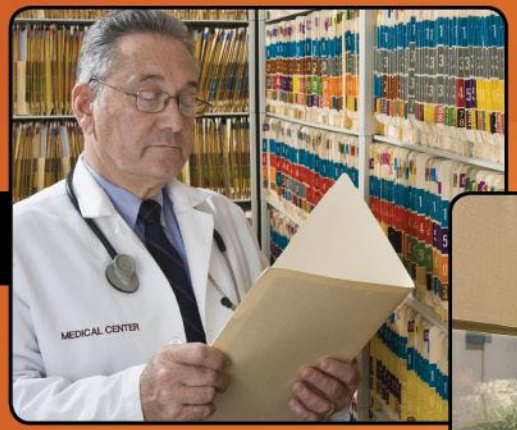
HEAT PROVIDER COMPLIANCE TRAINING

TAKE THE INITIATIVE.

Cultivate a Culture of Compliance With Health Care Laws



WELCOME

Sponsored by:

OFFICE OF INSPECTOR GENERAL (OIG)

HEALTH CARE FRAUD PREVENTION AND ENFORCEMENT ACTION TEAM (HEAT)

Agenda

- **Welcome**
- **Session 1: Cultivating a Culture of Compliance**
  - **Break**
- **Session 2: Know Where to Go When a Compliance Issue Arises**
  - **Break**
- **Session 3: Understanding the Consequences of Health Care Fraud**
- **Closing Remarks**

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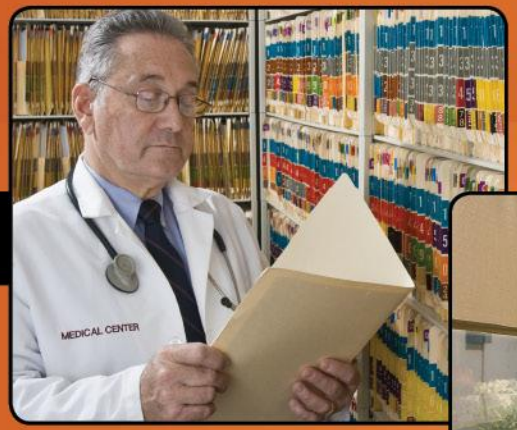

WELCOME

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Cultivating a Culture of Compliance

- Navigating the Fraud and Abuse Laws
- Compliance Program Basics
- Operating an Effective Compliance Program
- Understanding Program Exclusions

Navigating the Fraud and Abuse Laws

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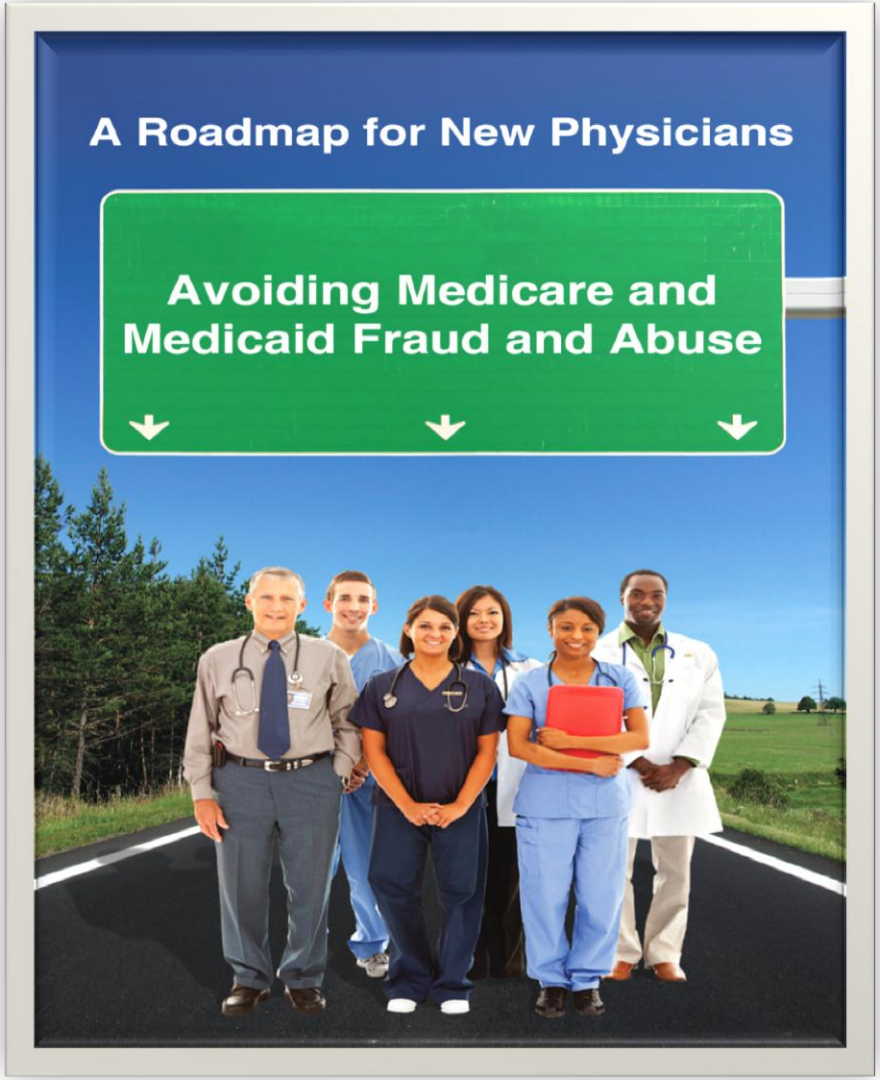
Navigating the Fraud and Abuse Laws

www.oig.hhs.gov



Office of Inspector General

Navigating the Fraud and Abuse Laws

- Physician Self-Referral Law
- Anti-Kickback Statute
- False Claims Act
- Civil Monetary Penalties Law
- Exclusion Authorities

Navigating the Fraud and Abuse Laws

Improper Referrals can lead to:

- Overutilization
- Increased costs
- Corruption of medical decision-making
- Patient steering
- Unfair competition

Navigating the Fraud and Abuse Laws

Physician Self-Referral Law

Limits physician referrals when there is a financial relationship with the entity

Navigating the Fraud and Abuse Laws

Three Questions:

1. Is there a *referral* from a *physician* for a *designated health service* (DHS)?

2. Does the physician (or an immediate family member) have a *financial relationship* with the entity providing the DHS?

3. Does the financial relationship fit in an *exception*?

Navigating the Fraud and Abuse Laws

Penalties for Physician Self-Referral Violations:

- Payment denial
- Monetary penalties
- Exclusion

Navigating the Fraud and Abuse Laws

Stark Law Compliance Tips:

1. **Meet a Stark Law exception.**
2. **Document financial relationships with referring physicians.**
3. **Have systems to ensure properly structured payments.**
4. **Watch out for "lease creep" problems.**
5. **Review productivity bonuses.**
6. **Gifts can implicate the Stark law too.**

Navigating the Fraud and Abuse Laws

Anti-Kickback Statute

Prohibits asking for or receiving anything of value to induce or reward referrals of Federal health care program business

Navigating the Fraud and Abuse Laws

Navigating the Fraud and Abuse Laws

Anti-Kickback Statute Compliance Tips:

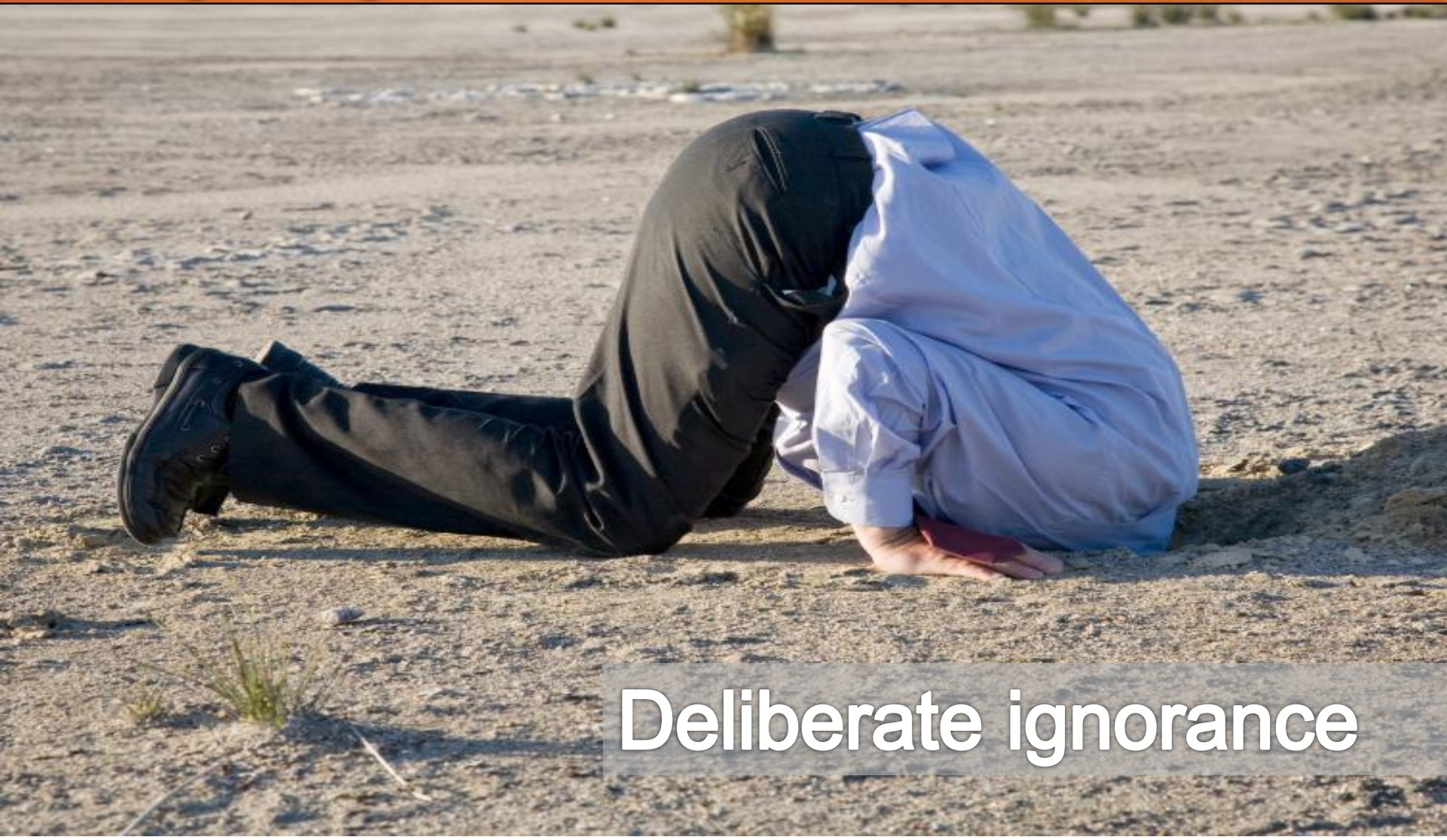
1. Use a safe harbor.
2. It's a "one purpose" test.
3. FMV for actual/necessary services.

Navigating the Fraud and Abuse Laws

The False Claims Act

Prohibits the submission of false or fraudulent claims to the Government

Navigating the Fraud and Abuse Laws



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HEALTH CARE FRAUD PREVENTION AND ENFORCEMENT ACTION TEAM (HEAT)

Navigating the Fraud and Abuse Laws

Civil Monetary Penalties

Navigating the Fraud and Abuse Laws

Exclusion from Medicare and Medicaid

Mandatory exclusions

Permissive exclusions

Compliance Program Basics

Compliance Program Basics

Affordable Care Act:
Mandatory Compliance Plans
Coming Soon

Where do things stand now?

- CMS has NOT finalized the requirements
- CMS will advance specific proposals at some point in the future

Compliance Program Basics

What is a compliance program?

Compliance Program Basics

Seven Fundamental Elements

1. Written policies and procedures
2. Compliance professionals
3. Effective training
4. Effective communication
5. Internal monitoring
6. Enforcement of standards
7. Prompt response

Compliance Program Basics

Where can I look for guidance?

Let’s go there now!

OIG Guidance

Fraud Prevention and Detection

- Compliance Program Guidance
- Fraud Alerts, Special Advisory Bulletins, and other Guidance
- Advisory Opinions

Practical Tips

#1 Make compliance plans a priority now

#2 Know your fraud and abuse risk areas

Practical Tips

#3 Manage your financial relationships

#4 Just because your competitor is doing something doesn't mean you can or should REPORT FRAUD

Practical Tips

#5 When in doubt, ask for help

Operating an Effective Compliance Program

Kick the Tires!

Once a compliance program has been established, develop a process to evaluate it and measure its effectiveness

Policies and Procedures

Policies and procedures are up-to-date and user-friendly

Tips to Measure Effectiveness

- Develop benchmarks and goals in team with Compliance Committee, Board, and department managers

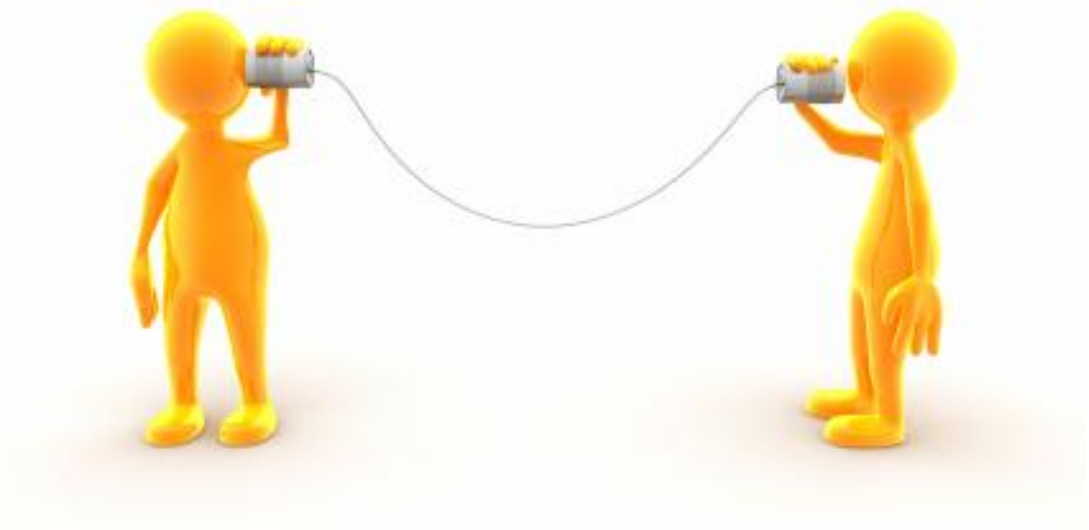
- What do you want to measure?

Train Your Staff

- Test knowledge
- Make training part of the job
- Compliance staff/officer education & networking

Open Lines of Communication

- Solicit feedback
- Maintain visibility with employees



Make an Audit Plan

- Proactively audit:

  Coding

  Contracts

  Care

Enforce Policies and Procedures

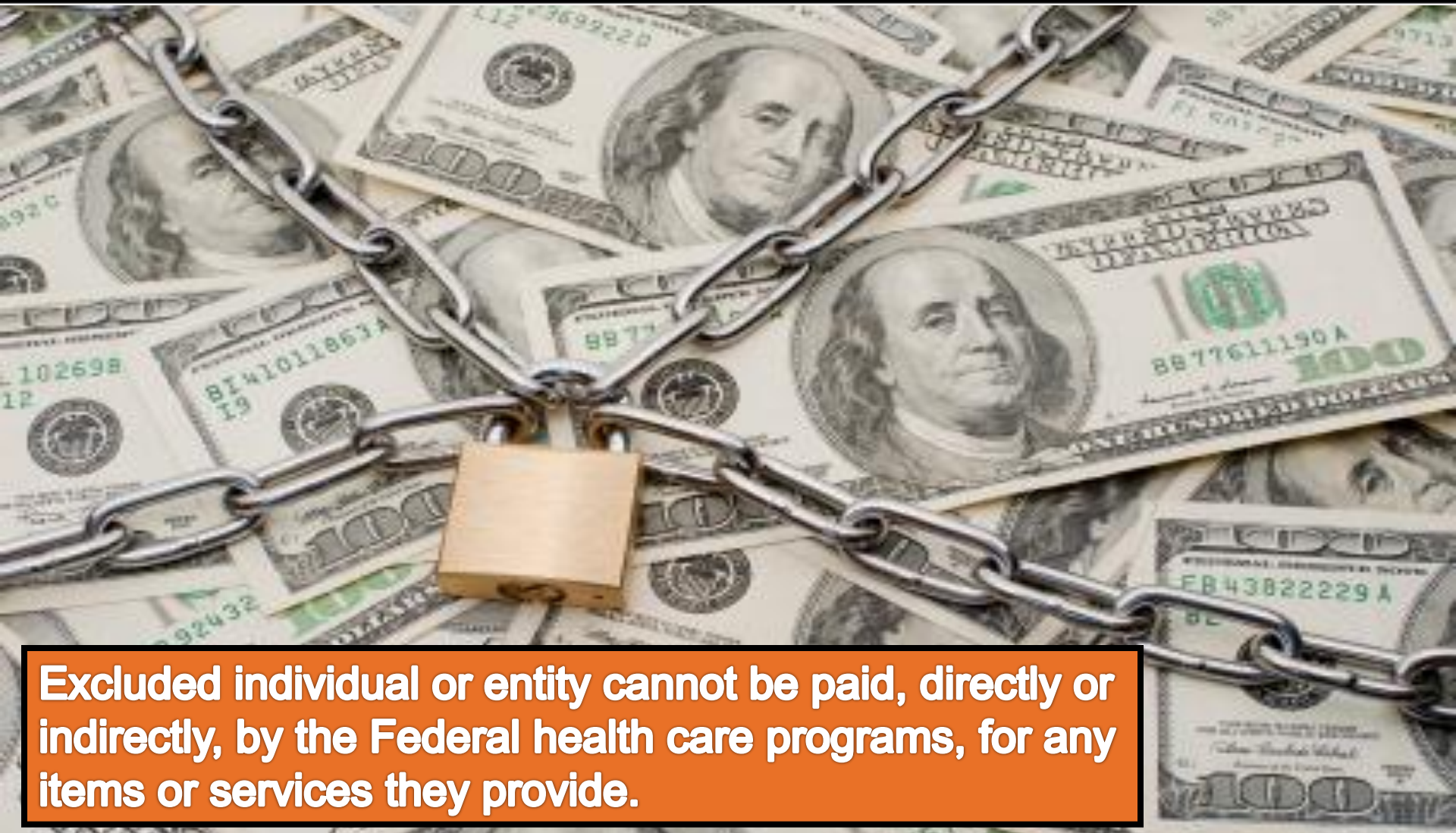
- Act promptly when issues arise
- Take and document corrective action

Understanding Program Exclusions

What is Exclusion?

The OIG has the authority to exclude individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs.

What is the effect of exclusion?



Excluded individual or entity cannot be paid, directly or indirectly, by the Federal health care programs, for any items or services they provide.

Exclusion Basics

- **Types:** Mandatory and Permissive.
- **Who:** Any individual or entity.
- **Time:** Generally defined period, but certain may be indefinite in length.

Checking for Exclusion

- Screen against the OIG's List of Excluding Individuals/Entities. www.oig.hhs.gov/fraud/exclusions.asp.

- Self-disclose if you discover you have employed an excluded individual

- Maintain documentation of searches

Break

Know Where to Go When a Compliance Issue Arises

- Navigating the Government
- Overview of CMS
- Importance of Documentation
- Subpoenas, Audits, and Surveys
- Self-Disclosure

Navigating the Government

Key Players in the Healthcare Industry

-Medicare and Medicaid

-Enforcement Entities

-Regulatory Agencies

Navigating the Government

How do you know where to turn for help?

KEY:
Identify the general nature of your issue.

Recommended Compliance Resources Handout

Nancy O'Connor

Regional Administrator

Washington, DC **May 18, 2011**

Dr. Don Berwick
CMS Administrator

Today's Presentation

- **CMS Structure and Approach to Program Integrity**
- **CMS Contractors and Partners**
- **Resources**

The Centers for Medicare & Medicaid Services

- **Federal agency that has oversight of the Medicare, Medicaid, and Children's Health Insurance Program (CHIP).**
- **Over $800 billion spent each year on these programs.**
  - **19% of the total Federal budget**
- **Over 100 million beneficiaries**
  - **Covering 1 in 4 Americans**

The Medicare Business

- Each working day, Medicare:
  - Pays over 4.4 million claims
  - To 1.5 million providers
  - Worth $1.1 billion

- Each month, Medicare
  - Receives almost 19,000 provider enrollment applications

- Each year, Medicare:
  - Pays over $430 billion
  - For more than 45 million beneficiaries

The Medicaid Business

- Each year, Medicaid, nationally:
  - Pays over 2.5 Billion claims
  - For more than 54 million beneficiaries
  - 56 State and territory-administered programs

- By 2014, Americans who earn less than 133 percent of the poverty level (approximately $29,000 for a family of four) will be eligible to enroll in Medicaid.

- 8.8 million (18%) of Medicaid beneficiaries are “dual eligibles” who also qualify for Medicare coverage.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP
As of February 3, 2011
* Acting

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Arlene E. Austin, Director
Anita Pinder, Dep. Dir.

MEDICARE OMBUDSMAN GROUP

OFFICE OF EXTERNAL AFFAIRS AND BENEFICIARY SERVICES
Teresa Nino, Director
Robert Tagalicod , Dep. Dir.
Mary Wallace, Dep. Dir.

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Amy Hall, Director
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FEDERAL COORDINATED HEALTH CARE OFFICE
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Cheryl Powell, Deputy Director*

Donald M.Berwick, M.D.
ADMINISTRATOR

Marilyn Tavenner
PRINCIPAL DEPUTY ADMINISTRATOR AND CHIEF OPERATING OFFICER

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Aryana Khalid
SENIOR ADVISOR

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SENIOR ADVISOR

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Paul McGann, MD, Dep. Chief Medical Officer

OPERATIONS
Michelle Snyder
Deputy Chief Operating Officer

OAGM—Daniel Kane, Director *

OESS- Karen Trudel, Director*

OFM--Deborah Taylor, Director & Chief Financial Officer

OIS-- Tony Trenkle, Director & CMS Chief Information Officer*

OOM--James Weber, Director

CFMFFSO--Nannette Foster-Reilly, Consortium Administrator

CMCHO--Jackie Garner, Consortium Administrator

CMHPO--James T. Kerr, Consortium Administrator

CQISCO--James Randolph Farris, MD, Consortium Admin.

PMAS--Sandy Kraft, Director

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Director*

Julie Boughn
Deputy Director*

CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT

Steve Larsen
Deputy Administrator and Director

Vacant
Deputy Center Director

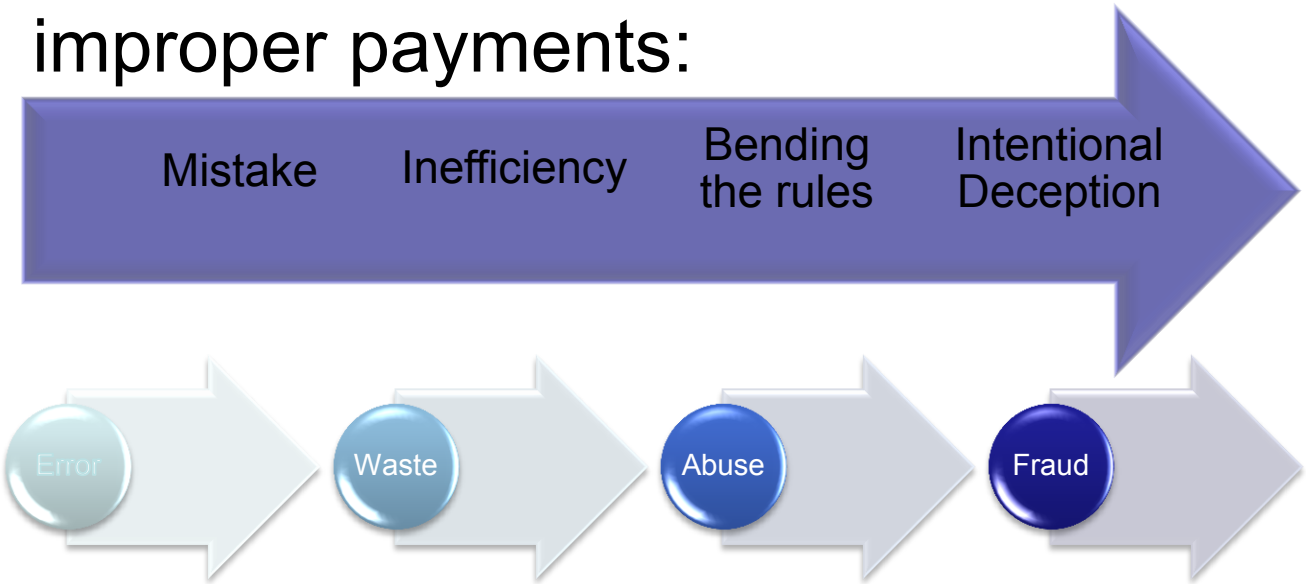
Background of CPI and Focus

- History of the Center for Program Integrity:
  - **March 23, 2010 – The Affordable Care Act was enacted.**
  - **April 11, 2010 – Secretary Sebelius realigns CMS into 5 Centers, creating the Center for Program Integrity.**

- Focus:
  - **Consolidate Medicare and Medicaid program integrity efforts.**
  - **Move away from the pay and chase approach toward focus on prepayment prevention efforts.**
  - **Focused intervention.**
  - **Increase public/private cooperation.**

Program Integrity

- **Program Integrity** encompasses a range of activities to target the various causes of improper payments:



CMS Contractors and Partners

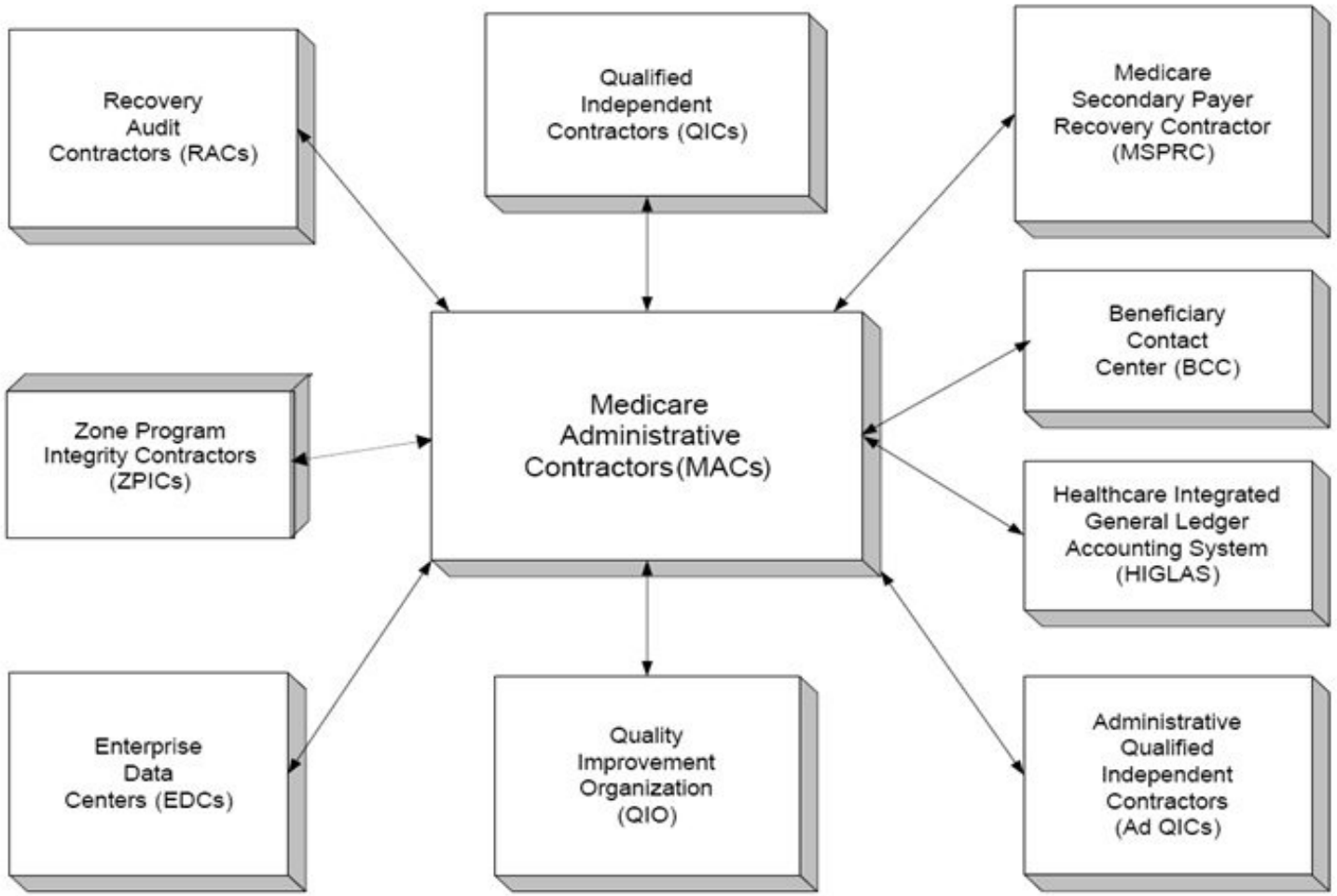
Medicare Program Integrity Partners & Approaches

MACs and Legacy Contractors	• Process claims, Enroll providers, screen beneficiary fraud complaints, Refer potential fraud to ZPICs
Zone Program Integrity Contractors	• Seven by end of 2010. • Investigate fraud leads and build fraud cases. • Work with MACs and law enforcement.
CMS Field Offices	• Current locations include Miami, Los Angeles, New York City; Boots on ground; Investigate fraud leads and liaison with law enforcement.
External Partners	• Law Enforcement, Accreditation Bodies, State Medicaid and Survey Agencies, Others
Data Analysis	• Used for pre and post payments to identify possible fraud schemes and review of claims from high risk providers and suppliers

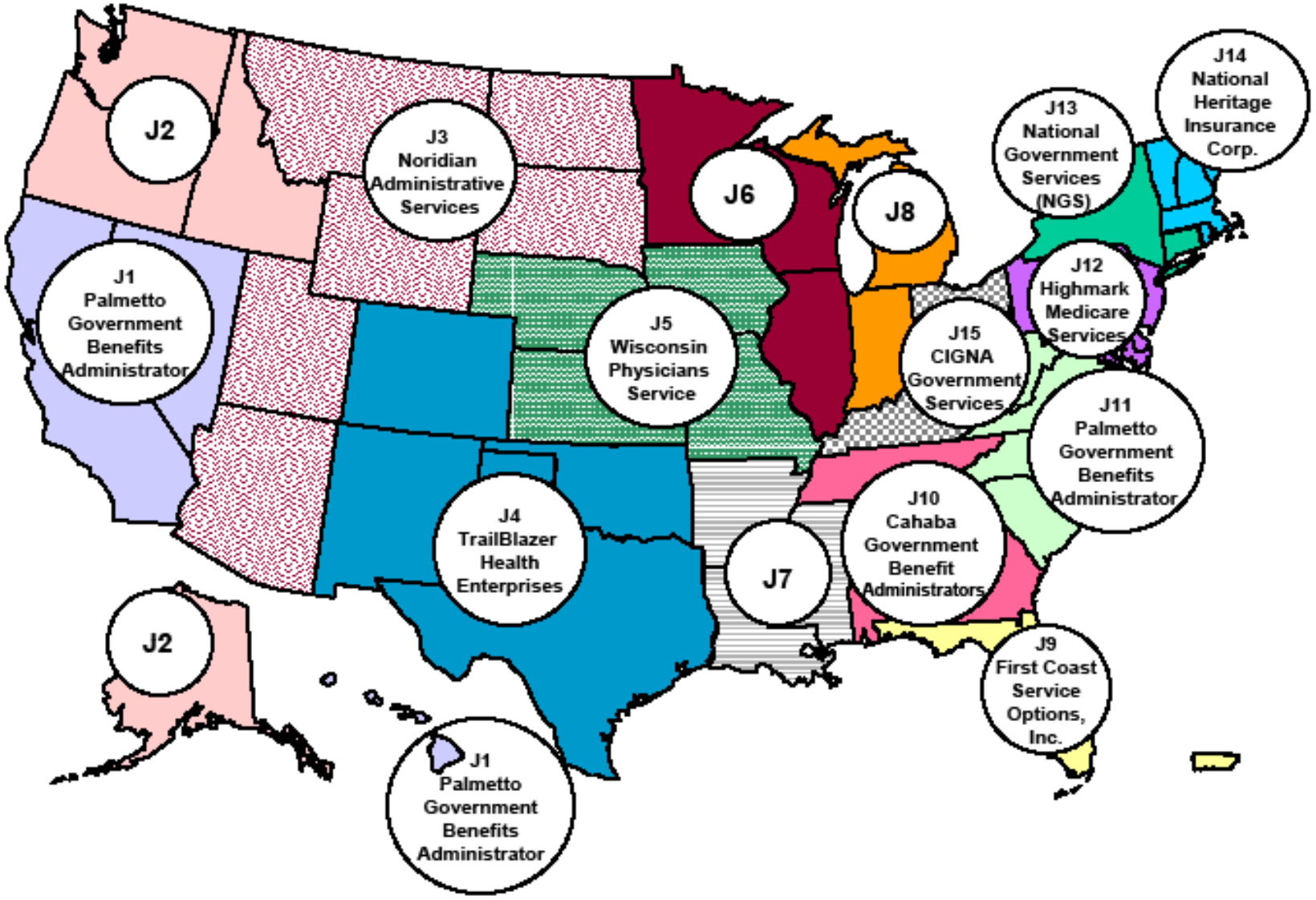
Medicare Program Integrity Partners & Approaches

RAC's	• Detects and corrects <u>past</u> improper payments • requests additional documentation, when necessary
QIC's	• "Qualified independent contractor" • Provides independent review of appealed claims
NSC	• National Supplier Clearinghouse • registers suppliers for participation in Medicare
COB	• Coordination of benefits contractor • determines whether Medicare is primary or secondary and assures payments comply

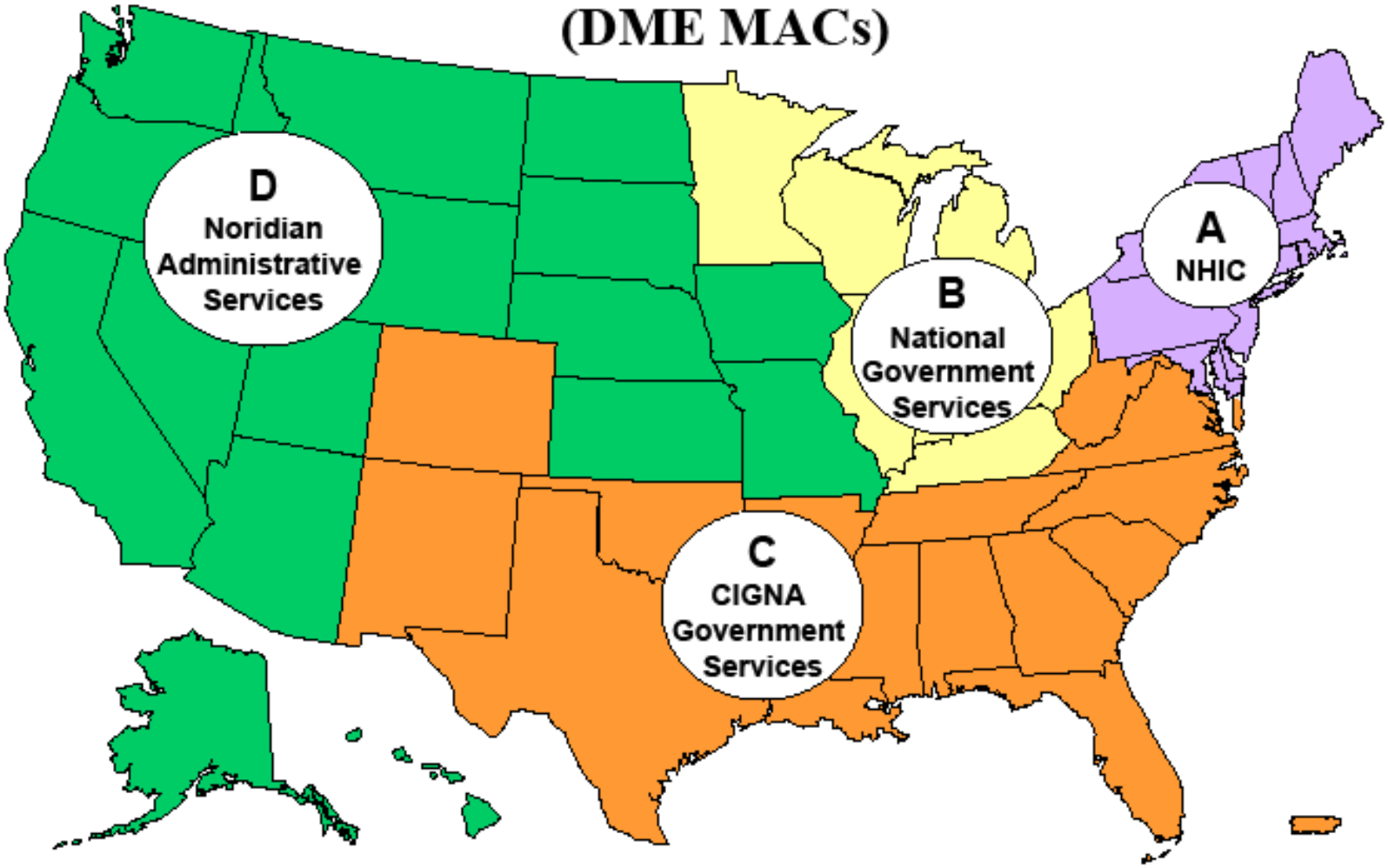
Medicare Fee-for-Service Program Administrative Functional Environment



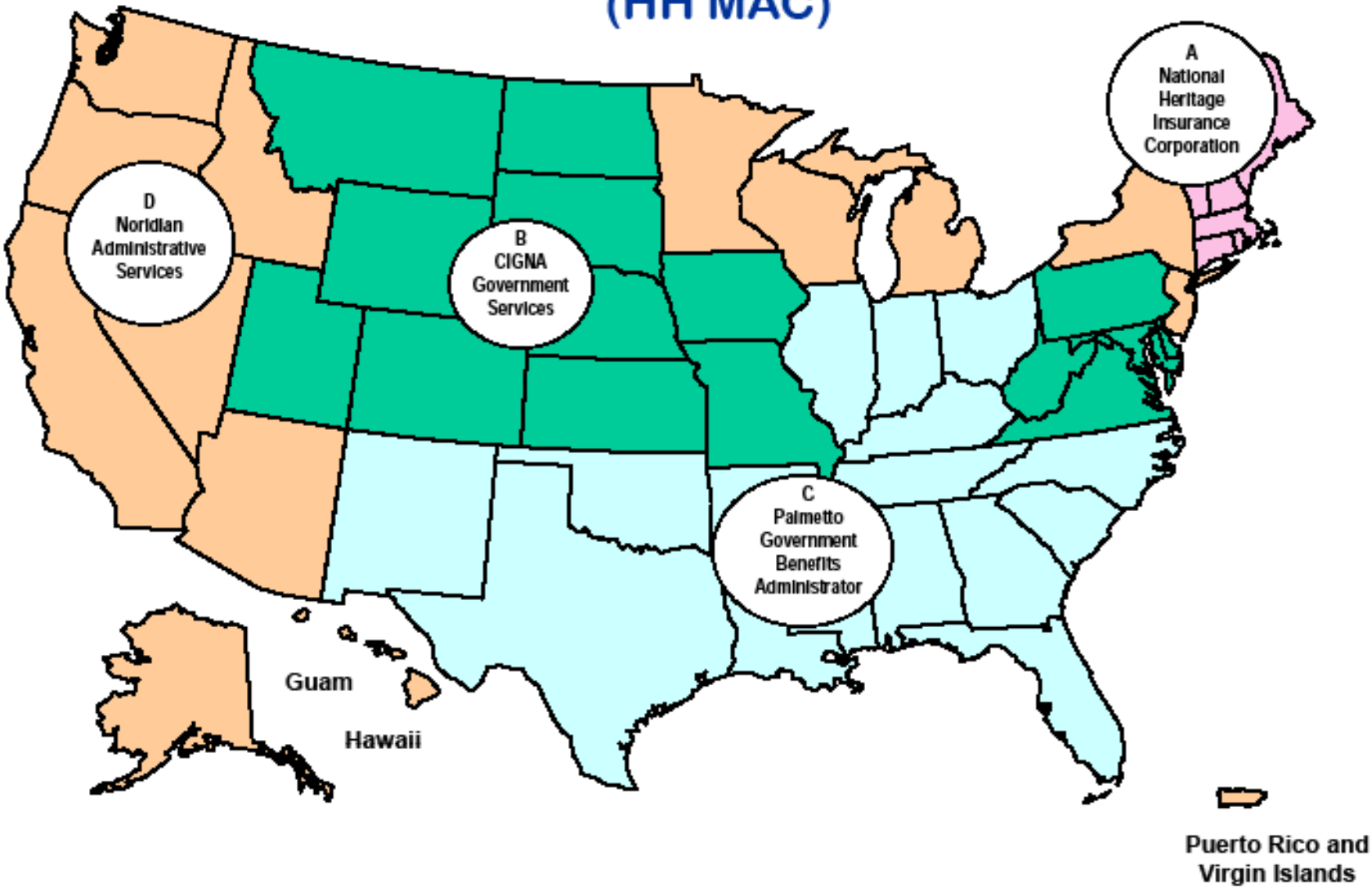
A/B Medicare Administrative Contractors



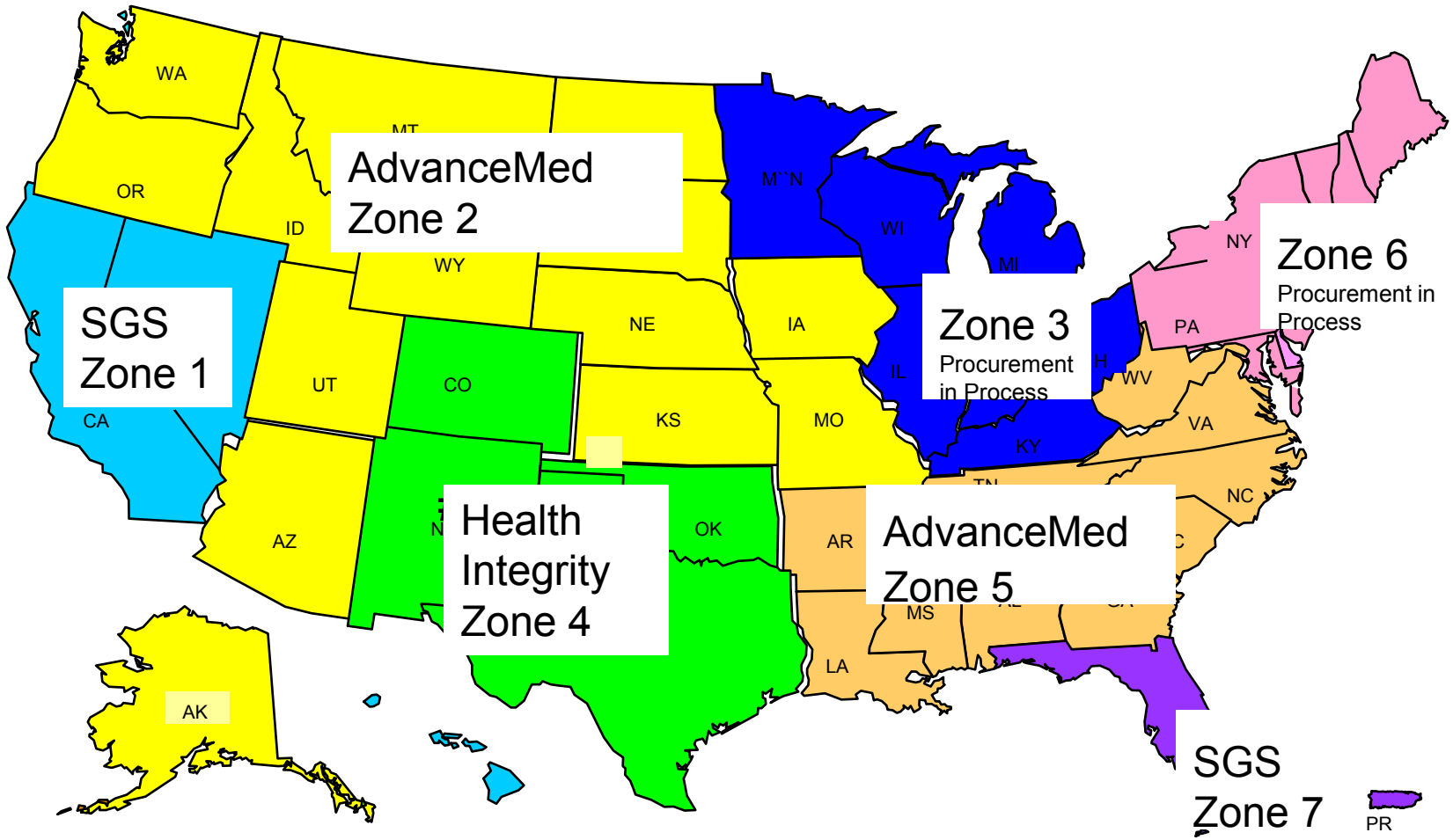
Durable Medical Equipment
Medicare Administrative Contractors
(DME MACs)



Home Health/Hospice Medicare Administrative Contractor Jurisdictions (HH MAC)



ZPIC Map


AdvanceMed
Zone 2
SGS
Zone 1
Health
Integrity
Zone 4
AdvanceMed
Zone 5
Zone 3
Procurement
in Process
Zone 6
Procurement in
Process
SGS
Zone 7
WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
NM
ND
SD
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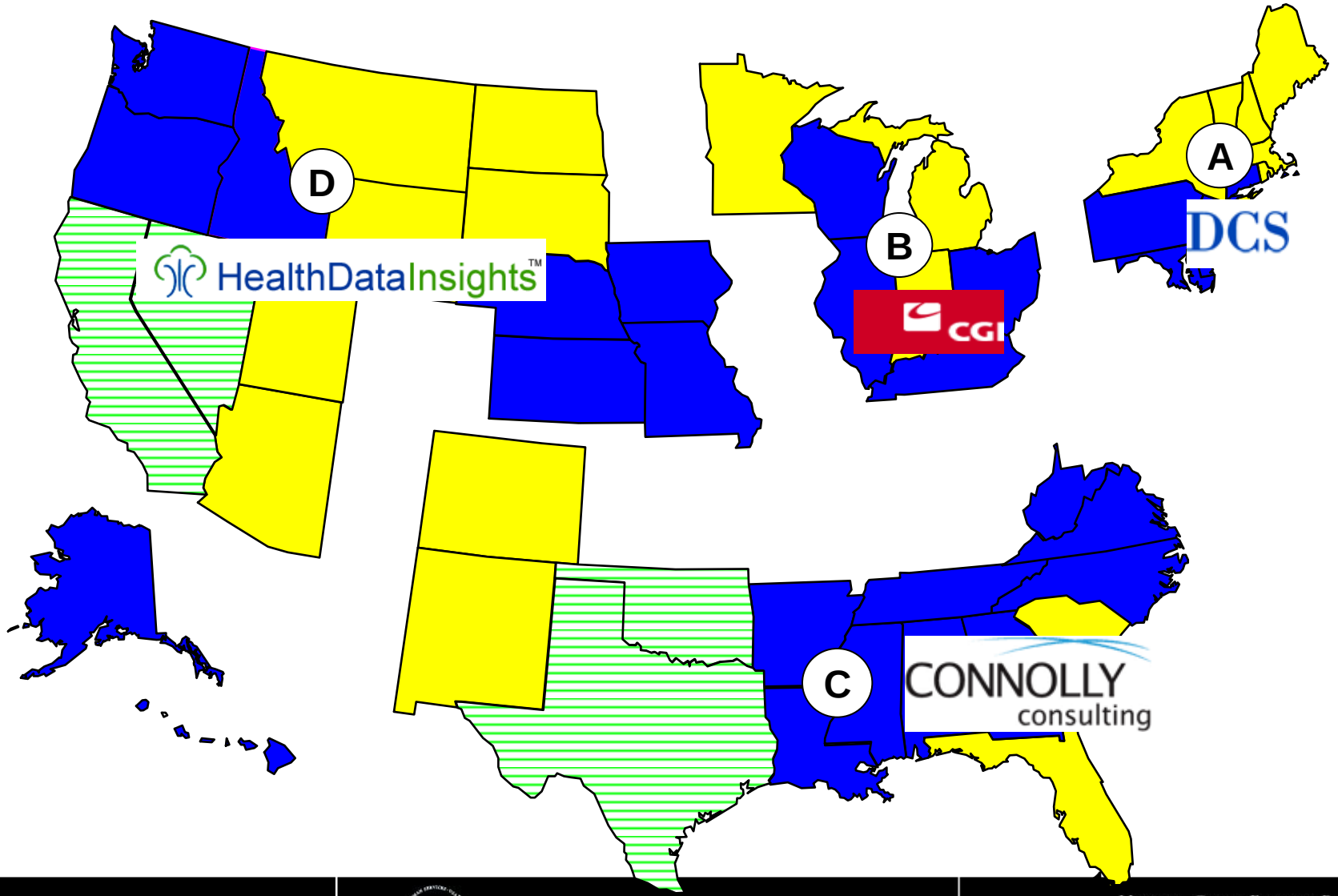
RAC Jurisdictions



MEDIC- Medicare Part C and D Benefit Integrity

– Program Integrity for Medicare Parts C and D

– National Jurisdiction

– Coordinate program integrity efforts of Plans

– Law Enforcement education and support

MEDIC Investigators/Assignments

- Investigators are assigned to a specified geographic area and responsible for cases, contacts, and all other MEDIC activity in his/her assigned area

- Investigators are not centrally located; investigators typically reside in or near their area of responsibility

- There are 20 offices located in:
  - St. Augustine, Miami, Atlanta, Greensboro, New Orleans, Dallas, Houston, San Antonio, McAllen (TX), Denver, Kansas City, San Diego, Los Angeles, Easton (MD), Plymouth (PA), New Jersey, Boston, Chicago, Detroit, and Seattle.

Medicaid Integrity Contractors

- **Audit of Provider MICs** – post payment audits identify overpayments. State adjudication process used.

- **Review of Provider MICs** – identify audit leads to Audit MICs through claims data and algorithms.

- **Education MICs** – provide training and education to prevent fraud, waste and abuse.

Who are the MICs

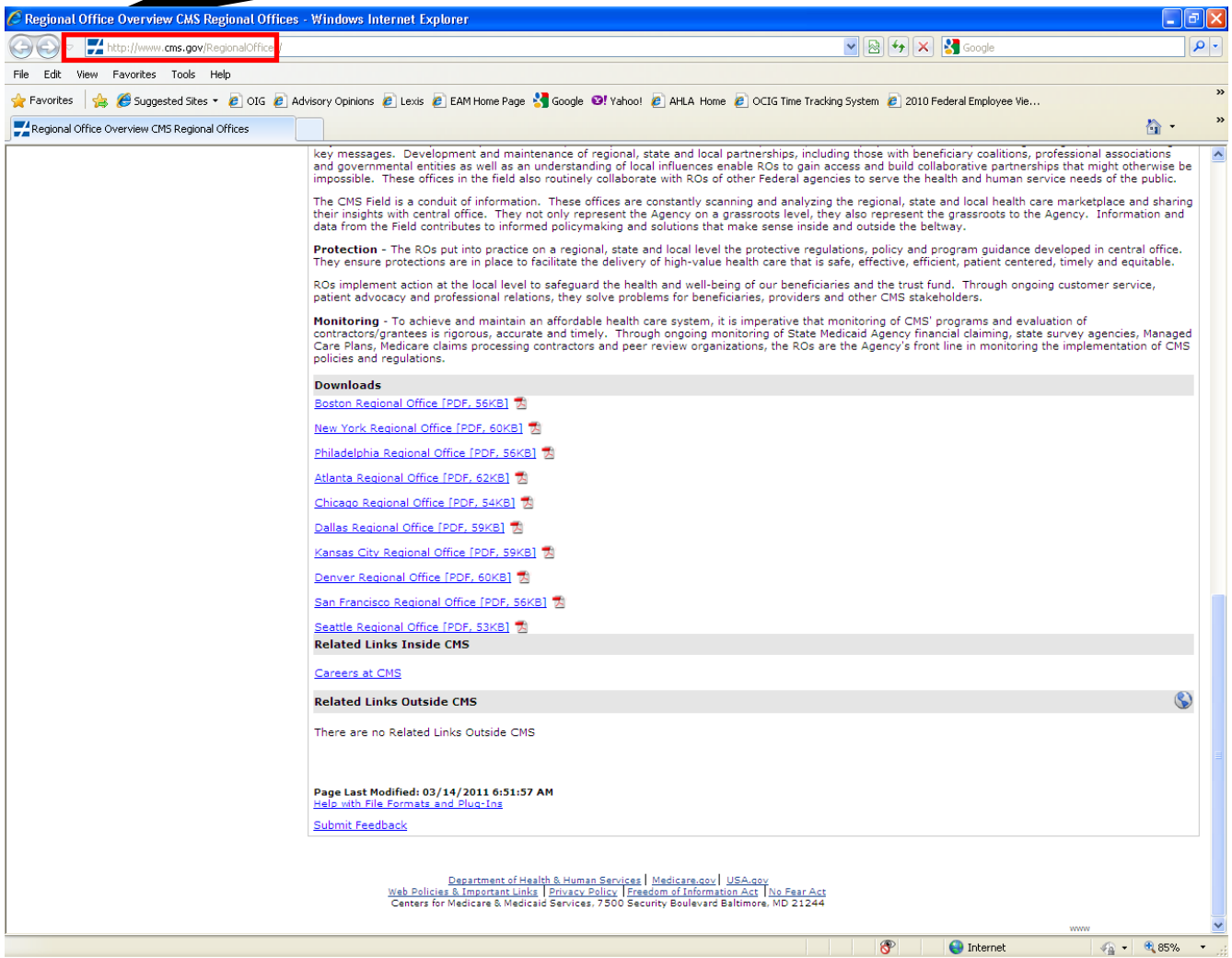
Audit MICs:	Review of Provider MICs:
Island Peer Review Organization (IPRO) **Regions I & II**	AdvanceMed Corporation **Regions V, VI, VII, VIII, IX & X**
Health Integrity **Regions III, IV, V & VII**	Thomson Reuters **Regions I, II, III, IV**
Health Management Systems (HMS) **Regions VI, VIII, IX & X**	

Education MICs:
Information Experts & Strategic Health Solutions LLC

For More Information: http://www.cms.gov/MedicaidIntegrityProgram

Resources

http://www.cms.gov/RegionalOffices/



MLN General Information

- **Overview**
- Spotlight
- Contact Us

Overview

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

Welcome to the **Medicare Learning Network® (MLN)** General Information Overview page, your destination fo educational information on Medicare Fee-For-Service (FFS) providers.

As a result of changes in policy and legislation, Medicare providers may be uncertain as to what Medicare policy changes have occurred and how those changes apply to them. The MLN provides a variety of training and educational materials that break down Medicare policy into plain language. The MLN delivers planned and coordinated provider education through the various mechanisms such as National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

In the "Downloads" section you will find information on:

- MLN Products Catalog -- an interactive catalog that provides descriptions and links to all MLN educational products and resources.
- Provider Call Center Toll Free Numbers Directory -- a directory that offers Providers information on how to contact the appropriate Provider call center.
- MLN Video - Public Service Announcement -- 30 second introduction to the MLN.
- MLN Video - Quick and Basic Information about the MLN and its Benefits to Providers -- a 7 minute overvie of the MLN.
- CMS Listservs Available for Medicare FFS Providers

In the "Related Links Inside CMS" section you will find links to the following:

MLN Products
MLN Product Ordering Page
MLN Educational Web Guides

Resources

- Our websites:

  for consumers: www.medicare.gov

  for professionals: www.cms.gov

  Medicare Learning Network:

  www.cms.gov/MLNGenInfo/

- Fraud related:

  > www.stopmedicarefraud.gov

  > **http://tinyurl.com/4dn6fwr (Medicare fraud factsheet)**

- **MAC Contacts for Providers: http://www.cms.gov/center/provider.asp and scroll down to the "Contacts" section - unzip the list of phone numbers, by state**

Website Links

- **RAC:** http://www.cms.gov/RAC
- **QICs:** http://www.cms.gov/OrgMedFFSAppeals/03_ReconsiderationbyaQualifiedIndependentContractor.asp
- **QIOs:** http://www.cms.gov/QualityImprovementOrgs/
- **COB:** http://www.cms.gov/COBGeneralInformation/

Website Links

- **NSC:** http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

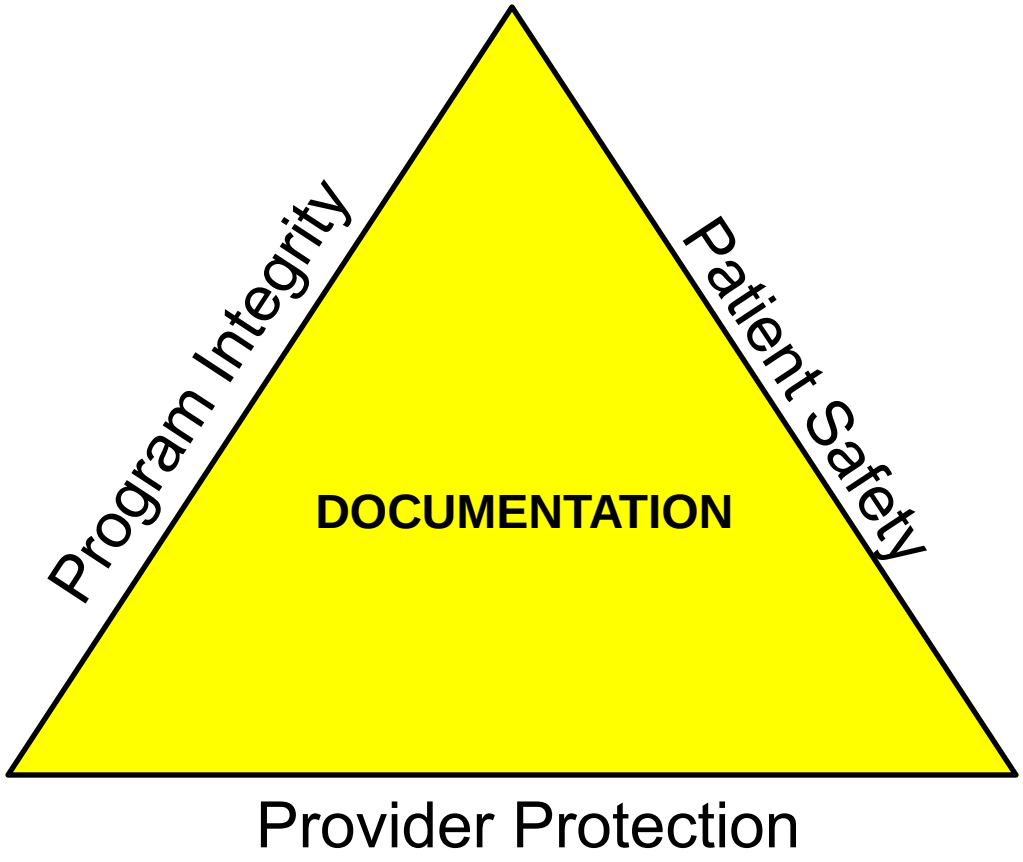
- **Medicaid Integrity Program:** http://www.cms.gov/MedicaidIntegrityProgram/

Thank you for your attention

Questions ?

Importance of Documentation

Importance of Documentation

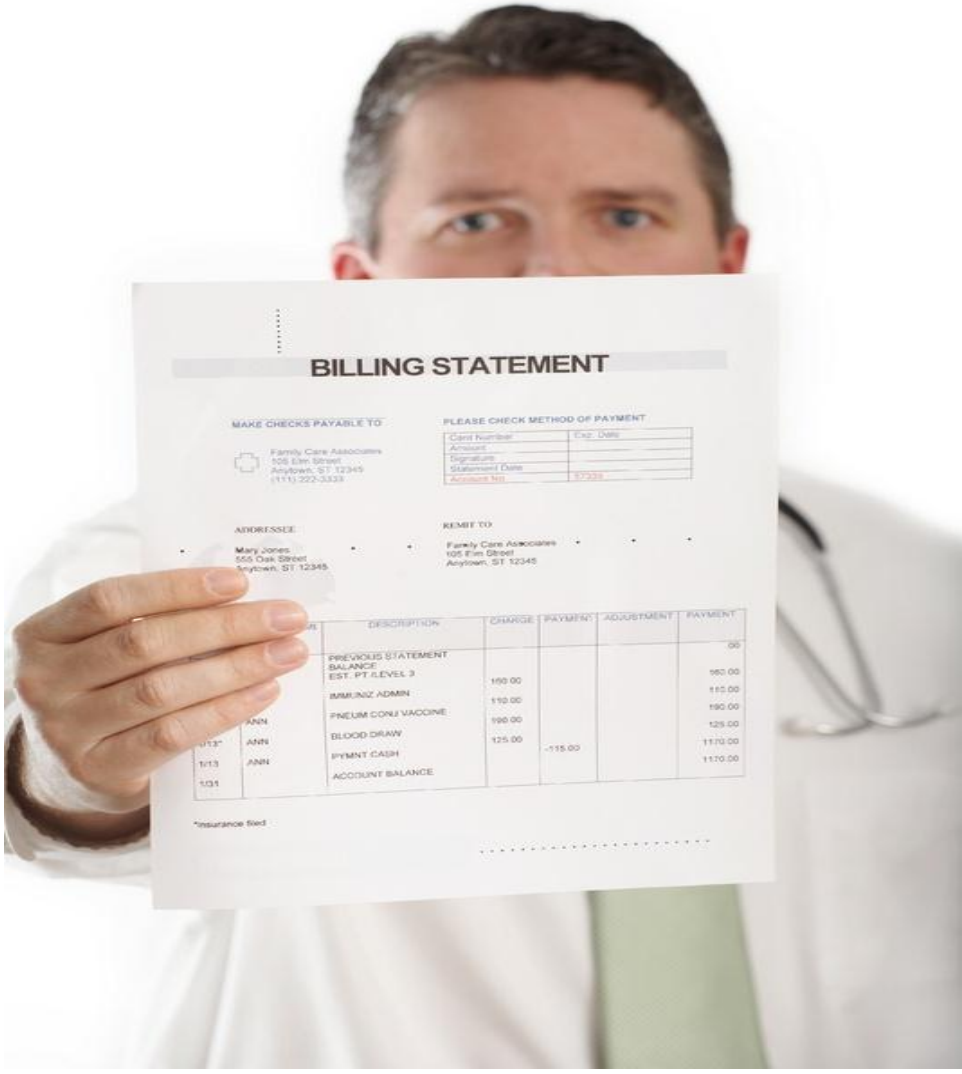


Accurate Coding and Billing are Critical

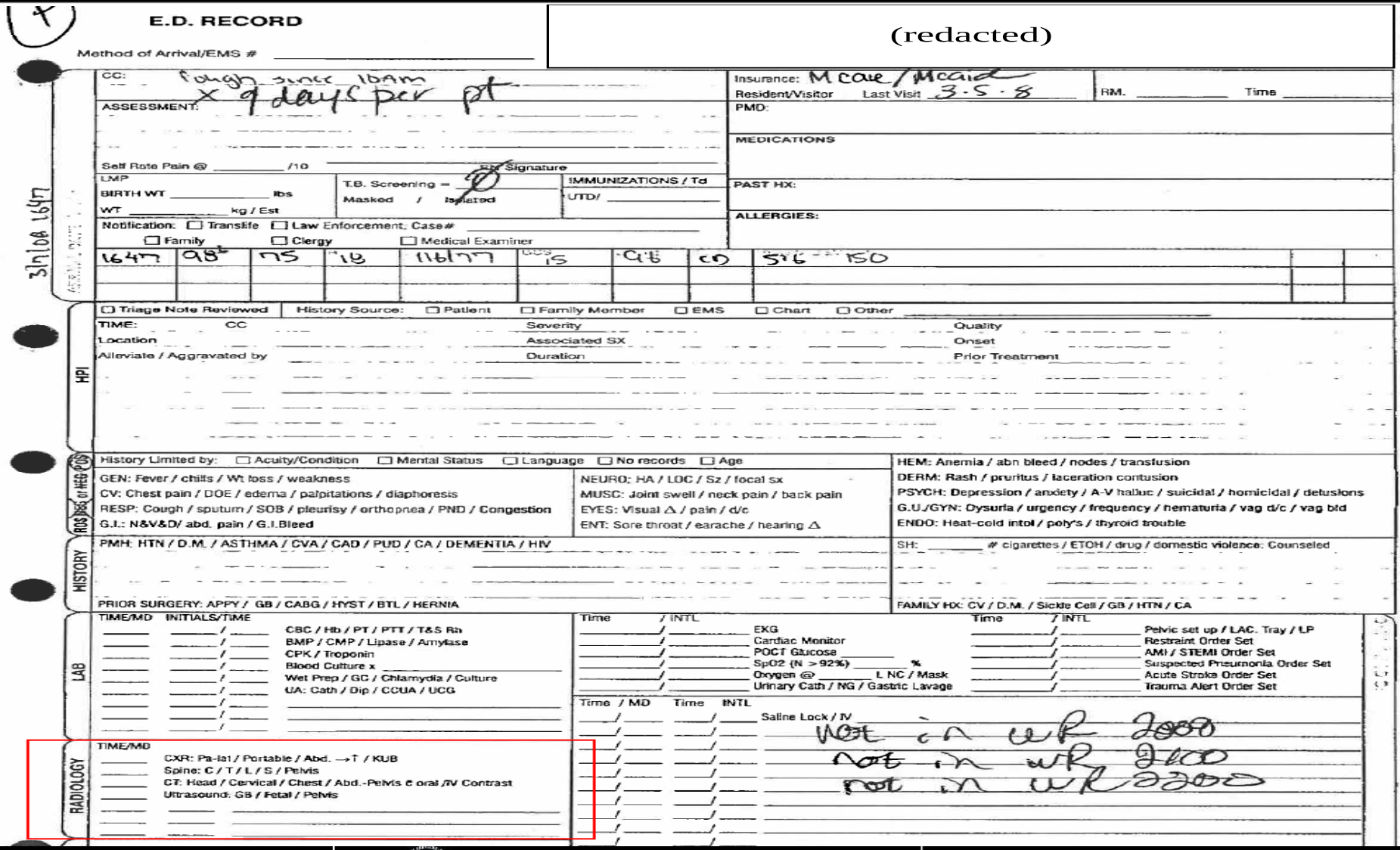
Good documentation helps ensure quality patient care
ALLERGIC TO:

Good Documentation Practices Help Protect You

Fraudulent billings result in stiff penalties



Incomplete Records



(+)

E.D. RECORD

Method of Arrival/EMS # _____

(redacted)

CC: Cough since 10AM x 9 days per pt

Insurance: Mcare / Mcaid

Resident/Visitor Last Visit 3.5.8

RM. _____ Time _____

ASSESSMENT:

PMD:

MEDICATIONS

Self Rate Pain @ _____ /10 _____ RN Signature

LMP

BIRTH WT _____ lbs

WT _____ kg / Est

T.B. Screening = Ø

Masked / Isolated

IMMUNIZATIONS / Td

UTD/ _____

PAST HX:

ALLERGIES:

Notification: ☐ Transfile ☐ Law Enforcement; Case# _____

☐ Family ☐ Clergy ☐ Medical Examiner

3/7/08 1647

1647	98	75	18	116/77	15	96	CD	516	150	

☐ Triage Note Reviewed History Source: ☐ Patient ☐ Family Member ☐ EMS ☐ Chart ☐ Other _____

HPI

TIME: CC Severity Quality

Location Associated SX Onset

Alleviate / Aggravated by Duration Prior Treatment

ROS DEG or NEG POS

History Limited by: ☐ Acuity/Condition ☐ Mental Status ☐ Language ☐ No records ☐ Age

GEN: Fever / chills / Wt loss / weakness

CV: Chest pain / DOE / edema / palpitations / diaphoresis

RESP: Cough / sputum / SOB / pleurisy / orthopnea / PND / Congestion

G.I.: N&V&D/ abd. pain / G.I.Bleed

NEURO: HA / LOC / Sz / focal sx

MUSC: Joint swell / neck pain / back pain

EYES: Visual Δ / pain / d/c

ENT: Sore throat / earache / hearing Δ

HEM: Anemia / abn bleed / nodes / transfusion

DERM: Rash / pruritus / laceration contusion

PSYCH: Depression / anxiety / A-V hallux / suicidal / homicidal / delusions

G.U./GYN: Dysuria / urgency / frequency / hematuria / vag d/c / vag bld

ENDO: Heat-cold intol / poly's / thyroid trouble

HISTORY

PMH: HTN / D.M. / ASTHMA / CVA / CAD / PUD / CA / DEMENTIA / HIV

SH: _____ # cigarettes / ETOH / drug / domestic violence: Counseled

PRIOR SURGERY: APPY / GB / CABG / HYST / BTL / HERNIA

FAMILY HX: CV / D.M. / Sickle Cell / GB / HTN / CA

LAB

TIME/MD INITIALS/TIME

CBC / Hb / PT / PTT / T&S Rh

BMP / CMP / Lipase / Amylase

CPK / Troponin

Blood Culture x _____

Wet Prep / GC / Chlamydia / Culture

UA: Cath / Dip / CCUA / UCG

Time / INTL

EKG

Cardiac Monitor

POCT Glucose _____

SpO2 (N > 92%) _____ %

Oxygen @ _____ L NC / Mask

Urinary Cath / NG / Gastric Lavage

Time / INTL

Pelvic set up / LAC. Tray / LP

Restraint Order Set

AMI / STEMI Order Set

Suspected Pneumonia Order Set

Acute Stroke Order Set

Trauma Alert Order Set

Time / MD Time INTL

Saline Lock / IV

not in WR 2000

not in WR 2100

not in WR 2200

RADIOLOGY

TIME/MD

CXR: Pa-lat / Portable / Abd. →↑ / KUB

Spine: C / T / L / S / Pelvis

CT: Head / Cervical / Chest / Abd.-Pelvis c oral /IV Contrast

Ultrasound: GB / Fetal / Pelvis

New Technologies: Benefits and Vulnerabilities

Amending Records

PROGRESS NOTE

NAME: _____ Age: 71 Date: 7/28/06

SUBJECTIVE: LMP ___ SMOKER: ✓ Y ___ N 1 PPD

Post MRI visit
R LE pain
— path fx by xray
ultram/clinoid only mild help.

EXAM: BP 110/70 T 97.1 P 68 R 20 HT ___ WT 205

General: ✓ WDWN ✓ NAD

HEENT: ___ NCAT ___ PERRL ___ EOMI ___ No ict/inj b/l ___ TMs Clr ___ TH Clr

Neck: ___ Supple ___ No LAN b/l ___ No JVD b/l ___ No Bruits b/l

Thyroid: ___ Nml Size ___ Symmetric ___ No nodules

Lungs: ✓ CTA b/l ___ No Wheeze b/l ___ No Ronchi b/l ___ No Rales b/l ___ Good aeration b/l

Heart: ✓ RRR ___ No murmurs ___ No rubs ___ No ectopy

Abdomen: ✓ Soft ___ No tenderness ___ No masses ___ No HSM
___ NABS ___ No guard ___ No rebound ___ No rigidity ___ No fl tenderness ___ No CVA tenderness

GU: ___ NEG ___ No ing LAN ___ no ureth/vag d/c ___ no ext lesions ___ no testicular masses ___ No hernia

Breasts:

Extremities: ___ No clubbing ___ No cyanosis ___ No edema

Back:

Neurological: ___ 2/4 DTR b/l u&l ext, ___ 5/5 str throughout, ___ EOMI ___ Babinski ___ Neg Rhomberg
___ rapid/acc alt hand mvmt b/l, ___ nml FN coord b/l, ___ nml gait, ___ nml toe walk, ___ nml heel walk

Integument: ___ nml color, ___ nml turgor, ___ No concerning rash/lesions, ___ No diaphoresis

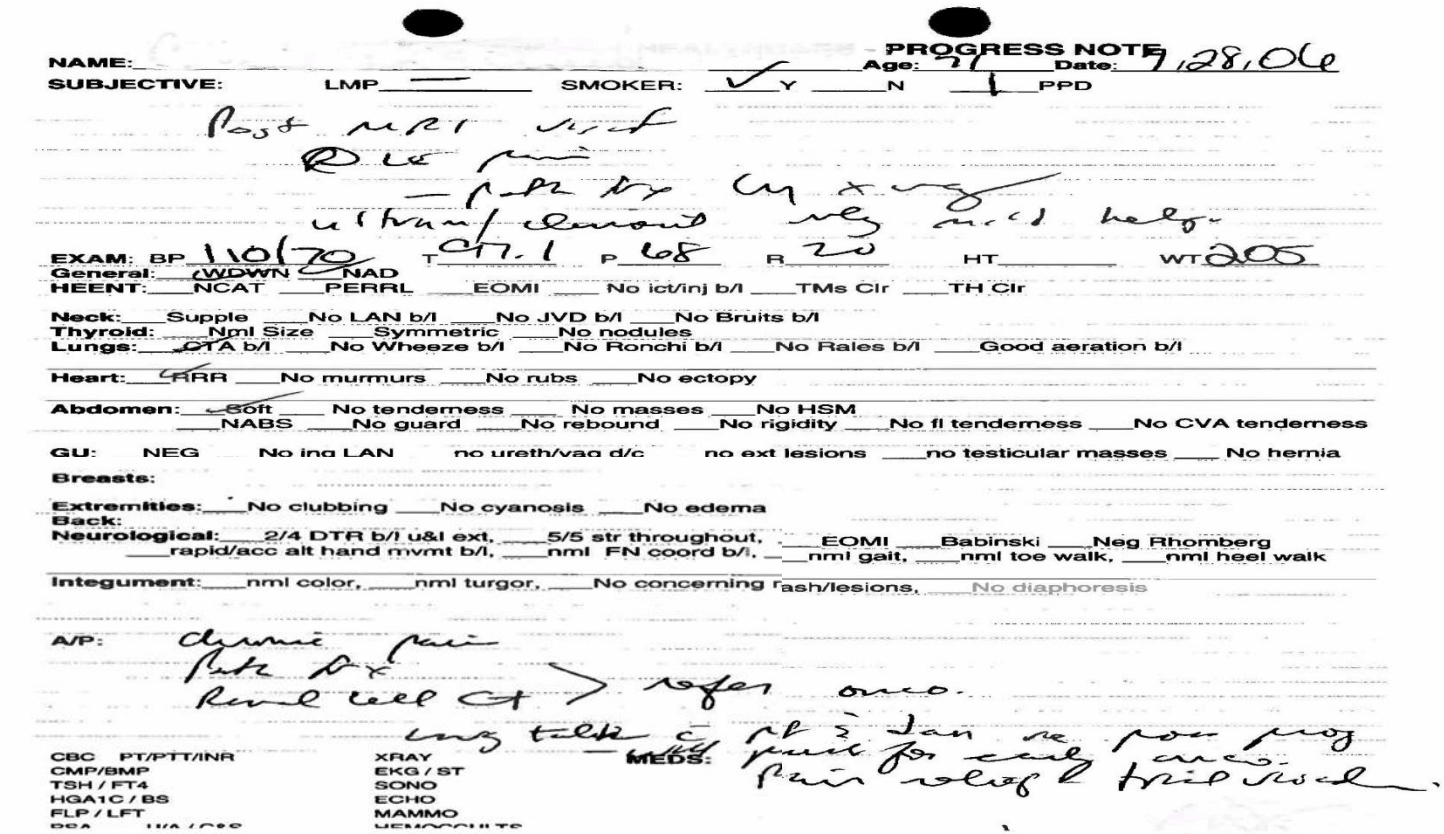
A/P: chronic pain
Path fx, CRI
Renal cell Ca > refer onco.
long talk c̄ pt & Jan re poor prog
— will push for early onco.
Pain relief & trial visc.

MEDS:

CBC PT/PTT/INR
CMP/BMP
TSH / FT4
HGA1C / BS
FLP / LFT
PSA UA / C&S

XRAY
EKG / ST
SONO
ECHO
MAMMO
HEMOCCULTS

Non-Contemporaneous Entries



PROGRESS NOTE

NAME: _____ Age: 71 Date: 7/28/06

SUBJECTIVE: LMP — SMOKER: ✓ Y ___ N 1 PPD

Post MRI visit
R LE pain
— path tx [illegible] x ray
ultram/clonout [illegible] help.

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CBC PT/PTT/INR
CMP/BMP
TSH / FT4
HGA1C / BS
FLP / LFT
PSA U/A / C&S

XRAY
EKG / ST
SONO
ECHO
MAMMO
HEMOCCULTS

Subpoenas, Audits, and Surveys

Subpoenas

- **An IG subpoena is as "real" as any court-issued subpoena**
- **Do not ignore the subpoena**

Audits and Surveys

- **Audits by the OIG's Office of Audit Services**

- **Studies by the OIG's Office of Evaluation and Inspections**

Participation is important

Self-Disclosure

Self-Disclosure

Self-Disclosure

Should I disclose?

Where should I disclose?

- **Contractor**
- **OIG**
- **DOJ**
- **CMS**

Get some advice

OIG Self-Disclosure Protocol

Include all the Information

Consult OIG's website

Resolution

- **OIG = Civil Monetary Penalties law settlement**
- **DOJ = False Claims Act settlement**
- **No Corporate Integrity Agreement if cooperative**

Break

Understanding the Consequences of Health Care Fraud

Moderator:
Spencer Turnbull
OIG HEAT Initiative Administrator

Panelists:

Dr. Peter Budetti
Deputy Administrator and Director
Center for Program Integrity, CMS

Nick DiGiulio
Special Agent in Charge
OIG Office of Investigations Region 3

John Pease
Assistant United States Attorney
Eastern District of Pennsylvania

Jacqueline Franklin
Supervisory Criminal Investigator
Medicaid Fraud Control Unit of Washington, D.C.

Closing Remarks

Thank You for Attending the HEAT Provider Compliance Training