Mitchell MCN

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Seattle, WA 98101
mcn.com | recruiting@mcn.com

t: 206.219.4941
t: 800.636.3926
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PROVIDER HANDBOOK

Dear Provider:

On behalf of Mitchell MCN, I welcome you into our national network of Providers. We select only the finest practitioners to provide medical assessments for our clients. Congratulations on joining our network.

Mitchell MCN provides value to our clients by assuring quality throughout the process of recruiting and credentialing providers, scheduling assessments, procuring records, and providing reports to clients that are timely, responsive, and actionable. We do not delegate or subcontract with other entities for medical assessment functions or activities within Mitchell MCN's current scope of business.

Likewise, we expect you to complete all functions of an assessment yourself, without utilizing assistants or boilerplate templates. We are proud to provide timely, high quality examinations and reviews that meet if not exceed regulatory requirements, accreditation standards, and client expectations. Independent medical examinations and peer reviews comprise the bulk of our business, and the content of this handbook reflects requirements for all products.

Requirements for practitioners providing medical assessments are very stringent and demand demonstrated expertise in traditional and alternative therapies. Mitchell MCN may assign cases involving highly specialized services to determine whether they are investigational or experimental, or to determine medical necessity and appropriateness of continued care, length of stay, continued disability, causality, etc. Once you gain access to mcn.com, you will gain access to lists of Guidelines references, government websites for general medical information, online links to medical information resources and coverage policies, and websites of specialty societies and journals.

It is imperative that you review the instructions and standards for medical assessments included within this manual. They highlight critical elements of our credentialing and medical assessment requirements. You will find our Fraud, Waste and Abuse Policy included as Attachment A.

If you have any questions or need additional information please do not hesitate to contact our Physician Recruiting Department for assistance.

Again, welcome and congratulations! We look forward to a rewarding relationship with you!

Sincerely,

Dwayne LaForce

Physician Recruiting Manager, Mitchell MCN

dlaforce@mcn.com | 206.508.4611

HOURS OF OPERATION

Monday - Friday, 7:00am to 5:00pm Pacific Time

TELEPHONE NUMBERS

Corporate Office	800.636.3926
Corporate Fax	206.623.4956

After hours and weekend telephone inquiries are answered by an automated attendant. Per recorded instructions, on-call personnel may be reached to respond to urgent after-hours inquiries.

MITCHELL MCN COMPANY CONTACTS

Dwayne LaForce, Physician Recruiting Manager	206.508.4611 | dlaforce@mcn.com
Brianna Bean, Director of Operations	206.456.6939 | bjbean@mcn.com
Kendra Shine, QA Operations Manager	206.508.4625 | kshine@mcn.com
Brian Grant, Medical Director	206.508.4596 | bgrant@mcn.com
Andrew Turner, Director of Information Technology	206.219.4980 | aturner@mcn.com

GENERAL PROVIDER POLICIES

NATIONAL MEDICAL ASSESSMENT STANDARDS

The American Medical Association supports the concept of a national standard and has endorsed impartial assessment. Publications such as the Journal of the American Medical Association and the New England Journal of Medicine have been instrumental in the development of national standards.

The American Accreditation HealthCare Commission/URAC was founded in 1990 to establish standards for the managed care industry. URAC establishes broad based standards and accreditation requirements through consensus driven committees. Regulators in numerous states recognize URAC's accreditation standards in the regulatory process. Meeting URAC standards assures a high level of quality.

To comply with URAC standards, Mitchell MCN must do the following:

1. Specify those responsibilities delegated to the Provider and those retained by Mitchell MCN.
2. Require services be performed in accordance with Mitchell MCN's requirements and URAC standards.
3. Require notification to Mitchell MCN of any material change in the Provider's ability to perform delegated functions.
4. Conduct surveys of the Provider as needed.
5. Require that the Provider submit periodic reports to Mitchell MCN regarding the performance of his/her delegated responsibilities.
6. Specify recourse and/or sanctions if the Provider does not make corrections to identified problems within a specified period.
7. Specify the circumstances under which activities may be further delegated by the Provider, including any requirements for obtaining permission from Mitchell MCN before any further delegation.
8. Specify that, if the Provider further delegates organizational functions, those functions shall be subject to the terms of the written agreement between the Provider and Mitchell MCN and in accordance with URAC standards.

Additionally, to sustain a preeminent network, Mitchell MCN will complete the following:

9. Conduct periodic review of Provider and product quality.
10. Ensure Providers hold a current, unrestricted license to practice medicine or relevant health profession; have post-graduate experience and maintain a minimum of 8 hours per week of patient care; and be board certified unless otherwise specified by client agreement.
11. Ensure assessments are conducted by a Provider qualified to typically manage the medical condition being assessed and qualified to render a relevant clinical opinion.
12. Keep records confidential in accordance with applicable federal and state laws.
13. Require Providers identify any conflicts of interest and refuse to conduct assessments for cases where a conflict of interest exists.

14. Require all assessments to be:
    i. Objective.
    ii. Clinically valid, stating specific reasons for the determination and a description of the source of the screening criteria that were utilized.
    iii. Compatible with established principles of healthcare.
    iv. Flexible enough to allow deviations from the norm when justified on a case-by-case basis.
15. Set assessment timeframes in accordance with regulatory and client requirements.
16. Allow certain determinations to be appealed in standard or expedited time frames.
17. Require Providers to participate in ongoing training to maintain professional competency, and knowledge of URAC, federal, and state regulations.

PROVIDER CREDENTIALING AND RE-CREDENTIALING

Your application information will be subjected to a thorough primary source verification process, NPDB, and OIG screening and evaluation by our Credentialing and Privileging Committee. Upon completion and acceptance by the Credentialing and Privileging Committee our Network Development Department will contact you to review the policies and procedures required with each assessment and arrange for you to begin performing assessments on behalf of Mitchell MCN clients.

All providers must be re-credentialed every three years. This should only involve updating any changes that have occurred since being credentialed. For instance, any changes in areas of specialty, license renewals, hospital privileges, education and training, etc. The Mitchell MCN-Provider relationship may be terminated by either party at any time.

HIPAA/PHI CONFIDENTIALITY

All providers must agree to keep patient confidentiality in accordance with applicable federal and state laws. Protected Health Information (PHI) is to be shared only with those entities that have authority to review such information and shared only with individuals who need access to implement such services. All providers must acknowledge in writing that medical records provided by Mitchell MCN are confidential and shall not be disclosed to anyone without lawful court order or applicable and appropriate written consent.

OPTIONS FOR COMPLETING REVIEWS

There are three options available to complete your assessments:

1. Secure website.
2. Encrypted e-mail.
3. Dial-in transcription service.

Our IT department can provide you with the necessary instructions and support. Please contact HELP DESK at 206.219.4895.

ONGOING TREATMENT

After an IME has taken place, you cannot provide ongoing treatment to the claimant and you cannot become the claimant's treating provider.

PAYMENT POLICY

All payments are made on the 15th of each month for any finalized reports received, or no shows & late cancels that took place during the previous month. For example, a report finalized anytime between April 1st and April 30th would be paid on May 15th. Please note that the payment date is based on when a report is finalized and not the exam date.

LEGAL SERVICES

Given reasonable advanced notice, Mitchell MCN clients may request that providers make themselves available for deposition or testimony. Typically, scheduling and payment for deposition and testimony are arranged directly with the client. It is understood that you will make reasonable accommodations for deposition or testimony time, and that your fees will be reasonable and customary.

NONDISRINIMATION AGAINST CLAIMANTS

Mitchell MCN prohibits consultant discrimination against claimants (aka injured worker, insured, beneficiary, eligible individual or employee, applicant, plaintiff) on the basis of age, race, religion, color, physical or mental disability, sex, gender, gender expression, gender identity, sexual orientation, medical condition, pregnancy, national origin, military or veteran status, genetic information, or any other status protected by applicable federal, state or local law.

When rendering binding or nonbinding opinions or decisions on claims or cases assigned by Mitchell MCN, contracted healthcare consultants may utilize claimant information pertaining to any of the above protected classes only in accordance with medical ethics standards and applicable federal, state, and local laws.

CONSULTANT AGREEMENT TO POLICIES

As a condition of accepting work assignments from Mitchell MCN, consultants shall abide by all policies and statements outlined in this Provider Handbook. Completion of any assignments from Mitchell MCN shall constitute provider agreement to these policies. Consultants with concerns regarding policy compliance are invited to contact Mitchell MCN at 206.219.4941 or recruiting@mcn.com.

EXAMINATION INSTRUCTIONS

As a Mitchell MCN examiner, you must adhere to the following protocols.

Ahead of the exam:

- Provide a professional setting for the evaluation in an office or clinic suitable for medical, podiatric, chiropractic, or psychiatric exams.
- Familiarize yourself with the case by reading the referral cover letter and medical records provided.

Meeting the examinee:

- Introduce yourself. A nametag may be helpful, especially if there is a language barrier. The examinee has a right to know your name and specialty.
- Ask the examinee to provide photo identification and make a photocopy. If they have no identification, note it in your report.
- Go over the examination process with the examinee:
    - Explain the purpose of the exam.
    - Describe how an independent assessment and a personal doctor's visit are different, specifically how you are not bound by doctor-patient confidentiality.
    - Inform the examinee that your report will be provided to their claims manager.
- Answer any related questions the claimant has without rendering any advice or opinions.
- Inform the examinee that you have received and reviewed the associated claim and medical records.

During the exam:

- Conduct the exam with dignity and respect for the examinee.
- Allow an adult friend or adult family member to attend non-psychiatric portions of the examination, unless otherwise instructed or legally stipulated.
- The examinee must be fully dressed while you take the history.
- Provide adequate draping, privacy, and a medical gown if the examinee needs to remove clothing for the physical exam.
- Advise the examinee that they should not perform any activities beyond their physical capabilities. Ask them to inform you should pain occur.
- Conduct your exam in an unbiased fashion, appropriate to the condition being evaluated, and sufficient to answer the referral questions.
- In general* it is inappropriate to express any opinions or make any comments to the examinee so please refrain from doing so. Specifically do not comment on:
    - The care the examinee has received. If you feel the claimant has inadequate care, make appropriate written comments in your report.
    - Personal opinions about the examinee, their employer, their insurance company, or their attending provider(s).

- Close the exam by telling the examinee that the exam is over and ask if they would like to know more information or ask further questions. Remember not to offer any opinions, and refer the examinee to their claim manager regarding their case.

  **In the extremely rare event of an identified urgent medical condition that poses significant risk to life or limb you may advise the claimant to go the nearest hospital or you may render emergency medical care yourself if necessary and appropriate. If this happens you must notify Mitchell MCN as soon as possible.*

Generating your report:

- Provide a narrative history of the claim and treatment from your record review, along with an itemization of the records that were provided to you.
- If the examinee has brought diagnostics to the exam, acknowledge receipt of them in your report.
- If needed, explain that you feel the necessity of ordering further diagnostic tests on the examinee. No diagnostic test may be conducted without prior consent of MCN and our mutual client. Diagnostics that do not receive prior consent will not be reimbursed.
- Upon close of the examination, complete your report by answering each question individually in question and answer format. Provide applicable clinical rationale. Cite the study, article, or other evidence-based-medicine reference utilized and include the relevant text. Should definitive answer not apply, answer questions on a more probable than not basis and note so in your answer.
- Provide a completed report to Mitchell MCN within the agreed upon timeframe.

REVIEW INSTRUCTIONS

As a Mitchell MCN reviewer, you must adhere to the following protocols:

General Review Guidelines

- Summarize the records provided, treatment, and history of the patient.
- Answer questions individually utilizing a question and answer format.
- Provide applicable clinical rationale for determinations. Cite the study, article, or other evidence-based-medicine reference utilized, and include the relevant text. A reference or citation shall be easily accessible through a library or internet search.
- If you feel there is not enough information provided to answer the client's questions, answer as many as possible and list the documentation that would be beneficial to the review.
- Give a decision to certify or not certify services as medically necessary, appropriate utilization.
- When reviewing cases for utilization of services, explain why the services rendered do or do not represent appropriate utilization.

Calling the Attending Provider

For some reviews, you will be asked to attempt to discuss the case with one or more of the claimant's Attending Providers (AP).

- For these, you must make three reasonable attempts during two consecutive days to reach the AP.
- Reasonable attempts occur during regular business hours spaced at least an hour apart.
- Indicate in your report any additional information provided by the AP.
- If you are unable to reach the AP, make at least one attempt the next day. The AP is granted a two-day window for phone contact. Ultimately, if you are unable to reach them please document it in your report. Please indicate the specific dates and times of your calls, the name of office staff who spoke with you, or if a message was left on voicemail.
- If you receive a return call from the AP after you have completed the review, please summarize the conversation and submit it to Mitchell MCN with any additional comments you wish to add to your original review.

Medical Necessity, Pre-Existing Conditions, and Disability

- When reviewing cases for ***medical necessity***, explain why services rendered are or are not medically indicated. If services rendered do not fall within indicated policy language, but in your opinion were medically necessary, please state such in your review. The same holds for policy definitions of experimental or investigational, general acceptance of treatments.
- When reviewing cases for a ***pre-existing condition or disability***, note the specific policy language definitions submitted by the client. Comment based on the policy language and records whether the documentation supports that the patient was or was not disabled, or that the condition was pre-existing. Provide rationale, support, and examples from the submitted records. For some disability cases, clients seek only

determination of the disability status of the patient and the patient's ability to return to work regardless of treatment.

Workers' Compensation Reviews

When reviewing cases for workers' compensation services, utilize a specific database such as ACOEM to support your opinion. In certain states, e.g. Texas, you will need to utilize Official Disability Guidelines (ODG). When utilizing ACOEM guidelines keep in mind that they consist of 16 chapters and over 500 pages of information. The first seven chapters focus on prevention, initial assessments, work relatedness, disability prevention, pain & suffering & restoration of function and IMEs. The subsequent chapters relate to specific complaints such as the neck, elbow, knee, etc. It is from these subsequent chapters that reference sources are needed. Chapters are outlined in areas to include initial assessment, medical history, physical examination, diagnostic criteria, work relatedness, initial care, physical methods, special studies and diagnostic and treatment considerations as well as surgical considerations.

Standards for Evidence-Based Reviews

Cases may involve questions regarding medical necessity or whether a therapy is experimental or investigational. A determination must be founded on sound judgment and scientific evidence. Scientific evidence is based on:

1. Reputable research, ideally from randomized, controlled clinical trials.
2. Evidence published in peer-reviewed medical journals.
3. Standards set by appropriate governing bodies.

Medical and Scientific Evidence

1. Peer-reviewed scientific studies published in, or accepted for, publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, or MEDLARS database Health Services Technology Assessment Research (STAR).
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act (42 U.S.C. 1395x).
4. The following standard reference compendia:
    i. The American Hospital Formulary Service-Drug Information
    ii. The American Medical Association Drug Evaluations
    iii. The American Dental Association Accepted Dental Therapeutics
    iv. The United States Pharmacopoeia Drug Information.
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

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ATTACHMENT A

FRAUD, WASTE & ABUSE POLICY

PURPOSE

To prevent, detect, and report fraud, waste, and abuse (FWA). Mitchell MCN is committed to comply with federal and state requirements for a FWA program. This commitment transcends all stakeholder relationships and entities including contractors. Mitchell MCN therefore requires employees, directors, contracted reviewers, and business associates to adhere to the guidelines set forth concerning this Fraud, Waste, and Abuse policy.

PRINCIPLES

- The key components of a comprehensive plan to detect, correct, and prevent FWA include: documented policies and procedures for fraud, waste, and abuse and a code of conduct; a regulatory compliance manager; training and education; effective lines of communication; enforcement of standards through well publicized disciplinary guidelines; monitoring and auditing; corrective action procedures; and, procedures to voluntarily self-report potential fraud or misconduct.
- **Fraud and Abuse** is an umbrella term that applies to a series of federal and state laws and regulations designed to prevent excessive and inappropriate claims reimbursement by a government entity or third party payor.
- **Fraud** is defined as: the intentional act of deceiving, concealing, or misrepresenting information that results in unauthorized health care benefits being paid to an individual or a group.
- **Waste** is defined as: the unnecessary incurring of costs as a result of over-utilization of services or inefficient practices, systems, or controls.
- **Abuse** is defined as: misuse without the intent to commit fraud and includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and directly or indirectly result in unnecessary costs or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.
- The real difference between fraud and abuse is the person's intent. Both activities have the same impact: they detract valuable resources from the benefit plan that would otherwise be used to provide care to beneficiaries.

PROCEDURES

I. Responsibility
   A. Mitchell MCN's Regulatory Compliance Manager is the Manager of Regulatory Compliance and Accreditations who has primary responsibility for oversight of the FWA Prevention Plan.
   B. The Compliance Committee is a sub-committee of the Executive Management Committee. Compliance topics including but not limited to FWA are standing agenda items at the monthly Executive Management Committee meetings.

C. Compliance activities are also a standing agenda item for discussion at the quarterly Quality Management Committee meetings.
D. This oversight includes but is not limited to the plan development and implementation, training, ongoing monitoring or auditing, investigating, reporting, accurate record documentation and evaluation for revisions as required.
E. All Mitchell MCN employees, directors, and contracted reviewers share the responsibility to identify irregularities in business and utilization practices of providers, enrollees, business associates, and employees.
F. All Mitchell MCN employees, directors, and contracted reviewers are responsible to maintain effective lines of communication with the Regulatory Compliance Manager throughout the process and to report suspected activities of FWA.

II. Prevention
A. Mitchell MCN's Compliance Program requires all company business to be conducted in an ethical manner and ensures adherence to all federal and state laws involving FWA.
B. To ensure ethical behavior all employees must adhere to Mitchell MCN's code of conduct which is detailed in the Mitchell MCN Employee Handbook.
C. Additional activities targeted at prevention include:
    i. Mandatory training
    ii. Screening processes for potential new hires
    iii. Credentialing and re-credentialing procedures for contracted reviewers
    iv. Conflict of Interest and Confidentiality policies and procedures
    v. Limited access to records, information, and data that could be used to facilitate FWA
    vi. Procedures to promptly correct unintentional errors in payment and/or data
    vii. Disciplinary guidelines for employees and contracted reviewers whose actions constitute FWA
    viii. Formal complaint process
    ix. Employee performance appraisals that evaluate adherence to the compliance program and code of conduct
D. As required by 41 USC 4172, Mitchell MCN prohibits discharge, demotion, or discrimination against a person or body who discloses information that an a person or body reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, abuse of authority or a violation of law, rule or regulation related to a Federal contract or grant. In addition, Mitchell MCN prohibits any type of retaliation against those who, in good faith, report any inappropriate activities, perceived problem, concern or FWA issue described in this policy.
    i. The False Claims Act protects qui tam relators.
    ii. Federal and State laws protect whistleblowers.

III. Identification or Detection
A. Detection activities include:

i. Availability of reporting resources
ii. Periodic random sample auditing; trends representing 20% of the randomized sample will constitute the benchmark for follow-up
iii. Prompt investigation and corrective action for all instances of suspected non-compliance

B. Examples of potential FWA done intentionally by providers may include the following:
    i. Billing or claiming reimbursement for services/items:
        a. that are not medically necessary
        b. that have not been provided (up-coding, false encounter or utilization data)
        c. provided by an unlicensed individual
        d. for compensable, covered health services under a primary payment source
    ii. Misrepresenting the diagnosis to justify payment
    iii. Misrepresenting dates or identities of members
    iv. Bundling/unbundling
    v. Characterizing the service differently than the service actually rendered
    vi. Falsely indicating that a particular health care professional attended a procedure
    vii. Quality concern of six months or more in duration of failing to provide medically necessary services/items or providing inappropriate treatment
    viii. Routine waiver of co-payments
    ix. Balance billing members for services
    x. Soliciting, offering, or receiving a kickback
    xi. Making reckless false statements about the credentials of another provider
    xii. Marketing violations
    xiii. Health care research grant fraud
    xiv. Improper financial interest
    xv. "Redlining" (a discriminatory practice by hospitals or payors of discouraging enrollment by higher risk patients)
C. Examples of potential fraud specific to pharmaceuticals may include the following:
    i. Medicare Part D Fraud:
        a. Duplicate billing
        b. Overcharging
        c. Enrollment fraud
        d. Red-lining
        e. Improper rebates from pharmaceutical manufacturers and wholesalers
    ii. Pharmaceutical companies:
        a. Off label marketing of drugs
        b. Illegal kickbacks to hospitals and/or physicians

c. Financial inducements to insurance companies to list a drug on the preferred formulary
d. Inflating the price
e. Best price fraud

iii. Pharmaceutical Benefits Manager (PBM) firms:
a. Illegal rebate and discount agreements with pharmaceutical companies
b. Offering kickbacks to insurance companies
c. Violating contractual responsibilities by shorting prescriptions, switching medications and canceling prescriptions to conceal failures to meet contractually mandated deadlines for filling prescriptions

D. Examples of potential FWA done intentionally by enrollees are called "soft fraud", are harder to detect and may include the following:
i. Forging, altering or selling a prescription
ii. Improperly obtaining prescriptions for controlled substances
iii. Emergency room abuse or overuse (at least 3 visits within 6 months) without an emergent diagnosis
iv. Sharing a benefit identification card
v. Falsifying benefit applications
vi. Using transportation benefit for non-medical related business

E. Identification and detection behaviors to consider:
i. The intentional attempt itself at any of the above actions is fraud, regardless of whether it is successful.
ii. Perpetrators seldom target only one entity exclusively; most are found to be defrauding several sectors simultaneously

IV. Investigation and Reporting

A. Individuals should report suspected or confirmed cases of FWA to the Regulatory Compliance Manager within 48 hours of detection.
B. Individuals may report the suspected case of FWA verbally or in writing.
C. The Regulatory Compliance Manager will conduct an investigation in a reasonable and timely manner from the notification of a suspected FWA case. A reasonable inquiry should be initiated immediately, but no later than two weeks from the date the potential misconduct is identified.
D. The Regulatory Compliance Manager will confer with the Chief Medical Director, Executive Vice President and the Chief Operations Officer and if indicated, legal counsel
E. During the investigation process, the confidentiality of the patient and or people referring the potential FWA case is maintained.
F. Other employees (i.e., Director of IT, Director of Report Review/QM) will be consulted as required for specific cases
G. The Regulatory Compliance Manager will facilitate any external audits and provide the requested information.

H. The Regulatory Compliance Manager in conjunction with the Chief Medical Director, Executive Vice President and/or the Chief Operations Officer will implement any corrective action plan required.
I. The Regulatory Compliance Manager will report all suspected or confirmed cases to the appropriate body:
    i. Executive Management Committee
    ii. Client (as indicated)
    iii. State's Special Investigative Unit
    iv. Office of Inspector General (OIG)
    v. Centers for Medicare & Medical Services
    vi. Law enforcement
    vii. Additional reporting options include:
        a. The Health Care Fraud Hotline (202-418-3300)
        b. The United States Office of Personnel Management
        c. Office of the Inspector General Fraud Hotline
        1900 E Street, NW, Room 6400
        Washington, DC 20415
J. Self-reporting of FWA is a critical element to an effective program to control FWA.

V. Documentation and Record Retention
A. The Regulatory Compliance Manager will maintain accurate documentation to include individual reports and a log of all incidences of suspected FWA
B. Documentation will include the following with corresponding dates:
    i. Subject of the alleged violation
    ii. Source of the information
    iii. Date the allegation was received
    iv. Time period involved
    v. Identification number
    vi. Issue of non-compliance
    vii. Details of the investigation
    viii. The investigation results
    ix. Any corrective actions taken
    x. Communication or reporting history
C. All records relating to a FWA case will be retained for a minimum of ten years or longer until all audit questions, appeal hearings, investigations and court cases are resolved.
D. All training must be documented and kept on record for ten years
E. Upon receipt of a request from a state or federal agency, all records involved with FWA investigations will be provided within the requested timeframe or as soon as possible.

VI. Training
A. The Regulatory Compliance Manager, or designee will conduct all training
B. Employee training will occur during the initial 120 day orientation period for new hires, within 30 days of any updates and annually thereafter.

C. Contracted reviewer training will occur during the initial orientation, within 30 days of any updates and annually thereafter.
D. Education will include:
    i. The FWA plan
    ii. Details about prevention, detection, investigation and reporting
    iii. Specific examples
    iv. Consequences for violating the associated laws
    v. State and federal laws
    vi. Federal False Claims Act
    vii. Employees rights and whistleblower protections
    viii. Code of Conduct
    ix. Review of Marketing materials approval process

VII. Disciplinary actions may include:
A. Imprisonment and fines
B. Civil monetary penalties
C. Loss of licensure
D. Loss of privileges / termination (employment or contractual)
E. Exclusion from participation in federal health programs
F. Reputational damage

VIII. Contact the Regulatory Compliance Manager to:
A. Obtain additional information or to ask questions in confidence
B. Obtain information about related references:
    i. Centers for Medicare & Medicaid Services: www.cms.hhs.gov
    ii. U.S. Department of Health & Human Services Office of Inspector General (OIG): oig.hhs.gov
    iii. Coalition Against Insurance Fraud
    iv. The National Health Care Anti-Fraud Assoc. (NHCAA)
C. Review the related laws:
    i. Department of Justice, False Claims Act (FCA)
    ii. Federal Whistleblower Protections
    iii. Private or Qui Tam Actions
    iv. Program Fraud Civil Remedies Act (PFCRA)
    v. Federal Anti-Kickback Statute
    vi. Federal Stark Law or Anti Self-Referral Law
    vii. Deficit Reduction Act (DRA of 2005)