FREQUENTLY ASKED QUESTIONS
2013-2014 UnitedHealthcare Annual Delegate Compliance Notice
re. Fraud, Waste and Abuse and General Compliance Requirements

Q1. Why am I receiving this notice?
A. Health care fraud, waste and abuse add billions to U.S. health care spending each year. To help
address the problem, the Centers for Medicare and Medicaid Services (CMS) requires Medicare
Advantage organizations and Part D Plan sponsors, including UnitedHealthcare, to annually
communicate specific compliance and fraud, waste and abuse (FWA) requirements to its employees
and contractors - including first tier, downstream, and related entities (FDRs) - as part of an
effective compliance program.

Q2. What specifically do the terms “fraud,” “waste” and “abuse” mean?
A. Fraud is knowingly and willfully executing, or attempting to execute, a scheme to defraud any
health care benefit program or to obtain by means of false pretenses, representations, or promises,
any of the money or property owned by, or under the custody or control of, any health care benefit
program. (18 U.S.C. § 1347)

Waste is the over-utilization of services, or other practices that directly or indirectly result in
unnecessary costs to the Medicare program. Waste is generally not considered to be caused by
criminally negligent actions but rather the misuse of resources.
Abuse includes actions that may directly or indirectly result in: unnecessary costs to the Medicare
program; improper payment; payment for services that fail to meet professionally recognized
standards of care; or services that are medically unnecessary.
Abuse involves payment for items or services when there is no legal entitlement to that payment and
the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse
cannot be differentiated categorically from fraud, because the distinction between “fraud” and
“abuse” depends on specific facts and circumstances, intent and prior knowledge, and available
evidence, among other factors.

Q3. What are the required elements of an effective compliance program?
A. All Medicare Advantage organizations and Part D Plan sponsors, like UnitedHealthcare, are
required to adopt and implement an effective compliance program, which must include measures to
prevent, detect and correct Part C or D program non- compliance and FWA per federal laws (42
C.F.R. §422.503(b)(4)(vi) and §423.504(b)(4)(vi)). CMS program guidelines that reflect its
interpretation of the compliance program requirements and related provisions for Medicare
Advantage organizations and Medicare prescription drug plans are published in both Pub. 100-18,
Medicare Prescription Drug Benefit Manual, Chapter 9 and in Pub. 100-16, Medicare Managed Care

The guidelines are identical and allow organizations offering both Medicare Advantage and
prescription drug plans to reference one document for guidance. It can be accessed at the following
websites:
Chapter 9 of the Prescription Drug Benefit Manual
Chapter 21 of the Medicare Managed Care Manual
Sponsors may enter into contracts with FDRs to provide administrative or health care benefits and services for enrollees on behalf of the sponsor, who maintains the ultimate responsibility for fulfilling the terms and conditions of its contract with CMS, and for meeting the Medicare program requirements. Therefore, CMS will hold the sponsor accountable for the failure of its FDRs to comply with Medicare program requirements.

Q4. What specific requirements need to be met by sponsors and their FDRs?
A. Sponsors and FDRs must show documentation to demonstrate they have met requirements related to: distribution of standards of conduct; FWA and general compliance training; and Office of the Inspector General (OIG)/General Services Administration (GSA) and state (if applicable for services provided to UnitedHealthcare Community Plan) exclusion checks.

Q5. What does “Deemed” or “Waiver” status mean as related to FWA certification requirements?
A. FDRs meeting the FWA certification requirements through enrollment in the fee-for-service Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers are deemed by CMS rules to have met the FWA and general compliance training and education requirements.

Q6. What is the requirement related to standards of conduct?
A. DRs contracted with UnitedHealthcare Medicare Advantage or Part D programs must provide either their own or the UnitedHealthcare Code of Conduct to their employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body members and sub-delegates who are involved in the administration or delivery of UnitedHealthcare Medicare Advantage or Part D benefits or services within 90 days of hire and annually thereafter, by Dec. 31 of each year.

Q7. Can an FDR use its own standards of conduct?
A. Yes, however, it must include a number of required elements. For the list of required elements, Please see Q3 in this document which provides the links to Chapter 9 and/or Chapter 21 of the Medicare Managed Care Manual.

Q8. What is UnitedHealthcare doing to help me meet the standards of conduct requirement?
A. UnitedHealthcare provides the UnitedHealth Group Code of Conduct for you to access and review at: http://www.unitedhealthgroup.com/~/media/UHG/PDF/About/UNH-Code-of-Conduct.ashx

Q9. What are the Fraud, waste and abuse and general compliance training requirements?
A. FDRs contracted with UnitedHealthcare Medicare Advantage or Part D programs must provide either their own or CMS Parts C and D FWA and General Compliance Training to all employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body members, and sub-delegates who are involved in the administration or delivery of UnitedHealthcare Medicare Advantage or Part D benefits or services within 90 days of hire and annually thereafter.

Q10. What elements must be included in FWA and general compliance training?
A. For the list of required training elements, please see Q3 in this document which provides the links to Chapter 9 and/or Chapter 21 of the Medicare Managed Care Manual.

Q11. What if we offer our own training or have completed another plan’s training?
A. If your organization has completed a FWA and general compliance training program – either your own or through another health plan sponsor – and that training meets CMS requirements, we accept
Q12. Do I have to take the training for every UnitedHealthcare Medicare Advantage and/or Part D plan or group my organization contracts with?
A. No. UnitedHealthcare uses the standard CMS training program and you only need to complete the training once for all UnitedHealthcare networks. If you have completed another training program and it meets CMS requirements, UnitedHealthcare will accept documentation of the completed training.

Q13. Where can I get the FWA training materials?
A. CMS Parts C and D FWA and General Compliance Training is available on the CMS Medicare Learning Network® at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
From the MLN Products page follow this path:
Under “Downloads”, choose the “Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training” zip file
Choose “Open” or “Save” to access the training module which is provided in both PDF and PowerPoint formats.

For CMS training materials, FAQs and access to locate state exclusion lists, go to: https://www.UnitedHealthcareOnline.com via the Fraud, Waste and Abuse and General Compliance Training Quick Link on the home page.

Q14. How often do I have to complete this training?
A. The training must be completed within 90 days of hire/contracting and then annually thereafter by Dec. 31 of each year.

Q15. What are my requirements related to Federal health care program exclusion checks?
A. FDRs contracted with UnitedHealthcare Medicare Advantage, Part D or UnitedHealthcare Community Plan must review the federal exclusion lists (DHHS-OIG List of Excluded Individuals and Entities) at: http://oig.hhs.gov/exclusions/index.asp and GSA Excluded Parties List System (EPLS) at System for Award Management at https://www.sam.gov/portal/public/SAM/ prior to hiring or contracting with employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body members, and sub-delegates who have involvement in the administration or delivery of UnitedHealthcare Medicare Advantage, Part D benefits or services and/or UnitedHealthcare Community Plan services to ensure that none of these persons or entities are excluded from participation in federal programs. FDRs must continue to review the federal exclusion lists on a monthly basis thereafter. FDRS contracted to provide services to UnitedHealthcare Community Plan may be subject to state-based exclusion lists as well (see Q17 below for more information).

Q16. How often do I have to complete these exclusion checks?
A. CMS recently provided guidance that now requires that exclusion checks be done upon hiring/contracting and then monthly thereafter. This is a change from previous guidance that required exclusion checks to be done annually or periodically.

Q17. What if we also provide benefits or services for UnitedHealthcare Community Plan?
A. UnitedHealthcare FDRs serving UnitedHealthcare Community Plan programs must also review state level exclusion lists as applicable to the services the FDR is contracted to perform prior to hire or contracting and monthly thereafter. This review includes employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body members,
and sub-delegates. The following document provides the links to state exclusion lists.

Q18. What if I work with other entities that do not contract directly with UnitedHealthcare?
A. If your organization has contracted with other entities to provide benefits or services on behalf of UnitedHealthcare Medicare Advantage or Part D plans, you will need to provide the relevant training materials to that entity and ensure records are kept by the entities that document that they meet the distribution of standards of conduct; FWA and general compliance training; and OIG/GSA and state (if applicable) exclusion checks requirements.

Q19. What kind of documentation do I need to show that the requirements have been met?
A. Examples of documentation that may be requested include: (1) communication of standards of conduct in an email, website portal or contract; (2) FWA and general compliance training method, materials used for training, employee sign-in sheet(s), attestations or electronic certifications that include the date of the training; (3) method of OIG/GSA and state (if applicable) exclusion checks and a copy of an exclusion check report for each employee/contractor; and (4) policy(s) and procedure(s) that describe the process(es) you use to meet the requirements. If you or your organization qualifies for deemed status, please retain records of evidence in your files.

Q20. How long do I need to keep documentation showing that training was completed?
A. CMS requires that documentation be kept for 10 years.

Q21. What should I do if I suspect fraud, waste or abuse or other compliance issues?
A. If you identify a compliance issue and/or an instance of potential fraud, waste, or abuse, please report it to UnitedHealthcare immediately so that we can investigate and respond appropriately. Please see below for contact information. UnitedHealthcare expressly prohibits retaliation if a report is made in good faith.

Q22. Who should I contact if I have questions about the compliance requirements?
A. If you have questions regarding the compliance requirements, please send an email to: ComplianceDelegateNotice@uhc.com

Q23. Who should I call to report suspected fraud, waste or abuse?
A. Contracted Network Providers can call the main phone number associated with the secure website(s) where they transact administrative activities for patients or call your local network contact.

Other Contracted Delegates can call the UnitedHealthcare Vendor Fraud Hotline at 877-401-9430. Callers are encouraged to provide contact information in case additional information is needed. You may also report anonymously. UnitedHealthcare expressly prohibits retaliation for reports made in good faith.

Q24. What if I identify an individual or entity that is excluded from participating in Federal or State government programs?
A. If you identify an excluded individual or entity employed or contracted by your organization, you must report this to UnitedHealthcare through either your UnitedHealthcare Account Manager, business contact or the UnitedHealth Group Compliance & Ethics Help Center at 800-455-4521. Thank you for your support.