COMMUNITY HEALTH PLAN of Washington™

The power of community

General Compliance & Fraud, Waste and Abuse Training

(GC/FWA)

General Compliance Education Program

Community Health Plan of WA (CHPW) is required by contract with the Centers for Medicare & Medicaid Services (CMS) and the Washington State Health Care Authority (HCA) to ensure its contracted provider network completes General Compliance and/or Fraud, Waste and Abuse (GC/FWA) Training within 90 days of contract and annually thereafter.

CHPW is required to maintain evidence that its contracted providers have completed training and must make available to the applicable state and federal agency, upon request.

As stated by CMS, there is one exception to the FWA training and education requirement. Regulations effective June 7, 2010 implemented a “deeming” exception which exempts Providers who are enrolled in Medicare Part A or B from annual FWA training and education. Therefore, if an entity or an individual is enrolled in Medicare Part A or B, the FWA training and education has already been satisfied and **your Attestation would only apply to General Compliance**.

All staff, including your senior leadership, managers, clerical/admin staff, billing, physicians and other clinical staff are required to receive this training.

When GC/FWA training has been completed, please attest using the online attestation form - https://forms.chpw.org/#/gcfwa

Should you have any additional questions or concerns, please email us at provider.relations@chpw.org . Include your clinic name and tax ID in the subject line.

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About this Training

Training consists of two parts:

Part 1: General Compliance Program (GC)

Part 2: Fraud, Waste, and Abuse (FWA)

CHPW's ability to meet its contractual obligations with state and federal laws and regulations require providers to complete GC/FWA training annually.

Newly contracted provider must complete GC/FWA training within ninety (90) days of contract.

CHPW is required to maintain evidence that its contracted providers have completed GC/FWA training and must make available to the applicable state and federal agency, upon request.

All staff, including senior leaders, managers, clerical/admin staff, physicians and other clinical staff are required to receive this training.

Part 1 – General Compliance Program

Objective

- Recognize how a Compliance Program operates
- Recognize how a Compliance Program violations should be reported

General Compliance Program Requirement

CHPW maintains a mandatory compliance program, to promote a culture of ethical behavior and the prevention, detection, and correction of conduct that does not comply with federal and state laws, regulations, or contractual obligations.

Providers treating Medicare and Medicaid beneficiaries should establish a compliance program. Establishing and following a compliance program helps providers avoid fraudulent activities and submit accurate claims.

An effective compliance program must:

- Articulate and demonstrate CHPWs commitment to legal and ethical conduct
- Provide guidance on how to handle compliance questions and concerns
- Provide guidance on how to identify and report compliance violations

What is an Effective General Compliance Program

An effective compliance program fosters a culture of compliance within an organization and at a minimum:

- Prevents, detects, and corrects non-compliance
- Is fully implemented and is tailored to CHPWs unique operations and circumstances
- Has adequate resources
- Promotes CHPWs Standards of Conduct
- Establishes clear lines of communication for reporting non-compliance

7 Core Elements of a General Compliance Program

General Compliance Program's required **Seven Elements** of an effective compliance program.

1. Written Policies & Procedures, Standards of Conduct – These articulate CHPWs commitment to comply with applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct

2. Compliance Officer, Compliance Committee, High Level Oversight – Must designate a compliance officer and compliance committee accountable and responsible for the activities and status of the program, including issues identified, investigated, and resolved by the compliance program.

Senior management and governing body must be engaged and exercise reasonable oversight of CHPWs Compliance Program

3. Effective Training & Education – This covers the elements of the compliance work plan to include preventing, detecting, and reporting FWA.

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7 Core Elements of a General Compliance Program(cont'd)

4. Effective Open Lines of Communication – Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good faith reporting at the plan and first tier, downstream, or related entities (FDR) levels.

5. Well Publicized Disciplinary Standards – CHPW must enforce standards through well-publicized disciplinary guidelines.

6. Effective System for Routine Monitoring & Identification of Compliance Risks – Conduct routine monitoring and auditing of CHPW and FDRs operations to evaluate compliance with contractual obligations as well as the overall effectiveness of the compliance program.

7. Procedures & System for Prompt Response to Compliance Issues – use effective measures to respond promptly to non-compliance and undertake appropriate corrective action

What is expected of You

Standards of Conduct state CHPWs compliance expectations and their operational principles and values. Reporting violations and suspected non-compliance is **everyone's** responsibility.

The Standards of Conduct, along with General Compliance Policies & Procedures identify this obligation and tell you how to report suspected non-compliance.

The Standards of Conduct follow four main Principles, each supported by a set of standards. These Principles are:

1. Responsibility
2. Confidentiality
3. Dignity, Respect and Inclusion
4. Member-Centered

For complete text of CHPW "Standards of Conduct" reference the Provider Manual

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Standards of Conduct

Responsibility

- **Stewardship of Tax-Payer Dollars** - Act as a steward of taxpayer dollars and use resources wisely, make every effort to utilize our resources efficiently.
- **Legal & Procedural Compliance** - Comply with the law and seek understanding of legal requirements
- **Take action** - If any of us become aware of a potentially unethical or illegal situation, report the situation.

Confidentiality

- **Preserve the Confidentiality of Business Information** – Whether verbal or written we protect any and all proprietary information.
- **Protect Member Privacy** – We value our members rights to privacy. Comply with laws, regulations and internal policies to protect member information from unlawful Use and Disclosure.
- **Workforce Members Confidentiality** - Preserve employee confidentiality to retain the full trust and confidence of all workforce members.

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For complete text of CHPW "Standards of Conduct" reference the Provider Manual

Standards of Conduct (cont)

Dignity, Respect and Inclusion

- **Foster a Safe, Equitable & Supportive Workplace** - Promote exceptional performance of our workforce. Individual contributions are respected, acknowledged, and fairly rewarded.
- **Our Working Environment Behavior** – Comply with CHPW's anti-harassment and anti-discrimination policy. Promote respect and appreciation for our differences and acknowledge the value of diversity to our organization.
- **Avoid & Disclose Conflicts of Interest** – We make decisions based on what is best for CHPW, not personal gain.
- **Engage in Mutually Beneficial Business Relationships** – Our business associates are our partners in serving the interests of our members. We treat them with fairness, respect, and integrity and expect the same in return.

Member Centered

- **Respectful -** We treat our members with courtesy, politeness, and kindness at all times.
- **Responsive -** We respond to all member concerns in a timely and accurate manner. We provide them with the information and support they need to effectively use their health insurance.
- **Empathy -** We put ourselves in our members' shoes. The member experience is a key driver of how we organize and conduct our business.
- **Health Equity -** We recognize the social and systemic barriers to our members health and well-being. We work to advance health equity and reduce disparities in health that result from these barriers.
- **Community Focus -** We address the whole person needs of our members through a community focused approach and collaboration with community partners.

For complete text of CHPW's "Standards of Conduct" reference the Provider Manual

Non-Retaliation Policy

CHPW prohibits retaliation for compliance-related questions or reports of potential non-compliance or potential FWA made in good faith. Making deliberate false or malicious reports is prohibited.

When you make a report, confidentiality will be maintained to the extent practical that a report can be addressed without disclosure.

Whistleblowers - A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15%, but not more than 30%, of the money collected.

Know the Consequences of Non-Compliance

Failure to follow General Compliance Program requirements and CMS guidance can lead to serious consequences, including:

- Contract termination
- Criminal penalties
- Exclusion from participating in all Federal health care programs
- Civil monetary penalties

Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in noncompliant behavior may be subject to any of the following:

- Mandatory training or re-training
- Disciplinary action
- Termination

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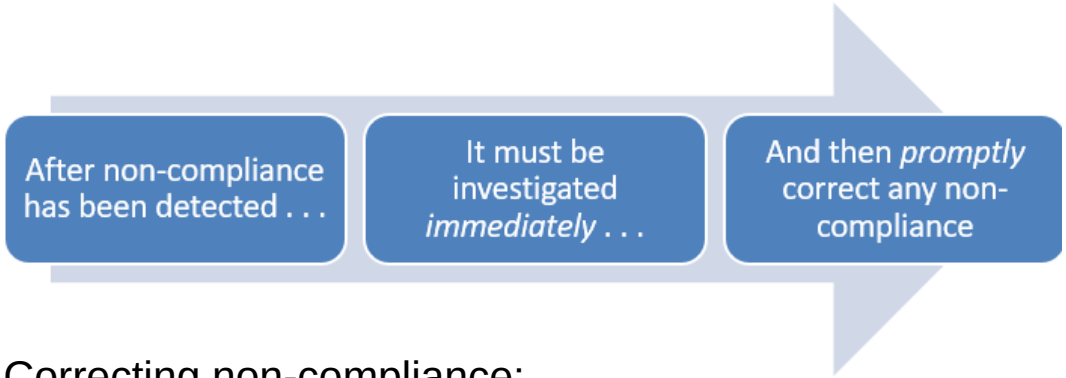
Consequences of Non-Compliance (cont)

Providers are required to comply with CHPW's Standards of Conduct, all state, or federal laws, regulations, and contractual obligations



Correcting non-compliance:

- Avoids the recurrence non-compliance
- Promotes efficiency and effective internal controls
- Protects enrollees
- Ensures ongoing compliance with contractual requirements

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HIPAA and Member Privacy

CHPW takes the privacy of its members seriously. As a health plan, we're required by the Health Insurance Portability and Accountability Act (HIPAA) to follow strict guidelines related to our members' protected health information (PHI).

In the event that you become aware of either a potential privacy or security incident involving a CHPW member, or a process that may place member PHI at risk, please report it immediately to the Compliance Officer.

Gifts and Gratuities

The federal Anti-Kickback Statute states that anyone who knowingly and willfully receives or pays anything of value, including gifts and gratuities, to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony.

Violations of the law are punishable by up to **five years** in prison, criminal fines up to **$25,000** per kickback, civil penalties up to **$50,000** per kickback, in addition to **three times the amount of damages to the government**, and exclusion from participation in federal health care programs.

Workforce members should not accept any gift or gratuity from any source which is offered, or reasonably appears to be offered, in exchange for a referral of business.

Conflict of Interest

A conflict of interest (COI) can occur when a person or a member of a person's family has an existing or potential interest, or relationship, which impairs, or might appear to impair, the person's independent judgment.

Contractors should require managers, officers, and directors involved in work that relates to CHPW members to report potential conflicts that may arise and sign a Conflict-of-Interest Statement at the time of hiring and annually thereafter.

Family members include a spouse, parents, siblings, children, and others living in the same household.

Certain relationships with an entity which does business with or directly/indirectly competes with CHPW may create a conflict of interest or appearance of a conflict of interest.

Examples may include:

- Serving as an officer, director, employee or independent contractor of such an entity
- Owning or controlling (directly or indirectly) 5% or more of the equity interests of such an entity
- Receipt of gifts or other favors from such an entity

A conflict of interest is not inherently illegal or unethical. It may be permissible given appropriate disclosure.

How to Report Fraud, Waste & Abuse

Report any potential violations of the Standards of Conduct, non-compliance, or fraudulent behavior you identify by phone, fax, mail, online or email at the following:

Contact Information:

Address:
Community Health Plan of Washington
Attn: Compliance Officer
1111 3rd Ave, Suite 400
Seattle, WA 98101

Phone: 206-613-5091
Email: compliance.officer@chpw.org
Fax: (206) 652-7017

Contact CHPW Customer Service at 1-800-440-1561/ CHPW Medicare Advantage Customer Service at 1-800-942-0247.

To report potential violations to CHPW, please go to CHPW https://www.chpw.org/provider-center/forms-and-tools/faq-instructions-on-the-gcfwa-attestation-form/. Report can be done using online or paper form.

You can also contact the appropriate state or federal agency to submit a report:
CMS at 1-800-Medicare
Washington State Healthcare Authority (HCA) at 1-800-562-6906
Office of the Inspector General at 1-800-HHS-TIPS, Website - http://oig.hhs.gov/fraud/hotline

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Objective

- Recognize FWA
- Identify laws & regulations related to FWA
- Recognize potential consequences & penalties associated with violations
- Identify methods of preventing FWA
- Recognize how to identify and correct FWA
- Where to report FWA

Your Responsibilities

The Social Security Act, CFR regulations, and the Centers for Medicare & Medicaid (CMS) guidance governing state and federal programs require CHPWs Compliance Program to include measures to prevent, detect, and correct FWA.

You are a vital part of the effort to prevent, detect, and report non-compliance and potential FWA.

FIRST you are required to comply with all applicable statutory, regulatory, and other contractual requirements, including adopting and implementing an effective compliance program.

SECOND you have a duty to to report any violations of laws that you may be aware of.

THIRD you have a duty to follow Standards of Conduct that articulates commitment to standards of conduct and ethical rules of behavior.

How do You Prevent FWA?

- Make sure you are up to date with laws, regulations, and policies
- Ensure you coordinate with other payers
- Ensure data/billing is both accurate and timely
- Verify information provided to you
- Be on the lookout for suspicious activity

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Fraud

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

The *Health Care Fraud Statute* makes it a criminal offense to knowingly and willfully execute a scheme to defraud a federal health care benefit program. Health care fraud is punishable by imprisonment for up to **ten** years for each count. It is also subject to criminal fines of up to **$250,000**.

- Billing for services or supplies not provided
- Knowingly billing for medically unnecessary services or supplies
- Falsely reporting patient information to support otherwise unnecessary procedures

CITATION: 42 CFR 455.2

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Waste & Abuse

Waste includes the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Examples of waste:

- Ordering excessive diagnostic tests
- Errors resulting in incorrect coding
- Dispensing medication or supplies refills without confirming continued need

Abuse includes actions that may, directly or indirectly, result in unnecessary costs. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.

Examples of abuse:

- Improper billing practices (upcoding or unbundling)
- Payment for services that fail to meet professionally recognized standards of care
- Billing for services that are medically unnecessary

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Differences Between Fraud Waste & Abuse (FWA)

There are differences between FWA. One of the primary differences is *intent* and *knowledge*.

Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong.

Waste and **Abuse** may involve obtaining an improper payment or creating an unnecessary cost but do not require the same intent and knowledge.

Everyone is expected to report potential FWA. Immediately report your concern to your Compliance Officer.

Fraud Waste & Abuse (FWA)

Who Commits Fraud, Waste and Abuse?

Anyone with a motive, means, and opportunity can commit fraud. Waste and abuse do not require intent and can be committed by anyone in any position.

Fraud, Waste, and Abuse can be committed by:

- Beneficiaries/Members
- Pharmacies
- Providers
- Sales Agents/Brokers
- Anyone *or* any combination of the above

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Fraud and Abuse Laws

The following slides provide a high-level overview of related laws governing fraud and abuse:

- Federal Civil False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)
- Criminal Health Care Fraud Statute
- Exclusion Statute from all Federal health care programs
- Civil Monetary Penalties Law (CMPL)
- Health Insurance Portability and Accountability Act (HIPAA)

Federal Civil False Claims Act (FCA)

The civil FCA, protects the Federal Government from being overcharged or sold substandard goods or services. The civil FCA imposes civil liability on any person who **knowingly** submits, or **causes** the submission of, a false or fraudulent claim to the Federal Government.

The terms “knowing” and “knowingly” mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim.

No specific intent to defraud is required to violate the civil FCA.

Example: A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than provided.

Penalties: Civil penalties for violating the civil FCA may include recovery of up to **three** times the amount of damages sustained by the Government as a result of the false claims, plus penalties per false claim filed.

Additionally, under the criminal FCA, 18 U.S.C. Section 287, individuals or entities may face criminal penalties for submitting false, fictitious, or fraudulent claims, including fines, imprisonment, or both.

31 United States Code (U.S.C.) Sections 3729–3733

Anti-Kickback Statute (AKS)

Prohibits knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (including the Medicare Program). Refer to 42 USC. Section 1320a-7b(b).

NOTE: Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. imprisonment, or both.

Example: A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals.

Damages and Penalties: Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participation in the Federal health care program. Under the CMPL, penalties for violating the AKS may include **three** times the amount of the kickback.

Physician Self-Referral Law (Stark Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or member of his or her family) has:

- an ownership/investment interest or
- a compensation arrangement

Example: A physician refers a beneficiary for a designated health service to a clinic where the physician has an investment interest.

Exceptions may apply, refer to 42 USC Section 1395nn

Damages and Penalties:
Claims tainted by an arrangement that does not comply with Stark are not payable. A penalty of around **$24,250** can be imposed for each service provided. There may also be a **$161,000** fine for entering into an unlawful arrangement or scheme.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute, 18 U.S.C. Section 1346-1347 prohibits **knowingly and willfully** executing, or attempting to execute, a scheme or lie in connection with the delivery of, or payment for, health care benefits, items, or services to either:

- Defraud any health care benefit program

- Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary claims for power wheelchairs.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines up to $250,000, imprisonment up to 20 years, or both.

Exclusion Statute

The Exclusion Statute, 42 U.S.C. Section 1320a-7, requires the OIG to exclude individuals and entities convicted of any of the following offenses from participation in all Federal health care programs:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances

Every month, CHPW Credentialing screens CHPW contracted providers against the List of Excluded Individuals/Entities (LEIE) database, maintained by the Office of Inspector General (OIG), and the Excluded Parties List (EPLS) maintained by the System for Award Management (SAM) database.

The LEIE list is located at: http://oig.hhs.gov/exclusions/exclusions_list.asp and EPLS located at: https://sam.gov.

Exclusion Statute (cont)

The OIG also may impose permissive exclusions on other grounds, including:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud, or misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard services
- Submitting false or fraudulent claims to a Federal health care program
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

Excluded providers may not participate in the Federal health care programs for a designated period. If you are excluded by OIG, then Federal health care programs, including Medicare and Medicaid, will not pay for items or services that you furnish, order, or prescribe. Excluded providers may not bill directly for treating Medicare and Medicaid patients, and an employer or a group practice may not bill for an excluded provider's services. At the end of an exclusion period, an excluded provider must seek reinstatement; reinstatement is not automatic.

Civil Monetary Penalties Law (CMPL)

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:

- Arranging for services or items from an excluded individual or entity
- Providing services or items while excluded
- Failing to grant OIG timely access to records
- Knowing of and failing to report and return an overpayment
- Making false claims
- Paying to influence referrals

For more information, refer to 42 USC 1320a-7a and the Act, Section 1128A(a).

Damages and Penalties

Violators are also subject to three times the amount claimed for each item or service, or CMPs also may include an assessment of up to **three** times the amount claimed for each item or service, or up to **three** times the amount of remuneration offered, paid, solicited, or received.

HIPAA and HITECH

The **Health Insurance Portability and Accountability Act (HIPAA)** of 1996 created greater access to health care insurance, strengthened the protection of privacy of health are data, and promoted standardization and efficiency in the health care industry. HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.

The **Health Information Technology for Economic and Clinical Health (HITECH) Act** enacted as part of the American Recovery Reinvestment Act of 2009 amended HIPAA civil monetary penalties for violations. Introduced four categories/tiers of penalties, extended civil and criminal liability to Business Associates, authorized State Attorney General's to enforce HIPAA, and requires plans to notify HHS of PHI breaches.

Damages and Penalties
Violations may result in CMPs. In some cases, criminal penalties may apply.

Section 13410(d) of the HITECH Act established the following:

Violation Category	Penalty for Each Violation	Penalty for all Such Violations of an Identical Provision in a Calendar Year
(A) Did Not Know	$100	$25,000
(B) Reasonable Cause	$1,000	$100,000
(C)(i) Willful Neglect – Corrected	$10,000	$250,000
(C)(ii) Willful Neglect – Not Corrected	$50,000 - $1.5 million	$1.5 million

Accurate Coding and Billing

As a provider, payers trust you to provide medically necessary, cost-effective, quality care. You exert significant influence over what services your patients get. You control the documentation describing services they receive, and your documentation serves as the basis for claims you submit. Generally, Medicare pays claims based solely on your representations in the claim's documents.

When you submit a claim for services provided to a Medicare beneficiary, you are filing a bill with the Federal Government and certifying you earned the payment requested and complied with the billing requirements. If you knew or should have known the submitted claim was false, then the attempt to collect payment is illegal.

Examples of improper claims include:

- Billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided
- Billing medically unnecessary services
- Billing services not provided
- Billing services performed by an improperly supervised or unqualified employee
- Billing services performed by an employee excluded from participation in the Federal health care programs
- Billing services of such low quality they are virtually worthless
- Billing separately for services already included in a global fee, like billing an evaluation and management service the day after surgery

Upcoding & Documentation

Medicare pays for many physician services using Evaluation and Management (E/M) codes. New patient visits generally require more time than established patient follow-up visits. Medicare pays new patient E/M codes at higher reimbursement rates than established patient E/M codes.

Example 1: Billing an established patient follow-up visit using a higher-level E/M code, such as a comprehensive new-patient office visit.

Example 2: E/M upcoding is misusing modifier –25. Modifier –25 allows additional payment for a significant, separately identifiable E/M service provided on the same day of a procedure or other service. Upcoding occurs when a provider uses modifier –25 to claim payment for a medically unnecessary E/M service, an E/M service not distinctly separate from the procedure or other service provided, or an E/M service not above and beyond the care usually associated with the procedure.

Maintain accurate and complete medical records and documentation of the services you provide. Ensure your documentation supports the claims you submit for payment.

Good documentation practices help to ensure your patients get appropriate care and allow other providers to rely on your records for patients' medical histories.

Medical Identity Theft and Theft of Services

Use of medical benefits by an unauthorized individual. This can be the result of outright theft or collusion between parties.

Tips to Battle Identity Theft:

Ask for identification: Don't be afraid to ask the patient or party obtaining the prescriptions or receiving the medical service for identification and make a copy for your records.

Ask for a signature: Don't be afraid to require a signature from the party obtaining the prescriptions or the medical service, even when one is not required.

Report it: Call the local police and the impacted insurance company if you believe you have encountered a case of medical identity theft.

Inform the Beneficiary: If you know who the true beneficiary is, immediately alert that individual so they can take steps to protect against further activity.

Whistleblower Protection

As a result of reporting possible fraud, the federal False Claims Act protects employees who report a violation under the False Claims Act from:

- discrimination,
- harassment,
- suspension, or
- termination of employment.

Employees who report fraud and consequently suffer discrimination may be awarded:

- two times their back pay plus interest,
- reinstatement of their position without loss of seniority, and
- compensation for any costs or damages they incurred.

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How to Report Fraud, Waste & Abuse

Report any potential violations of the Standards of Conduct, non-compliance, or fraudulent behavior you identify by phone, fax, mail, online or email at the following:

Contact Information:
Address:
Community Health Plan of Washington
Attn: Compliance Officer
1111 3rd Ave, Suite 400
Seattle, WA 98101

Phone: 206-613-5091
Email: compliance.officer@chpw.org
Fax: (206) 652-7017

Contact CHPW Customer Service at 1-800-440-1561/ CHPW Medicare Advantage Customer Service at 1-800-942-0247.

To report potential violations to CHPW, please go to https://www.chpw.org/provider-center/forms-and-tools/faq-instructions-on-the-gcfwa-attestation-form/ . Report can be done using online or paper form.

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CMS at 1-800-Medicare
Washington State Healthcare Authority (HCA) at 1-800-562-6906
Office of the Inspector General at 1-800-HHS-TIPS, Website - http://oig.hhs.gov/fraud/hotline

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CHPW Provider FWA Attestation

Thank-you for taking the General Compliance and Fraud, Waste and Abuse Training

IMPORTANT – ACTION REQUIRED

Please click on the following link to complete the Online FWA Attestation

Online Attestation Form

Questions concerning this training, please contact CHPW Provider Relations at provider.relations@chpw.org