

DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES

**EFFECTIVE DATE:** November 19, 2008

**DATE ISSUED:** November 19, 2008  
(Rescinds Division Circular #54A issued October 10, 2007)

**I. TITLE:** FEDERAL DEFICIT REDUCTION ACT OF 2005, Section 6032  
Policy on Compliance

**II. PURPOSE:** The purpose of this circular is to establish policies and procedures for all employees and contractors or agents in regard to the Deficit Reduction Act of 2005 and to provide detailed information about compliance with the requirements of the act.

**III. SCOPE:** This circular applies to the Division of Developmental Disabilities' developmental centers and Community Care Waiver services program.

Contracted providers may use the information in this circular as guidance in developing their own policies and procedures for compliance.

**IV. POLICY:**

Section 6032 of the federal Deficit Reduction Act of 2005 (Public Law 109-171) requires certain governmental, for-profit and non-profit providers and other entities that receive Medicaid funding to take actions that will address fraud, waste and abuse in health care programs that receive federal funds. It is the policy of the Division of Developmental Disabilities (DDD) to be in compliance with the federal and state laws and regulations related to the Deficit Reduction Act, the federal False Claims Act, and the New Jersey Conscientious Employee Protection Act. (Refer to Division Circular #54, Deficit Reduction Act of 2005, Policy on Fraud, Waste and Abuse.)

**V. GENERAL STANDARDS:**

**A. Compliance Monitoring Elements:**

At minimum, comprehensive compliance program should contain the following elements:

1. The development and distribution of written standards of conduct, as well as written policies and procedures that promote the facility's commitment to compliance, e.g., by including adherence to compliance as an element in evaluating managers and employees, and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;
2. The designation of a chief compliance officer and other appropriate bodies, e.g., a Division compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who report directly to the Assistant Commissioner;
3. The development and implementation of regular, effective education and training programs for all affected employees;
4. The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation;
5. The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements;
6. The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area; and
7. The investigation and remediation of identified systemic problems and the non-employment or retention of sanctioned employees.

**B. Compliance Program Areas:**

Written Policies and Procedures are required for the following areas:

1. **Standards of Conduct** – the Division and each facility should have standards of conduct for all affected employees that include a clearly delineated commitment to compliance by the facilities management and employees and include providers operating under the facility's control.
2. **Risk Areas** – Written policies and procedures should take into consideration the regulatory exposure of reach function or department of the facility, such as:
  - a. Billing for items or services not actually rendered;
  - b. providing medically unnecessary services;

- c. duplicate billing;
  - d. false cost reports;
  - e. unbundling of billing claims;
  - f. patient's freedom of choice;
  - g. financial arrangements between facilities and providers that violate the anti-kickback statute or other similar Federal or State statute or regulation;
  - h. joint ventures;
  - i. knowing failure to provide covered services or necessary care to members of a health maintenance organization.
3. Additional risk areas should be assessed as well as by facilities and incorporated into written policies and procedures and training elements developed as part of their compliance programs.
- a. Claim development and Submission Process
  - b. Cost Reports
  - c. Medical Necessity – Reasonable and Necessary Services
  - d. Anti-Kickback and Self Referral Concerns
  - e. Bad Debts
  - f. Credit Balances
  - g. Retention of Records
  - h. Compliance as an Element of a Performance Plan

**B. Designation of a Compliance Officer and a Compliance Committee**

Each entity should designate a Compliance Officer to serve as the focal point for compliance activities and establish a compliance committee to assist in the implementation of the compliance program.

The Compliance Officer shall have authority to review all documents and other information held by the Division or contracted providers or sub-providers that are relevant to Division compliance activities, including but not limited to: client records, billing records, employee records, contracts, policies and procedures.

1. Compliance Officer - The Division shall appoint a Compliance Officer whose primary responsibilities shall include:
- a. Overseeing and monitoring the implementation of the compliance program;
  - b. Reporting on a regular basis to the Assistant Commissioner and compliance committee on the progress of implementation, and assisting these components in establishing methods to improve the Division's efficiency and quality of services, and to reduce the Division's vulnerability to fraud, abuse and waste;

- c. Periodically revising the program in light of changes in the needs of the Division, and in the law and policies and procedures of Medicaid;
- d. Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent Federal and State standards;
- e. Ensuring that independent contractors and agents who furnish medical services to the Division are aware of the requirements of the Division's compliance program with respect to coding, billing, and marketing, among other things;
- f. Coordinating personnel issues with the Division's Human Resource office to ensure that the National Practitioner Data Bank and Cumulative Sanction Report have been checked with respect to all employees, medical staff and independent contractors;
- g. Assisting the Division's financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments;
- h. Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all Division components, providers and sub-providers agents and, if appropriate, independent contractors; and
- i. Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

## 2. Compliance Committee:

The committee's functions should include:

- a. Analyzing the Division's industry environment, the legal requirements with which it must comply, and specific risk areas;
- b. Assessing existing policies and procedures that address these areas for possible incorporation into the compliance program;
- c. Working with appropriate Division components to develop standards of conduct and policies and procedures to promote compliance with the Division's services;
- d. Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the Division's standards, policies and procedures a part of its daily operations;
- e. Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms; and

- f. Developing a system to solicit, evaluate and respond to complaints and problems.
3. Compliance Liaisons:

Each developmental center and each regional Community Services office shall have a compliance liaison designated to further operationalize compliance and to ensure the oversight of regulatory compliance for all services at the Division component. The Compliance Liaison shall assist the Division Compliance Officer in:

- a. The implementation of Compliance Program elements and initiatives.
- b. The investigation and correction of compliance related issues.
- c. The communication of the Compliance Program to employees and contractors.

**C. Conducting Effective Training and Education**

- 1. Education - Each Division component is required to ensure that employees receive information regarding reporting Medicaid fraud, waste and abuse. Employees shall be trained in the information contained in Division Circular #54, "Federal Deficit Reduction Act of 2005, Policy on Fraud, Waste and Abuse" and the Division's Standards of Conduct.
  - a. New employees shall receive the information contained in Division Circular #54 within 30 days of hire.
  - b. Employees involved with compliance activities and risk areas may attend relevant training as warranted.
- 2. Developing Effective Lines of Communication:
  - a. Access to Division's Compliance Officer - each employee shall be made aware of the name, address, phone number and email address of the Division's Compliance Office via the educational material.
  - b. Hotlines and Other Forms of Communication - each employee shall be made aware of the Department of Human Services Medicaid Fraud Hotline via the education material and posters to be displayed in employee common areas.
- 3. Enforcing Standards through Disciplinary Guidelines:
  - a. Employees who do not comply with the policies and procedures or who have otherwise engaged in wrongdoing shall be subject to

disciplinary action as described in DHS Administrative Order 4:08, "Disciplinary Action Policies and Responsibilities".

- b. New employees may be subject to background checks for criminal convictions and/or who are listed as disbarred, excluded or otherwise ineligible for participation in Federal health care programs in accordance with these policies.
4. Auditing and Monitoring:
- a. Ongoing evaluation should occur to ensure compliance either via routine audits of the Division's systems or other methods such as the Division's Internal Controls process as described in Division Circular 29.
  - b. Methods of monitoring may include on-site visits, interviews with staff or contractors, questionnaires, DHS/Developmental Disabilities Licensing inspections, reviews of policies and procedures, trend analysis or other methods as deemed appropriate by the Division's Compliance Officer.
  - c. Refer to Appendix C, "Evaluation of Compliance Program" for additional guidance in auditing the Division's compliance.
5. Responding to Detected Offenses and Developing Corrective Action Initiatives:
- a. Violations and Investigations – A system for receiving reports of alleged offenses and investigation of offenses shall be established by the Division's Compliance Officer.
  - b. The Compliance Officer shall initiate steps to investigate the allegations, including but not limited to reporting the allegation to the Department of Human Services or law enforcement, as warranted.



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Assistant Commissioner

Appendices:

Appendix A – Existing Division Practices, Policies and Procedures for Addressing Fraud, Waste and Abuse

Appendix B – DHS Policies and Procedures for Addressing Fraud, Waste and Abuse

**DIVISION OF DEVELOPMENTAL DISABILITIES**

**SUBJECT: Existing DDD Practices, Policies and Procedures for Addressing Fraud, Waste and Abuse in Medicaid and Other Health Care Programs for the Community Care Waiver Program and the State Developmental Centers**

**EFFECTIVE: November 19, 2008**

**POLICY:** The Division of Developmental Disabilities (DDD) will ensure that policies and procedures are in effect to detect and prevent fraud, waste and abuse of funding resources and pursuant to the Federal Deficit Reduction Act of 2005.

**STANDARDS:**

DDD has established practices, policies and procedures to detect and prevent fraud, waste and abuse of funding resources, including Medicaid funding, and pursuant to the Federal Deficit Reduction Act of 2005. These practices, policies and procedures are found in the DDD Division Circulars, DDD component policies and the Department of Human Services' policies as described below.

Note: Division Circulars can be found at the DDD website by going to <http://www.state.nj.us/humanservices/ddd/DCs.html>

**A. DDD Policies:**

1. Division Circular 3, "Determination of Eligibility" N.J.A.C. 10:46, requires that an individual receiving Community Care Waiver (CCW) services applies to become Medicaid eligible and maintains eligibility.
2. Division Circular 35, "Service Plan" assures that policies and procedures exist for the proper formulation of the service plans for CCW services. As part of that process, the plan oversight and approval is made by a Qualified Mental Retardation Professional (QMRP) as per 42 CFR 483.430. Reviews of services received, other than adult day programs, are conducted on a quarterly basis.
3. Division Circular 14, "Reporting Unusual Incidents" requires reporting of the abuse, neglect or exploitation of individuals, including inappropriate handling of the individual's resources.

4. Division Circular 29, "Internal Controls", A.O. 6:12, establishes standards and guidelines for an internal controls system to adequately insure a high quality of services and operations and to insure that DDD maintains a system of internal controls that complies with DHS A.O. 6:12. and Treasury Circular 03-08 OMB.
5. Division Circular 7, "Guardianship Services" N.J.A.C. 10:45, ensures the availability of guardianship services for individuals who have been adjudicated incapacitated. Although not the primary role of guardianship services, misuse of an individual's resources or benefits may be detected by a guardian in their effort to safeguard the individual.
6. Division Circular 15, "Complaint Investigations in Community Programs", establishes policies for conducting civil investigations in response to allegations or suspicions of abuse, neglect, and exploitation. An investigation may center on financial exploitation of the individual.
7. Division Circular 25, "Access to Electronic Files" is a policy for permitting access to electronic records, seeks to restrict access to an individual's information to protect that individual's privacy. To take this to another level, DDD is currently working on a process to protect against identity theft.
8. Division Circular 30, "Records Confidentiality and Access to Client and Agency Records" N.J.A.C. 10:41-2, develops policies and procedures to safeguard the confidentiality of an individual's records and access to agency records.
9. Division Circular 40, "Background Checks" N.J.A.C. 10:48A, establishes guidelines for obtaining criminal history background checks of employees of agencies under contract with DDD.
10. Division Circulars 53, 53A, and 53B, following DHS A.O. 2:01, were established to implement the requirements of HIPAA as it relates to privacy practices, and 45 C.F.R. parts 160 and 164 for the protection of client health information.

**B. Department of Human Services:**

1. The Department of Human Services (DHS) Office of Auditing (OOA) performs yearly contract audits for select agencies identifying inappropriate contractor expense items.



2. Each contractor agency is required to have an annual single audit (section P7.06 of the Contract Policy Manual), performed in accordance with federal OMB Circular A-133 and DHS policy by a licensed accounting firm, to ascertain that the financial statements fairly represent the financial position of the organization, including a review of the DDD/DHS final reports of expenditure (ROE) as mandated by section P2.01 of the Contract Policy Manual.
3. Licensing regulations under N.J.A.C. 10:44A-2.4b, 10:44B-2.1a.1, and 10:44C-2.4b, states that except as otherwise provided in the Rehabilitated Convicted Offenders Act (N.J.S.A. 2A:168A-1 et seq.), no licensee shall employ any person who has been convicted of forgery, embezzlement, obtaining money under false pretenses, extortion, criminal conspiracy to defraud, crimes against the person or other like offenses.
4. DHS contract policy allows DDD to have input into and oversight of the development and approval of contractor contracted programs and budgets that will render services that are federally claimable through the CCW.

**C. DDD Fiscal Office:**

1. In completing cost report rates, the Fiscal Office performs an analysis of exceptionally high and low individual contractor rates by Fiscal Year to insure that federal claim rates have been appropriately calculated and have not been skewed by inaccurate reporting.
2. The Central Office Fiscal Office reviews Unusual Incident Reports (UIRs) on at least a monthly basis to identify individuals who are deceased, insuring that claims cease as of the date of death.
3. The Fiscal Office scrutinizes posted contractor attendance and ROE data in the DDD systems to correct potential errors and omissions.
4. The Fiscal Office creates reports that identify patterns and variances in reported attendance data to detect errors and omissions.
5. In accordance with contract policy, contractors who do not submit required documents may be sanctioned by a withholding of payment.

**D. Information Technology:**

1. Fiscal and Information Technology (IT) staff match DDD eligibility files (one component of the claim file) to the eligibility files of the Division of Medical Assistance and Health Services (DMAHS) in order to reconcile discrepancies.
2. On an ongoing basis, any errors in claiming discovered by the IT Office, Unisys, or Fiscal staff are submitted to IT to process voids and corrections.
3. The DDD IT Office reconciles submitted claims to paid claims. This process insures that Medicaid has handled claims appropriately.
4. DDD has implemented a web-based attendance collection system which allows contractors to key data at the source. Agencies will be able to key Reports of Expenditures (ROE) directly to a DDD system or work with the DDD IT office to arrange for automatic uploading of the agency accounting information to the DDD ROE system. This process will eliminate inaccuracies caused by double-keying.

**E. Community Care Waiver (CCW) Program:**

1. DDD requires that contractor management staff attest, through on-line certification or signature, to the accuracy of attendance records and expenditure reports, the basis for CCW claims.
2. A DDD waiver staff person is responsible for performing ongoing reviews of contractor and DDD case file records to insure that individuals receiving waiver services are in need of the services, maintain eligibility, and receive the services as documented in their individual service plans.
3. DDD, in calculating final CCW rates, includes material OOA contract findings that would affect the final CCW rates.
4. DDD performs data warehouse rate reviews to verify that final paid CCW claims have been reimbursed by the Federal government at the appropriate final CCW rates in the Medicaid system.
5. DDD utilizes claiming codes that comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to avoid billing for duplicative services. For example: hospital, nursing home, and

group home services are all residential services that cannot be billed on the same day.

6. Monitoring is conducted through DMAHS to disallow the eligibility of an individual for more than one Medicaid 1915c Home and Community Based Services (HCBS) waiver program at the same time in compliance with applicable federal law on HCBS waivers.
7. Federal regulations at 42 C.F.R. 441.302(h) require state agencies to provide annual reports (HCFA 372) on the CCW program. These reports address the waiver's impact on (1) the type, amount and cost of services provided under the State Plan; and (2) the health and welfare of the beneficiaries. According to 42 C.F.R. 441.304(d), the Centers for Medicare and Medicaid Services (CMS) may terminate the CCW program if the actual costs for any year of the waiver period exceed the amount that would be incurred for those individuals in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).
8. In order to insure financial integrity and accountability of payments made for CCW services and to insure compliance with federal regulations, the DDD waiver states the following:
  - a. "Independent audit of provider agencies on an annual basis is a requirement for agencies operating under contract with the Single State Medicaid Agency (DHS). This requirement is delineated in the State Contract Manual in The Department of Human Services' Policy Circular P2.01. Specifically section 3.09 of this policy requires an annual audit that is agency wide in scope. The audit must be conducted in accordance with the Federal Single Audit Act of 1984, generally accepted auditing standards as specified in the Statements of Auditing Standards issued by the American Institute of Certified Public Accountants (AICPA) and Government Auditing Standards issued by the Comptroller General of the United States. In addition the policy stipulates that at any time an agency may be audited by the Department of Human Services (DHS), the Single State Medicaid Agency, or any other appropriate unit of the state or federal government and/or by a private firm approved by the DHS. In addition, agencies providing Individual Support services in residential settings for Traumatic Brain Injury (TBI) are required by state regulation N.J.A.C. 10:44C to have an agency wide audit conducted annually. DHS does not dictate the auditing corporation selected by a provider agency but rather ensures compliance re. scope and standards for the annual audit. A more detailed explanation of the mandatory

audit requirements are documented in DHS Policy Circular P7.06.”

- b. “Provider billing is done by UNISYS, a corporation under contract with the Division of Medical Assistance and Health Services (DMAHS), the component of the DHS designated with general oversight of HCBS waivers. UNISYS is audited annually according to the SAS 70 auditing standard of the AICPA. The audit evaluates systems control design process, key controls that support control objectives, effectiveness of the control design, and any control gaps which would indicate a risk factor. The SAS 70 auditing standard also comports with CMS focus on quality in that in addition to an audit of controls the system also provides for an evaluation of the operating effectiveness of specified controls over a specified time period (generally six (6) months). The audit is bid by RFP. Currently the auditing agency is Ernst & Young, LLP. The specific policies and procedures for the UNISYS audit are available through the State Medicaid agency.”

**F. Developmental Centers:**

1. Turnaround Documents (TADs) - monthly reconciliations completed at each developmental center:
  - a. client movement reports to census report;
  - b. census reports to billing;
  - c. reconciliation of TAD to Remittance Advice.
2. DHS OOA – at least annual audit is conducted at each facility.
3. Separated oversight:
  - a. Developmental centers are directly responsible for purchasing, billing, etc.;
  - b. Central Office DHS is responsible for analyzing expenditures to determine final rates and adjustments;
  - c. Comparative analysis of ICF/MR expenditure increases by service category occur.
4. DDD conducts oversight in terms of insuring compliance with state and departmental guidelines via the review and approval of travel, training, contracts, waivers and equipment purchases.
5. Each center complies annually with Treasury regulations by providing an overall Internal Control Certification, which covers both administrative and fiscal areas.

6. Staff at the developmental centers establish that the individual meets the ICF-MR level of care. Staff then process eligibility through the Institutional Service Section (ISS) of the Division of Medical Assistance and Health Services and assist the individual in maintaining his/her eligibility.
7. Internal Controls policies at the developmental centers include:
  - a. Medicaid Billings Reconciliation;
  - b. Daily Census Procedure;
  - c. TAD Procedure;
  - d. Billing long term care TAD to UNISYS.

**G. Websites for Obtaining Additional Information:**

- Deficit Reduction Act – Public Law 109-171  
[www.gpoaccess.gov/plaws/index.html](http://www.gpoaccess.gov/plaws/index.html)  
(insert public law 109-171 in the quick search box)
- New Jersey Statutes  
[www.njleg.state.nj.us](http://www.njleg.state.nj.us)
- U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Deficit Reduction Act  
<http://www.cms.hhs.gov/DeficitReductionAct/>

**DIVISION OF DEVELOPMENTAL DISABILITIES**

**SUBJECT:** Department of Human Services—Policies and Procedures for Addressing Fraud, Waste and Abuse in Medicaid and Other Health Care Programs for All DDD Providers Participating in the Medicaid Program that are Subject to Section 6032 of the Deficit Reduction Act of 2005

**EFFECTIVE:** November 19, 2008

**POLICY:** The Division of Developmental Disabilities (DDD) will ensure that policies and procedures are in effect to detect and prevent fraud, waste and abuse of funding resources and pursuant to the Federal Deficit Reduction Act of 2005.

**STANDARDS:**

A. It is the goal of the Department of Human Services (DHS) that all DHS facilities and agencies subject to Section 6032 of the Deficit Reduction Act of 2005 (referred to here as “DHS Section 6032 Providers”) comply with the Compliance Program Guidance for Hospitals published in 1998, the Supplemental Compliance Program Guidance for Hospitals published in 2005, and the Compliance Program Guidance for Nursing Facilities published in 2000 by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services, to the extent that those guidelines are applicable, relevant and cost-effective to implement for the particular facility or program involved.

- The 1998 OIG compliance guidelines for hospitals can be found at: <http://www.oig.hhs.gov/authorities/docs/cpghosp.pdf>
- The 2005 OIG supplemental compliance guidelines for hospitals can be found at: <http://www.oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>
- The 2000 OIG compliance guidelines for nursing facilities can be found at: <http://www.oig.hhs.gov/authorities/docs/cpgnf.pdf>

B. The OIG compliance guidelines have seven basic elements:

- i. Designation of a Compliance Officer and Compliance Committee.
  - ii. Development of Compliance Policies and Procedures, Including Standards of Conduct
  - iii. Developing Open Lines of Communication
  - iv. Appropriate Training and Education
  - v. Internal Monitoring and Auditing
  - vi. Response to Detected Deficiencies
  - vii. Enforcement of Disciplinary Standards
- C. In addition, DHS Section 6032 Providers will comply with all federal and state laws and policies governing Medicaid fraud, waste and abuse. To see the New Jersey statutes dealing with fraud, waste and abuse, go to [http://www.cms.hhs.gov/apps/mfs/State\\_Select.asp](http://www.cms.hhs.gov/apps/mfs/State_Select.asp), select “New Jersey” from the drop-down menu, and then click on “Search”. To review the federal websites containing information on Medicaid fraud and abuse, go to <http://www.cms.hhs.gov/MCAIDFraudAbuseGenInfo/> for the site of the Centers for Medicare and Medicaid Services (CMS), and go to [www.oig.hhs.gov](http://www.oig.hhs.gov) for the OIG’s website.
- D. The DHS Section 6032 Providers will also comply with all applicable DMAHS Newsletters and Alerts relating to fraud, waste and abuse. DMAHS Newsletters and Alerts can be found in a searchable database at <http://www.njmmis.com/servlet/eSrvDesktopServlet>, select “Newsletters & Alerts” under “Information”.
1. One example is a Medicaid Alert issued in 2004, which can be viewed at <http://www.njmmis.com/servlet/GetContentServlet?ID=000000001358>. It states that a provider cannot seek reimbursement for any services, goods or supplies that are furnished, ordered, directed, managed or prescribed in whole or in part by any individual or entity that has either been excluded from participation in Medicaid and other programs by the OIG or DMAHS, or is unlicensed. The Alert lists three databases that should be checked to assure that providers do not hire or do business with individuals and entities that have been excluded or have lost their professional licenses. The three databases are:
    - i. The OIG List of Excluded Individuals/Entities at <http://oig.hhs.gov/fraud/exclusions.html>;

- ii. The New Jersey Department of Treasury Consolidated Debarment Report at <http://www.state.nj.us/treasury/debarred/>;
  - iii. The Division of Consumer Affairs website located at <http://www.state.nj.us/cgi-bin/consumeraffairs/search/searchentry.pl>.
2. In addition, a new site at the Division of Consumer Affairs website provides important information about medical doctors, podiatrists and optometrists, including licensure disciplinary actions and criminal convictions. That site can be found at <http://12.150.185.184/dca/>.

Additional website resources:

Cumulative Sanction Report  
<http://www.dhhs.gov/progorg/oig>

U.S. GSA – list of debarred contractors  
<http://www.arnet.gov/epls>

3. An important means of detecting and preventing fraud, waste and abuse is the annual internal controls certification process mandated by the New Jersey Department of Treasury and DHS. The Department of Treasury internal controls guidelines can be found in OMB Circular Letter 03-08-OMB at <http://www.state.nj.us/infobank/circular/cir0308b.htm>.
- E. Compliance Officers within DHS are responsible for assuring that all laws, policies and procedures relating to fraud, waste and abuse are being followed. Here is a list of Compliance Officers, with their telephone numbers and e-mail addresses, for DHS and all DHS Section 6032 Providers:
1. DHS: William Cutti, [bill.cutti@dhs.state.nj.us](mailto:bill.cutti@dhs.state.nj.us), 609-292-9752
  2. DDD: [dddcomplianceofficer@dhs.state.nj.us](mailto:dddcomplianceofficer@dhs.state.nj.us) or 800-626-6077
- F. When the DDD Compliance Officer receives evidence or allegations of fraud, waste or abuse, or patient abuse or neglect, involving Medicaid or NJ FamilyCare should refer them to the Office of Medicaid Inspector General, with copies to the DHS Compliance Officer and to the Director of the DHS Office of Program Integrity and Accountability. Evidence or allegations regarding other health care programs funded in whole or in part with state funds should be referred to the DHS



Compliance Officer and to the Director of the DHS Office of Program Integrity and Accountability. If as a result of any review or investigation there is evidence of suspected fraud or patient abuse or neglect, the case will be referred to the Medicaid Fraud Section within the Office of Insurance Fraud Prosecutor of the New Jersey Division of Criminal Justice.

4. Compliance Officers who receive evidence or allegations of fraud, waste or abuse involving Medicare or any other health care program receiving only federal funds should refer them to the federal OIG in one of the ways described at <http://www.oig.hhs.gov/hotline.html>.
5. In addition to following the procedures outlined above, existing procedures for handling these problems (such as DDD Division Circular 14 on "Reporting Unusual Incidents", and DDD Division Circular 15 on "Complaint Investigations in Community Programs") also should be followed.