
Overview This section of the Provider Handbook addresses the respective responsibilities of participating providers.

Primary Care Offices Primary Care Physicians (PCPs) provide comprehensive primary care services to Plan members. Primary care offices participating in the Plan provider network have access to the following Plan services:

- Support of the Provider Relations, Customer Service, Health Services, Community and Member Outreach teams;
- Information on Plan network providers for the purposes of referral management and discharge planning.

Primary Care Physician Responsibilities Following is a summary of responsibilities specific to PCPs who render services to Plan members. Please also refer to the listing of responsibilities for all physicians. These are intended to supplement the terms of the Provider Agreement.

- Coordinate, monitor and supervise the delivery of primary care services to each member.
- Maintain continuity of each member's health care and medical records to include documentation of all services provided by the PCP as well as any specialty service.
- Assure the availability of physician services to members in accordance with appointment scheduling as outlined in this section.
- Arrange for on-call and after-hours coverage in accordance with the after-hours service as outlined in this section.
- Assure members are aware of the availability of public transportation, where available, and non-emergency transportation (NET) available by calling WellCare customer service.

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- Provide access to the plan or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as: having influence, ownership, or control and either a financial relationship or a relationship for rendering services to the primary care office.
- Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS[®] (Health Plan Employer Data and Information Set) service.
- Follow the guidelines as outlined in the **Claims Submission** section.
- Ensure members utilize network providers. If unable to locate a participating provider for services required, contact the Plan's utilization management for assistance.
- See members for an initial office visit and assessment within the first 90 days of enrollment with the plan, for pregnant women, the first 14 days of enrollment.
- Ensure sufficient supply and provide immunizations in accordance with the childhood immunization schedule as approved by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service and the American Academy of Pediatrics, or when it is shown to be medically necessary for the child's health. For a copy of the immunization schedule by the Advisory Committee on Immunization Practice (ACIP), refer to the **Provider Education Materials** section of this handbook.
- Have the following equipment available to adequately perform EPSDT screening exams:
 - i. Weight scale for infants;
 - ii. Weight scale for children and adolescents;
 - iii. Measuring board or device for measuring

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- length or height in the recumbent position for infants and children up to age 2;
 - iv. Measuring board or device for measuring height in the vertical position for children 2 years old or older;
 - v. Blood pressure apparatus with infant, child and adult cuffs;
 - vi. Screening audiometer;
 - vii. Centrifuge or other device for measuring hematocrit or hemoglobin;
 - viii. Eye charts appropriate to children by age;
 - ix. Developmental and behavioral screening tools; and
 - x. Ophthalmoscope and otoscope.
- Report all immunizations to the Georgia Registry of Immunization Transactions and services (GRITS) in a format to be determined by DCH.
 - Participate in the Vaccine for Children (VFC) program for Georgia Families children 18 years old and younger to help raise childhood immunization rates. Immunizations should be given in conjunction with well-child/health check care. WellCare will reimburse providers for the administration of the vaccine but not the vaccine itself since vaccines are supplied to the provider at no charge through the VFC program. Providers must administer only VFC-supplied vaccinations for Medicaid and PeachCare for Kids members for all immunizations supplied through the VFC program. For additional information, refer to the VFC Program Overview found in the **EPSDT Guidelines** section of this handbook.

Second Medical Opinion

A second medical opinion may be requested at no cost to the member in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. A second opinion may be requested by any member of the health care team, a member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

The second opinion must be provided by a qualified health care professional within network, or a non-participating provider, if there is not a participating provider with the expertise required for the condition.

Members With Chronic or Life Threatening Conditions

Members with chronic conditions are defined as adults and children who have:

- Any ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities;
- An expected duration of at least 12 months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is normally considered routine.

Physicians who render services to members who have been identified with chronic or life threatening conditions should:

- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the member's condition or needs;
 - To obtain a standing authorization request the provider should complete the Outpatient Authorization Request form and document the need for a standing authorization request under the pertinent clinical summary area of the form.
- Coordinate with the Plan to ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated

as primarily responsible for coordinating the health care services furnished to the member; and

- Members may request a specialist as PCP through Customer Service or their case manager. If the medical director agrees the specialist is appropriate as a PCP and the specialist agrees to act as the PCP, the member will be assigned to that specialist by the Customer Service department.
- Ensure members requiring specialized medical care over a prolonged period of time have access to a specialty care center.
 - Members will have access to a specialty care center through standing authorization requests, if appropriate.

Domestic Violence and Substance Abuse Screening

Physicians should identify indicators of substance abuse or domestic violence. The screening tools for domestic violence and substance abuse are located in the **Provider Education Materials** section of this handbook. Should a member need assistance regarding domestic violence, the PCP should direct the member to contact Customer Service and ask to speak with the Case Management department. If a member needs assistance regarding substance abuse, the PCP should direct the member to call the toll free Behavioral Health line for the Plan. Refer to the **Quick Reference Guide** for telephone numbers.

Adult Health Screening

An adult health screening should be performed by a physician to assess the health status of a member age 21 or older. The adult member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines and also the member physical screening tool in the **Provider Education Materials** section of this handbook.

HealthCheck

HealthCheck, Georgia's Early and Periodic Screening, Diagnostic and Treatment program, (EPSDT) services shall be

provided to Medicaid eligible children less than 21 years of age, as well as PeachCare for Kids eligible members from birth up to 19th birthday. All newly enrolled children must receive an initial health and screening visit within 90 calendar days of enrollment and within 24 hours of birth for all newborns.

EPSDT services include outreach and informing, screening, tracking and diagnostic and treatment services.

Outreach and Education

EPSDT services include:

- Importance of preventive care;
- Periodicity schedule and the depth and breadth of services;
- How and where to access services, including necessary transportation and scheduling services; and
- Services provided without cost.

Newly enrolled families with HealthCheck eligible children will be informed about the program within 60 calendar days of enrollment. This includes informing pregnant women and new mothers, either before or within seven days of the birth of their children, of the HealthCheck services available.

The Plan will send all PCPs a monthly listing of their HealthCheck eligible children who have not had an encounter during the initial 120 calendar days of enrollment, and/or are not in compliance with the HealthCheck periodicity schedule. PCPs are required to contact the members' parents or guardian by telephone or mail to schedule an appointment.

Screening

Such screens must include all of the following:

- Documentation of Vital Signs

- A comprehensive health, psycho-social and developmental history;
- Developmental assessment, including mental, emotional and behavioral health department;
- Measurements (including head circumference for infants);
- An assessment of growth nutritional status;
- A comprehensive unclothed physical exam;
- Assessment of Immunizations status and provision of appropriate immunizations according to the Advisory Committee of Immunization Practices (ACIP) schedule
- Certain laboratory tests (including the federally-required blood lead screening);
- Anticipatory guidance and health education;
- Vision screening;
- Tuberculosis and lead risk screening;
- Hearing screening;
- Oral health screening, preventive counseling, and referral to a dentist for ongoing dental care
- Identify children with elevated blood lead levels and recommend follow-up treatment and education.
- Screening for and if suspected, reporting of child abuse and neglect
- Referrals/follow-ups where appropriate based on history and exam

Tracking

The Plan will utilize provider encounter data to track information

on compliance with HealthCheck requirements. The Plan will track at minimum:

- Initial newborn HealthCheck visit occurring in the hospital;
- Periodic and preventive/well-child screens and visits as prescribed by the periodicity schedule;
- Diagnostic and treatment services, including referrals;
- Immunizations, lead, tuberculosis and dental services; and
- A reminder/notification system.

Diagnostic and Treatment Services

If through the screening examination a problem is suspected, the child shall be evaluated as necessary for further diagnosis as deemed medically necessary. Such medically necessary diagnostic and treatment services must be provided regardless of whether such services are covered by the state Medicaid plan, as long as they are Medicaid-Covered Services as defined in Title XIX of the Social Security Act.

WellCare will periodically evaluate member medical records to ensure compliance to EPSDT screening guidelines are met. Providers are randomly selected for chart review based on EPSDT claim submissions. This activity is performed on a quarterly basis. Please see the EPSDT Guidelines section for additional program detail. The Medical Record Tools section of this handbook provides information on the scope of the review.

Member Rights and Responsibilities

Plan members have specific rights and responsibilities. These are available to all members in the WellCare of Georgia Member Handbook and are also listed in the Member Services section of this handbook. These may be posted in your office for all members to see.

**Living Will and
Advance
Directive**

A member has the right to control decisions relating to his or her medical care, including the decision to withhold or take away the medical or surgical means or procedures to prolong his or her life.

The law provides that Plan members of sound mind, age 18 years or older or emancipated minors, and/or their legal representatives should receive information concerning advance directives and have the opportunity to execute an advance directive. This allows the member to designate another person to make a decision if he or she becomes mentally or physically unable to do so or chooses not to make the decisions. Prior to July 1, 2007, a resident of Georgia could either complete a living will or a durable power of attorney for health care. On July 1, 2007, Governor Sonny Perdue signed into law the Georgia Advance Directive for Health Care Act which simplified the process of making patient wishes known. There are three parts to this legal document: 1. Healthcare Agent – this allows the patient to designate a person to make healthcare decisions on their behalf when the patient cannot (or does not want to). 2. Treatment preferences – this allows the patient to list treatment preferences should they become unable to communicate or if a terminal condition exists which places the member in a state of permanent unconsciousness. 3. Guardianship – allows the patient to nominate a person to be their guardian in case one is ever needed.

The Georgia Advance Directive for Health Care forms must be made available in provider's offices and/or facilities. Discussion with the member, as well as the completed forms, should be documented and filed in the member's medical record. A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive. However, the provider should include documentation in the member's medical record regarding the discussion and whether or not the member chose to fill out an advance directive for himself/herself. If the member chose to complete an advance directive for healthcare, a copy of that advance directive should be placed in the member's medical record. This information will be reviewed as part of the ongoing Medical Record Review which is performed quarterly on a random number of providers.

A copy of the Georgia Advance Directive for Health Care can be found at the following web address:

www.aging.dhr.georgia.gov and a full recitation of the Act can be found at:

http://www.legis.state.ga.us/legis/2007_08/versions/hb24_HB_24_AP_11.htm

After-Hours Services

PCPs must provide one of the following after hours options:

- A 24 hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
- Answering system with option to page the physician; or
- An advice nurse with access to the PCP or on-call physician.

Closing of Physician Panel

When requesting closure of their panel to new and/or transferring Plan members, PCPs must:

- Submit the request in writing at least 60 days prior to the effective date of closing his/her panel (or such other period of time provided in their Provider Agreement);
- Maintain his or her panel open to all Plan members who were provided services prior to the closing of his/her panel; and
- Submit written notice of the re-opening of his/her panel including a specific effective date.

Out-of-Area Member Transfers

Participating physicians and providers should assist the Plan in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by the Plan physician and/or provider and the out-of-network attending physician.

**PCP Request
for Transfer
of a Member**

A Plan physician or provider may not seek or request to terminate their relationship with a member or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required or the cost of covered services required by the Plan's member.

A Plan physician or provider must accept all individuals without restrictions and does not discriminate against individuals on the basis of religion, gender, race, color, or national origin and will not use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color or national origin or on the basis of health, health status, pre-existing condition or need for health care services.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The provider should provide adequate documentation in the member's medical record to support his or her efforts to develop and maintain a satisfactory provider and member relationship.

If a satisfactory relationship cannot be established or maintained, the provider shall continue to render medical care to the Plan member. Services to the member shall continue until such time written notification is received from the Plan stating that the member has been transferred from the physician's practice.

In the event a participating provider desires to terminate their relationship with a Plan member, the provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory provider and member relationship, the member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively.

The provider completes a PCP Request for Transfer of Member form, attaching supporting documentation and faxes the form to the Customer Service department. A copy of the form is available in the **Forms** section of this handbook.

Responsibilities of All Providers

The remainder of this section of the handbook is an overview of responsibilities for which all Plan providers are accountable. Please refer to the Provider Agreement or contact a Provider Relations representative for clarification on any of the following.

Providers must, in accordance with generally accepted professional standards:

- Use physician extenders appropriately. Physician assistants (PA) and advanced registered nurse practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the state and Plan guidelines.
- The sponsoring physician will assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
- ARNPs and PAs should clearly identify their titles to members, as well as to other health care professionals.
- Any member request to be seen by a physician, rather than a physician extender, must be honored at all times.
- Make available treatment for any member in need of health care services they provide.
- Refer Plan members with problems outside of his or her normal scope of practice for consultation and/or care to appropriate specialists contracted with Plan.
- Refer members to participating physicians or providers, except when they are not available or in an emergency.
- Admit members only to participating hospitals, skilled nursing facilities and other inpatient care facilities, except in an emergency.
- Respond promptly to Plan requests for medical records in order to comply with regulatory requirements.

- Inform the Plan in writing within 24 hours of any revocation or suspension of the Bureau of Narcotics and Dangerous Drugs number, and/or suspension, limitation or revocation of his or her license, certification or other legal credential authorizing medical practice in the state of Georgia.
- Consistent with the Plan's credentialing and re-credentialing policies, inform the Plan in writing prior to changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his or her status with Plan. Failure to notify the Plan prior to these changes will result in a delay in claims processing and payment.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Plan member, subscriber or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a "fee-for-service" basis. Non-covered services are services not covered in the member's Plan contract.
- Maintain the privacy of our member's Protected Health Information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI includes oral, written or electronic information that can be used to identify the member and has been created or received about their past, present or future health or condition, the provision of health care, or the payment for their health care.
- Apply for and maintain a current a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Maintain accurate medical records and adhere to all Plan policies governing the content and confidentiality of medical records as outlined in the Plan's Quality Improvement Guidelines. All entries in the member record must identify the date and the

rendering provider.

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state, and federal regulations concerning safety and public hygiene.
- Communicate clinical information between Plan providers in a timely manner. Communication will be monitored during medical /chart review. Upon request, provide timely transfer of clinical information to the Plan, the member or the requesting party, at no charge, unless otherwise agreed upon.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not discriminate in any manner between members and non-members.
- Freely communicate with and advise members regarding the diagnosis of the member's condition and advocate on member's behalf for member's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are covered services.
- Allow members to be involved in treatment planning.
- Inform member of specific health care needs which require follow-up and provide, as appropriate, training in self-care and other measures members may take to promote their own health.
- Encourage members to utilize the Personal Health Advisor line (Plan's telephone-based triage program) for free telephonic, medical

advice twenty-four (24) hours a day, seven days a week. It is a service that a member may use before calling the PCP. After the assessment, the Health Advisor may suggest that the member call or make an appointment to see the PCP. Please refer to the **Quick Reference Guide** for the Plan's Personal Health Advisor telephone number.

- Identify members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/ postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to plan-sponsored or community-based programs.
- The provider must document the referral to plan-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.
- Consistent with the terms of the provider contract, notice of termination of network participation should be submitted in writing to Plan at least 90 days prior to the termination effective date.

During the notice period, the terminating physician(s) must continue to fulfill the obligations of the provider contract and maintain access to care for Plan members including, but not limited to, services defined in the Provider Handbook.

The Plan will notify affected members who have been under the ongoing care of the terminating physician(s), no later than 30 days prior to the termination effective date and assist with selection of a new physician as needed.

Continuity of care obligations following contract termination include continuation of active treatment for

up to 90 calendar days after the date of termination or until conclusion of the postpartum period for members in the second or third trimester of pregnancy and such other pregnant members as may be required under applicable law.

Specialist Responsibilities

Specialists are responsible for treating Plan members referred to them by the PCP and communicating with the Plan's Health Services department for authorizations. Specialists may not refer to another specialist.

Confidentiality of Member Information & Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the HIPAA privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996, as may be amended (HIPAA).

All physician practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members' medical records and other protected health information (PHI as defined under HIPAA); and the practice is following those procedures and/or obtaining appropriate authorization from members to release information or records where required by applicable state and federal law.

PHI includes oral, written or electronic information that can be used to identify you and has been created or received about your past, present or future health or condition, the provision of health care to you, or the payment for this health care. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every practice is required to provide members with information regarding their privacy practices and to the extent required by

law, with their Notice of Privacy Practices (NPP). Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Some examples of confidential information include:

- Medical records;
- Communication between a member and a physician regarding the member’s medical care and treatment;
- All personal and/or protected health information as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
- Any communication with other clinical persons involved in the member’s health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc);
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem;
- Any communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

The Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or the Plan may use or disclose the members’ PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or member.

Appointment Scheduling

In an effort to ensure members have timely access to care, WellCare of Georgia providers are required to follow the guidelines outlined below.

The following chart outlines the Maximum Appointment Wait Time requirements:

PCPs (routine visits)	Not to exceed 14 calendar days
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PCP (pediatric routine visits)	Not to exceed 14 calendar days
PCP (adult sick visits)	Not to exceed 24 hours
PCP (pediatric sick visits)	Not to exceed 24 hours
Specialists	Not to exceed 30 Calendar Days
Dental Providers (routine visits)	Not to exceed 21 Calendar Days
Dental Providers (urgent care)	Not to exceed 48 hours
Non-emergency hospital stays	30 Calendar Days
Mental health Providers	14 Calendar Days
Urgent Care Providers	Not to exceed 24 hours
OB/GYN – Initial Pregnancy Visit	14 Calendar Days
Health Check eligible children	Within ninety (90) Calendar Days of Enrollment into the CMO plan
Emergency Providers	Immediately (24 hours a day, 7 days a week) and without prior authorization

Providers must ensure wait times in the provider office do not exceed the following standards:

Scheduled Appointments	Waiting times shall not exceed 60 minutes. After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting times shall not exceed 90 minutes. After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment

Providers must ensure response times for returning calls after hours do not exceed the following standards:

Urgent Calls	Shall not exceed 20 minutes
Other Calls	Shall not exceed one hour

Reporting Requirements

The Plan is required to submit, on a quarterly basis, Timely Access Reports that monitor the time lapsed between a member's initial request for an office appointment and the date of the appointment.

Covering Physicians

In the event participating physicians are temporarily unavailable to provide care or referral services to Plan members, providers should make arrangements with another Plan-contracted and credentialed physician to provide services on their behalf, unless there is an emergency. In non-emergency cases, should you have a covering physician who is not contracted and credentialed with the Plan, contact the Plan for approval.

The physician should be credentialed by the Plan, must sign an agreement accepting the negotiated rate and agreeing not to balance bill Plan members.

For additional information, please contact the local Provider Relations department.

Provider Billing and Address Changes

Prior notice to the Plan is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and/or fax number

Marketing and Sales

Providers are required to submit any marketing materials; this includes, but is not limited to, posters, brochures, Web sites, and any materials that contain statements regarding the member benefit package to the Plan. Neither the Plan nor the providers can distribute any marketing materials without prior, written approval from DCH. Providers are required to follow all applicable federal guidelines related to Plan marketing. Please contact WellCare if you have any specific questions around Georgia Families marketing rules or guidelines.

Disclosure of Information

Periodically members may inquire as to the operational and financial nature of their health plan. In accordance with federal and state disclosure requirements, the Plan will provide that information to the member upon request. Members can

request the above information verbally or in writing. For more information about how to request this information, members should contact the Plan's Customer Service department.

**Delegated
Entities**

All participating providers or entities delegated for Network Management and Network Development should meet all plan requirements, pre/post delegation assessments and applicable standards. Reviews are performed and compliance is monitored on a regular basis. The plan reserves the right to revoke or rescind any delegated activities, in whole or in part, based on delegated entity performance and continued ability to meet plan standards and requirements.

**Fraud
and Abuse****What is Peer Profiling?**

The WellCare Special Investigations Unit (SIU) performs a multitude of pre-pay and post-pay functions. One of those specifically being Peer Profiling.

Peer profiling is primarily a post-pay function conducted using a myriad of analytical engines and driven by established norms within a specialty. For example, every pediatrician that provides services within the demographic for WellCare is pooled into one data set. The SIU is careful to remove pediatricians with sub-specialties so as not to include a pediatric cardiologist in with a straight pediatrician. We group each pediatric sub-specialty and perform that function separately.

From that data set our Data Analytics team is able to determine the normal curve and define the distribution for any range of codes. One of the most commonly profiled ranges of the SIU screen would be CPT codes 99211, 99212, 99213, 99214 and 99215.

Once established we focus our initial concern on the providers that have billing patterns two to three deviations from the norm, or also known as 'skewed right' of the bell curve. This normally triggers an audit or further investigation related to determining if the documentation supports the billing.

A corporate Special Investigations Unit (SIU) has been

established according to federal and state statutory, regulatory and contractual requirements and includes management, investigators, analysts, medical coding auditors and claim review specialists. SIU capabilities include pre-payment and retrospective reviews, provider profiling models, performance metrics, data mining, analysis and reporting and specialized business partner arrangements to augment in-house resources.

The mission of the SIU is outlined below:

- Comply with applicable federal and state statutory, regulatory and contractual requirements regarding fraud, waste and abuse;
- Effectively detect, investigate and report suspected fraud, waste and abuse;
- Identify and recover overpayments caused by error, fraud, waste or abuse;
- Assist in the development of anti-fraud plans, policies and procedures, and fraud and abuse awareness, education and training materials;
- Assist in conducting education and training for associates, providers, members, first-tier, delegated and related entities on fraud and abuse awareness and other related topics according to established training schedules; and
- Assist in conducting vulnerability assessments, auditing and monitoring activities of first-tier, delegated and related entities.