



2026 Annual Compliance Training for Providers

Covering Medicare & Medicaid
Fraud and Abuse, Privacy & Security
Awareness *with MSSP ACO*

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CME Accreditation

Faculty Disclosure Summary

The content of this activity is not related to products or services of an ACCME-defined ineligible company; therefore, no one in control of content has a relevant financial relationship to disclose and there is no potential for conflicts of interest. All planners and presenters attested that their content suggestions and/or presentation(s) will provide a balanced view of therapeutic options and will be entirely free of promotional bias. All presentations have been reviewed by a planner with no conflicts of interest to ensure that the content is evidence-based and unbiased.

The information provided addresses several requirements of the Accreditation Council for Continuing Medical Education (ACCME) to help ensure independence in CME activities. Everyone in a position to control the content of a CME activity must disclose all relevant financial relationships with ineligible companies to the CME provider. This information must be disclosed to participants prior to the beginning of the activity. Also, CME providers must mitigate relevant conflicts of interest prior to the educational activity. The ACCME defines “ineligible companies” as those whose primary business is producing, marketing, selling, re-selling or distributing healthcare products used by or on patients. Among the exemptions to this definition are government organizations, non-health care related companies and non-profit organizations that do not advocate for commercial interests. Circumstances create a “conflict of interest” when an individual has an opportunity to affect CME content about products or services of an ineligible company with which he/she has a financial relationship. ACCME focuses on financial relationships with ineligible companies in the 24-month period preceding the time that the individual is being asked to assume a role controlling content of the CME activity. ACCME has not set a minimal dollar amount for relationships to be significant. Inherent in any amount is the incentive to maintain or increase the value of the relationship. The ACCME defines “relevant financial relationships” as financial relationships in any amount occurring within the past 24 months that create a conflict of interest.

Accreditation with Commendation

CME Accreditation Information

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Swedish Medical Center and Providence St. Joseph Health. Swedish Medical Center is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA Category 1 Credits™

Swedish Medical Center designates this internet enduring material for a maximum of 2.0 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Compliance At Providence

- The Compliance Program sets a framework for adherence to laws, regulations, and organizational policies, as detailed in the approved Compliance Program Description. The Program supports our workforce members in fulfilling their legal, professional, and ethical obligations. A function of the Program is to recognize and prevent regulatory risk.
- The Compliance program applies to all workforce members, including independent physicians.
- Compliance Services manages Providence's Code of Conduct, compliance and privacy policies, the Conflicts of Interest disclosure program, Exclusion Screening program, and educates on various healthcare laws.
- Compliance Services has a presence in each division (North, South, and Central) and at each ministry we serve. [CLICK HERE](#) for a contact list.

Chief Compliance Officer (CCO)

- Providence has designated a CCO who is responsible for oversight of the Compliance Program
- The CCO strives to implement the seven elements of an effective compliance program as outlined in the General Compliance Program Guidance (GCPG) published by the OIG.
 1. Written Policies and Procedures, including a Code of Conduct
 2. Compliance Leadership and Oversight
 3. Training and Education
 4. Effective Lines of Communication and Disclosure Programs
 5. Enforcing Standards: Consequences and Incentives
 6. Risk Assessment, Auditing, and Monitoring
 7. Responding to Detected Offenses and Developing Corrective Action Initiatives
- The CCO is available to workforce members to answer compliance questions.



Chief Compliance Officer,
David Lane, Ph.D.

Code of Conduct (COC)

- The Compliance Program owns and is responsible for the upkeep of our organization's Code of Conduct and the [Code of Conduct policy](#). All providers are asked to review and agree to abide by the COC on an annual basis while working for Providence.
- The COC provides overviews on important topics such as:
 - Culture of diversity and respect
 - Quality of care and patient safety
 - Ethical and legal standards
 - Safeguarding patient information and protecting privacy and confidentiality
 - Compliance with applicable federal and state laws and regulations and policies
 - Duty to report suspected violations and protection from retaliation
- The COC reinforces our organizations values, which drive our actions and the principles that underlines decision making. Therefore, the Code becomes the most important part of the organization's ethical framework.

You can access our COC anytime on our Providence.org site:

[Code of Conduct | Compliance Program | Providence](#)

Doing the Right Thing Right

Our Code of Conduct

Culture of Diversity and Respect

We adhere to all laws and regulations and are committed to a workplace culture where all individuals are treated with respect and dignity, regardless of protected characteristics, as defined by local, state, or federal law, including but not limited to race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), genetic information, marital status, age, sex (which includes pregnancy, childbirth, breastfeeding and related medical conditions), gender, gender identity, gender expression, sexual orientation, and military and veteran status. [POLICY](#)

Quality of Care and Patient Safety

We commit to provide the best, *compassionate* care and service every time and strive to meet and exceed national standards for quality and patient *safety*. Workforce members have the responsibility and obligation to report any Quality of Care and Patient Safety issues. [POLICY](#)

Stewardship of Resources

We commit to effective stewardship of resources in support of patient care and organizational goals and only use resources for legitimate business purposes. [POLICY](#)

Conflicts of Interest (COI) Commitment

We will avoid actual or perceived COI and agree to disclose any outside interests or activities, contracts, and relationships that may be in conflict to the organization. We maintain impartial relationships with vendors, research sponsors, and contracts by not requesting or accepting gifts, cash, or cash equivalents. [POLICY](#)

Ethical and Legal Standards

We conduct ourselves in a professional and ethical manner in support of *justice* and will perform our job duties in accordance with all federal, state, and local laws. [POLICY](#)



Ways to report a compliance, privacy, or other concern

- Discuss the matter or concern with your immediate supervisor
 - Discuss the matter or concern with your department leader
 - Discuss with your HR Partner, HR Service Center, or send report via HR Portal
 - Contact your local or regional compliance or privacy representative
 - Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option
 - For Caregivers in India:
 - From an outside line, dial the direct access number: 000-117
 - At the English prompt dial 888-294-8455
- You may report concerns anonymously**



To report a quality or patient safety concern

- Discuss the matter or concern with your immediate supervisor
- Discuss the matter or concern with your department leader
- Discuss with your Quality leader or representative
- Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option
- [HRP- High Reliability Platform](#)
 - Must be on organization network to report



Safeguarding Patient Information and Protecting Privacy and Confidentiality

We take every precaution to safeguard patient information, and we will treat protected health information (PHI) of all with special care and follow all federal, state, and local laws. [POLICY](#)

Ethical Conduct of Research

We follow the highest ethical standards and comply with all laws, regulations, guidelines, and ethical directives (where applicable) that govern human, animal, and basic applied science research. [POLICY](#)

Licensure and Certification

We require all health care and education professionals to follow all federal, state, and local laws applicable to licensing, credentialing, and certification requirements. Individuals on the excluded provider lists cannot work for our organization. [POLICY](#)

Compliance with Applicable Federal and State Laws and Regulations, and Policies

We ensure *excellence* by requiring all parties that work for or on behalf of an employer within our family of organizations learn and follow all laws, regulations, and policies. [POLICY](#)

Fair Business Practices

We conduct ourselves ethically, honestly, and with *integrity* at all times. [POLICY](#)

Duty to Report Violations and Protection from Retaliation

It is every workforce member's responsibility to report, in good faith, any violation or suspected violations of our code, fraud, waste, abuse or quality or patient safety concerns as required. Providence's Non-Retaliation policy, and to an extent, government law, protects workforce members from retaliation or harassment for having raised concerns about actual or potential wrongdoing or misconduct ". [POLICY](#)

Our mission, vision, values, and promise provide guidance and inspiration as we deliver quality care, make sound, ethical choices, and meet our organizational goals. As workforce members, we are accountable for the integrity of our decisions and actions on the job. We are obligated to report any suspected violations or concerns. The Code of Conduct provides a foundation of expectations for us as we do our work each day.



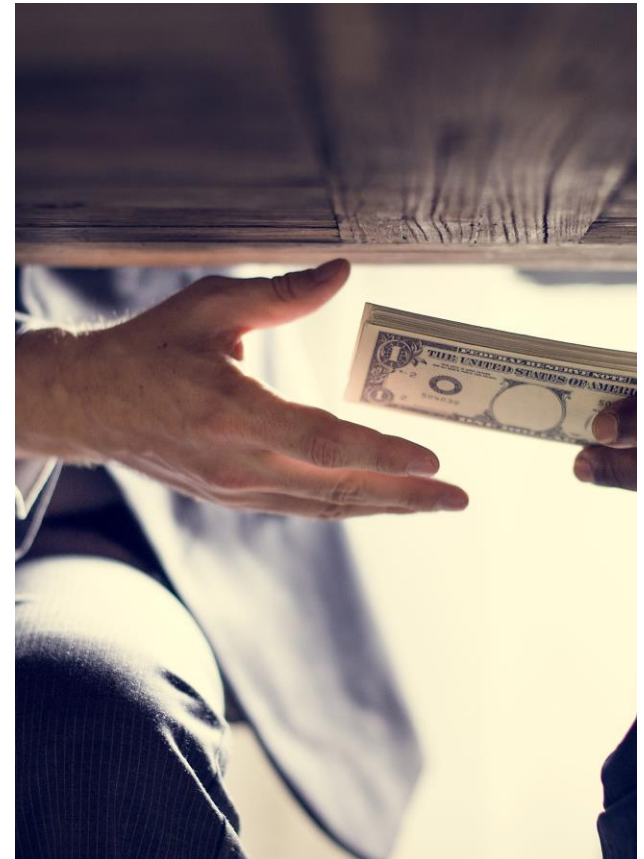
A Roadmap for New Physicians

Avoiding Medicare and Medicaid Fraud and Abuse

[CLICK HERE](#) to download your own copy of this Roadmap

Health Care Fraud is a Serious Problem

- The Government spends almost a trillion dollars each year on the Medicare and Medicaid programs.
- Although there is no precise measure of health care fraud, experts estimate that fraudulent billings to the programs are in the range of 3–10 percent.
 - **That means that fraud, waste, and abuse cost taxpayers between \$30 billion to \$100 billion dollars each year.**
- The estimated cost of fraud, waste, and abuse in 2025, was estimated that the taxpayers lost \$14.6 billion in a single “DOJ take down” to \$300 billion annually, to fraud. These figures highlight the substantial impact of fraud and waste on taxpayers.



Fraud, Waste, and Abuse

Fraud includes obtaining a benefit through intentional misrepresentation or concealment of material facts.

Waste includes incurring unnecessary costs as a result of deficient management, practices, or controls.

Abuse includes any practice that is not consistent with the goals of providing patients with services that (1) are medically necessary, (2) meet professionally recognized standards, and (3) are priced fairly.

Fraud and Abuse Laws

Physicians are an important part of protecting the integrity of the Medicare and Medicaid programs. The Government needs physicians to understand the fraud and abuse laws so that they can be partners in preventing fraud, waste, and abuse. There are a number of Federal and State laws to deter and punish those who fraudulently seek to obtain improper payments from Medicare and Medicaid. Federal laws include, but are not limited to, the following:

1. The Health Care Fraud Statute;
2. The False Claims Act;
3. The Anti-Kickback Statute;
4. The Physician Self-Referral Statute
5. Exclusion Provisions; and
6. The Civil Monetary Penalties Law



For more information, click [HERE](#) for a Fact Sheet.

False Claims Act

Prohibits the submission of false or fraudulent claims to the Government.

The Department of Justice obtained more than \$6.8 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, 2025. Over \$5.7 billion related to matters that involved the health care industry.

Claims may be false if the service is not actually rendered to the patient, is provided but already covered under another claim, is miscoded, or is not supported by the medical record.

The [False Claims Act](#) requires a [penalty](#) for each violation. The FCA penalty amount also increases with inflation each year. Currently in 2025, FCA penalties range from \$14,308 to \$28,619 per violation.

For example: a hospital compensated its physicians in a way that violated the Stark Law against physician self-referrals therefore violating the False Claims Act. The hospital had submitted 21,730 false claims to Medicare with a total value of \$39,313,065. The district court assessed 21,730 civil False Claims Act penalties. Ultimately, the hospital was on the hook for **\$119,515,000** in False Claims.

Deliberate Ignorance

You do not have to intend to defraud the Government to violate the False Claims Act. You can be punished if you act with **deliberate ignorance or reckless disregard** of the truth.

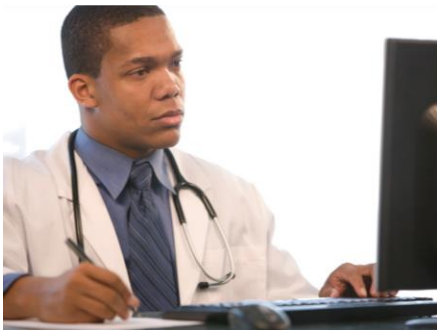
Accurate Coding and Billing

Forms of medical billing fraud include duplicate billing, phantom billing, upcoding, under coding, medical equipment fraud, and billing separately for services already included in a global fee.



Accurate medical records are critical

The Medicare and Medicaid programs may review the patient's medical records to verify the claim, as well as the quality of care. If the medical record does not support the claimed service, the claim may be denied.



Good documentation helps ensure quality patient care

Good documentation is also a quality-of-care issue. It helps ensure that patients get the best possible clinical care from you and other providers who may rely on your records.

If you have questions about coding and documentation, please reach out to your [local compliance contact](#).

Participating Physicians...

- Most physicians bill Medicare as participating physicians and receive Medicare's 80 percent directly from Medicare and bill patients for the remaining 20 percent.
- This means that you accept the Medicare payment, plus any copayment or deductible Medicare requires the patient to pay, as the full payment.
- You may not require any extra payment from your patient. In other words, you may not ask Medicare patients to pay a second time for services for which Medicare has already paid.





Non- Participating Physicians...

- Bill directly to patients
- Patients reimbursed by Medicare
- It is illegal to charge more than 15% above the Medicare rate



Incentives to Report Fraud

The False Claims Act also provides a strong financial incentive to whistleblowers to report fraud. Whistleblowers can *receive up to 30 percent* of any False Claims Act recovery.

Often whistleblowers turn out to be ex-business partners, hospital or office staff, competitors, or even patients. Data analytic companies are increasingly becoming whistleblowers. [Check out this press release from January 2026.](#)

PRESS RELEASE

Justice Department Files False Claims Act Complaint Against Priority Hospital Group and Three Long Term Care Hospitals

Wednesday, January 21, 2026

For Immediate Release

2025 judgments exceed \$6.8B - highest in a single year in the history of the False Claims Act

🔦 Healthcare fraud a leading source of False Claims Act settlements & judgments

\$5.7B involved the health care industry, which includes:

Medicare Advantage Provider Seoul Medical Group and Related Parties to Pay Over \$62M to Settle False Claims Act Suit

Renaissance Imaging, a California based radiology group that worked with Seoul Medical, has also agreed to pay \$2.35M

Medicare Advantage Provider Independent Health to Pay Up To \$98M to Settle False Claims Act Suit

Justice Department intervened in a qui tam against national insurers Aetna Inc., Elevance Health Inc., and Humana Inc.

A unanimous jury found Omnicare liable for fraudulently dispensing drugs without valid prescriptions to elderly and disabled people

Types of FCA Violations

The current version of the False Claims Act lists seven types of violations

1. **False Claims** – Presenting, or causing the presentment, of a false claim for payment or approval. [31 U.S.C. §§ 3729\(a\)\(1\)\(A\)](#).
2. **False Records or Statements** – Making, using, or causing others to make or use, a false record or statement that is material to a false or fraudulent claim. [31 U.S.C. §§ 3729\(a\)\(1\)\(B\)](#).
3. **Conspiracy** – Conspiring to violate the False Claims Act. [31 U.S.C. §§ 3729\(a\)\(1\)\(C\)](#).
4. **Conversion** – Failing to return government property. [31 U.S.C. §§ 3729\(a\)\(1\)\(D\)](#).
5. **False Receipts** – Making or delivering a receipt of government property without completely knowing that the information in it is true. [31 U.S.C. §§ 3729\(a\)\(1\)\(E\)](#).
6. **Unlawful purchase of Government Property** – Buying public property from a government employee who may not lawfully sell it. [31 U.S.C. §§ 3729\(a\)\(1\)\(F\)](#).
7. **Reverse False Claims** – Making, using, or causing to be made or used, a false record or statement material to an obligation to pay money to the government; or conceals, avoids, or decreases an obligation to pay money to the government. [31 U.S.C. §§ 3729\(a\)\(1\)\(G\)](#).

Within these seven categories of violation, there are many ways to run afoul of the False Claims Act. If you are still curious, check out [False Claims Act Violations and Prohibitions Explained](#).

Anti-Kickback Statute (AKS)

The AKS is a federal criminal law and applies to both payers and recipients of kickbacks. The law prohibits obvious kickbacks, such as cash for referrals, as well as more subtle kickbacks, such as free rent, below fair market value rent, free clerical staff, or excessive compensation for medical directorships. The HHS-OIG and the Department of Justice enforce each of these provisions.

As a result, each violation of the AKS is **a felony punishable by a maximum fine of \$100,000, imprisonment up to 10 years, or both.** [42 U.S.C. § 1320a-7b \(b\)](#).

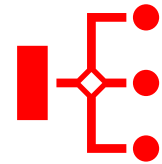
Conviction also will lead to mandatory exclusion from Federal health care programs, including Medicare and Medicaid. [42 U.S.C. § 1320a-7 \(7\)](#).

Violation of the AKS also triggers liability under the Civil Monetary Penalties Law (CMPL). The CMPL carries penalties of **up to \$100,000 per kickback**, in addition to three times the amount of the remuneration. It also makes the resulting bills to the government false under the [False Claims Act](#). As a result, the violator is responsible for three times the value of the bills, and a [False Claims Act Penalty](#) of **up to \$27,894 per bill.** [42 U.S.C. § 1320a-7a \(a\)](#).

Numerous physicians have been sanctioned under the False Claims Act by the Justice Department or by private individuals in a qui tam proceeding for selling their product loyalty to drug or device companies or other vendors.

False Claims Act Liability

A provider submitting a claim to government health care programs implicitly promises to comply with federal and state anti-kickback laws. Therefore, if the provider violates the AKS, **all tainted claims become false** under the federal and state False Claims Acts.



This is because the False Claims Act **pulls in other theories of liability**. When a service rendered by a provider is motivated by kickbacks, the **resulting claims are false or fraudulent as well**. Consequently, civil False Claims Act complaints will often allege a violation of criminal law as grounds for civil liability.



Damages under the False Claims Act **include three times the value** of the tainted claims caused to the Government by the fraud plus a False Claims Act penalty. **The penalty also increases each year**. By February 2024, False Claims Act penalties ranged as high as **\$27,894 per violation**.



Physician Self-Referral Law

[42 U.S.C. § 1395nn] - Commonly referred to as the *Stark Law*

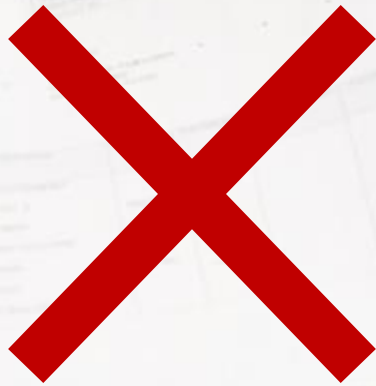
Prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities **with which the physician or an immediate family member has a financial relationship**, unless an exception applies.

- Financial relationships include both ownership/investment interests and compensation arrangements.
 - **For example:** If you invest in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception, or you may not refer patients to the facility, and the entity may not bill for the referred imaging services.
- "Designated health services" include clinical laboratory services, physical therapy, and home health services, among others.



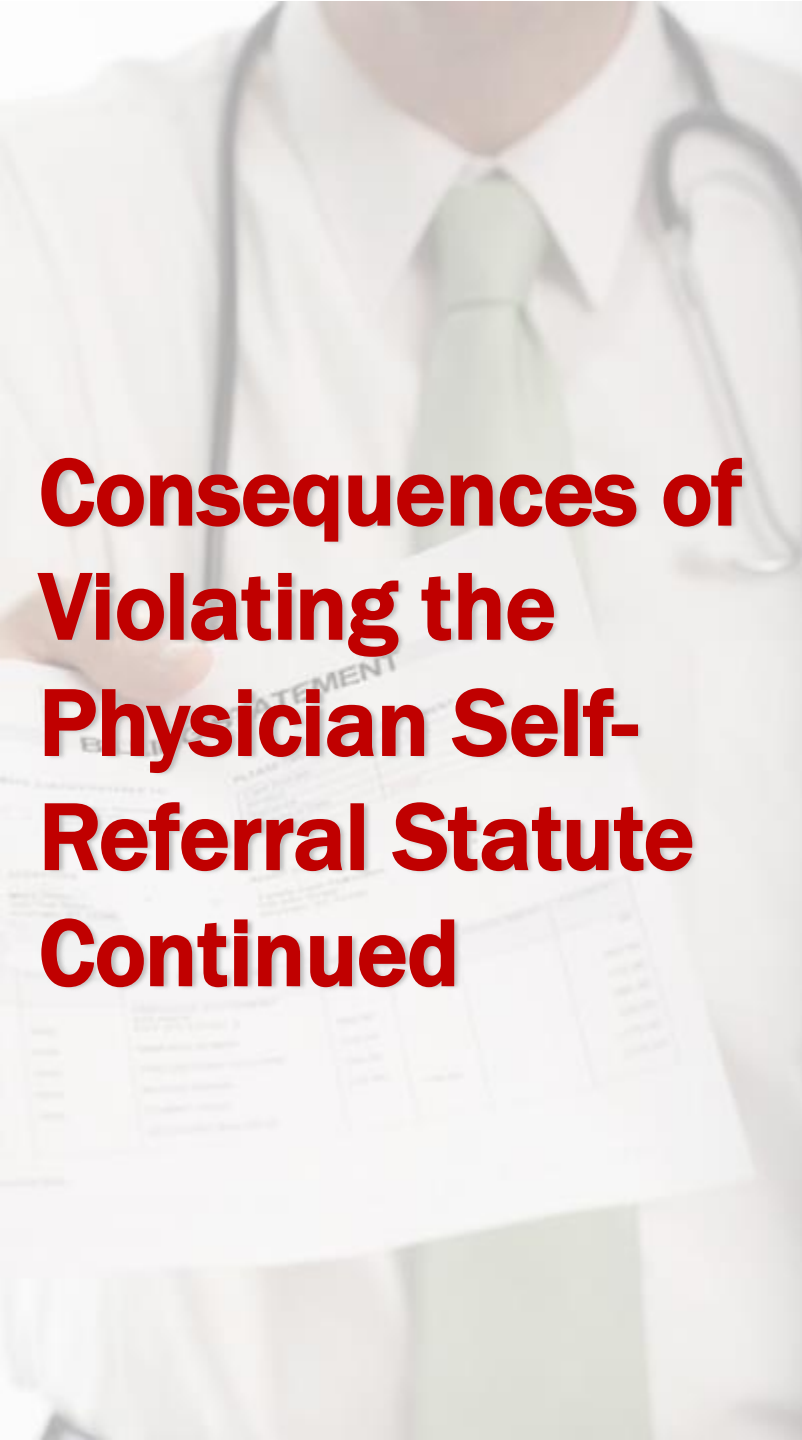
Consequences of Violating the Physician Self-Referral Statute:

- **Payment denial**
- **Monetary penalties**
- **Exclusion**
- **Overpayment/refund obligations**



The Physician Self-Referral Statute is a strict liability law, which means proof of **specific intent to violate the law is not required.**

- The entity submitting improper claims is subject to repayment of all amounts received from Medicare and Medicaid that are connected with the improper relationship and may be subject to additional penalties.
- Physicians who violate the law may be subject to monetary penalties as well as exclusion from participation in the Federal health care programs.
- If a referral is made violating the Stark law and payment is received by the entity providing the designated health service, penalties can include **civil penalties up to \$15,000 for each unlawful referral**, exclusion from participation in federal health care programs, denial of payment for services, refunding of payments received, a **fine of up to \$100,000** for each illegal cross-referral arrangement, and **civil penalties up to \$10,000 per day for failing to report violations.**



Consequences of Violating the Physician Self-Referral Statute Continued

Submitting claims for payment to Medicare or Medicaid that are known or should be known to be false or fraudulent is illegal. **Claims resulting from violations of the Stark Law or AKS may also trigger liability under the [False Claims Act](#).**

The FCA contains a whistleblower provision allowing private individuals to sue on behalf of the United States and are entitled to a percentage of any monetary recoveries.

FCA penalties: Under the civil False Claims Act, no specific intent to defraud is required for a violation to occur.

- **Civil penalties:** Filing false claims may result in fines of up to three times the programs' loss plus \$11,000 per claim filed.
- **Criminal penalties:** There is also a criminal False Claims Act. Criminal penalties for submitting false claims include imprisonment and criminal fines.

Avoid Violating the Anti-Kickback Statute and Physician Self-Referral Statute by Fitting into a “Safe Harbor” or Exception

Many arrangements can be structured to avoid the risk of fraud. Additionally, there are “safe harbors” and exceptions to the Anti-Kickback and Stark Laws, but you must meet required every element and condition of the exception to qualify.

For example, a full-time lease agreement between a physician and a provider to whom the physician refers patients can meet the *space rental safe harbor* if the agreement:

- is set out in writing and signed by the parties;
- covers all the premises rented by the parties;
- is for a term not less than 1 year;
- has an aggregate rental charge set in advance, is consistent with fair market value in arm’s length transactions, and does not consider the volume or value of Federal health care program referrals; and,
- the aggregate space rented may not exceed the space that is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

The “Safe Harbor” Regulations [42 CFR 1001.952 (a)-(u)] Describe Protected Business Relationships in the Following Areas

The below examples are not all inclusive:

- **investments in other practices and businesses** (typically up to 40%)
- **rental of space** (at fair market value)
- **rental of equipment** (same limitations as "rental of space," above)
- **personal services and management contracts** (not determined by volume or value of referrals)
- **sale of practices** (cannot make referrals or otherwise generate business)
- **referral services** (cannot exclude any individual or entity)
- **warranties of equipment** (must accurately report any price reductions)
- **discounts** (must be based on purchases of the same good or service fiscally)
- **remuneration to employees** (cannot be considered a kickback)
- **group purchasing organizations** (cannot pay more than a 3% fee to the group purchasing organization)

Exclusion from Medicare and Medicaid

Healthcare agencies that do business with excluded individuals, entities or partners on these lists may be subject to penalties, fines or civil monetary penalties (CMP) and possible suspensions from participation in government health care programs.

Mandatory Exclusions

Imposed based on certain criminal convictions.

Permissive Exclusions

Based on sanctions by other agencies, such as a state medical board suspending or revoking a medical license, or other misconduct including defaulting on health education loans or providing unnecessary or substandard care.

Exclusions are handed down by the OIG and last for periods of typically three to five years in most cases before a potential reinstatement may be made.

If you are excluded by OIG from participation in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as TRICARE and the Veterans Health Administration, will not pay for items or services that you furnish, order, or prescribe. **Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.** In addition, if you furnish services to a patient on a private-pay basis, no order or prescription that you give to that patient will be reimbursable by any Federal health care program.



Some refer to exclusion as a *“financial death sentence”* for any health care provider

Scope & Effect of Exclusion: § 42 CFR 1001.1901

(a) *Scope of exclusion.* Exclusions of individuals and entities under this title will be from Medicare, Medicaid and any of the other Federal health care programs, as defined in [§ 1001.2](#).

(b) *Effect of exclusion on excluded individuals and entities.*

(1) Unless and until an individual or entity is reinstated into the Medicare, Medicaid, and other Federal health care programs in accordance with [subpart F of this part](#), no payment will be made by Medicare, including Medicare Advantage and Prescription Drug Plans, Medicaid, or any other Federal health care program for any item or service furnished, on or after the effective date specified in the notice—

(i) By an excluded individual or entity; or

(ii) At the medical direction or on the prescription of a physician or an authorized individual who is excluded when the person furnishing such item or service knew, or had reason to know, of the exclusion.

(2) This section applies regardless of whether an individual or entity has obtained a program provider number or equivalent, either as an individual or as a member of a group, prior to being reinstated.

(3) An excluded individual or entity may not take assignment of an enrollee's claim on or after the effective date of exclusion.

(4) An excluded individual or entity that submits, or causes to be submitted, claims for items or services furnished during the exclusion period is subject to civil money penalty liability under section 1128A(a)(1)(D) of the Act and criminal liability under section 1128B(a)(3) of the Act and other provisions. In addition, submitting claims, or causing claims to be submitted or payments to be made, for items or services furnished, ordered, or prescribed, including administrative and management services or salary, may serve as the basis for denying reinstatement to the programs.

Providence's Exclusion Screening Program & Requirements

- In accordance with the Medical Staff Excluded Individual Checks policy, Providence **prohibits the credentialing and privileging of Medical Staff members and does not do business with those** who are deemed by a Federal and/or State agency as debarred, excluded or otherwise ineligible for participation in federal or state funded health care programs, or who have been convicted of a criminal offense related to health care.
- **All Medical Staff members are screened before hiring or contracting and then monthly thereafter** against the Office of the Inspector General (OIG)'s List of Excluded Individuals and Entities (LEIE) and the General Services Administration (GSA)/System for Award Management (SAM), OFAC-SDN, CMS Preclusion, Medicare Opt Out, **and all State Medicaid exclusion lists** to ensure that none of these persons are excluded or become excluded from participation in federal programs.

Civil Monetary Penalties Law

You should also be aware that OIG may seek civil monetary penalties for a wide variety of abusive conduct, including presenting a claim that is false or fraudulent because it is for a medically unnecessary procedure. OIG also may impose civil monetary penalties for violating the Medicare assignment agreement by overcharging or double billing Medicare beneficiaries.

The [adjusted civil penalty amounts](#) updated in 2025 vary depending on the agency and the type of violation. Here are some examples:

1. **Department of Justice:** The adjusted civil penalties assessed or enforced by components of the Department range from **\$7,256 to \$84,852** for violations occurring after November 2, 2015.
2. **Federal Election Commission (FEC):** Violations of federal campaign finance law can result in penalties ranging from **\$7,028 to \$82,188**.
3. **Department of Labor:** The 2025 civil money penalty amounts for labor-related violations are specified in a table published in the Federal Register.
4. **Executive Office of the President:** The inflation-adjusted penalty amount for 2025 is approximately **\$14,308** when rounded to the nearest dollar.

Please note that these amounts apply to *specific violations and agencies*.



No matter your specialty or practice setting, as a physician you may develop relationships with three important groups. Your relationships with these groups will be subject to the provisions of the 5 key fraud and abuse laws.

Reminder!

- **Payers**, like Medicare, Medicaid, patients, and private insurance companies;
- **Other providers**, including physicians and hospitals; and
- **Vendors**, including drug, biologic, and medical device companies.

Future Business Relationships

- Colleagues
- Hospitals
- Nursing Homes
- Medical Companies



Outside Investments

The Office of Inspector General ("OIG") has expressed concern that physician investments in medical device and distribution entities *should be closely scrutinized under the fraud and abuse laws.*

- Physicians are frequently approached with investment opportunities in enterprises related to the delivery of health care.
- Sometimes, you are a legitimate source of capital. Other times, you are a source of patient referrals.
- Because the return on an investment sometimes is used to offer kickbacks in exchange for referrals, you should be vigilant when considering health care business opportunities.
- You should send your patients to the provider that, in your medical judgment, can best meet their medical needs.
- Legal counsel may be helpful in understanding the purpose of the business venture and its associated risks.



Is the Arrangement Legitimate?

To avoid violation of the fraud and abuse laws, test the propriety of any proposed engagement by asking yourself the following questions:

- Does the company really need my particular expertise or input?
- Is the venture promising you high rates of return for little or no financial risk?
- Are you being asked to guarantee that you will refer patients or order services from the venture?
- Does the amount of money the company is offering seem fair and appropriate for what it is asking me to do?
- Is it possible the company is paying me for my loyalty so that I will prescribe its drugs or use its devices?

If you want to pursue an industry relationship but are not sure it is legitimate, take steps to learn whether the arrangement is proper.

Scrutinize Promotional Speaking or Consulting Opportunities!

As a physician, you may have opportunities to consult with or be a promotional speaker for the drug or medical device industry.



Providence Policy Considerations

[PSJH-CPP-718](#) Vendor/Supplier Interactions

Consulting Arrangements

Speaker's Bureau and Educational Events

[PSJH-CPP-719](#) Gifts, Gratuities, and Business

Courtesies

Honoraria/Honorarium and Consultations

Free Drug Samples

If free drug samples are authorized in your clinic by local leadership; there are very specific criteria for use, and there should be a leadership committee at the local level determining if those practices are going to allow to have samples and what policies and procedures govern the sample drug process.

- Free drug samples should be used for the purpose of testing for tolerance or titrating dose; they are not to be used to provide financial assistance.
- Free drug samples should never be commingled with commercial stock drugs.



Drug Diversion

Introduction to Drug Diversion

As part of this course, learners will:

- Have reviewed an overview of Controlled Substances handling and diversion prevention
- Know how to identify potential risks
- Know how to dispose of Controlled Substances
- Understand state/federal regulations
- Prevent drug diversion
- Know how to report drug diversion or suspicion of drug diversion

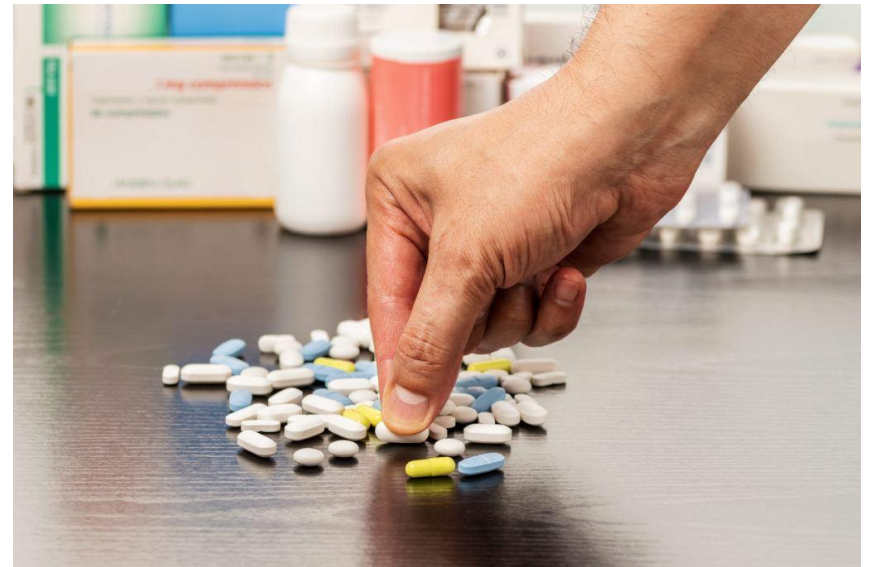
What is Drug Diversion?

- Drug diversion is the transfer or use of a prescription drug to anyone other than the intended recipient of the medication.
- Misappropriation of medications in any way other than how they are intended for use or prescribed for use. Medications of any kind can be misappropriated or diverted. When medications are misappropriated by a workforce member it is considered theft.
- Drug diversion is a crime that can have negative impacts on our patients, caregivers and health system.
- Patients: Denial of pain relief, exposure to blood borne pathogens, identity theft, fraud & direct patient harm.
- Caregivers: Loss of license, career and professional reputation

Approximately 10-15% of healthcare professionals will struggle with substance use disorders during their career, and many of these turn to drug diversion.

Where Does Drug Diversion Occur?

- Acute care (e.g. hospitals) – main focus of this section
- Retail pharmacies
- Outpatient infusion centers
- Nursing homes
- Hospice
- Home infusion



What are Controlled Substances?

A drug that is regulated by the Drug Enforcement Administration (DEA) because it may be abused or cause addiction

Controlled Substance Schedules

- Drugs and other substances that are considered Controlled Substances under the Controlled Substances Act (CSA) are divided into 5 schedules.
- According to the US Bureau of Labor Statistics, drugs in the highest risk schedules (II, III and IV) account for 94% of abused prescription drugs

Controlled Substance Schedules

Schedule I: No currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

- Examples include heroin, methamphetamine, MDMA (ecstasy)

Schedule II: A high potential for abuse which may lead to severe psychological or physical dependence

- Examples include oxycodone, hydrocodone, amphetamines (Adderall)

Schedule III: Potential for abuse is less than substances in Schedules I or II, and abuse may lead to moderate or low physical dependence or high psychological dependence.

- Examples include buprenorphine, testosterone

Schedule IV: Low potential for abuse, relative to substances in Schedule III

- Examples include alprazolam, carisoprodol

Schedule V: Low potential for abuse relative to substances listed in Schedule IV and consist of primarily of preparations containing limited quantities of certain narcotics.

- Examples include phenergan with codeine, pregabalin

What is the Chain of Custody?

A process that tracks the movement of a product through its lifecycle, to include; documenting each person who handled the medication, the date/time it was collected or transferred, and the purpose for the transfer.

- Drug diversion does not only affect Controlled Substances. Anytime a medication is removed, taken, given, or redirected to someone for whom it was not ordered or intended, this is drug diversion.



How to Identify

Examples of drug diversion

- Personal use of hospital issued drugs on or off hospital property
- Redistribution of hospital issued drugs to unauthorized users (e.g. family members)
- Removal, misuse, stealing, and/or diverting non-controlled medication/drugs (and/or related supplies)
- Self-prescribing of Controlled Substances
- Removing Controlled Substances from a hospital location to be used on patients in another facility




The Facts

Opioid addiction is a major driver of drug diversion.

- More than 822,000 have died since 2015 from a drug overdose. In 2024, 80,391 drug overdose deaths occurred in the United States.
- Among nurses, substance use disorders affect 500,000 individuals nationally
- 87% of physicians have prescribed medications for themselves, and over 55% with painkiller prescriptions wrote them for themselves
- There are an estimated 37,000 drug diverters each year

Common Characteristics of a Diverter

Many diverters appear to be high-functioning professionals who are well-liked by their peers as the diverter may be willing to go “above and beyond” in their roles

-  Frequent volunteering for overtime or shift coverages
-  Come early / stay late or insisting to cover nights, weekends or holidays
-  Offering to administer medications for other nurses and handle waste for Controlled Substances

Contributing Factors for Abuse

Similar to healthcare fraud, drug diversion is typically driven by three factors:

1. Pressure / Motivation to divert
2. Access / Opportunity
3. Rationalization / Justification by the diverter



Commonly Diverted Drugs

Opioids

- HYDRomorphine
- Morphine
- FentaNYL (including patches)
- HYDRocodone
- OxyCODONE
- Methadone

Depressants

- Benzodiazepines (ALPRAZolam, clonazePAM, lorazePAM)

Stimulants

- Dextroamphetamine
- Methylphenidate

Others

- Propofol
- Trazodone
- Nalozone

Classes of Prescription Drugs Commonly Misused

- National Institute on Drug Abuse (NIDA)
 - [Commonly Abused Drugs Chart](#)
- Institute for Safe Medication Practices
- (2023, February 23) Drug diversion and COVID-19. ISMP Medication Safety Alert! Acute Care Edition, 28(4)).
 - [Volume 28, Issue 4 February 23, 2023](#)

Warning Signs

Early Warning Signs

- Overly helpful in certain situations (e.g. medication delivery, offer to medicate colleagues' patients)
- Review medication orders of patients not in their care
- Heavy or no wasting of drugs
- Picking the same colleagues to waste with (waste buddies)
- Pattern of holding waste until end of shift

Later Warning Signs

- Unpredictable work performance
- Recurring mistakes/poor judgment
- Interpersonal relations suffer
- Blames others for errors
- Arrives late to work, no-shows, increased absenteeism
- Frequent personal crises
- Noticeable changes in appearance or hygiene

Red Flags (Report Immediately)

- ❏ Broken or missing tamper seals
- ❏ Damaged or altered packaging
- ❏ Medication or associated supplies (e.g. syringes, needles) found in inappropriate locations or in personal belongings
- ❏ Suspected false documentation medical record or other chain of custody logs (Pyxis, paper, etc.)

Risks

Individual

- Criminal offense
- Loss of career
- Health consequences
 - Overdose
 - Neglected health
 - Infection

Patients

- Compromised safety (e.g. infectious disease exposure)
- Inaccurate documentation leading to poor record of care and potentially fraudulent billing
- Compromised treatment (e.g. inadequate pain relief or neglected care plan)
- Patient privacy (HIPAA violations by caregiver/diverter)

Risks

Hospital

- Loss of reimbursement
- Repayment
- Loss of accreditation
- Drug diversion fines
- Reputational damage and decreased community confidence

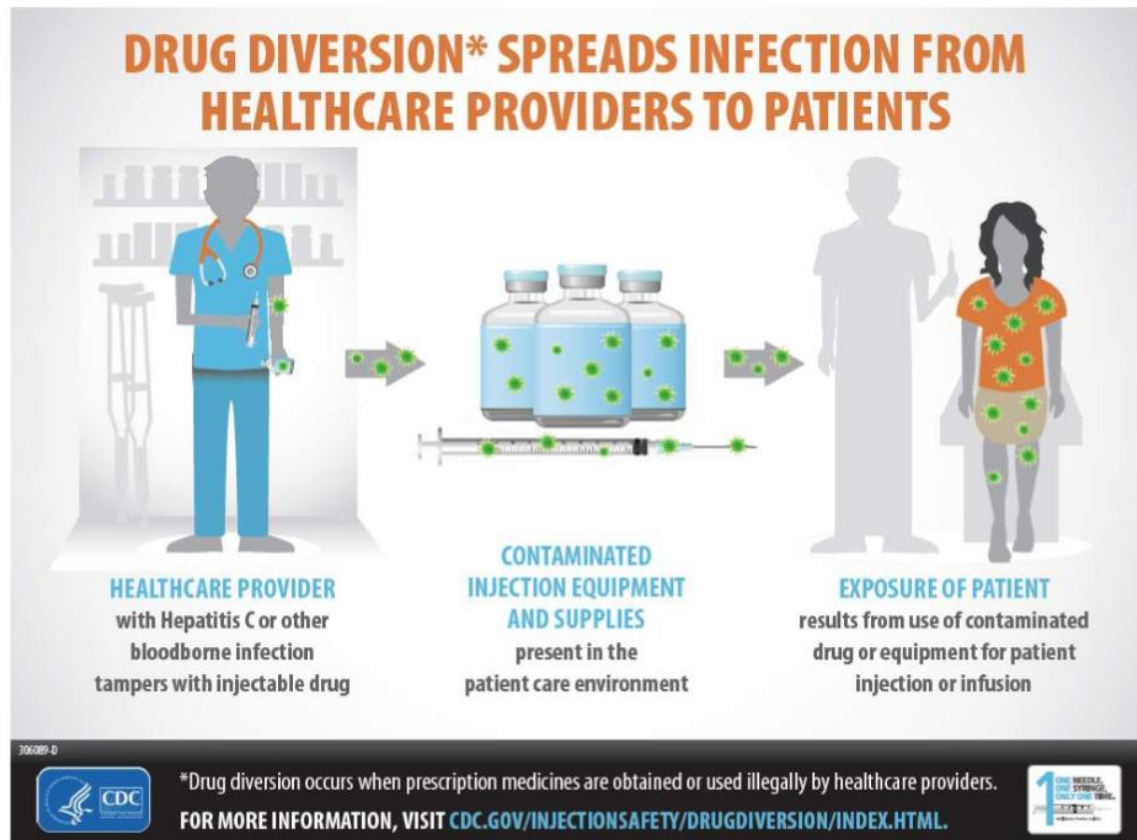
Society

Diversion & Opioid Use Disorder (OUD) is costly to society!

- Increased health expenditures (est. over \$700 billion per year)
- Loss of productivity (est. over \$120 billion per year)

Drug Diversion is Dangerous

Diversion is also costly to the health of patients and healthcare providers



Recent DEA fines related to drug diversion range from \$1 million to \$8 million.

Best practices for Handling Controlled Substances

Eliminate gaps in process

- (e.g. time to administration)
- Remove controlled substances for **one patient at a time**
- Administer CS immediately after removal from Automated Dispensing Machine (ADM; e.g. Pyxis)

Waste on removal

- Partial doses should be wasted at the time of removal, with another caregiver witnessing both the disposal and the ADM entry.
- If a witness is unavailable, return and perform the waste procedure ASAP

30-minute rule

- Removal to Administration/Waste and Documentation process should be

completed within 30 minutes

- Exception: Procedural/trauma cases should be completed by the end of the case

Chain of custody

- Gaps in process or transfer of possession require documentation.
- Ensure a clear chain of custody if you remove a medication but do not administer it
- CS belonging to a patient should only be handled by caregivers in very limited circumstances according to applicable policy/procedure
- CS should NEVER be held or stored in clothing, pockets, or bags/kits belonging to caregivers

Best practices for Handling Controlled Substances

Witness = direct physical observation

- Witnesses must actually see the medication being wasted AND witness the documentation action
- NEVER co-sign a waste in the ADM without seeing the disposal
- Controlled Substances (CS) must be wasted and discarded irretrievably using approved disposal device (e.g. CSRx)

Overrides & discrepancies

- Override removals from ADM can result in a chain of custody gap (no associated patient profile) and should be limited to urgent/emergent situations
- All ADM discrepancies must be resolved

promptly. The Unit Coordinator/Charge Nurse is responsible for ensuring all open discrepancies are resolved before their shift ends

Variances

- Variances warrant investigation. Caregivers should report any deviation from the above practices to their manager and via the High Reliability Platform (HRP)
- Document accurately what you administer and waste, as inaccuracies may initiate an investigation

Questions

- Contact your local pharmacy team

Disposal of Controlled Substances (CS)

Wrong way to Dispose of Controlled Substances

- Drug Diversion occurs when diverters reach in and take out partial vials of Controlled Substances! Some even drain out liquid out of the bottom of sharps containers or trash bins without knowing the risks!



Disposal of Controlled Substances (CS)

Correct way to Dispose of Controlled Substances

Stericycle – CsRx Container

After witnessed waste, dispose as follows:

- Liquids & injectables: Draw up remaining controlled substance and inject contents into CsRx container (solution in container deactivates Controlled Substance)
- Tablets/capsules removed from packaging and dropped into containers
- Patches placed in container



State & Federal Regulations

Legal / Regulatory Oversight

- Drug Enforcement Administration (DEA) – Primary Regulator/Enforcer of the Controlled Substance Act.
- State and/or local law enforcement
- Board of Nursing
- Board of Pharmacy
- Medical Board
- The Joint Commission
- Centers for Medicare and Medicaid Services (CMS)
- Det Norske Veritas National Integrated Accreditation of Healthcare Organizations (DNV NIAHO)

Systems of Prevention



Culture

- The organization expects staff to report any suspected diversion or suspicious behavior

Human Factor

- Vigilance cannot be understated! Every caregiver has a responsibility to safeguard against drug diversion



Proactive Diversion Monitoring

Providence utilizes next generation diversion monitoring software to provide enhanced transparency in Controlled Substance handling.

- Diversion prevention is a multidisciplinary effort. Core Leaders may be asked to review patterns or trends identified by this software.
- Please ensure you continue to practice safe Controlled Substance management and encourage best practices with your peers.
- If you become aware of a Controlled Substance discrepancy or missing Controlled Substance, please report your concerns immediately.

Reporting

Report suspected diversion to a manager/supervisor or the Providence Integrity Hotline

Providence Integrity Hotline (can be reported anonymously):

- Report online or call 1-888-294-8455
- Available 24/7

Do you need help?

These resources listed below can help to protect you and your license:

Substance abuse and mental health services administration (SAMHSA) national helpline: 1-800-662-HELP (4357)

- Free, confidential, 24/7 treatment referral and information service for individuals and families facing mental and/or substance use disorders

National Drug Helpline: 1-844-289-0879

- Free, confidential, 24/7 information about substance use, treatment options, and support resources

Professional Recovery Programs by State

State	Board of Medicine Licenses	Board of Nursing Licenses	Board of Pharmacy Licenses	All Others
AK				AK Office of Substance Misuse & Addition Prevention (OSMAP) Office of Substance Misuse and Addiction Prevention (OSMAP) State of Alaska Department of Health
WA	WA Physicians Health Program Phone: 206-583-0127 https://wphp.org	WA Health Professional Services (WHPS) Phone: 360-236-2880, Option 1 https://nursing.wa.gov/whps	WA Recovery Assistance Program for Pharmacy (WRAPP) Phone: 800-446-7220 https://www.wsparx.org/page/WRAPP/WRAPP.htm	WA Recovery & Monitoring Program (WRAMP) Phone: 360-236-2880, Option 2 https://doh.wa.gov/wramp
MT	Montana Recovery Program www.montanarecoveryprogram.com	Montana Recovery Program www.montanarecoveryprogram.com	Montana Recovery Program www.montanarecoveryprogram.com	
OR	Health Professionals' Services Program (HPSP) Phone: 888-802-2843 Oregon Medical Board: Health Professionals' Services Program	Health Professionals' Services Program (HPSP) Phone: 888-802-2843 Oregon Medical Board: Health Professionals' Services Program	Health Professionals' Services Program (HPSP) Phone: 888-802-2843 Oregon Medical Board: Health Professionals' Services Program	
CA	Diversion Program Administered by Premier Health Group Phone: 800-522-9198	Diversion Program Administered by Premier Health Group Phone: 800-522-9198 https://www.rn.ca.gov/intervention/index.shtml	Diversion Program Administered by Premier Health Group Phone: 800-522-9198 https://www.pharmacy.ca.gov/licensees/personal/pharmacist_recovery.shtml	
TX	Texas Physician Health Program (TXPHP) Phone: 512-305-7462 https://www.txphp.state.tx.us/	Texas Peer Assistance Program for Nurses (TPAPN) https://www.texasnurses.org/mpage/TPAPN	Professional Recovery Network Phone: 800-727-5152 http://www.txpm.com/	
NM		Diversion Program Administered by RecoveryTrek Phone: 505-841-9091 https://www.hon.nm.gov/diversion		

Do You Think Someone Needs Help?

We have a duty to respond to diversion in a manner that promotes the safety of our patients and caregivers. Help is available!

- Reach out to any core leader
- Call Human Resources
- Caregiver Assistance is available 24/7 through Lyra:
 - 844-311-6223, Confidential & free

Medical Directorships & Substantive Responsibility Requirements



Medical Director Agreement Considerations

- **Government Scrutiny:** Given the potential impact on referrals, government agencies closely examine medical director compensation arrangements.
- **Fair Market Value (FMV):** When establishing medical directorships, it's essential to ensure that compensation is fair and reasonable.
- **Substantive and Well-Defined Roles:** Medical directorships should have clear responsibilities and expectations. These roles should be substantive, meaning they contribute significantly to the organization's functioning.
- **Uniform Contracts:** Consistency in contract terms is crucial. Standardized agreements for medical directorships must be used to maintain transparency and fairness.
- **Timekeeping:** If timesheets are required, they should include time spent and work performed so that the hours listed and activities performed can be confirmed as legitimate, necessary services for the facility, activities do not overlap with other roles, and that compensation is aligned with actual work performed.

Gift Reporting Requirements

Although some physicians believe that free lunches, subsidized trips, and gifts do not affect their professional judgment, research shows that these types of perquisites and humans' natural desire to reciprocate can influence prescribing practices and generally affect how physicians act.

The Sunshine law requires public disclosure of gifts and limiting the types of gifts physicians may accept. This law ensure that certain activities are conducted openly and ethically, allowing public observation, participation, and access to records.

The Patient Protection and Affordable Care Act of 2010 requires drug, device, and biologic companies to publicly report nearly all gifts or payments they make to physicians since 2013. This information is posted on the Internet so the public will know what gifts and payments a physician receives from industry!

The "Internet test" is important to use in your relationships with the health care industry. *"How would I feel if this arrangement were trending on the internet?"*

Giving Gifts to Providence Caregivers

Per [Providence policy](#) (PSJH-CPP-719 Gifts, Gratuities, and Business Courtesies), directly employed caregivers of Providence are not permitted to accept gifts from independent physicians, even as a *Thank You* or around the holidays. **Examples of gifts include but are not limited to:**

- *Frequent* meals (breakfast, lunch, dinners)
- Tickets to events/shows
- Gift cards/Certificates/Vouchers
- Gifts that cannot be shared with the department
 - Electronics
 - Jewelry
 - Clothing items/accessories



Providence's Disclosure Program - *Reporting Concerns*

The purpose of the *Providence Disclosure Program* is to foster a culture of integrity, transparency, and accountability within our family of organizations. This program is designed to support the identification, correction, and prevention of compliance and quality issues, helping ensure the highest standards of ethical and legal conduct and patient care. It aims to empower all workforce members to speak up and report compliance and quality of care related issues and concerns confidentially and without fear of retaliation. *PSJH-CPP-741 Disclosure Program*

[Integrity Hotline](#)

1-888-294-8455



[High Reliability Platform \(HRP\)](#)



*Found in the My Apps portal via Providence network.
Must be on Providence network to create a report.*

More Ways to Report FWA Concerns



You can also report suspected cases of fraud, waste, or abuse in Federal HHS programs with the U.S. Department of Health and Human Services, Office of Inspector General electronically through the Office of Inspector General's Complaint Portal, available at <https://oig.hhs.gov/fraud/report-fraud/index.asp>, or by mail or phone at:

U.S. Department of Health and Human Services, Office of Inspector General,
ATTN: OIG HOTLINE OPERATIONS, P.O. Box 23489, Washington, DC 20026.

Phone: 1-800-HHS-TIPS (1-800-447-8477) or 1-800-377-4950 (TTY)

Privacy Compliance at Providence



➤ **Mission and Values:** Privacy compliance is about respecting individuals - Safeguarding information is the “right thing to do”.



➤ **Legal and Regulatory:** The risk of civil monetary penalties and litigation is reduced when we comply with privacy requirements.

➤ **Quality of Care:** Patient confidence that their information is safeguarded promotes communication/transparency for higher quality of care.



➤ **Reputation:** Patients expect their information is going to be safeguarded. When we protect their information, it creates an environment of trust.

Know the 18 Patient Identifiers

1. Names
2. Geographic subdivisions smaller than a state (address, zip code, etc.)
3. All elements of dates (birth date, admission date, discharge date, date of death)
4. Telephone Number
5. Fax numbers
6. E-mail address
7. Social security numbers
8. Medical record numbers
9. Health plan numbers
10. Account numbers
11. Certificate/License number
12. Vehicle numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URL)
15. Internet Protocol (IP)
16. Biometric Identifiers (fingerprint, voice)
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code (tattoos, birthmarks, scars, initials, tax ID #, radiology and surgical procedure images)

Using PHI for Treatment

You may use and disclose PHI to provide the patient with appropriate treatment and may disclose PHI to other health care professionals that have a care relationship with the patient (Examples: nurses, labs, technicians, etc.)

- PHI **may not** be shared in any format, including electronic, paper or verbal with clinicians who are **not involved** with the patient's care.
- A former care relationship with the patient, curiosity purposes or a personal relationship, **does not** qualify as meeting the definition of treatment.

Examples of Appropriate Disclosures



A physician may discuss a patient's treatment with the patient in the presence of a family member/friend when the patient brings them to a medical appointment and asks if they can come into the treatment room. *Physicians should use caution with sensitive information.



A physician may discuss the after-care plans with an individual who has accompanied the patient to a medical appointment. The information must be "need to know" for the person supporting the patient.



A pharmacist may give a prescription to a patient's friend who the patient has sent to pick up the prescription.



A health care provider may give information regarding a patient's drug dosage to the patient's health aide who calls the provider with questions about a prescription.

Epic[©] Privacy Education

As a provider with access to Epic, it is important to understand and follow Providence's policies regarding its access and use.

If you access any aspect of a patient's record when you don't have a legitimate business reason to access the record, this leads to privacy policy violations.

This next section will provide an overview of appropriate Epic use.

Epic[©] and PHI

All patient information in Epic is considered Protected Health Information (PHI) and this includes but is not limited to PHI on track boards, the status bard, census reports, demographic information on Patient Lookup, or using the hover feature.

Providers may only view PHI, whether access is made by clicking on or hovering over it, for Providence related business purposes based on your role and being part of the patient's care team.

All clicks, hover activity, downloading, printing or other activity in Epic is monitored on a 24/7 basis.

Epic[©] Privacy Education

Having a Business Purpose

Having a "business purpose" to access information in Epic means that the provider accesses PHI for reasons related to their job functions but not for their own personal reasons or for reasons related to tasks that are not part of the provider's role at Providence.

Having a business purpose to access PHI in any part of Epic will always include completing role-based tasks related to treatment, payment, and/or healthcare operations, also referred to as TPO.

- Providing healthcare to a patient (documenting in the record)
- Consulting with another provider
- Looking at historical encounters because doing so is necessary to treat the patient

Epic[©] Privacy Education

Minimum Necessary

When using or disclosing PHI, a covered entity must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Access only what's necessary: If it is not necessary to look at previous encounters that a current patient may have had, or certain information about the patient contained within the media tab when providing current patient care, then it should not be viewed by you.

Limit sharing of information: When using or disclosing PHI for payment or internal healthcare operations purposes (i.e. quality improvement) use only that which is necessary for the intended purpose.

Access to EPIC[®] & Other Information Systems

Can I access my family, friend or co-worker's medical record?

If you are not part of the care team, you may not access a patient's medical record for any reason. Privacy laws and Providence policies only allow access to a patient's medical record for treatment, payment, and healthcare operations purposes. There are no exceptions to this, even if someone requests that you access their record when you are not involved in their care.

Is EHR access monitored?

Providence monitors workforce member access to its systems 24/7. All activity, including clicks and hovering, are recorded and suspicious access is investigated. This includes but is not limited to access to identity look-up, ED track boards, census lists, etc.

Can I access my own medical record?

Providence policy prohibits workforce members, including physicians, from using their work provided credentials to access their own medical record in Providence's systems. Workforce members must request access and/or copies of their medical records the same way any other patient would, through the patient portal or by contacting HIM/medical records or their physician's office

What happens if I violate privacy policies?

Privacy violations will be leveled in accordance with Providence's privacy sanction policy & appropriate corrective action taken.

Employed physicians may be subject to disciplinary actions up to and including termination.

Prohibited Uses of Epic

Searching For a Patient You are Not Caring For

Search for a Patient Copyright © 2026 Epic Systems Corporation ✕

Add all available criteria to narrow your search. Broad queries may take a long time to complete.
PCP/Care Team field will query by both current and former providers recorded in the Care Teams Activity.

Name/MRN	SSN	Sex	Birth date	City
zztest, Harlow				
PCP/Care Team	State	Department	Phone	

[Find Patient](#) [Clear](#)

[Results](#) [Recent Patients](#)

Accessing PHI without a legitimate Providence business reason that is related to treatment, payment, or healthcare operations is a violation of Providence policy.

Using functionality to search for a patient by name or other identifier when you are not involved in their care is a policy violation. This includes searching for and viewing a patient's demographic information on the Patient Lookup screen, even if you do not click "Accept" to enter the full record.

[See recently opened patients](#)

Prohibited Uses of Epic








Searching For a Patient You are Not Caring For

Results Recent Patients

Match	Patient Name	MRN	Date Of Birth	Legal Sex	Address	City	State	Zip Code	SSN
17.98	ZZTEST,HARLOW	20018682920	10/09/2003	F	2319 DISNE...	ANAHEIM	CA	92806	xxx-xx-0001

Unauthorized access to patient demographic information is a policy violation. Always ensure that you are using appropriate patient search methods and that your access to patient information is justified and within the permitted business purposes.

Zztest, Harlow - 20018682920
This patient's name is an exact match to what was entered.

-  Born 10/9/2003 (21 y.o.)
-  Female
-  2319 DISNEY WAY
ANAHEIM CA 92806
-  No PCP on file
-  xxx-xx-0001
-  858-867-5309 (H)
858-867-5309 (M)
-  ilovedisney143@gmail.com
- Language: English
- Ethnicity: Unknown
- Race: Unknown to patient

→ Create New Patient

Copyright © 2026 Epic Systems Corporation

✓ Accept ✗ Cancel

Use of Hovering

Note: This screenshot is test data from Epic. It is NOT real patient information

Hovering is not permitted unless the workforce member has a business reason to do so.

Hovering means holding your cursor over a patient name or other identifier resulting in additional patient health information becoming visible to the workforce member for that patient.

Adhering to these policy requirements is vital to maintaining patient confidentiality and compliance with Providence policy.

The screenshot displays the 'EO Track Board' interface for Providence LCOM Torrance Emergency Center. It features a list of patients with columns for name, age, gender, and medical history. A tooltip is visible over a patient's name, displaying a comment: 'Comments (through 12/12/24 0910): Nurse Inpatient, RN 05/01/17 1207. Stroke call at 10:55'. The bottom of the screen shows a 'All Pts Metrics' bar with various status indicators.

Name	Age	Gender	Medical History
Perlicki, Peter	71 y.o.M	Male	
Chavez, Catalina	51 y.o.F	Female	stroke (epilepsy)
Jah, Deborah	57 y.o.F	Female	Back Pain
Espinola, Ethel	81 y.o.F	Female	Chest Pain
Fernandez, Patricia	47 y.o.F	Female	Respiratory Emphyse
Murphy, Margaret	21 y.o.F	Female	Neurological Pain
Ston, Kelly	21 y.o.F	Female	back pain
Sealing, Maria	31 y.o.F	Female	
Chavez, Antonia	31 y.o.F	Female	
Lee, Overton	31 y.o.F	Female	Overton (Westwood)
McDermott, David	61 y.o.M	Male	
John, David	51 y.o.M	Male	

Sharing EPIC[®] Credentials





Bob and Jake are physicians who were involved in Jane's hospitalization last year and got to know Jane and her family very well.


Jane has recently been admitted to the hospital.

Bob is concerned about the patient and accesses her medical record to find her location in the hospital.



Jane is here.

Do you know why she's here?



No. I saw Jane's mom walking down the hall, so I looked in Epic to see if she had been admitted.

Hmm, I think that could be a policy violation.



We were involved in her care, so it's all right.

I am just concerned and want to know how she is doing.

Plus, we got to know Jane and her family last year when she was in the hospital; I'm sure they wouldn't mind.

Is Bob correct in thinking that because he was involved in the patient's previous care that he is still able to view the patient's medical records?

NO

Bob is not correct in thinking that because he was part of the patient's prior care that he can continue to review the patient's medical record.

Yeah, but you aren't part of her current stay.

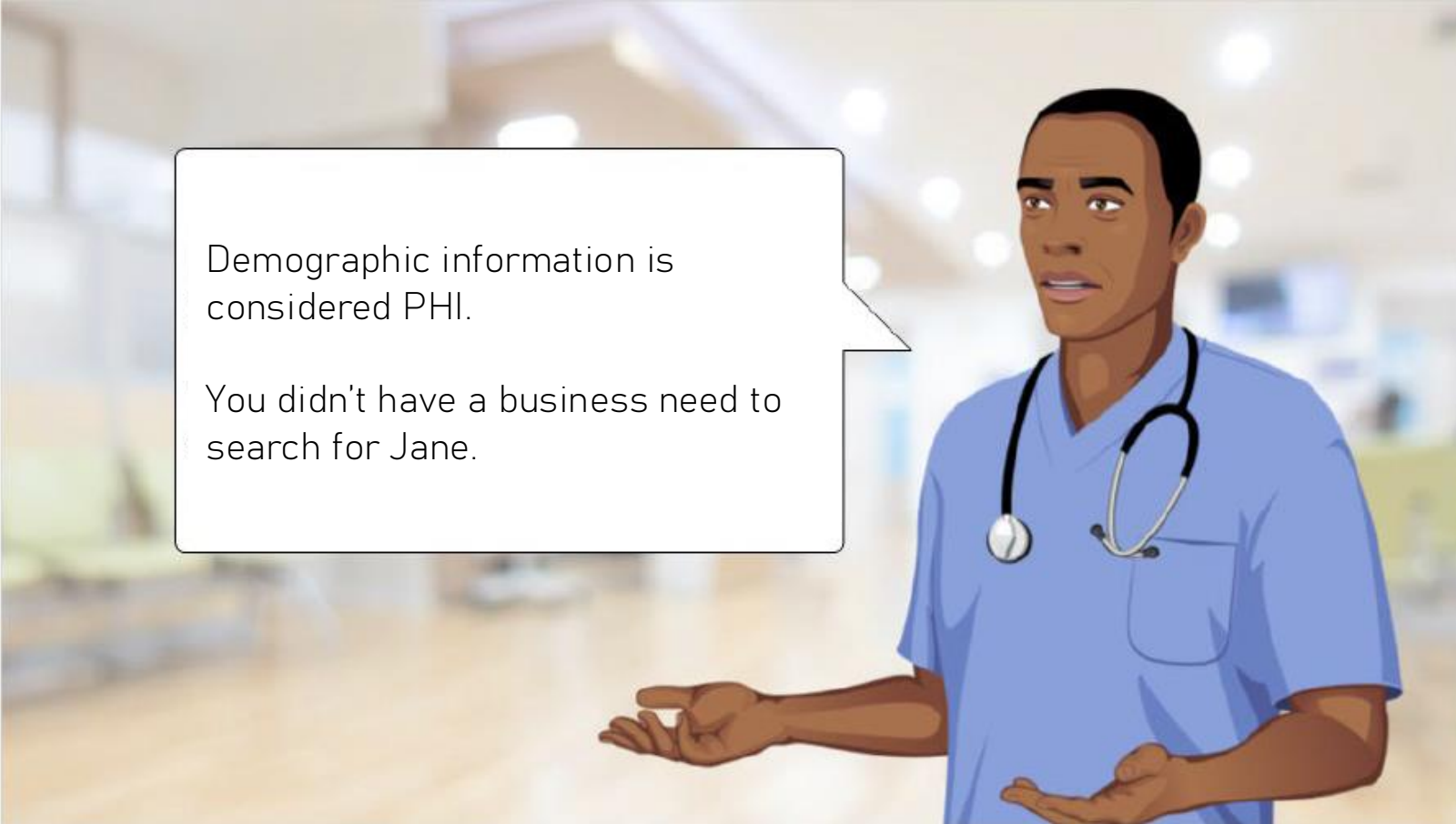
I am pretty sure privacy education teaches that a former care relationship, curiosity, personal relationship and even concern about a patient's well-being does not qualify as being involved with the patient's care.

I think accessing Jane's record is a policy violation.





I didn't access Jane's record though; I just searched for her to see if she had been admitted then saw her location in the hospital.



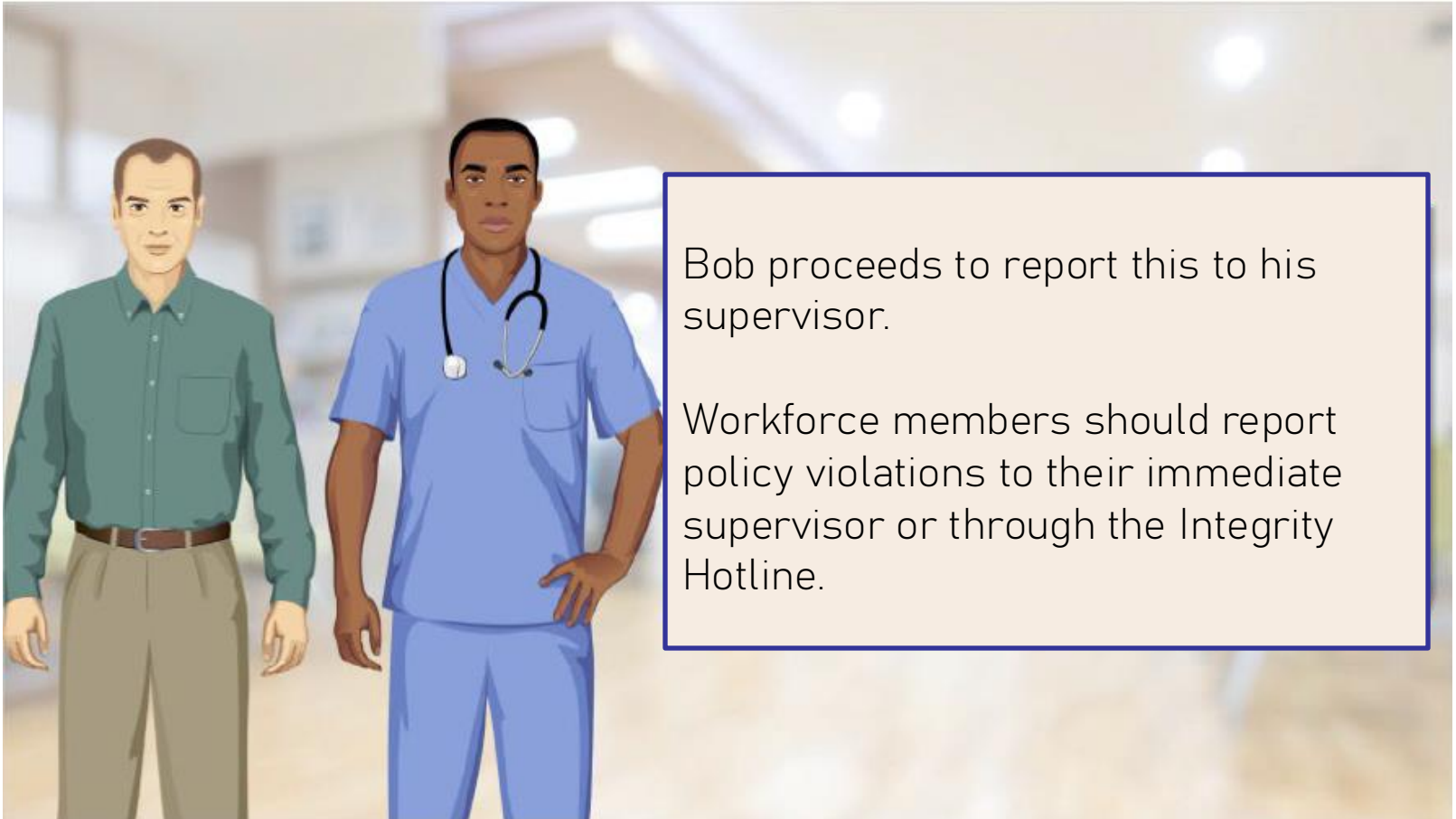
Demographic information is considered PHI.

You didn't have a business need to search for Jane.



Wow, thanks for letting me know! I'll not do that in the future.

I should self-report that I looked her up, and that I now know not to do that in the future.



Bob proceeds to report this to his supervisor.

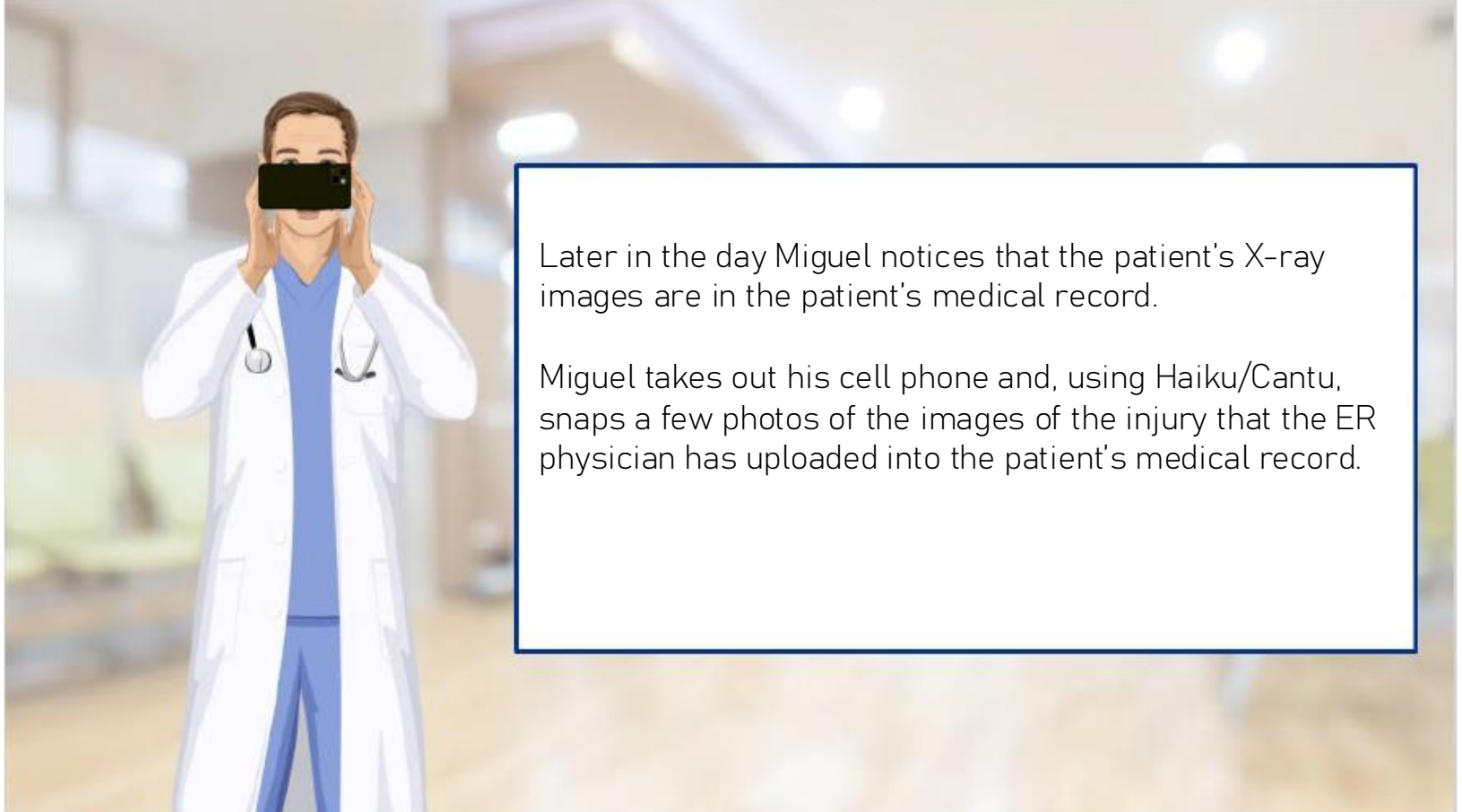
Workforce members should report policy violations to their immediate supervisor or through the Integrity Hotline.



While driving to work, Miguel passed a serious automobile crash.

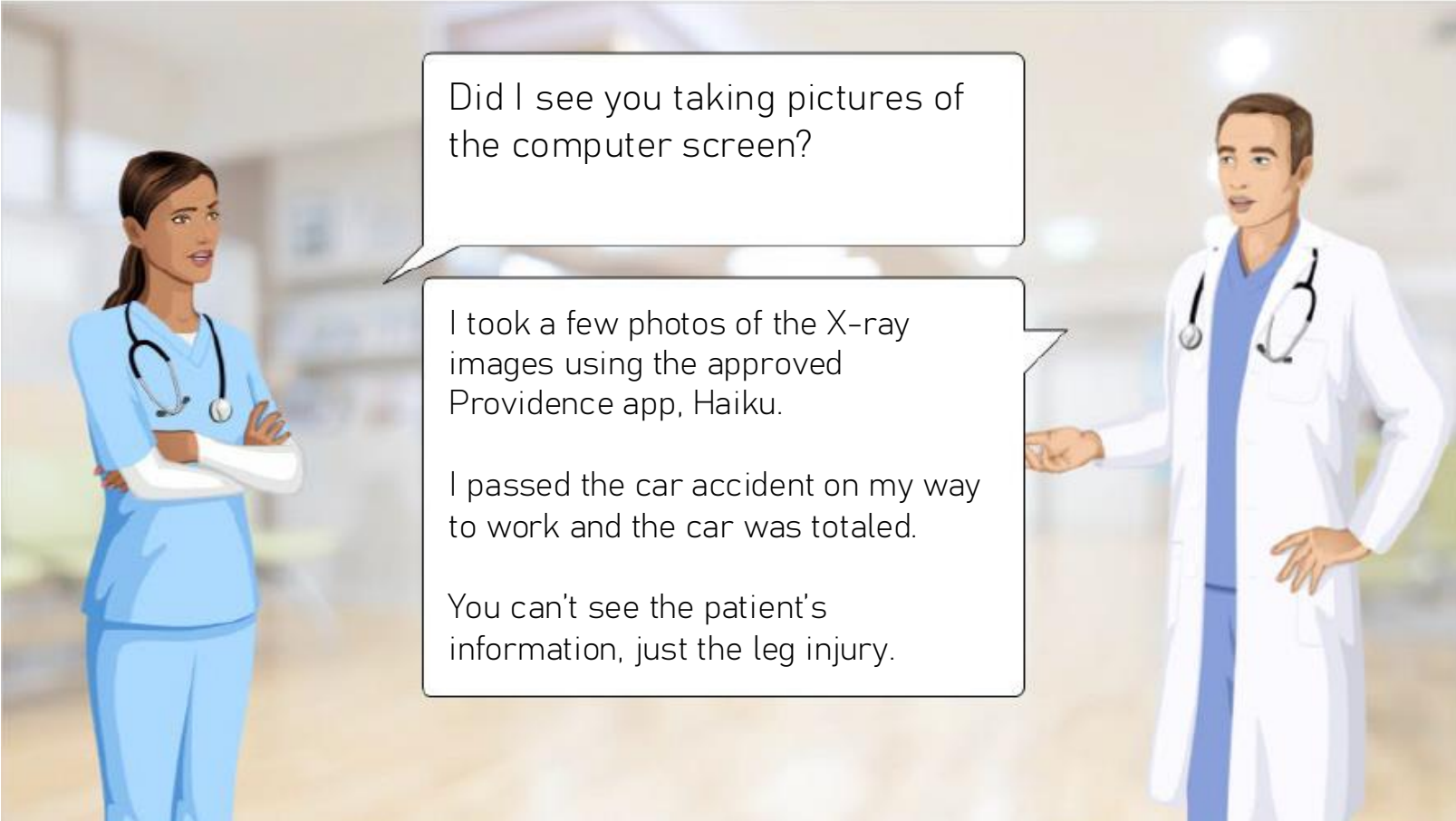
As Miguel arrives at the hospital he notices the ambulance outside the Emergency Department entrance.

As the day progresses, Miguel realizes that he is assigned to the care of this patient and that it is the patient from the accident he witnessed.



Later in the day Miguel notices that the patient's X-ray images are in the patient's medical record.

Miguel takes out his cell phone and, using Haiku/Cantu, snaps a few photos of the images of the injury that the ER physician has uploaded into the patient's medical record.



Did I see you taking pictures of the computer screen?


I took a few photos of the X-ray images using the approved Providence app, Haiku.

I passed the car accident on my way to work and the car was totaled.

You can't see the patient's information, just the leg injury.



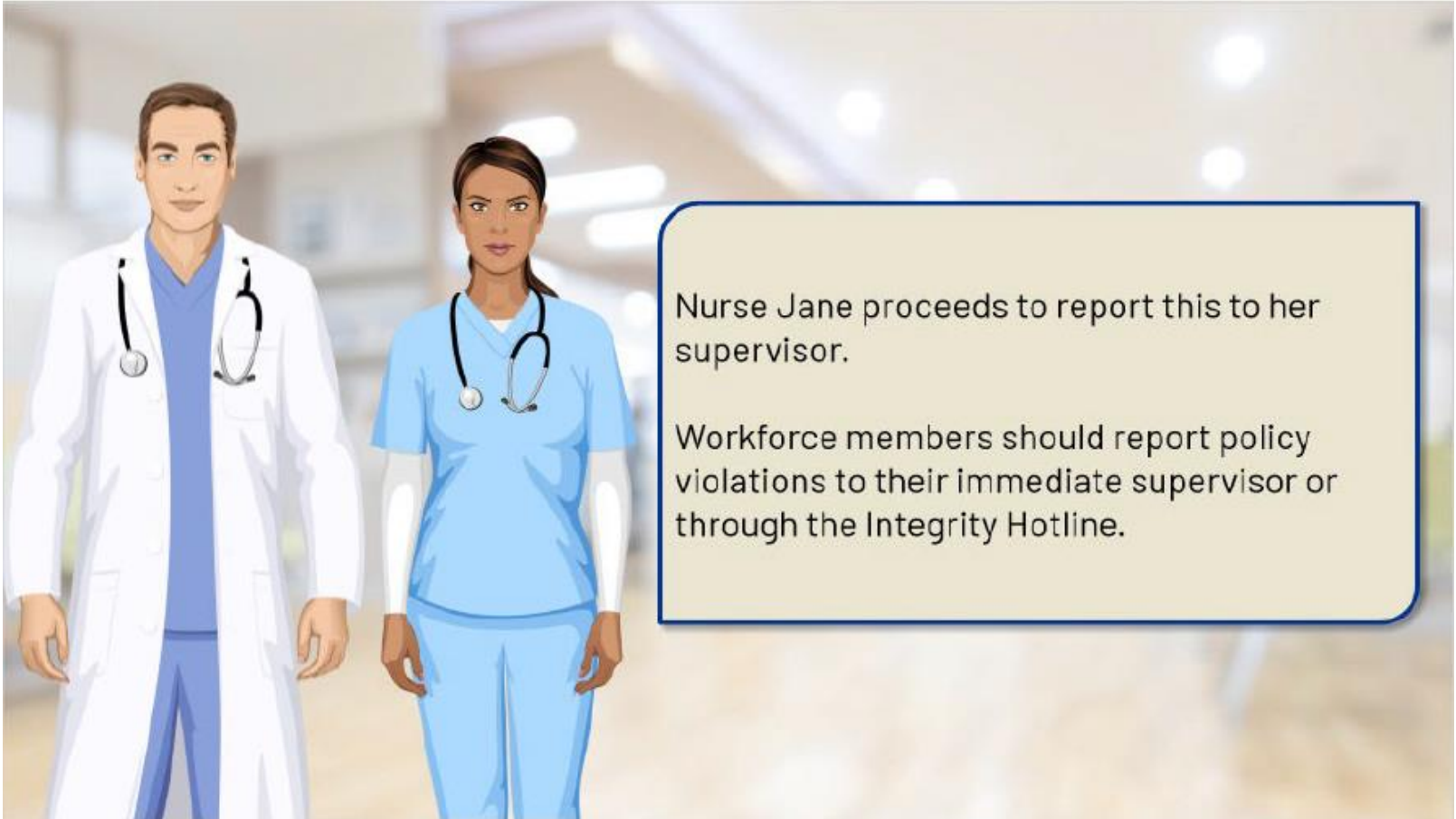
It is a policy violation to use a personal recording device in patient care areas and you definitely cannot use your phone to take a picture of PHI that is in a patient's medical record.



Oh, I didn't think it'd be a violation because the photo doesn't identify the patient.



You don't know that for sure and either way, it's not appropriate and you are violating policy and patient privacy by taking that picture and using your personal recording device in a patient care area.



Nurse Jane proceeds to report this to her supervisor.

Workforce members should report policy violations to their immediate supervisor or through the Integrity Hotline.

Use of Portable Devices

It is a policy violation to transmit or communicate PHI (including images/pictures) through any mechanism except through a Providence approved secured technology or application, even when using a Providence issued cell phone.

Please talk to your core leader to learn what specific Providence approved secured technologies or applications are available to you to message, capture and/or upload images into the patient's medical record for treatment purposes.

Please call the integrity hotline for guidance

Remember: Even if you are using a Providence owned cell phone, you still must use the secured technologies or applications to send secure PHI.

Personal Electronic Devices in Patient Care Areas

It is a violation of policy for workforce members to utilize any personal photography or recording devices in patient care areas (even if no patients are present) or where patients are present including, but not limited to, operating rooms, nursing stations, patient rooms, hallways, and elevators.









For example, all below are prohibited:

- Recording social media videos (for fun or educational purposes)
- Selfies or pictures with staff members
- Pictures with patients even when they give their approval
- Partial pictures of covered patients in the OR
- Pictures related to patient care/procedures
 - Medical trays in Operating Rooms
 - Medical waste in ER Rooms

Using Email for Providence Tasks

Personal email addresses must not be used to send or receive PHI.

- Providence policy PSJH-CYBR-950.08 Acceptable Use Standard prohibits the “use of third-party e-mail providers (e.g., personal e-mail accounts) to conduct Providence business”.
- Providers are prohibited from using their personal email address or a non-Providence email address to conduct business for/with Providence.
- Even if you think it is deidentified information, you may not send it via third party email accounts.

ACCEPTABLE	NOT ACCEPTABLE
 PHI and PII that IS YOUR OWN	 PHI and PII that is NOT your own
 Your Tax documents and Paystubs	 Passwords and logins to Providence-related systems
 Your personal information (<i>education related, PSLF forms, resume etc.</i>)	 Providence Work Product (<i>anything you were paid to create at Providence e.g. code, project plans, financial reports etc.</i>)
 Your HR related documents (<i>performance reviews, salary information, benefits etc.</i>)	 EPIC Intellectual Property (<i>e.g. screenshots, templates, smart phrases etc.</i>)

Privacy and Patient Rights Safeguards: *What Should You Do?*



Verify patient identity by using 3 identifiers. Many patients share full names and dates of birth and errors cause significant billing issues for patients along with privacy concerns. (Verify w Lindsay)



Be cautious with verbal conversations whether in treatment areas or in public areas. Know the audience listening.



Escalate all requests by patients promptly to avoid missing legal deadlines (i.e.; requests for medical record access or changes to medical records). Store portable devices and other electronic media in a secure location—your car is not a secure location!



Keep all papers/electronics with PHI out of view of the public. Secure your computer, voicemail and other passwords—lock and don't share! Ensure that screens are secured from being viewed by unauthorized individuals.



Ensure that treatment related communications or treatment photography is done via Providence secure applications.



Ensure you are not using a third-party email application to send PHI.

Law Enforcement and Government Oversight Agencies

If approached by law enforcement while on shift for Providence, immediately connect with the unit/department supervisor.

Disclosures of a patient's personal or medical information to law enforcement or government agents must be handled by Health Information Management or the designated operations area, even if they have a subpoena or a warrant for medical records.

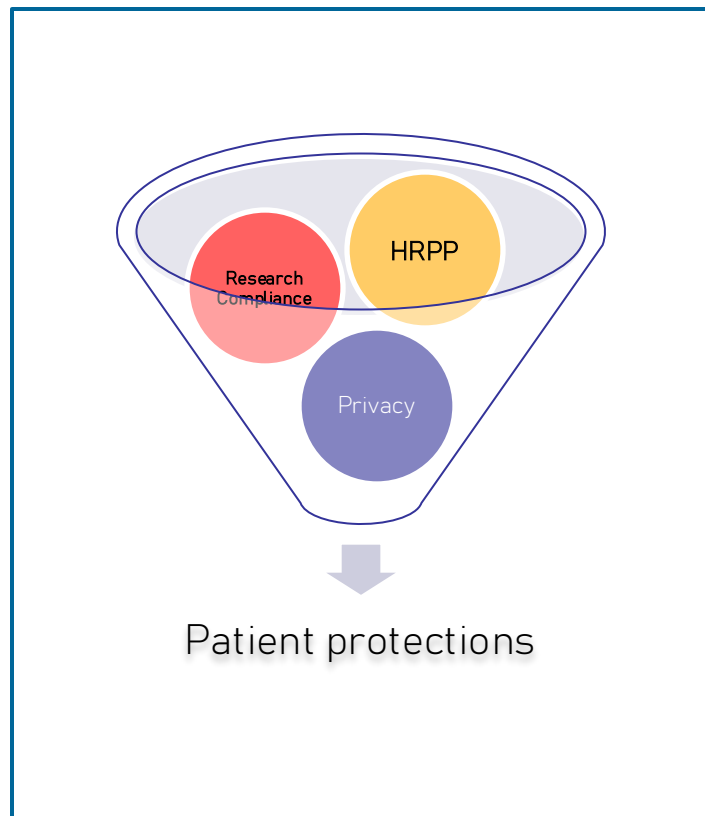
It is important to note that Providence will always cooperate with requests from government agencies, our response will be clear and truthful, and no alteration or destruction of records will occur.

Media Requests

- If contacted by a reporter or the media about a patient, you should notify a Providence core leader or the house supervisor (politely declining requests for information).
- Only designated individuals within Providence are authorized as public spokespeople to speak with the media.
- The media should never be permitted within patient care areas and are treated as general visitors to the hospital (unless appropriately authorized by senior leadership) and appropriate patient consents and authorizations are in place.

Intersection of Research and Patient Information

When it comes to research there are 3 distinct areas at Providence that are set up to protect the well-being of patients.



If you are planning to be involved in research here at Providence, ensure you are familiar with:

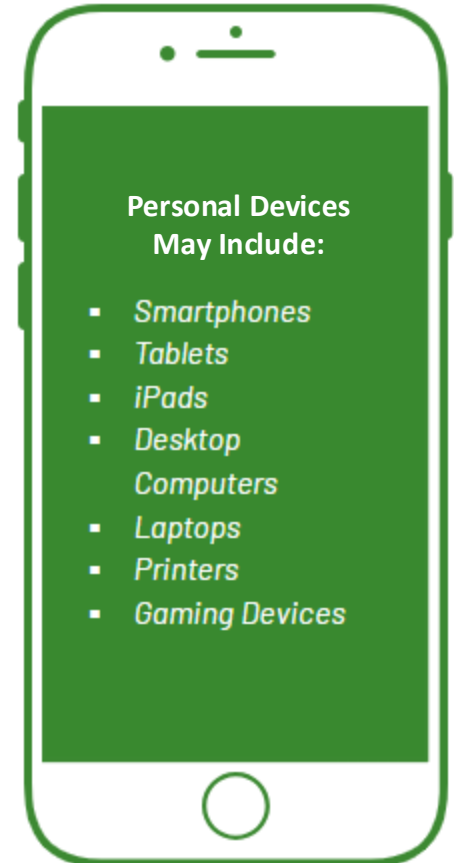
- [The Providence Human Research Protections Program](#)
- [Research Compliance at Providence](#)
- [Required study documentation](#) such as an Informed Consent form, Study Protocol and others.

Below are two publicly available NIDPOEs (“reprimands”) the FDA cited researchers on:

[NIDPOE issued for lack of IRB Approval](#)
[NIDPOE issued for failure to obtain consent \(among other violations\)](#)

Cyber Security at Providence

- Providence monitors the use of all information systems, all access to electronic data, and all devices that are used to access our systems or data.
- Personal device use must comply with all security policies (password protected, updated Operating System, patches, anti-virus, etc.) and the Use of Personal Device HR policy.
- Personal devices that contain Providence applications, programs, and apps are not to be used by anyone else or shared with anyone else.
- Any attempt to circumvent Providence security controls or non-compliance with policies can result in disciplinary action up to including termination of contract/partnership.



Artificial Intelligence (AI) Governance at Providence

Workforce members should only use Providence approved AI solutions for Providence work and on Providence devices

Policy: PSJH-EIS-908 Use of Providence-Approved AI Solutions

- Providence prohibits the use of non-approved AI systems by workforce members while working within the Providence IT systems/assets. Since *ProvidenceChat* was retired, Copilot is Providence's main AI system that is integrated with M365 for those who have the license.
- If there is an AI system not already approved that you want to use at Providence, it must be formally approved through the appropriate enterprise guardrails processes. The current processes are explained at [Enterprise AI Guardrails Program Management](#)
 - For AI systems ***related to patient care or clinical decision-making***, specific approval from the Providence Clinical AI Review Council is required for both internally developed and third-party solutions. This Council is accountable for certifying that the appropriate guardrails have been followed and the Clinical AI system can go to production deployment.
- All data collected or generated through Providence-approved AI systems must be used ethically and securely, accessed only by authorized workforce members, and handled in accordance with existing privacy policies, with use beyond product improvement requiring approval from the Providence Data Protection Council and Board.
- Caregivers who fail to comply with these requirements will be subject to disciplinary actions up to and including termination as outlined in PSJH-CPP-851 Privacy Sanctions Policy as well as the Counseling and Corrective Actions Policy (located on the Caregiver Services Portal).

Copilot for M365: Compliance & Usage Restrictions

At Providence, IS Cybersecurity has approved Copilot and it is integrated into Microsoft 365 and is automatically subject to all Providence policies, including but not limited to policies related to confidentiality, security, privacy, acceptable use, and Minimum Necessary Use of Protected Health Information (PHI) and Personally Identifiable Information (PII).

- Copilot for M365 must NOT be used for patient care or clinical decision making.
 - Users will be required to attest to NOT using Copilot for M365 for patient care or clinical decision making during the license request process.
- Copilot for M365 can be used with PHI/PII and Providence internal and confidential information, in accordance with Providence policy.
 - **IMPORTANT:** Use of PHI should be limited to the minimum necessary to accomplish the intended purpose. This means that in most cases caregiver (i.e. names, addresses) or patient identifiers (i.e. names, MRNs) should not be typed into Copilot for M365 input fields.
- Caregivers are responsible for how they use Copilot for M365 results.
 - Information should be reviewed to make sure it is accurate.
 - Copilot for M365 is for Providence business purposes only; it should not be used for personal reasons.

If you use Copilot, check out this [Copilot for M365 Tip Sheet](#) for helpful best practices.

Cyber Security Best Practices

- Keep all passwords private and secure. Do not share with anyone, **ever!**
- Lock or log off your computer when you walk away.
- To avoid phishing schemes, work related or personal, do not click on suspicious links or download attachments from unfamiliar senders, especially from email addresses you've never encountered before.



Health Connect Partners, LLC MSSP ACO Integrity & Compliance Training

Why Do I Need ACO Compliance Training?

Why do I need ACO compliance training?

- Compliance training is required by CMS for all MSSP ACOs – including employees, providers, and suppliers
- Your organization has chosen to participate in the HCP MSSP ACO. This means that *you* are now participating in the MSSP ACO too
- There are a few things you need to know to help ensure HCP complies with CMS requirements

What Am I Going to Learn & is it Important?

This compliance training program will address:

- Specific compliance requirements of MSSP ACOs
- Compliance issues, including fraud, waste, and abuse
- HCP's Integrity & Compliance Program
- Who to contact with questions or concerns

Compliance training is important; non-compliance can be very serious and result in:

- Termination of HCP's contract with CMS
- Loss of substantial amounts of funding
- Possible civil and/or criminal penalties for serious or intentional violations

What is a Medicare Shared Savings Program (“MSSP”) Accountable Care Organization (“ACO”)?

MSSP ACOs are groups of doctors, hospitals, and other health care providers who voluntarily work together to coordinate care for Medicare fee-for-service beneficiaries.

MSSP ACOs share in savings that result from providing beneficiaries with coordinated, high-quality care.

MSSP ACOs are not managed care organizations, do not use closed networks of providers, and do not limit a Medicare beneficiary's freedom to choose his or her providers.

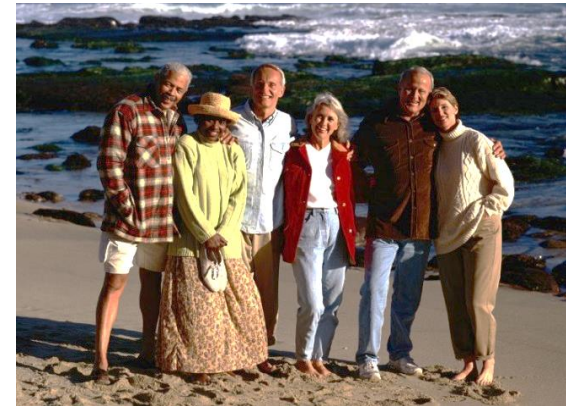
MSSP ACOs must meet specific requirements established by the Centers for Medicare and Medicaid Services (“CMS”)

Health Connect Partners, LLC (HCP) is the Providence MSSP ACO for Alaska, Washington, Montana, Oregon, and California.

MSSP ACO Compliance Requirements

CMS has established specific compliance requirements for all MSSP participants that go beyond those that otherwise apply to health care providers including:

- Medically necessary and appropriate care
- At-risk beneficiaries
- Beneficiary choice
- Beneficiary notices
- Communications with beneficiaries
- Marketing materials
- Gifts to beneficiaries
- Other MSSP requirements



Let's look at each of these areas further

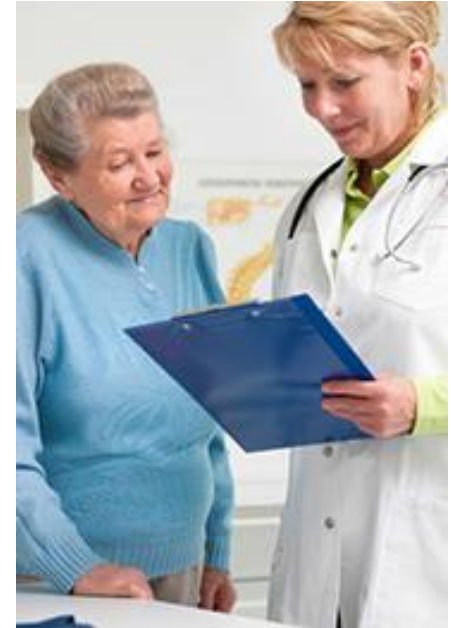
Medically Necessary & Appropriate Care

- Your MSSP ACO is committed to achieving the goals of:
 - Better health
 - Better care
 - Lower costs
- Health care that is **medically necessary** and **appropriate**
- MSSP participants may not:
 - Deny, reduce, or limit medically necessary services
 - Over-utilize services provided to non-MSSP beneficiaries to offset reduced revenues
 - Condition participation in the MSSP ACO on referrals of non-ACO business



At Risk Beneficiaries

- MSSP participants may not avoid beneficiaries with high-cost medical needs
- An "at risk" beneficiary is a patient who:
 - Has a high CMS risk score on the CMS-HCC risk adjustment model;
 - Is considered high cost due to having two or more hospitalizations or emergency room visits each year
 - Is dually eligible for Medicare and Medicaid;
 - Has a high utilization pattern
 - Has one or more chronic conditions;
 - Has had a recent diagnosis that is expected to result in increased cost;
 - Is entitled to Medicaid because of disability; or
 - is diagnosed with a mental health or substance abuse disorder.



Beneficiary Choice

Can the MSSP ACO limit Medicare beneficiaries to seeing only other ACO providers?

- No – HCP is not a managed care plan or a closed network program.
- Medicare fee-for-service beneficiaries are free to seek care from providers outside of Providence organizations and its affiliate organizations participating in the MSSP ACO.
- MSSP participants may not engage in practices or adopt policies that restrict or limit the right of Medicare fee-for-service beneficiaries to obtain health care services from providers they choose.



Communications with Beneficiaries

Are there other MSSP ACO requirements for communications with Medicare beneficiaries?

Yes – CMS has placed significant limitations on MSSP ACO communications (also referred to as “Marketing Materials”) with Medicare beneficiaries:

“Marketing Materials” include

- Beneficiary notices
- Brochures
- Websites
- Advertisements
- Outreach events
- Mailings
- Social media

“Marketing Materials” do not include

- Billing and claims information
- Materials on other specific individual health related issues
- Educational materials on health care conditions
- Materials customized or limited to a subset of beneficiaries
- Materials that do not contain information about the ACO, its participants, or providers
- Written referrals for health care services

MSSP ACO Materials – CMS Requirements

- All ACO marketing and communication materials for actual or potential Medicare beneficiaries require advance approval by CMS
- ACOs are prohibited from using incorrect or misleading information in marketing materials
- ACOs may not modify template marketing materials provided by CMS without approval of CMS
- Medicare and ACO contact information must be included in all materials developed or distributed to Medicare beneficiaries
- CMS prohibits the use of certain specific language, phrases, and terms in MSSP ACO marketing materials

MSSP ACO Materials – CMS Requirements

ACO-created materials may not contain:

- Language suggesting beneficiaries are required to see only ACO providers, or are in any way prohibited from seeing providers outside the ACO
- Language suggesting beneficiaries enroll or are participating in ACOs; wording should be clear the provider, not the beneficiary, has chosen to participate in the ACO
- Language suggesting CMS endorses one ACO over another
- Language suggesting an ACO is in any way superior to other ACOs, or other types of ACOs, or that providers participating in the ACO are superior to other providers participating in other ACOs or CMS initiatives

MSSP ACO Materials: CMS Requirements

CMS prohibits the use of certain terms and phrases in ACO-created materials:

Prohibited	CMS Suggested Alternative
"Managed care" or "care management"	"Coordinated care" or "care coordination"
Beneficiaries "enroll" or "enrollment"	Providers "participate"
"You have been selected to participate"	"Your provider has chosen to participate"

Refer to CMS' *Guidelines for MSSP ACO Marketing Materials* for additional information

MSSP ACO Materials – CMS

Requirements Beneficiary Notifications

- **Initial Notification:** MSSP ACOs must provide beneficiaries with a Beneficiary Notification Letter at or before their first primary care visit of the year for each five-year agreement period. Any new beneficiaries added throughout the agreement period will also need the initial Beneficiary Notification.
- **Follow-Up Notification:** MSSP ACOs must also furnish a follow-up communication at the beneficiary's next primary care visit or within 180 days of the beneficiary receiving the first notification. This notification is intended to provide the beneficiary with a meaningful opportunity to ask any outstanding questions they might have and serve as a tool to reduce beneficiary confusion and increase comprehension of the ACO program and cannot be simply resending the first notification.
- **Signage:** All MSSP ACO facilities must post the current CMS MSSP Poster in an area viewable to patients.
- **Templates:** CMS provides templates that must be used for notifications and signage and may not be altered.

Gifts to Beneficiaries

Can an MSSP ACO participant offer free or discounted services to Medicare beneficiaries?

Yes – but strict limitations apply. Organizations are allowed to provide Medicare beneficiaries free or below market value items and services to encourage care coordination and beneficiary health awareness when it meets all of the following requirements:

- “In-kind” (e.g. goods, commodities, and services, but not cash);
- Reasonably connected to the medical care of the beneficiary;
- Either preventive care items or services or intended to advance one or more of the following clinical goals:
 - Adherence to a treatment regime
 - Adherence to a follow-up care plan; and/or
 - Management of a chronic disease or condition
- Not a Medicare covered item or service.

Gifts to Beneficiaries

MSSP ACO participants may not give Medicare beneficiaries:

- Cash or items unrelated to health care under any circumstances (e.g. sporting event tickets, gift certificates for non-health care items)
- Items or services as a reward for receiving services from the organization
- Items or services to persuade a Medicare beneficiary to remain in the ACO or with a particular ACO provider



Appropriate

An ACO may provide a blood pressure monitor to a patient with hypertension to encourage regular blood pressure monitoring

Inappropriate

An ACO may not waive or reduce Medicare copayments or deductibles unless based on a beneficiary's financial need. This would be considered a financial incentive, not "in-kind" goods and services

Other MSSP ACO Requirements

MSSP ACO participants must also adhere to additional requirements of the MSSP ACO program including:

- Development of processes supporting evidence-based medicine, quality assurance, and patient engagement
- Periodic submission of quality data, certifications, and other information in accordance with CMS requirements
- Retention of all records related to MSSP for a minimum of 10 years after the ACO agreement period ends

All HCP participant organizations are expected to cooperate in the gathering, recording, and submitting of data in a timely, accurate, and complete manner, and assist in meeting all other requirements

Seeking Answers to Your Questions

- All HCP participants are encouraged to seek answers to questions and report issues and concerns
- HCP participants are expected to report, in good faith, any actual or suspected fraud, waste, and abuse, violations of law or regulations, or MSSP policies
- You may choose one or more of the following options for reporting:
 - *A manager, supervisor, or compliance officer in your organization*
 - *MSSP ACO Compliance Officer (Amy Riedel): amy.riedel@providence.org*
 - *Providence Compliance Hotline: 888-294-8455*

Completion Attestation

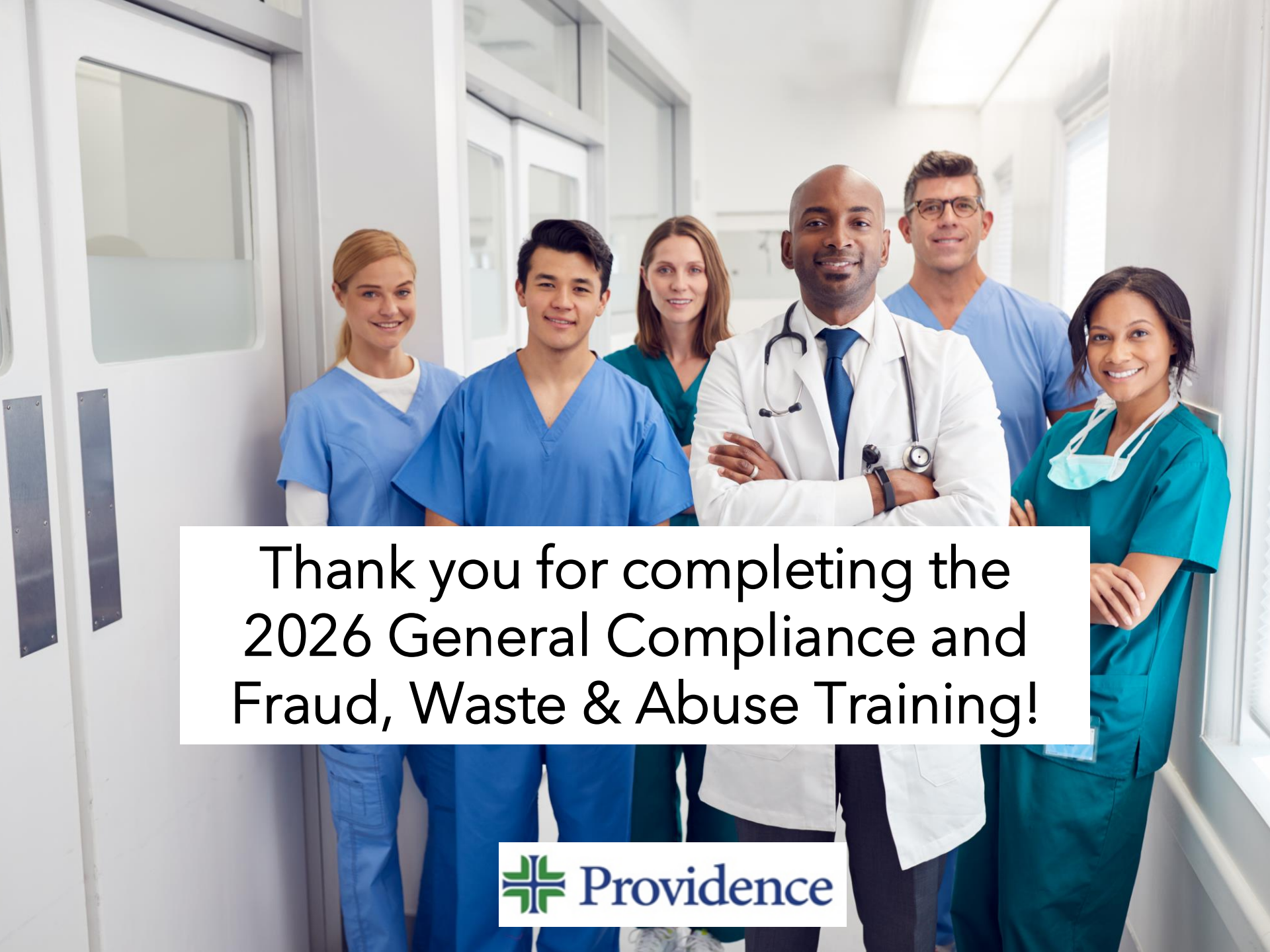
STOP!

To be marked complete for reviewing this education, please fill out the [Education Attestation](#). It will take less than 3 minutes of your time.

You will be asked to provide an email to receive your Certificate of Completion and *the opportunity to claim 2.0 CME credits.*



ATTESTATION

A diverse group of six healthcare professionals are standing in a bright, modern hospital hallway. From left to right: a woman in light blue scrubs, a man in blue scrubs, a woman in teal scrubs, a man in a white lab coat with a stethoscope and a blue tie, a man in blue scrubs and glasses, and a woman in teal scrubs with a surgical mask hanging from her neck. They are all smiling and looking towards the camera. The hallway has white walls, glass doors, and a window on the right side.

Thank you for completing the
2026 General Compliance and
Fraud, Waste & Abuse Training!

