

# 2022 Specialized Anti-Healthcare Fraud Training: Overview

## 1. Navigation

### 1.1 Title

#### Anti-Fraud and Abuse Awareness

Only a small fraction of health care claims are fraudulent or abusive but even in small numbers they represent tens of billions of dollars lost each year. This translates into higher premiums and out-of-pocket expenses for everyone. That's why we pay attention.

UnitedHealth Group has an anti-fraud program committed to routing out inaccurate claims that may be fraudulent or abusive. Your responsibility in that effort is to understand the basic differences between fraud, waste and abuse and know where to report anything you notice that is out of the ordinary in the course of your daily activities.



Click the **Help** link at the top of the screen for information about course navigation.

This course does not contain audio.

#### Notes:

## 1.2 Course Objectives

### Objective 1

#### Why is this course important?

State regulations require that health care insurance personnel receive annual continuing education in 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.



Regulatory Compliance Statement

#### Course Objectives



#### Notes:

### Regulatory (Slide Layer)

CLOSE

The anti-fraud plan elements shall include, but are not 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 CO2

### Objective 2

What do I need to know about fraud, waste and abuse?

- Definitions
- Key indicators
- Purpose and function of the Special Investigations Unit (SIU)
- Where the SIU fits within the organization
- Your responsibilities as an employee
- How to report suspicious activity



DATES OF SERVICE	CODE	PROCEDURE
05/21/10-05/21/10	8272	PULM
05/21/10-05/21/10	94010	PULM
05/21/10-05/21/10	94375	PULM
05/21/10-05/21/10	94375	CARDIOVASCULAR SEKV
05/21/10-05/21/10	36000	VENIPUNCTURE
05/21/10-05/21/10	36410	VENIPUNCTURE
		Total

#### Course Objectives



## 1.4 CO3

### Objective 3

How can I prevent fraud, waste and abuse?

Regardless of your role, understanding fraud, waste and abuse will help you better identify and report suspicious activity for investigation 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 the basics of fraud, waste and abuse detection and reporting.



#### Course Objectives



Notes:

## 2. Fraud Indicators

### 2.1 Introduction

1 Definitions 2 Fraud Indicators

## Section 2: Fraud Indicators



### What is a Fraud or Abuse Indicator?

Fraud and abuse indicators are types of activity that in the past, have been shown to be reliable for pointing out fraudulent and abusive behavior.

Here are a few things to remember about fraud and abuse activities. They can:

- be illegal enterprises carried out for profit.
- take many forms - fraudulent billing, unnecessary services, kickbacks and duplicate claims.
- target large health care programs.
- be found throughout the health care system.

### 2.2 Fraud Indicators in Healthcare

1 Definitions 2 Fraud Indicators

### How is fraud and abuse different throughout health care?

Each area of health care has different fraud and abuse indicators and behaviors. Click on a button below to see examples for that area of health care. You must review each area before moving on.

[General](#) [Provider](#) [Member](#) [Pharmacy](#) [Broker](#) [Employee](#)

Review each area before moving forward.

## General (Slide Layer)

1 Definitions 2 Fraud Indicators

### How is fraud and abuse different throughout health care?

Each area of health care has different fraud and abuse indicators and behaviors. Click on a button below to see examples for that area of health care. You must review each area before moving on.

#### General Warning Signs of Fraud

- Altered record dates, charges, diagnosis.
- Use of "white-out," different colored ink, different handwriting, photocopies of documents.
- Misuse or misspelling of medical or legal terms, or use of layman's terms.
- Receipts, invoices or reports on plain stationery.
- Records appear to always be the same (template records).
- Late entries into the health record that are out of chronological order.
- Different versions of the same record from different sources (e.g. physicians, hospitals).

▲

General Provider Member Pharmacy Broker Employee

Review each area before moving forward.

## Provider (Slide Layer)

1 Definitions 2 Fraud Indicators

### How is fraud and abuse different throughout health care?

Each area of health care has different fraud and abuse indicators and behaviors. Click on a button below to see examples for that area of health care. You must review each area before moving on.

#### Provider Fraud

- Submitting claims for services not provided.
- Falsifying the date of service to correspond with a member's coverage period.
- Billing for non-covered services by using payable, but incorrect codes.
- Providing "free" services and then billing insurance.
- Submitting the same claims on different dates showing the same dates of services.
- Unbundling (billing for all services separately).
- Upcoding (billing for a more expensive service than what was provided).

▲

General Provider Member Pharmacy Broker Employee

Review each area before moving forward.

## Member (Slide Layer)

1 Definitions 2 Fraud Indicators

### How is fraud and abuse different throughout health care?

Each area of health care has different fraud and abuse indicators and behaviors. Click on a button below to see examples for that area of health care. You must review each area before moving on.

#### Member or Patient Fraud

- Use of aliases.
- Unusual number of dependent claims.
- Misrepresenting facts to gain access/eligibility to a healthcare plan or program.
- Being enrolled in multiple plans in multiple states.
- Using an insurance card that belongs to someone else.
- Benefiting from "free offer" schemes that the provider bills for later at excessive rates.
- Submitting false claims for services never received.
- Resubmitting claims with a different provider name.
- Doctor shopping to acquire or stockpile pharmaceuticals.
- Selling or loaning member identification information.

▲

General Provider **Member** Pharmacy Broker Employee

Review each area before moving forward.

## Pharmacy (Slide Layer)

1 Definitions 2 Fraud Indicators

### How is fraud and abuse different throughout health care?

Each area of health care has different fraud and abuse indicators and behaviors. Click on a button below to see examples for that area of health care. You must review each area before moving on.

#### Pharmacy Fraud

**Inappropriate billing**

- A pharmacy bills for medication that it never dispensed.
- A pharmacy bills for brand name drugs when generics are dispensed.

**Prescription drug shorting**

- The pharmacy provides less than the prescribed quantity and does not inform the patient.

**Prescription forging or altering**

- Existing prescriptions are altered without authorization.

▲

General Provider Member **Pharmacy** Broker Employee

Review each area before moving forward.

## Broker (Slide Layer)

1 Definitions 2 Fraud Indicators

### How is fraud and abuse different throughout health care?

Each area of health care has different fraud and abuse indicators and behaviors. Click on a button below to see examples for that area of health care. You must review each area before moving on.

#### Sales Broker or Agent Fraud

- Enrolling a member by forging a signature on an application.
- Coaching individuals to enter erroneous enrollment information so they will be eligible for insurance.
- Enrolling group as nonexistent company.
- Misrepresenting benefits to persuade an individual to join a particular health plan. Usually because the agent will receive a kickback or reward.
- Falsifying the location of a group to obtain insurance or lower premium rate.
- Group owner enrolls family members (parents, siblings and children) as employees when they do not in fact work for the group.

▲

General Provider Member Pharmacy **Broker** Employee

Review each area before moving forward.

## Employee (Slide Layer)

1 Definitions 2 Fraud Indicators

### How is fraud and abuse different throughout health care?

Each area of health care has different fraud and abuse indicators and behaviors. Click on a button below to see examples for that area of health care. You must review each area before moving on.

<h4>Employee Plan Fraud</h4> <ul style="list-style-type: none"><li>• Filing a claim for an injury that did not occur on, or has no relation to the job they perform.</li><li>• Misrepresenting their work status when formally questioned in a deposition or a hearing in order to continue receiving temporary disability benefits.</li><li>• Misrepresenting the severity of the injury they are claiming.</li></ul>	<h4>Health Care Employee</h4> <ul style="list-style-type: none"><li>• Falsification of patient records by an employee.</li><li>• Using a member's ID number to obtain prescriptions, services, supplies, etc.</li><li>• Identity theft.</li><li>• Redirecting a payment to a new address.</li></ul>
--	---

▲

General Provider Member Pharmacy Broker **Employee**

Review each area before moving forward.

## 2.3 Drag and Drop

*(Drag and Drop, 10 points, 1 attempt permitted)*

1 Definition 2 Fraud Indicators

### What Type of Fraud is it?

Using an insurance card that isn't yours.

Forging signatures to enroll members.

Falsifying a patient health care record.

Submitting claims for services not provided.

Dispensing generic drugs but billing for brand name.

**Instructions:** Drag and drop labels to identify the type of fraud. A green check means you are correct. Move the labels around until all are in the correct positions. You can return them to their starting position too.

Provider

Broker

Pharmacy

Member

Employee

Drag Item	Drop Target
	Drop 1
	Drop 3
	Drop 2

Drag and drop properties
Snap dropped items to drop target (Snap to center)

**Notes:**

## Conclusion (Slide Layer)

2 Fraud Indicators

### What Type of Fraud is it?

Using an insurance card that isn't yours.	Forging signatures to enroll members.	Falsifying a patient health care record.	Submitting claims for services not provided.	Dispensing generic drugs but billing for brand name.
---	---------------------------------------	--	--	--

Instructions: Drag labels around the board to identify types of fraud. A green label indicates a correct answer. You can return the labels to the top of the board at any time.

Nice job identifying types of fraud!  
Click **Next** to move forward.

Broker  
Member  
Employee

**NEXT**

## 2.4 When to Report

1 Definitions 2 Fraud Indicators



Remember, you don't need to know if a particular situation is fraud, waste or abuse to report it. Staying aware and reporting anything you observe that is not in keeping with normal procedure, processes or policy means you've done your part.

When you report something out of the ordinary, it will be investigated to determine the appropriate action to take. You'll learn more about the SIU in the next section of this course.

Click **Next** to continue.

## 3. Definitions

### 3.1 Introduction

1 Definitions

## Section 1: Definitions

Fraud, waste and abuse each have distinct legal definitions. In this section you will learn the basic differences between them.



### Fraud and Abuse Defined

Fraud is different from abuse but they both can look and feel very similar, making it difficult at times to tell them apart.

Fraud and abuse happen when perpetrators take advantage of the complexity of the health care system for personal gain. Waste can usually be deterred through education.

**Notes:**

## 3.2 Definitions

1 Definitions

### What are fraud, waste and abuse?

Explore the definitions below. Look for key things that make fraud, waste and abuse different from one another. **Click on the buttons below to review definitions and examples.**

**Fraud**  
Intentional misrepresentation of fact.

**Waste**  
Practices that result in unnecessary costs.

**Abuse**  
Inappropriate or inefficient use of resources.

Review each definition before moving forward.

### Fraud (Slide Layer)

1 Definitions

### What are fraud, waste and abuse?

Explore the definitions below. Look for key things that make fraud, waste and abuse different from one another. **Click on the buttons below to review definitions and examples.**

**Fraud**

Intentionally misrepresenting or concealing material facts to obtain something of value. There are three primary components to fraud:

- **Intentional dishonest action**, reckless disregard or misrepresentation of a material fact,
- **Committed by a person or an entity**,
- With knowledge that the dishonest action, disregard or material representation **could result in an inappropriate gain or benefit.**

**EXAMPLES**

**Fraud**  
Intentional misrepresentation of fact.

**Waste**  
Practices that result in unnecessary costs.

**Abuse**  
Inappropriate or inefficient use of resources.

Review each definition before moving forward.

## Waste (Slide Layer)

1 Definitions

### What are fraud, waste and abuse?

Explore the definitions below. Look for key things that make fraud, waste and abuse different from one another. **Click on the buttons below to review definitions and examples.**

#### Waste

Includes **inaccurate payments** for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources.

Waste is generally not considered to be caused by criminal, intentional or negligent actions, but rather the **misuse of resources**.

There generally is not a consistent pattern to wasteful behavior and many times **can be deterred by providing education**.

EXAMPLES

▲

<b>Fraud</b> Intentional misrepresentation of fact.	<b>Waste</b> Practices that result in unnecessary costs.	<b>Abuse</b> Inappropriate or inefficient use of resources.
--	---	--

Review each definition before moving forward.

## Abuse (Slide Layer)

1 Definitions

### What are fraud, waste and abuse?

Explore the definitions below. Look for key things that make fraud, waste and abuse different from one another. **Click on the buttons below to review definitions and examples.**

#### Abuse

Abuse includes **practices that**, either directly or indirectly, **result in unnecessary costs** to health care benefit programs. These include any practice that results in the provision of services that:

- Are **not medically necessary**, or
- Do **not meet professionally recognized standards** for health care, or
- Are **not fairly priced**.

EXAMPLES

▲

<b>Fraud</b> Intentional misrepresentation of fact.	<b>Waste</b> Practices that result in unnecessary costs.	<b>Abuse</b> Inappropriate or inefficient use of resources.
--	---	--

Review each definition before moving forward.

## Fraud - Examples (Slide Layer)

1 Definitions

### What are fraud, waste and abuse?

Explore the definitions below. Look for key things that make fraud, waste and abuse different from one another. **Click on the buttons below to review definitions and examples.**

#### Fraud Examples

Intentionally billing for services, procedures and/or supplies that were not provided or intentionally misrepresenting of any of these:

- The nature of services, procedures and/or supplies provided.
- The dates that services were provided.
- The medical record of services and/or treatment provided.
- The condition or diagnosis.
- The identity of the provider or recipient of services, procedures and/or supplies.

**Fraud**  
Intentional misrepresentation of fact.

**Waste**  
Practices that result in unnecessary costs.

**Abuse**  
Inappropriate or inefficient use of resources.

Review each definition before moving forward.

## Waste - Examples (Slide Layer)

1 Definitions

### What are fraud, waste and abuse?

Explore the definitions below. Look for key things that make fraud, waste and abuse different from one another. **Click on the buttons below to review definitions and examples.**

#### Waste Examples

- Prescribing high priced medications because they are unaware of the generic alternatives.
- Distributing printed hardcopy of work when it can be done electronically.
- Defects that cause rework or corrected claims (medication errors, billing mistakes, minor coding errors).
- Over production (duplicate charting, multiple forms with same information).
- Confusing practices (unclear MD orders or system for indicating charges for billing).
- Excessive processing (redundant information gathering or charting).

**Fraud**  
Intentional misrepresentation of fact.

**Waste**  
Practices that result in unnecessary costs.

**Abuse**  
Inappropriate or inefficient use of resources.

Review each definition before moving forward.

## Abuse - Examples (Slide Layer)

1 Definitions

### What are fraud, waste and abuse?

Explore the definitions below. Look for key things that make fraud, waste and abuse different from one another. **Click on the buttons below to review definitions and examples.**

**Abuse Examples**

- Billing for treatment that is inconsistent with the diagnosis being reported.
- Important information is consistently missing (TIN, provider name, diagnosis).
- Delayed or staggered billing.
- Billing under multiple providers in the same clinic once a line item is denied.
- Billing separately for services that should be bundled together.

**Fraud**

Intentional misrepresentation of fact.

**Waste**

Practices that result in unnecessary costs.

**Abuse**

Inappropriate or inefficient use of resources.

Review each definition before moving forward.

### 3.3 Drag and Drop

(Drag and Drop, 10 points, 1 attempt permitted)

1 Definitions

### Is it Potential Fraud, Waste or Abuse?

A number of patients visiting the same new clinic are reporting that their Explanation of Benefits have the wrong provider and location information.

A provider periodically submits codes that are billed for individual services when a bundled code should be used to bill those services.

A small town provider's office occasionally submits claims with minor coding errors that are denied and then resubmitted correctly.

**Instructions:** Drag and drop labels to identify each scenario as fraud, waste or abuse. A green check means you are correct. Move the labels around until all are in the correct positions. You can return them to their starting position too.

Fraud

Abuse

Waste

Drag Item	Drop Target
Error	

Fraud

Abuse

Drag and drop properties

Snap dropped items to drop target (Snap to center)

### Untitled Layer 1 (Slide Layer)

1 Definitions

## Is it Potential Fraud, Waste or Abuse?

A number of patients visiting the same clinic are reporting their Explanatory Benefits have the provider and location information.

You did a great job identifying fraud, waste and abuse.

Remember, you don't need to know if a situation is fraud, waste or abuse to report it. When you see situations that are out of the ordinary they need further review and you should report them. You will have done your part.

Click **Next** to move forward in the course.

Instructions: Drag items as fraud, waste or abuse as correct. Move them to the correct positions. You can return them to their starting position too.

Waste

## 4. Special Investigations

### 4.1 Introduction

1 Definitions 2 Fraud Indicators 3 Special Investigations

### Section 3: Special Investigations

The Special Investigations Units at UnitedHealth Group work in collaboration with other fraud investigation groups within the Enterprise.



#### What Does the Special Investigations Unit Do?

You're probably wondering what happens to the information you provide when you report a suspected case of fraud, waste or abuse. This is where the Special Investigations Unit (SIU) comes in.

They manage the fraud hotline and web page that receives fraud and abuse tips. They conduct preliminary investigations and make determinations about whether there is enough evidence to review claims, request records, recover overpayments or make a report to regulatory authorities of fraud or abuse.

Click [here](#) to view a chart showing SIU and Payment Integrity teams within UnitedHealth Group.

#### Notes:

## 4.2 Functions of the SIU

1 Definitions 2 Fraud Indicators 3 Special Investigations

### What happens within Special Investigations?

The Special Investigations Unit (SIU) proactively investigates claims to uncover fraud, waste and abuse before and after payments are made. **Click each button below for more details.**

Analytics & Detection   Pre-Pay Investigations   Post-Pay Investigations   Compliance & Reporting

Review each section before moving forward.

### Notes:

## Analytics (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations

### What happens within Special Investigations?

The Special Investigations Unit (SIU) proactively investigates claims to uncover fraud, waste and abuse before and after payments are made. **Click each button below for more details.**

**Analytics & Detection**

The SIU uses data analytics to identify potential fraudulent and abusive activities and identify suspect or unusual billing patterns. They use pre-defined algorithms and other mathematical formulas to accomplish this.

Providers identified through the use of analytics may be investigated prospectively (prior to payment) or retrospectively (after a payment is made).

Analytics & Detection   Pre-Pay Investigations   Post-Pay Investigations   Compliance & Reporting

Review each section before moving forward.

## Pre-Pay (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations

### What happens within Special Investigations?

The Special Investigations Unit (SIU) proactively investigates claims to uncover fraud, waste and abuse before and after payments are made. **Click each button below for more details.**

#### Pre-Pay Investigations

Providers may be flagged within the payer system. This allows an opportunity to review future claims to determine whether a claim should be paid in part, in full or not at all.

Investigations may include:

- Analysis of relevant historic claims.
- Request for and review of relevant medical records.
- Review provider verification information such as licensure.
- Interviews with persons who may have information.

▲

Analytics & Detection Pre-Pay Investigations Post-Pay Investigations Compliance & Reporting

Review each section before moving forward.

## Post-Pay (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations

### What happens within Special Investigations?

The Special Investigations Unit (SIU) proactively investigates claims to uncover fraud, waste and abuse before and after payments are made. **Click each button below for more details.**

#### Post-Pay Investigations

Data analytics or information from other sources, like tips and referrals may identify whether there is a need for an investigation after payment of a claim.

Post-pay investigations use data analysis techniques to review claims to determine if provider billing practices suggest a pattern or practice of fraud or abuse over time.

When a case is determined to be a possible case for recovery of overpayments, evidence for the case is fully developed to facilitate maximum financial recovery from fraudulent, wasteful or abusive practices.

▲

Analytics & Detection Pre-Pay Investigations Post-Pay Investigations Compliance & Reporting

Review each section before moving forward.

## Compliance (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations

### What happens within Special Investigations?

The Special Investigations Unit (SIU) proactively investigates claims to uncover fraud, waste and abuse before and after payments are made. **Click each button below for more details.**

#### Compliance & Reporting

Health insurance is a regulated industry and audited periodically to ensure compliance. Organizations are required to:

- report confirmed instances of potential or suspected fraud and abuse to regulatory agencies.
- respond to subpoenas and other requests for information.

Note: California requires suspected fraud to be reported to the California Department of Insurance (CDI) Fraud Division within 60 days of reasonable belief (CIC §1872.4).

▲

Analytics & Detection Pre-Pay Investigations Post-Pay Investigations Compliance & Reporting

Review each section before moving forward.

## 5. Reporting

### 5.1 Introduction

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

## Section 4: Reporting

You play a vital role in detecting and preventing fraud, waste and abuse. Prompt reporting of suspicious activity protects both you and UnitedHealth Group from potential risk and loss.

How	When	Policies
Reporting is the first step in combating fraud, waste and abuse. There are several reporting resource options.	Reporting is always the right decision as soon as you suspect something. For anyone who reports activity that is out of the ordinary, there are workplace and legal protections.	The "Code of Conduct" and "Non-Retaliation" policies apply to all employees and contractors.



## 5.2 Reporting Options

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### To Report Health Care Fraud, Waste and Abuse



#### Health Care Fraud Tip Line

- Phone: 1-866-242-7727
- Online: **Tip Referral Form** on the Report Health Care Fraud portal

Make sure that you are familiar with your business area's reporting instructions. Some business areas such as OptumRx have alternative methods of reporting. Optum Rx customer service representatives should use the online RxWeb audit referral form for reporting potential pharmacy fraud.

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

### Notes:

### Additional Reporting Methods (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### To Report Health Care Fraud, Waste and Abuse



#### Additional Reporting Resources

- 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](mailto:ethicsoffice@uhg.com)

CLOSE

## 5.3 Examples of Fraud and Abuse

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### When should you report suspicious activity?

Report suspicious activity immediately. Fraud schemes can occur anywhere in the health care system. Review the different types of fraud schemes by clicking the images below.



Review the information for each icon before moving forward.

### Notes:

## Medical Equip (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### When should you report suspicious activity?

Report suspicious activity immediately. Fraud schemes can occur anywhere in the health care system. Review the different types of fraud schemes by clicking the images below.

#### Medical Equipment Fraud

Durable Medical Equipment (DME) includes home care equipment and supplies.

This type of fraud happens when equipment is offered "free" in exchange for Medicare or health plan identification numbers. Insurers are then charged for equipment that was not needed or never delivered.

It also happens when medical equipment is prescribed but the patient never receives it or devices are diverted for sale on the underground market. Sometimes it is a substitution of medical equipment for less expensive or an inferior product. For example, a power wheel chair is billed but a manually operated chair is delivered.



Review the information for each icon before moving forward.

## Diagnostic (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### When should you report suspicious activity?

Report suspicious activity immediately. Fraud schemes can occur anywhere in the health care system. Review the different types of fraud schemes by clicking the images below.

#### Diagnostic Test Schemes

"Rolling Labs" are a type of scheme that occurs when unnecessary and sometimes fake medical tests are given to individuals at health clubs, retirement homes or shopping malls. Insurance companies, Medicare, or Medicaid are then billed for these tests.

Independent Diagnostic Testing Labs operate independently but provide services to physicians and hospitals. These labs are often targets for abuse by criminals. Sometimes the entire operation can be a front for criminal activity.

Unfortunately, older or vulnerable people are often the targets for this type of scam.

Review the information for each icon before moving forward.

## Services not provided (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### When should you report suspicious activity?

Report suspicious activity immediately. Fraud schemes can occur anywhere in the health care system. Review the different types of fraud schemes by clicking the images below.

#### Services Not Provided

In this type of fraud scheme members or providers bill insurers for services that were never provided to the patient.

Usually this is done by changing bills and/or patient medical records. Sometimes entirely fake bills are submitted.

An obvious case is when an individual provider's bills add up to more hours of work than there are hours in a day.

Review the information for each icon before moving forward.

## Prescription (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### When should you report suspicious activity?

Report suspicious activity immediately. Fraud schemes can occur anywhere in the health care system. Review the different types of fraud schemes by clicking the images below.

#### Prescription Schemes

The illegal use and trafficking of drugs is exploding. Prescription fraud and abuse often involves highly addictive painkillers that are obtained illegally or under false claims and then diverted to the underground market for sale.

Perpetrators often obtain these narcotics by obtaining prescriptions for the treatment of phantom injuries or visiting multiple Emergency Departments with a complaint of pain. Other deceptions include forging prescriptions using stolen prescription pads or physicians or pharmacists selling prescriptions to abusers or street dealers.

▲



Review the information for each icon before moving forward.

## Medical Identity (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### When should you report suspicious activity?

Report suspicious activity immediately. Fraud schemes can occur anywhere in the health care system. Review the different types of fraud schemes by clicking the images below.

#### Medical Identity Theft

Medical identity theft in the health care system occurs when someone uses another person's name or insurance information to get medical treatment, prescription drugs or even surgery.

Individuals whose identity is being used are sometimes willing (as in the case of someone lending their medical ID to a family member), but more often than not, they are unwilling parties to the fraud.

False claims are submitted to insurance companies hoping they will receive an unlawful payment in return.

▲



Review the information for each icon before moving forward.

## Unlicensed (Slide Layer)

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

### When should you report suspicious activity?

Report suspicious activity immediately. Fraud schemes can occur anywhere in the health care system. Review the different types of fraud schemes by clicking the images below.

#### Unlicensed Provider

In this type of fraud, services are performed by an unlicensed provider but billed under a licensed provider's name.

Bills for services provided by an unlicensed provider can be found in all medical specialties including dental, medical, behavioral health, and pharmacy.

The status of a provider's license is commonly checked when bills are submitted to help prevent these claims from being paid.

▲



Review the information for each icon before moving forward.

## 5.4 Code of Conduct

1 Definitions 2 Fraud Indicators 3 Special Investigations 4 Reporting

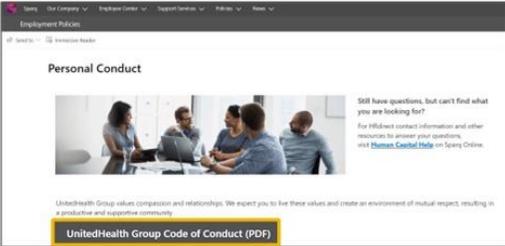
### Code Of Conduct

#### Our Principles of Ethics & Integrity

The UnitedHealth Group **Code of Conduct** applies to all employees and contractors. It represents a core element of the company's fraud, waste and abuse Compliance Program.

Because the Code cannot address every situation you might encounter, UnitedHealth Group relies on your good judgment and values to uphold the spirit and intent of the Code. If you are ever unsure about what to do in a particular situation, ask questions.

Visit the Compliance and Ethics Department website on Spark for more information.



UnitedHealth Group values compassion and relationships. We expect you to live these values and create an environment of mutual respect, resulting in a productive and supportive community.

[UnitedHealth Group Code of Conduct \(PDF\)](#)

## 5.5 Non-Retaliation

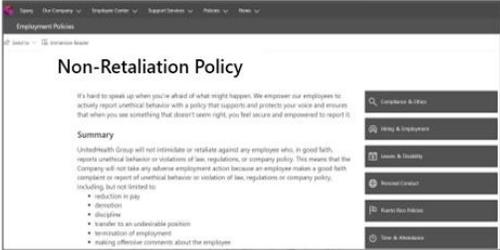
1 Definitions   2 Fraud Indicators   3 Special Investigations   **4 Reporting**

### Non-Retaliation Policy

One of UnitedHealth Group's basic responsibilities to its employees is to create an environment that encourages and protects employees when there is a report of unethical behavior, illegal activity or policy violations.

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.

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.



The screenshot shows a web page with a dark header containing navigation links: Home, All Content, Employment, Support, and More. The main content area is titled 'Non-Retaliation Policy' and includes an introductory paragraph, a 'Summary' section, and a list of prohibited actions. A sidebar on the right contains a search bar and a menu with items: Employment & HR, Policy & Document, Team & Training, Recent Content, News & Events, and Site & Account.

**Summary**

UnitedHealth Group will not intimidate or retaliate against any employee who, in good faith, reports unethical behavior or violations of law, regulations, or company policy. This means that the Company will not take any adverse employment action because an employee makes a good faith complaint or report of unethical behavior or violation of law, regulations or company policy, including, but not limited to:

- reduction in pay
- demotion
- discipline
- transfer to an undesirable position
- termination of employment
- making offensive comments about the employee.

Notes:

## 6. Mod 5\_Assessment

### 6.1 Module 5

## ASSESSMENT

**To Complete this Course**

Now that you have an understanding of fraud, waste and abuse you are equipped to identify any suspicious activity and know when to report it as required by the UnitedHealth Group Code of Conduct.

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

To complete this course you must pass the assessment with a score of 80% or better to show that you understand the basics of fraud, waste and abuse detection.

[Click here to start the assessment](#)

### 6.2 Q1

*(Multiple Choice, 10 points, 1 attempt permitted)*

The distinguishing factor that makes an incident suspected **fraud** is:

- Evidence of intentional misrepresentation or concealment of facts.
- Wasteful spending or practices.
- Unnecessary services are provided.
- Several tips come into the fraud hotline.

Correct	Choice
X	Evidence of intentional misrepresentation or concealment of facts.
	Wasteful spending or practices.
	Unnecessary services are provided.
	Several tips come into to the fraud hotline.

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

The distinguishing factor that makes an incident suspected fraud is that there is evidence of intentional misrepresentation.

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

The distinguishing factor that makes an incident suspected **fraud** is:

- Evidence of intentional misrepresentation.
- Was the provider licensed?
- Unnecessary services.
- Severe injury.

**Incorrect**

The distinguishing factor that makes an incident suspected fraud is that there is evidence of intentional misrepresentation.

## 6.3 Q2

*(Multiple Response, 10 points, 1 attempt permitted)*

Which of the following are examples of provider fraud?  
(Select all that apply.)

- Submitting claims for services not provided.
- Falsifying the date of service to correspond with a member's coverage period.
- Providing "free" services and then billing insurance.

Correct	Choice
X	Submitting claims for services not provided.

X	Falsifying the date of service to correspond with a member's coverage period.
X	Providing "free" services and then billing insurance.

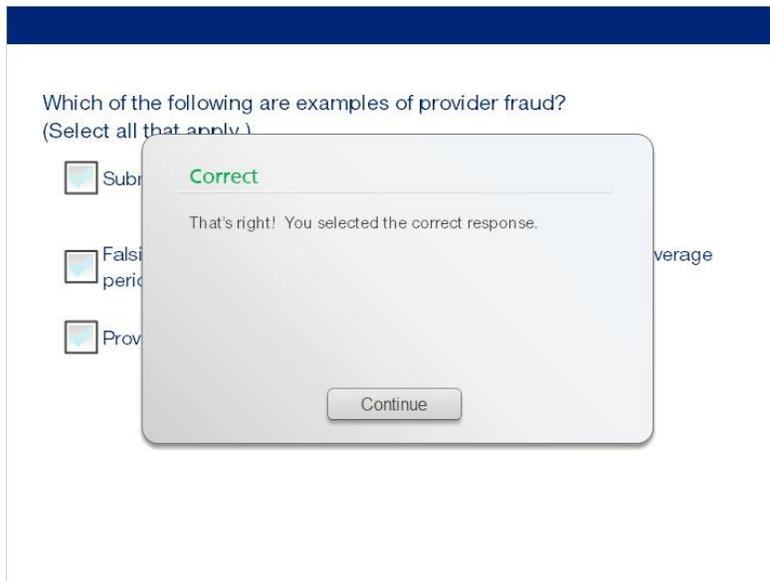
**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

All of these are examples of provider fraud: submitting claims for services not provided, falsifying the date of service to correspond with a member's coverage period, and providing "free" services and then billing insurance.

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

Which of the following are examples of provider fraud?  
(Select all that apply.)

- Submitting claims for services not provided
- Falsifying the date of service to correspond with a member's coverage period, and then billing insurance
- Providing "free" services and then billing insurance

**Incorrect**

All of these are examples of provider fraud: submitting claims for services not provided, falsifying the date of service to correspond with a member's coverage period, and providing "free" services and then billing insurance.

Continue

## 6.4 Q3

(Multiple Response, 10 points, 1 attempt permitted)

Which of the following are true about **waste** in health care?  
(Select all that apply.)

- Wasteful behaviors add unnecessary costs to the health care system.
- Wasteful practices are done intentionally and knowingly to take advantage of the health care system.
- Waste can often be deterred through education.

Correct	Choice
X	Wasteful behaviors add unnecessary costs to the health care system.

Wasteful practices are done intentionally and knowingly to take advantage of the health care system.

X Waste can often be deterred through education.

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

Waste is the overuse of resources that add unnecessary costs to the system. Often waste can be deterred through education.

**Correct (Slide Layer)**

Which of the following are true about **waste** in health care?  
(Select all that apply.)

- Waste is done intentionally and knowingly to take advantage of the health care system.
- Waste can often be deterred through education.
- Waste is the overuse of resources that add unnecessary costs to the system.

**Correct**

That's right! You selected the correct response.

Continue

## Incorrect (Slide Layer)

Which of the following are true about **waste** in health care?  
(Select all that apply.)

- Waste is the overuse of resources that add unnecessary costs to the system.
- Waste is the overuse of resources that add unnecessary costs to the system. Often waste can be deterred through education.
- Waste is the overuse of resources that add unnecessary costs to the system.

**Incorrect**

Waste is the overuse of resources that add unnecessary costs to the system. Often waste can be deterred through education.

Continue

## 6.5 Q4

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

You need to know if a particular situation is fraud, waste, or abuse in order to report it.

- True
- False

Correct	Choice
	True

X

False

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

The statement is false. You don't need to know if a particular situation is fraud, waste, or abuse to report it.

**Notes:**

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

You need to know if a particular situation is fraud, waste, or abuse in order to report it.

True

False

**Incorrect**

The statement is false. You don't need to know if a particular situation is fraud, waste, or abuse to report it.

Continue

## 6.6 Q5

(Multiple Choice, 10 points, 1 attempt permitted)

Which of these defines **abuse**?

A knowing and intentional deception, misrepresentation, or reckless disregard of facts with the intent to receive a benefit or something of value.

Practices that, either directly or indirectly, result in unnecessary costs to health care benefit programs but lack sufficient evidence to prove criminal intent.

Mistakes, inaccuracies, or misunderstandings that can usually be identified and fixed quickly.

Correct	Choice
	A knowing and intentional deception, misrepresentation, or reckless disregard of

	facts with the intent to receive a benefit or something of value.
X	Practices that, either directly or indirectly, result in unnecessary costs to health care benefit programs but lack sufficient evidence to prove criminal intent.
	Mistakes, inaccuracies, or misunderstandings that can usually be identified and fixed quickly.

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

Abuse includes practices that may be inconsistent with sound business, financial or medical practices but lack sufficient evidence to prove criminal intent.

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

Which of these defines **abuse**?

- A kn...
- disre...
- valu...
- Prac...
- heal...
- crim...
- Mist...
- iden...

Abuse includes practices that may be inconsistent with sound business, financial or medical practices but lack sufficient evidence to prove criminal intent.

Continue

## 6.7 Q6

(Multiple Response, 10 points, 1 attempt permitted)

Which of the following are true about **medical fraud and abuse**?  
(Select all that apply.)

- They come in all forms including billing, medically unnecessary services or prescriptions and duplicate claims, for example.
- They are perpetrated to take advantage of the complexity of the health care system for personal gain.
- They can be committed at many levels by many types of people like health care providers, medical facility owners or labs.
- They are rarely uncovered or prosecuted in a court of law.

Correct	Choice
X	They come in all forms including billing, medically unnecessary services or

	prescriptions and duplicate claims, for example.
X	They are perpetrated to take advantage of the complexity of the health care system for personal gain.
X	They can be committed at many levels by many types of people like health care providers, medical facility owners or labs.
	They are rarely uncovered or prosecuted in a court of law.

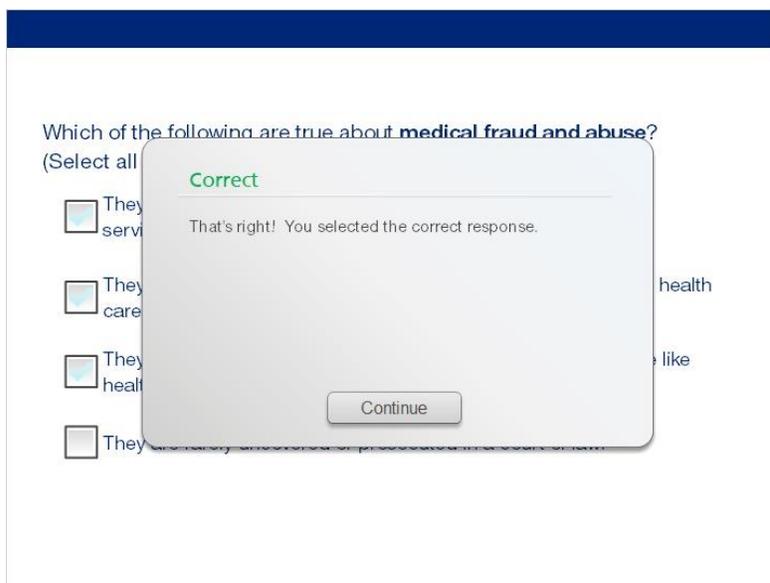
**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

Fraud and abuse come in all forms and can be seen at all levels of an organization. Large health care programs are often the target. When uncovered cases of fraud and abuse are prosecuted to the fullest extent under the law.

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

Which of the following are true about **medical fraud and abuse**?  
(Select all that apply)

- They are only seen at the highest levels of an organization.
- They are only seen in large health care programs.
- They are only seen in health care programs like Medicare and Medicaid.
- They are only seen in health care programs like Medicare and Medicaid.

**Incorrect**

Fraud and abuse come in all forms and can be seen at all levels of an organization. Large health care programs are often the target. When uncovered cases of fraud and abuse are prosecuted to the fullest extent under the law.

Continue

## 6.8 Q7

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

Falsification of patient records and medical identity theft are two examples of employee **fraud**.

True

False

Correct	Choice
X	True

False

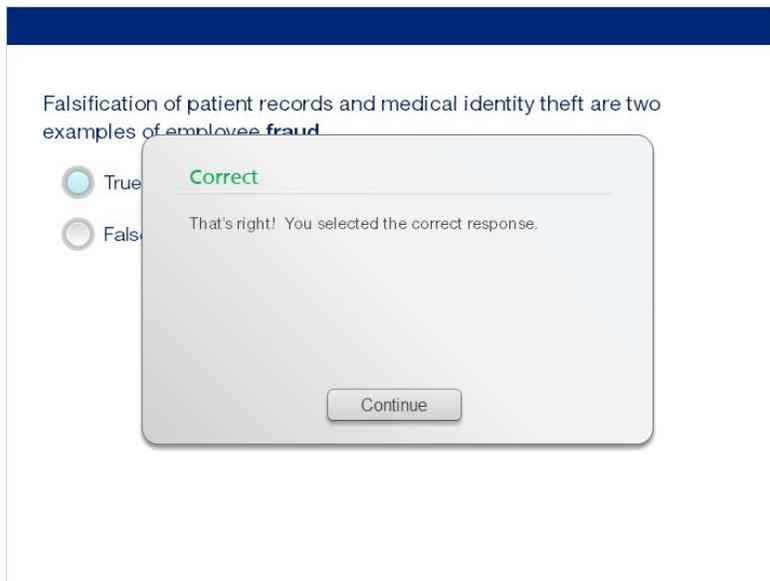
**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

The statement is true. Falsification of patient records and medical identity theft are examples of employee fraud.

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

Falsification of patient records and medical identity theft are two examples of employee fraud.

True

False

**Incorrect**

The statement is true. Falsification of patient records and medical identity theft are examples of employee fraud.

Continue

## 6.9 Q8

(Multiple Choice, 10 points, 1 attempt permitted)

When should you report suspicious activity?

Immediately

Within 24 hours

Once fraud, waste, or abuse is confirmed

Correct	Choice
X	Immediately

Within 24 hours
Once fraud, waste, or abuse is confirmed

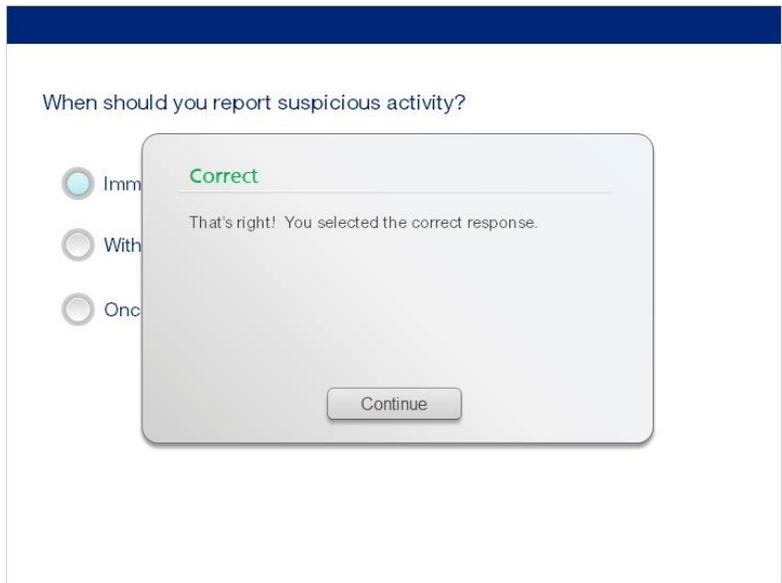
**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

That is incorrect. Suspicious activity should be reported immediately.

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

When should you report suspicious activity?

Immediate

Within 24 hours

Once a week

**Incorrect**

That is incorrect. Suspicious activity should be reported immediately.

Continue

## 6.10 Q9

*(Multiple Response, 10 points, 1 attempt permitted)*

Which of these does the Special Investigations Unit (SIU) engage in to combat fraud, waste and abuse? (Select all that apply.)

Use analytics to detect potential fraud, waste and abuse.

Investigate allegations of fraud, waste and abuse from tips or referrals provided through the hotline or website.

Submit compliance reports and potential cases of fraud and abuse to regulatory agencies.

Monitors incoming claims to ensure payments are made in a timely manner.

Correct	Choice
X	Use analytics to detect potential fraud, waste and abuse.

X	Investigate allegations of fraud, waste and abuse from tips or referrals provided through the hotline or website.
X	Submit compliance reports and potential cases of fraud and abuse to regulatory agencies.
	Monitors incoming claims to ensure payments are made in a timely manner.

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

The Special Investigations Unit (SIU) uses analytics to uncover fraud, waste, abuse and errors prior to payment, investigates suspected cases after payments have been made, investigates tips and referrals and submits reports to regulatory compliance agencies as required.

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

Which of these does the Special Investigations Unit (SIU) engage in to combat fraud, waste and abuse? (Select all that apply.)

- Use analytics
- Investigate suspected cases after payments have been made
- Submit reports to regulatory compliance agencies as required
- Monitor referrals

**Incorrect**

The Special Investigations Unit (SIU) uses analytics to uncover fraud, waste, abuse and errors prior to payment, investigates suspected cases after payments have been made, investigates tips and referrals and submits reports to regulatory compliance agencies as required.

Continue

## 6.11 Q10

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

All employees and contractors require annual training in fraud, waste and abuse and are responsible for reporting any suspicious activity or misconduct in keeping with the UnitedHealth Group Code of Conduct.

True

False

Correct	Choice
X	True

False

**Feedback when correct:**

That's right! You selected the correct response.

**Feedback when incorrect:**

The statement is true. All employees and contractors require annual training in fraud, waste and abuse and are responsible for reporting any suspicious activity or misconduct seen.

**Notes:**

**Correct (Slide Layer)**



## Incorrect (Slide Layer)

All employees and contractors require annual training in fraud, waste and abuse and are responsible for reporting any suspicious activity or misconduct seen.

True

False

**Incorrect**

The statement is true. All employees and contractors require annual training in fraud, waste and abuse and are responsible for reporting any suspicious activity or misconduct seen.

Continue

## 6.12 Results Slide

*(Results Slide, 0 points, 1 attempt permitted)*

### Results

**Your Score:** %Results.ScorePercent%% (%Results.ScorePoints% points)

**Passing Score:** %Results.PassPercent%% (%Results.PassPoints% points)

---

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

Results for
6.2 Q1
6.3 Q2
6.4 Q3
6.5 Q4
6.6 Q5
6.7 Q6
6.8 Q7
6.9 Q8
6.10 Q9
6.11 Q10

Result slide properties

Passing 80%

Score

**Notes:**

## Success (Slide Layer)

### Results

**Your Score:** %Results.ScorePercent%% (%Results.ScorePoints% points)

**Passing Score:** %Results.PassPercent%% (%Results.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:** %Results.ScorePercent%% (%Results.ScorePoints% points)

**Passing Score:** %Results.PassPercent%% (%Results.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](#)

## 7. Untitled Scene

### 7.1 Untitled Slide



The slide features a dark blue header with the text "Navigation Help" in white. Below the header, on the left side, there is a vertical stack of five dark blue buttons with white text: "Navigation", "Menu Tab", "Glossary & Resource Tabs", "Hover Instructions", and "Hyperlinks". To the right of these buttons is a large light gray rectangular area containing the text: "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 label to view additional information.

PRIVATE PLANS	MEDICARE PLANS	MEDICAID PLANS
Health Maintenance Organization (HMO)	Medicare Part A	Domestic
Preferred Provider Organization (PPO)	<b>Medicare Part B</b>	Eligibility
Consumer Directed Health Plans	Medicare Advantage Plans	Insurance Exchanges
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**

## 8.2 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:

## 9. 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.