home health, durable medical equipment, pharmacies, mental health facilities, laboratories, transportation and dentists as well.

Though the majority of providers are honest, some may intentionally try to take advantage of complex billing systems to increase their reimbursements, or even bill for services, equipment or supplies that were never delivered.

These types of fraud and abuse are known as:

- Excessive Charges
- Overutilization
- Unnecessary Services
- Services Not Rendered



Notes:


3.2 Excessive Charges

1 Reports 2 Services

Excessive Charges

Excessive charges are instances of price gouging, usually done by manipulating billing codes and include cases of a provider furnishing, or causing to be furnished:

- Items or services that are substantially in excess of the patient's needs.
- Items or services that fail to meet professionally recognized quality standards of health care.
- Charges that are significantly higher for insured patients than for cash paying patients or for government health care patients.



Payment Integrity runs claims through sophisticated analytic tools to uncover excessive charges, which can then be investigated. Cases with evidence of fraud or abuse may be litigated in court.

3.3 Overutilization

1 Reports 2 Services

Overutilization

Overutilization refers to medical services that are provided with a higher volume or cost than is appropriate, adding unnecessary costs to health care and possibly resulting in adverse outcomes. Defining "appropriate" is difficult, but there are a number of factors that contribute to the overutilization of health care services.

Defensive Medicine	Stark	
Physicians who order clinically unnecessary tests or other medical procedures as a means to avoid medical malpractice lawsuits or to boost their personal income are practicing defensive medicine.	Physicians who order genetic testing to address psychiatric medication regimens with a lab owned by a family member.	

[Click Here for Overutilization Examples](#)

Overutilization Examples (Slide Layer)

1 Returns 2 Services

Overutilization

Overutilization refers to medical services that are provided with a higher volume or cost than is appropriate, adding unnecessary costs to health care and possibly resulting in adverse outcomes. Defining "appropriate" is difficult, but there are a number of factors that contribute to the overutilization of health care services.

Defensive Medicine

Physicians who order clinically unnecessary tests or other medical procedures as a means to avoid medical malpractice lawsuits or to boost their personal income are practicing defensive medicine.

Stark

Physicians who order genetic testing to address psychiatric medication regimens with a lab owned by a family member.

Overutilization Examples

Examples of overutilization include but are not limited to:

- Screening patients with advanced cancer for other cancers.
- Unnecessary hospitalization.
- Routine ordering of advanced imaging tests (MRI, CT etc.).
- Requiring urinalysis/drug screening with no medical necessity to do so.
- Genetic testing with no medical justification to do so.

CLOSE

3.4 Unnecessary Services

1 Returns 2 Services

Unnecessary Services or Supplies

Just like overutilization, it can be difficult to prove a case for "unnecessary services" because the decisions a provider makes when caring for patients is based on that patient's individual medical needs. However, unnecessary abusive or fraudulent practices can expose patients to potentially painful or dangerous services. Determining fraud and abuse related to unnecessary services or supplies relies on three common questions:

- Were the services provided necessary?
- Did the provider, or someone at their direction, represent that the services billed were necessary?
- And, were the representations of necessity stated truthfully?



Payment Integrity runs claims through sophisticated analytic tools to identify suspect services or supplies. One highly suspicious pattern of billing is when each patient receives the same diagnostic tests or treatment, regardless of the patient's condition.


3.5 Services Not Rendered

1 Referrals 2 Services

Services Not Rendered

Billing for services not rendered, also known as "phantom billing," can happen in several ways:

- Claims include charges, either in whole or in part, for procedures or services that were never provided.
- Billing for services for non-existent patients, perhaps using genuine patient information obtained through identity theft for either living or deceased individuals.
- Posing as a legitimate licensed practitioner and submitting claims for services that were not rendered.
- Service providers disguise referral fees (kickbacks) as salaries and pay referring physicians for services that are never rendered or in excess of fair market value.



3.6 Overcharges and Overpayments 1

1 Referrals 2 Services

Payment Integrity Review Process

Payment Integrity has a process that helps to identify fraud, waste and abuse and recover overcharges and overpayments.

- Information is received from the Health Care Fraud reporting hotline, claims processing, or an internal predictive analytics review.
- A review, audit or investigation is conducted and a determination is made whether it is potential fraud, abuse, waste or error.
- Some cases may be routed to prepare a fraud or abuse case for litigation in a court of law or arbitration before an arbitration panel.



3.7 Overcharging and Overpayments 2

1 Reforms 2 Services

Payment Integrity Review Process

Waste and error cases are reviewed for overcharges and overpayments.

If similar overpayments are found to have been made in the past, the provider may be referred for potential flagging to prevent claims from being paid until a documentation review has been completed prior to payment. Other reviews/monitoring may be conducted to ensure overpayments do not continue.

```
graph LR; Intake[Intake] --> Fraud[Fraud]; Intake --> Abuse[Abuse]; Intake --> Waste[Waste and Errors]; Fraud --> Litigation[Litigation]; Abuse --> Litigation; Waste --> Litigation; Abuse --> Negotiation[Negotiation]; Waste --> Negotiation; Litigation --> Recovery[Recovery]; Negotiation --> Recovery;
```

The diagram illustrates the Payment Integrity Review Process. It begins with an 'Intake' box on the left, which feeds into three categories: 'Fraud' (red), 'Abuse' (blue), and 'Waste and Errors' (yellow). From these categories, cases flow to either 'Litigation' (black) or 'Negotiation' (orange). 'Fraud' and 'Abuse' lead to 'Litigation', while 'Abuse' and 'Waste and Errors' lead to 'Negotiation'. Both 'Litigation' and 'Negotiation' paths culminate in a 'Recovery' box on the right.

Notes:

4. Module 3 Coding

4.1 Coding & Billing Fraud

1 Referrals 2 Services 3 Coding

Section 3: Coding Related Fraud and Abuse


This section covers the fraud and abuse that may occur when reporting codes are misused during the billing process. The different types of medical coding fraud and abuse used to deceive payers will also be reviewed.

Medical Coding

Medical coding is a process of taking descriptions of diseases, injuries, medications and health care procedures and transforming them into standardized numeric codes.

These codes are used by everyone in health care to determine what costs will be paid and maintain a consistent communication across the health care system.

There are a number of ways billing codes can be used to intentionally deceive payers and take advantage of complex billing systems. First, you should understand the common code systems used.



Notes:

4.2 Code Types

1 Referrals 2 Services 3 Coding

Common Coding Systems and Usage

These are the common coding systems in use today. Hover your cursor over the boxes below for a brief description of each coding system.

- CPT®
- HCPCS
- ICD
- ICF
- NDC
- CDT®

Common uses for payers, providers and hospitals include:

- Identifying symptoms
- Maintaining reporting and payment integrity services
- Determining staffing and scheduling of services
- Comparing facilities and planning for new service areas

CPT (Slide Layer)

1 Referrals 2 Services 3 Coding

Common Coding Systems and Usage

These are the common coding systems in use today. Hover your cursor over the boxes below for a brief description of each coding system.

- CPT®
- HCPCS
- ICD
- ICF
- NDC
- CDT®

CPT®
Current Procedural Terminology Codes

Numeric codes developed by the American Medical Association (AMA) that describe surgical, medical and diagnostic health care services. CPT® is a registered trademark of the American Medical Association.

Common uses for payers, providers and hospitals include:

- Identifying symptoms
- Maintaining reporting and payment integrity services
- Determining staffing and scheduling of services
- Comparing facilities and planning for new service areas

HCPCS (Slide Layer)

1 Patients 2 Services 3 Coding

Common Coding Systems and Usage

These are the common coding systems in use today. Hover your cursor over the boxes below for a brief description of each coding system.

- CPT®
- HCPCS**
- ICD
- ICF
- NDC
- CDT®

HCPCS

Health Care Common Procedure Coding System

Alphanumeric codes that primarily include non-physician products, drugs, supplies and procedures not included in CPT®.

Common uses for payers, providers and hospitals include:

- Identifying symptoms
- Maintaining reporting and payment integrity services
- Determining staffing and scheduling of services
- Comparing facilities and planning for new service areas

ICD (Slide Layer)

1 Patients 2 Services 3 Coding

Common Coding Systems and Usage

These are the common coding systems in use today. Hover your cursor over the boxes below for a brief description of each coding system.

- CPT®
- HCPCS
- ICD**
- ICF
- NDC
- CDT®

ICD

International Classification of Diseases

Designed to promote international comparability of mortality statistics. The National Center for Health Statistics (NCHS) maintains them for North America.

Common uses for payers, providers and hospitals include:

- Identifying symptoms
- Maintaining reporting and payment integrity services
- Determining staffing and scheduling of services
- Comparing facilities and planning for new service areas

ICF (Slide Layer)

1 Patients 2 Services 3 Coding

Common Coding Systems and Usage

These are the common coding systems in use today. Hover your cursor over the boxes below for a brief description of each coding system.

- CPT®
- HCPCS
- ICD
- ICF
- NDC
- CDT®

ICF
International Classification of Functioning, Disability and Health

These codes describe the outcomes of a disability - functionality of patients.

Common uses for payers, providers and hospitals include:

- Identifying symptoms
- Maintaining reporting and payment integrity services
- Determining staffing and scheduling of services
- Comparing facilities and planning for new service areas

NDC (Slide Layer)

1 Patients 2 Services 3 Coding

Common Coding Systems and Usage

These are the common coding systems in use today. Hover your cursor over the boxes below for a brief description of each coding system.

- CPT®
- HCPCS
- ICD
- ICF
- NDC
- CDT®

NDC
National Drug Codes

The NDC code identifies the manufacturer, product, and package size of all medications recognized by the Federal Drug Administration (FDA). Providers must use NDC codes when medications are dispensed.

Common uses for payers, providers and hospitals include:

- Identifying symptoms
- Maintaining reporting and payment integrity services
- Determining staffing and scheduling of services
- Comparing facilities and planning for new service areas

CDT (Slide Layer)

1 Referrals 2 Services 3 Coding

Common Coding Systems and Usage

These are the common coding systems in use today. Hover your cursor over the boxes below for a brief description of each coding system.

- CPT®
- HCPCS
- ICD
- ICF
- NDC
- CDT®**

CDT®
Current Dental Terminology®

The Current Dental Terminology® CDT® code set is maintained by the American Dental Association and includes all commonly accepted dental procedures. The codes were named as a HIPAA standard code set in 2000 and are used on both electronic and paper claim forms.

Common uses for payers, providers and hospitals include:

- Identifying symptoms
- Maintaining reporting and payment integrity services
- Determining staffing and scheduling of services
- Comparing facilities and planning for new service areas

4.3 Codes and HIPAA

1 Referrals 2 Services 3 Coding

Medical Coding and HIPAA


The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

In addition to setting the standards for how patient information is to be protected, HIPAA also sets the standards for the medical code classification systems that health providers must use on claims, encounter forms, and other electronic health care information.

Electronic Data Interchange (EDI)

HIPAA has set standards for the transmission of electronic health care data. The transactions controlled by these standards are:


- Claims and encounter information
- Payment and remittance advice
- Claims status, eligibility, enrollments
- Referrals and authorizations
- Premium payments



4.4 Common Coding Schemes

1 Referrals 2 Services 3 Coding

Common Coding Schemes




Inconsistent coding among partners within a group, consistently submitting "unspecified" diagnoses and poor documentation are a few of the activities that could indicate potential fraud and abuse. Hover your cursor over each box for descriptions of the common coding schemes.

- Upcoding
- Unbundling
- Inflated Charges
- Inconsistent Billing

Upcoding (Slide Layer)

1 Referrals 2 Services 3 Coding

Common Coding Schemes



Inconsistent coding among partners within a group, consistently submitting "unspecified" diagnoses and poor documentation are a few of the activities that could indicate potential fraud and abuse. Hover your cursor over each box for descriptions of the common coding schemes.

- Upcoding
- Unbundling
- Inflated Charges
- Inconsistent Billing


Upcoding occurs when a code is assigned for a diagnosis or procedure that costs more, has a higher rate of reimbursement than is medically necessary, or indicates they spent more time than was actually spent with the patient.

Payers look for clear documentation for all services performed. Unless services are well documented, charges may be interpreted as potentially upcoded visits. These claims will be reviewed and may be denied.

Unbundling (Slide Layer)

1 Referrals 2 Services 3 Coding

Common Coding Schemes



Inconsistent coding among partners within a group, consistently submitting "unspecified" diagnoses and poor documentation are a few of the activities that could indicate potential fraud and abuse. Hover your cursor over each box for descriptions of the common coding schemes.

- Upcoding
- Unbundling**
- Inflated Charges
- Inconsistent Billing

Unbundling is the process of separating the procedures performed at one time into separate treatments or separate visits.


Medicare and Medicaid often have special reimbursement rates for groups of procedures commonly done together. An example is blood test panels.

Some health care providers will seek to increase profit by unbundling blood tests and billing separately for each test, resulting in significantly higher reimbursement rates.

Inflated Charges (Slide Layer)

1 Referrals 2 Services 3 Coding

Common Coding Schemes



Inconsistent coding among partners within a group, consistently submitting "unspecified" diagnoses and poor documentation are a few of the activities that could indicate potential fraud and abuse. Hover your cursor over each box for descriptions of the common coding schemes.

- Upcoding
- Unbundling
- Inflated Charges**
- Inconsistent Billing


When medical claims do not accurately represent the actual cost of procedures or prescriptions used to treat patients, this may be a case of inflated charges.

When a provider or pharmacist intentionally inflates the actual cost of health care services or medications provided it may be an indicator of fraud or abuse.

Inconsistency (Slide Layer)

1 Patients 2 Services 3 Coding

Common Coding Schemes



Inconsistent coding among partners within a group, consistently submitting "unspecified" diagnoses and poor documentation are a few of the activities that could indicate potential fraud and abuse. Hover your cursor over each box for descriptions of the common coding schemes.

- Upcoding
- Unbundling
- Inflated Charges
- Inconsistent Billing**

Inconsistent billing occurs when patient records do not match the diagnosis or procedure codes used on the medical billing.

Changing a patient's main diagnosis code abruptly to correspond with a planned surgical procedure or without evidence there was a change in the patient's symptoms may be an indicator of fraud.

5. Module 4 Hospital

5.1 Hospital Billing Fraud

1 Patients 2 Services 3 Coding 4 Hospitals

Section 4: Hospital and Skilled Nursing Facility Billing

Service and coding fraud and abuse can also be seen in hospitals and skilled nursing facilities. Below are several emerging fraud and abuse trends within hospitals identified by the Office of the Inspector General (OIG).



- Patients kept longer than necessary for observation in order to increase reimbursement
- Outsourcing the care of patients in hospitals to private physicians can result in duplicate billing
- Ordering unnecessary radiology procedures to offset the high cost of specialized equipment
- Ordering medically unnecessary procedures such as electro physiology studies and echo cardiograms
- Billing for higher and more expensive levels of medical service than were actually performed
- Skilled nursing facilities failing to provide appropriate medical services, or providing medically unnecessary services
- Theft of patient medications

Notes:

6. Module 4 Applications for Coverage

6.1 Applications Fraud

1 Referrals 2 Services 3 Coding 4 Discharge 5 Applications

Section 5: Fraudulent Applications for Coverage


In this section we will review the potential for fraud and abuse during the application process for benefits and services (insurance coverage) for individuals and groups.

Eligibility And Small Business Group Coverage Fraud And Abuse

Application or eligibility fraud is significant because it involves the validity of a person's coverage benefits. A claim payment made on an ineligible person is a 100% loss.

It is also likely that a person who would misrepresent eligibility is likely to incur high expenses or a large volume of claims. Applicants, insurers, employees, employers, and agents can all perpetrate eligibility fraud or abuse.

Businesses that misrepresent how their organization is structured, or the number or types of employees when applying for coverage, also contribute to the problem of health care fraud and abuse.



6.2 Application Fraud

1 Referrals 2 Services 3 Coding 4 Discharge 5 Applications

Application Fraud

Two primary ways this type of fraud is committed is by making false statements on a health plan application or adding someone who is not eligible for coverage.



Common Types of False Information

- False date of birth and/or home addresses
- Indicating individuals are family members when, in fact, they are not
- Use of alias names or multiple spellings of the same name

Risk Management is responsible for policies and procedures related to member and group eligibility.


Their mission is to provide maximum benefits allowed to our members and employer groups under the terms of our contracts, policies, requirements and benefit plans.

6.3 Group Coverage Fraud

1 Referrals 2 Services 3 Coding 4 Preplans 5 Applications

Small Business Group Coverage Fraud

Below are examples of fraud that has been identified by Underwriting during the application process for benefits and services for small business group coverage. Hover your cursor over the boxes below for descriptions of each type of scheme.



- Combining
- Primary Locations
- Carve Outs
- Brokers
- K-1 Investors
- Phantom Employee


Notes:

Combining (Slide Layer)

1 Referrals 2 Services 3 Coding 4 Preplans 5 Applications

Small Business Group Coverage Fraud

Below are examples of fraud that has been identified by Underwriting during the application process for benefits and services for small business group coverage. Hover your cursor over the boxes below for descriptions of each type of scheme.



- Combining
- Primary Locations
- Carve Outs
- Brokers
- K-1 Investors
- Phantom Employee


Unrelated companies (that do not file taxes as one entity) combine businesses together for the sole purpose of acquiring health insurance or discounted pricing.

Primary Locations (Slide Layer)

1 Referrals 2 Services 3 Coding 4 Templates 5 Applications

Small Business Group Coverage Fraud

Below are examples of fraud that has been identified by Underwriting during the application process for benefits and services for small business group coverage. Hover your cursor over the boxes below for descriptions of each type of scheme.



- Combining
- Primary Locations**
- Carve Outs
- Brokers
- K-1 Investors
- Phantom Employee

A group requests a change in its site location or state or falsifies its address on an application for coverage to avoid state mandates and achieve a lower premium for coverage.


An example would be a company indicating it is located in Delaware to avoid medically adjusted rates in New York where the company is actually located.

Carve Outs (Slide Layer)

1 Referrals 2 Services 3 Coding 4 Templates 5 Applications

Small Business Group Coverage Fraud

Below are examples of fraud that has been identified by Underwriting during the application process for benefits and services for small business group coverage. Hover your cursor over the boxes below for descriptions of each type of scheme.



- Combining
- Primary Locations
- Carve Outs**
- Brokers
- K-1 Investors
- Phantom Employee

Carve outs are when a company excludes (or carves out) employees they do not want to cover but should.

A company affiliated with a larger company is carved out and not included on the application for coverage because they perform high risk work.


Certain employees are also sometimes omitted from the census to manipulate the age/sex factor and achieve coverage at a lower rate.

Brokers (Slide Layer)

1 Reports 2 Services 3 Coding 4 Templates 5 Applications

Small Business Group Coverage Fraud

Below are examples of fraud that has been identified by Underwriting during the application process for benefits and services for small business group coverage. Hover your cursor over the boxes below for descriptions of each type of scheme.



- Combining
- Primary Locations
- Carve Outs
- Brokers**
- K-1 Investors
- Phantom Employee

Broker fraud occurs when sales agents or brokers submit false documentation to increase their commission or volume of business. Here's an example:

A broker affiliated with an insurer was soliciting members through a website. The broker billed the subscribers directly for their health insurance but charged them more than the actual monthly premium.

The broker pocketed the difference between the premium cost and what he charged subscribers.

K-1 Investors (Slide Layer)

1 Reports 2 Services 3 Coding 4 Templates 5 Applications

Small Business Group Coverage Fraud

Below are examples of fraud that has been identified by Underwriting during the application process for benefits and services for small business group coverage. Hover your cursor over the boxes below for descriptions of each type of scheme.



- Combining
- Primary Locations
- Carve Outs
- Brokers
- K-1 Investors**
- Phantom Employee

In this case, individuals that are not actually employees are included in the application for coverage.

K-1 individuals associated with a business are listed on tax documents as investors. They are not employees.

As investors, K-1 individuals are not entitled to group coverage. If that were the case, then everyone who has stock in a company should be given benefits through the group's health insurance program.

Phantom Employee (Slide Layer)

1 Referrals 2 Services 3 Coding 4 Hospital 5 Applications

Small Business Group Coverage Fraud

Below are examples of fraud that has been identified by Underwriting during the application process for benefits and services for small business group coverage. Hover your cursor over the boxes below for descriptions of each type of scheme.



- Combining
- Primary Locations
- Carve Outs
- Brokers
- K-1 Investors
- Phantom Employee**

A phantom employee is adding a family member to the insurance plan when they are not an employee of the business. Here's an example:

An employee in a group carrying health insurance passed away. That deceased employee's spouse pretended to be the employee to continue to be covered on the insurance (not part of COBRA).


The group's administrator had even submitted tax documents indicating that the owner was still alive.

7. Untitled Scene

7.1 Reporting Resources

1 Referrals 2 Services 3 Coding 4 Hospital 5 Applications 6 Reporting

Section 6: Reporting Resources



WHAT IS YOUR RESPONSIBILITY?

If you encounter what you believe to be a potential violation of law, regulation, or you suspect a situation may be potential fraud, waste or abuse, speak up. Speaking up is not only the right thing to do, it's required by the UnitedHealth Group **Code of Conduct**.

Do not be concerned about whether what you are seeing is potential fraud, waste or abuse. Just report any concerns you have. The SIU will investigate and make a proper determination.

UnitedHealth Group prohibits any form of intimidation or retaliation against any employee who, in good faith, reports unethical behavior or violations of law, regulations, or company policy.

[Click Here to view Additional Reporting Resources](#)

Health Care Fraud Tip Line

Phone: 1-866-242-7727

Online: [Tip Referral Form](#)

Tip hotline and website are available 24 hours a day, 7 days a week.

Notes:

Additional Reporting Resources (Slide Layer)

1 Referrals 2 Services 3 Coding 4 Preprints 5 Applications 6 Reporting

Section 6: Reporting Resources

CLOSE



Health Care Fraud Tip Line

Phone: 1-866-242-7727

Online: [Tip Referral Form](#)

Tip hotline and website are available 24 hours a day, 7 days a week.

ADDITIONAL REPORTING RESOURCES

Note: Some business areas have alternative methods of reporting. Make sure you are familiar with your business area's reporting instructions.

Additional reporting resources include:

- Your manager
- Your business Compliance or Legal representative
- Compliance & Ethics HelpCenter
 - Phone: 1-800-455-4521 (U.S.) or find your country's dialing instructions within the online HelpCenter portal.
 - Online: [HelpCenter](#)
**The HelpCenter is available 24 hours a day, 7 days a week.*
- UnitedHealth Group Compliance & Ethics
 - Phone: 1-952-936-7463
 - Email: ethicsoffice@uhg.com

8. Assessment

8.1 Introduction

Assessment

Completing this Course

With a better understanding of the different types of health insurance plans, how they work and the regulations that apply to them we hope that you can better identify and report suspicious activity for investigation. As outlined in the UnitedHealth Group Code of Conduct, it is your responsibility to report anything that looks unusual or is not consistent with standard operational procedures.

Completing the assessment that follows with a score of 80% or better will show that you understand the basics of health insurance operations and regulations provided in this course.

You can review any of the topics from this course before starting the assessment by using the Menu, located on the upper left of the screen. Select Assessment from the Menu to return to this page.

[Click here to start the assessment](#)

8.2 Q1

(Multiple Choice, 10 points, 1 attempt permitted)

The Health Insurance Portability and Accountability Act (HIPAA) sets standards for how patient information is to be protected. The act also sets standards for _____.

- the medical code classification systems that are used
- the transmission of electronic health care data
- the medical code classification systems **and** the transmission of health care data

Correct	Choice
	the medical code classification systems that are used
	the transmission of electronic health care data
X	the medical code classification systems and the transmission of health care data

Feedback when correct:

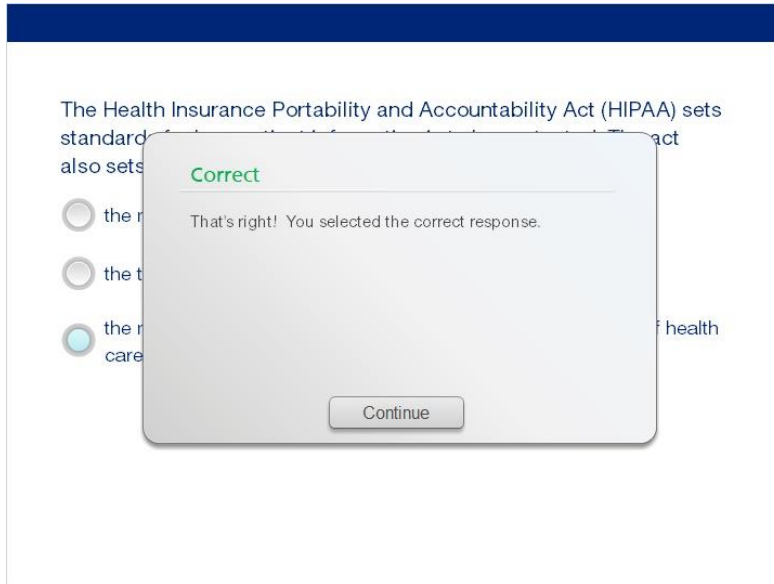
That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. In addition to the standards HIPAA sets for how patient information is to be protected, the Act also sets standards for the transmission of electronic health care data and the medical code classification systems used.

Notes:

Correct (Slide Layer)



The Health Insurance Portability and Accountability Act (HIPAA) sets standards for the transmission of electronic health information. The Act also sets standards for the protection of patient information.

Correct

That's right! You selected the correct response.

the r

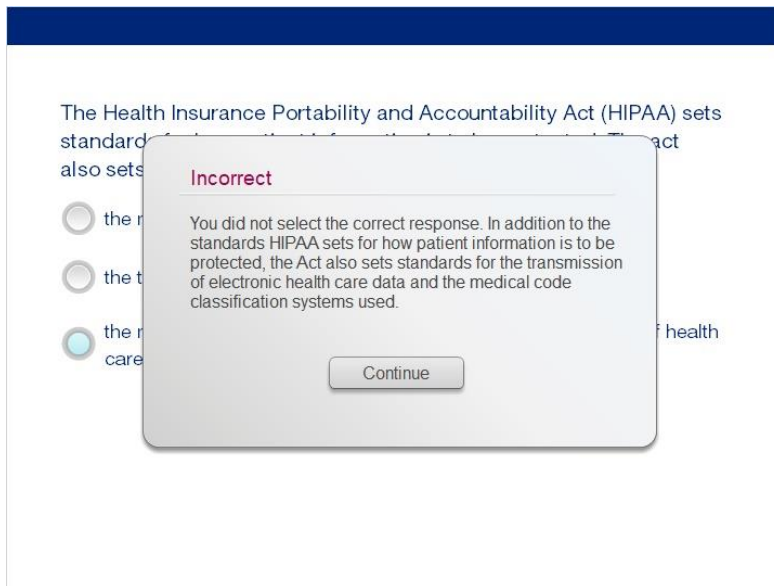
the t

the r
care

health

Continue

Incorrect (Slide Layer)



The Health Insurance Portability and Accountability Act (HIPAA) sets standards for the transmission of electronic health information. The Act also sets standards for the protection of patient information.

Incorrect

You did not select the correct response. In addition to the standards HIPAA sets for how patient information is to be protected, the Act also sets standards for the transmission of electronic health care data and the medical code classification systems used.

the r

the t

the r
care

health

Continue

8.3 Q2

(True/False, 10 points, 1 attempt permitted)

Medical coding is a process of taking descriptions of diseases, injuries, medications, and health care procedures and transforming them into standardized codes.

True

False

Correct	Choice
X	True
	False

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. The statement is true. Medical coding is a process standardizing descriptions of diseases, injuries, medications, and health care procedures by representing them as codes.

Correct (Slide Layer)

Medical coding is a process of taking descriptions of diseases, injuries, medications, and health care procedures and representing them into standard codes.

True

False

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

Medical coding is a process of taking descriptions of diseases, injuries, medications, and health care procedures and representing them into standard codes.

True

False

Incorrect

You did not select the correct response. The statement is true. Medical coding is a process standardizing descriptions of diseases, injuries, medications, and health care procedures by representing them as codes.

Continue

8.4 Q3

(Multiple Response, 10 points, 1 attempt permitted)

Which of the following are common types of false information seen on potentially fraudulent applications of coverage? (Select all that apply.)

- False dates of birth and/or home addresses.
- Use of alias names or multiple spellings of the same name.
- Indicating that individuals on the application are family members when, in fact, they are not.

Correct	Choice
X	False dates of birth and/or home addresses.
X	Use of alias names or multiple spellings of the same name.
X	Indicating that individuals on the application are family members when, in fact, they are not.

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct responses. Use of false dates of birth or death, aliases and/or indicating an individual is a family member when, in fact, they are not. These are all types of fraud that may be seen on potentially fraudulent applications of coverage.

Correct (Slide Layer)

Which of the following are common types of false information seen on potential applications for life insurance? (Select all that apply.)

- False dates of birth or death
- Use of aliases
- Indicating an individual is a family member when, in fact, they are not

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

Which of the following are common types of false information seen on potential applications for life insurance? (Select all that apply.)

- False dates of birth or death
- Use of aliases
- Indicating an individual is a family member when, in fact, they are not

Incorrect

You did not select the correct responses. Use of false dates of birth or death, aliases and/or indicating an individual is a family member when, in fact, they are not. These are all types of fraud that may be seen on potentially fraudulent applications of coverage.

Continue

8.5 Q4

(True/False, 10 points, 1 attempt permitted)

For Federal/State health care programs, paying or rewarding someone for referring business is a crime.

- True
 False

Correct	Choice
X	True
	False

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. The statement is true. For Federal/State health care programs, paying or rewarding someone for referring business is a crime.

Correct (Slide Layer)

For Federal/State health care programs, paying or rewarding someone for referring

True
 False

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

For Federal/State health care programs, paying or rewarding someone for referring

True
 False

Incorrect

You did not select the correct response. The statement is true. For Federal/State health care programs, paying or rewarding someone for referring business is a crime.

Continue

8.6 Q5

(Multiple Response, 10 points, 1 attempt permitted)

Which are types of fraud and abuse? (Select all that apply.)

- Overutilization
- Excessive charges
- Services not rendered

Correct	Choice
X	Overutilization
X	Excessive charges
X	Services not rendered

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct responses. Overutilization, excessive charges, and services not rendered are types of fraud and abuse.

Correct (Slide Layer)

Which are types of fraud and abuse? (Select all that apply.)

Overutilization

Excessive charges

Services not rendered

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

Which are types of fraud and abuse? (Select all that apply.)

Overutilization

Excessive charges

Services not rendered

Incorrect

You did not select the correct responses. Overutilization, excessive charges, and services not rendered are types of fraud and abuse.

Continue

8.7 Q6

(Multiple Response, 10 points, 1 attempt permitted)

Common uses of coded data by payers, providers and hospitals include which of the following? (Select all that apply.)

- Access to health records according to diagnosis and/or procedure.
- Ability to use the coded information in claims analysis, research and education.
- Allows payers to maintain reporting and payment integrity services.

Correct	Choice
X	Access to health records according to diagnosis and/or procedure.
X	Ability to use the coded information in claims analysis, research and education.
X	Allows payers to maintain reporting and payment integrity services.

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct responses. The coding of health care data permits the access of health records according to diagnosis and/or procedure, the ability to use coded information in claims analysis, research and education, and helps payers maintain reporting and payment integrity services.

Correct (Slide Layer)

Common uses of coded data by payers, providers and hospitals include which of the following?

- Access to health records
- Ability to use coded information in claims analysis, research and education
- Allow payers to maintain reporting and payment integrity services

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

Common uses of coded data by payers, providers and hospitals include which of the following?

- Access to health records
- Ability to use coded information in claims analysis, research and education
- Allow payers to maintain reporting and payment integrity services

Incorrect

You did not select the correct responses. The coding of health care data permits the access of health records according to diagnosis and/or procedure, the ability to use coded information in claims analysis, research and education, and helps payers maintain reporting and payment integrity services.

Continue

8.8 Q7

(Multiple Choice, 10 points, 1 attempt permitted)

Section 1877 of the Social Security Act is also known as:

- Stark Law
- Physician self-referral law
- All of the above

Correct	Choice
	Stark Law
	Physician self-referral law
X	All of the above

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. The correct response is all of the above. Section 1877 of the Social Security Act is also known as the Stark Law and physician self-referral law.

Notes:

Correct (Slide Layer)

Section 1877 of the Social Security Act is also known as:

- Stark Law
- Physician self-referral law
- All of the above

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

Section 1877 of the Social Security Act is also known as:

- Stark Law
- Physician self-referral law
- All of the above

Incorrect

You did not select the correct response. The correct response is all of the above. Section 1877 of the Social Security Act is also known as the Stark Law and physician self-referral law.

Continue

8.9 Q8

(Multiple Choice, 10 points, 1 attempt permitted)

A psychologist who intentionally and consistently bills for 50 minute visits but only spends 25 minutes with patients is committing which type of coding fraud?

- Upcoding
- Unbundling
- Inconsistent billing

Correct	Choice
X	Upcoding
	Unbundling
	Inconsistent billing

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. The correct response is upcoding.

Correct (Slide Layer)

A psychologist who intentionally and consistently bills for 50 minute visits but does not use CPT code 90.01, which type of coding is this?

- Upcoding
- Unbundling
- Incomplete coding

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

A psychologist who intentionally and consistently bills for 50 minute visits but does not use CPT code 90.01, which type of coding is this?

- Upcoding
- Unbundling
- Incomplete coding

Incorrect

You did not select the correct response. The correct response is upcoding.

Continue

8.10 Q9

(Multiple Choice, 10 points, 1 attempt permitted)

A provider who intentionally bills separately for blood work lab tests even though one code exists that combines the same lab tests together is committing which type of coding fraud?

- Upcoding
- Unbundling
- Inconsistent billing

Correct	Choice
	Upcoding
X	Unbundling
	Inconsistent billing

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct response. The correct response is unbundling.

Correct (Slide Layer)

A provider who intentionally bills separately for blood work lab tests even though of committ other is

Upc

Unb

Inco

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

A provider who intentionally bills separately for blood work lab tests even though of committ other is

Upc

Unb

Inco

Incorrect

You did not select the correct response. The correct response is unbundling.

Continue

8.11 Q10

(Multiple Response, 10 points, 1 attempt permitted)

Which of the following control the financial relationships allowed between providers who service patients receiving benefits from government health care programs? (Select all that apply.)

- The Stark Law
- Anti-Kickback Statute
- The False Claims Act

Correct	Choice
X	The Stark Law
X	Anti-Kickback Statute
	The False Claims Act

Feedback when correct:

That's right! You selected the correct response.

Feedback when incorrect:

You did not select the correct responses. The Stark Law and Anti-Kickback Statute both control the financial relationships allowed between providers who service patients receiving benefits from government health care programs.

Notes:

Correct (Slide Layer)

Which of the following control the financial relationships allowed between providers who service patients receiving benefits from government health care programs?

- The Stark Law
- Anti-Kickback Statute
- The False Claims Act

Correct

That's right! You selected the correct response.

Continue

Incorrect (Slide Layer)

Which of the following control the financial relationships allowed between providers who service patients receiving benefits from government health care programs?

- The Stark Law
- Anti-Kickback Statute
- The False Claims Act

Incorrect

You did not select the correct responses. The Stark Law and Anti-Kickback Statute both control the financial relationships allowed between providers who service patients receiving benefits from government health care programs.

Continue

8.12 Results Slide

(Results Slide, 0 points, 1 attempt permitted)

Results

Your Score: %Results1.ScorePercent%
(%Results1.ScorePoints% points)

Passing Score: %Results1.PassPercent% (%Results1.PassPoints%
points)

[Review Quiz](#) [Retry Quiz](#)

Results for
8.2 Q1
8.3 Q2
8.4 Q3
8.5 Q4
8.6 Q5
8.7 Q6
8.8 Q7
8.9 Q8
8.10 Q9
8.11 Q10

Result slide properties

Passing

80%

Score


Notes:

Success (Slide Layer)

Results

Your Score: %Results1.ScorePercent%%
(%Results1.ScorePoints/% points)

Passing Score: %Results1.PassPercent%% (%Results1.PassPoints/% points)

 Congratulations, you passed.

You may now click **Exit** located on the upper right corner of the slide or simply close your browser.


[Review Quiz](#) [Retry Quiz](#)

Failure (Slide Layer)

Results

Your Score: %Results1.ScorePercent%
(%Results1.ScorePoints% points)

Passing Score: %Results1.PassPercent% (%Results1.PassPoints% points)

 You did not pass.

You must achieve a score of 80% to successfully complete this course.
Click the **Retry Quiz** button below to attempt the quiz again.

[Review Quiz](#) [Retry Quiz](#)

9. Navigation Help

9.1 Untitled Slide

Navigation Help

- Navigation
- Menu Tab
- Glossary & Resource Tabs
- Hover Instructions
- Hyperlinks

Click any button on the left to review how to navigate using that element of the course.

Notes:

Hyperlink Inst (Slide Layer)

Navigation Help

- Navigation
- Menu Tab
- Glossary & Resource Tabs
- Hover Instructions
- Hyperlinks

Some slides include hyperlinks to additional information. The underlined text in the paragraph below is an example of the hyperlinks used in this course. Clicking the hyperlink will open a document or reveal additional information.

UnitedHealth Group strictly enforces its **Non-Retaliation Policy** for employees, contract workers, and temporary staff who, in good faith, report any cases of suspected misconduct.

Hover Inst (Slide Layer)

Navigation Help

- Navigation
- Menu Tab
- Glossary & Resource Tabs
- Hover Instructions
- Hyperlinks

Some slides may instruct you to hover over sections of the slide to view information. Pointing your cursor over that area of the slide will reveal the additional information.

Key Types of Health Care Plans

Review the plans in each category. You can hover over any item to view additional information.

PRIVATE PLANS	MEDICARE PLANS	MEDICAID PLANS
Health Maintenance Organization (HMO)	Medicare Part A	Donor
Preferred Provider Organization (PPO)	<u>Medicare Part B</u>	Eligibility
Consumer Directed Health Plans	Medicare Advantage Plans	Insurance Exchange
Administrative Services Only (ASO)	Medicare Part D	Managed Care
Fully Insured	MediGap Policy	Funding

Medicare Part B: Medicare Part B is an optional plan that covers preventative services, as well as, services or supplies needed to diagnose or treat a medical condition. Medicare eligibility is required to purchase Part B plans.

Glossary and Resources (Slide Layer)

Navigation Help

- Navigation
- Menu Tab
- Glossary & Resource Tabs**
- Hover Instructions
- Hyperlinks

The **GLOSSARY** link is located at the top right of your screen. Click the link to view definitions and additional information about things you have learned about in the course.

The **RESOURCES** link at the top right of your screen contains links to policies mentioned in the course and documents related to fraud, waste and abuse.

Menu (Slide Layer)

Navigation Help

- Navigation
- Menu Tab**
- Glossary & Resource Tabs
- Hover Instructions
- Hyperlinks

The **MENU** link is located at the top left of your screen.

If you have completed all the slides in the course and are ready to take the assessment, you can use the menu to review any of the content in the course.

If you have not completed all the slides in the course, you can use the menu to view any slides in the course that you have already visited. Slides that you have not yet visited cannot be accessed using the Menu.

After selecting Menu, scroll down to the slide you wish to revisit and click on it to navigate to that page.

Navigation (Slide Layer)

Navigation Help

- Navigation**
Click on the word **CONTINUE** to move forward in the course.
- Menu Tab**
Click on the word **NEXT** to move to the next slide.
- Glossary & Resource Tabs**
Click on the word **PREVIOUS** to move back to the previous slide.
- Hover Instructions**
You can navigate to any slide in the course you have already visited by clicking the **MENU** button on the upper left of the screen and selecting the slide that you wish to revisit.
- Hyperlinks**

10.2 Disclaimer

Disclaimers

Patient Information: All patient information has been de-identified in accordance with HIPAA regulations regarding Protected Health Information (PHI). Information contained in this presentation is for training purposes only.

Training Disclaimer: Changes to business policies and procedures may cause the information provided in this Participant Guide to become out-of-date. Information provided in training should not be used as your sole source of guidance regarding how to perform your job to quality standards. Always refer to the policy and procedure documentation provided to you within your business unit and/or consult with your manager or team lead if you have any questions and to validate sources of truth.

External links or websites appearing in this document are provided for convenience only. Their appearance in this training document are not to be used as an explicit or implicit reference as being a source of truth.

Confidential Proprietary Statement: All specific written procedures, documents, records, work products, or manuals prepared by Optum Training shall remain the property of Optum and shall be treated as confidential and proprietary information. Optum prohibits unauthorized use or distribution of this material.

Notes:

11. Course Attestation

Click [Course Attestation](#) to acknowledge your completion of this course. Save the document to your computer and follow the instructions to return the complete attestation to Compliance.