Banner
University Health Plans

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www.BannerUHP.com

May 2021 Provider Update

Provider Survey from AHCCCS – due May 17

AHCCCS is conducting a survey to determine its contracted Managed Care Organizations' (MCOs') performance and responsiveness to providers. We are asking that providers contracted with the below listed health plans complete this survey to determine your level of satisfaction with MCO Claims, Customer Service, Credentialing and Prior Authorization processes.

- Arizona Complete Health-Complete Care Plan
- Banner University Family Care
- Care 1st Health Plan Arizona
- Health Choice Arizona
- Magellan Complete Care
- Mercy Care
- UnitedHealthcare Community Plan

Limited provider information will be collected as part of this survey. AHCCCS does not intend to release details identifying individual provider submissions.

Your feedback is very important to our assessment and processes for improvement. If you haven't already done so, please take a few minutes to complete this survey at:

https://www.surveymonkey.com/r/C7QP2TX

The survey will be open from April 15, 2021 through May 17, 2021.

Vaccine Navigators available to assist Medicaid Members

The Arizona Health Care Cost Containment System (AHCCCS), in partnership with Crisis Response Network, announces a new COVID-19 appointment and transportation navigation program for Medicaid members. Now, Medicaid members who need assistance scheduling a COVID-19 vaccine appointment, as well as transportation to and from that appointment, can call 1-844-542-8201, 8 a.m. to 5 p.m., seven days a week.

"With COVID-19 vaccines now widely available, AHCCCS is working to ensure that its 2.1 million enrolled members have the opportunity to schedule and attend a vaccine appointment, and that technology and transportation do not present any barriers to receiving the vaccine," Jami Snyder, AHCCCS director, said.

Through a partnership with Crisis Response Network, which operates the 2-1-1 Arizona information and referral service program, trained navigators are available to help callers find and schedule vaccine appointments, and, if needed, also assist with scheduling non-emergency medical transportation.

"Making vaccine appointments and arranging for transportation to and from appointments for Medicaid members is crucial in the ongoing battle against the COVID-19 pandemic in our community. We are honored to join AHCCCS in this important effort," said Justin Chase, President and CEO of Crisis Response Network.

For COVID-19 vaccine information, a map of all COVID-19 vaccination sites, and eligibility criteria, visit azhealth.gov/findvaccine.

Arizona's Medicaid program is a leader in the nation in adjusting Medicaid rates to ensure its members are vaccinated, and the first state to adjust NEMT rates to account for wait times at drive-through vaccination sites. AHCCCS serves approximately 30 percent of Arizonans.

For more information about how AHCCCS has responded to the needs of its members and providers during the COVID-19 pandemic, see azahcccs.gov/AHCCCS/AboutUs/covid19 and AHCCCS COVID-19 Frequently Asked Questions.

Claims Update Reminder

Change to BUHP pre-adjudication claims process

Instead of making edits through your clearinghouse, BUHP will instead be denying any claims with incorrect codes. This will allow you to more easily identify the errors, correct them and resubmit the claim for payment.

BUHP and other AHCCCS Health Plans are required to follow AHCCCS guidelines in claims processing and procedure. BUHP has identified four common processing errors that result in payments that later result in a recoupment.

Most common reasons for denial:

- NPI not registered with AHCCCS on the Date of Service – Edit P378
- Provider not active on the Date of Service – Edit P281
- Provider type not eligible – Edit 353
- Provider not eligible for Category of Service – Edit 330

Tips to reduce denials

Ensure provider registration and NPI are current with AHCCCS

During the AHCCCS registration process providers are assigned category of service and provider type, based on the licensing submitted by the provider. Furthermore, AHCCCS mandates that prior to payment of claims, Health Plans ensure providers have an NPI registered with AHCCCS on the date of service and that the billing provider be active on the date of service.

Ensure AHCCCS has the correct Category of Service (COS) registration for services billed

As provider groups grow and/or change, licensing may change. Licensing changes must be submitted to AHCCCS to ensure the causes for the Encounter Edits are corrected prior to providing services. When not updated in a timely manner or if there is a lapse in registration,

claims payments are impacted. For providers that have been impacted, AHCCCS may grant retrospective approval.

Determine if provider type is eligible to bill
Some provider types are not eligible to submit claims, so it is important to verify provider type to avoid future claims denials.

Address questions about other information that can affect billing practices
Other factors can impact billing practices. Be sure to contact AHCCCS to receive answers to those questions prior to submitting claims.

AHCCCS Contact Information
Provider Enrollment
In Maricopa County: 602-417-7670 and select option 5
Outside Maricopa County: 1-800-794-6862
Out-of-State: 1-800-523-0231
Call Center Hours: Mon.-Fri., 8 a.m.- Noon and 1 p.m. - 4 p.m.

Important ROPA Reminder

After June 1, 2021, claims that include referring, ordering, prescribing and attending (ROPA) providers who are **not enrolled** with AHCCCS **will not be reimbursed**. This means that claims will be denied if ROPA providers are not enrolled with AHCCCS.

All ROPA providers who are currently submitting claims are strongly encouraged to register as an AHCCCS provider **as soon as possible.**

In addition, service providers whose claims include ROPA providers who are not registered with AHCCCS should work with these providers to complete their registration.

To ensure payment of claims when submitting for items and/or services attended, ordered, referred, or prescribed by another provider, the rendering provider must ensure that the ordering/referring/prescribing provider is actively registered with AHCCCS.

A provider who chooses to attend, order, refer, or prescribe items and/or services for AHCCCS members, but does not to submit claims to AHCCCS directly, **must still be registered** with AHCCCS to ensure payment of those items and/or services where he attended, ordered, referred or prescribed.

To facilitate communication as to these requirements and provide related guidance AHCCCS has developed and posted the FAQ's outlined below.
https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html

Helping members thrive after hospitalization: the importance of follow-up appointments

Members hospitalized for behavioral health issues are vulnerable after discharge without appropriate follow-up care in place. In order to prevent hospital readmission, AHCCCS requires follow-up appointments at 7 and 30 days after discharge to monitor the member's progress towards recovery.

Getting member buy-in is critical for discharge planning
Reducing hospital readmission can be complex because it involves a wide variety of factors. However, these factors can be identified with proper assessment and engagement strategies during the discharge planning process. Specifically, best practice indicates behavioral health staff should include members during the discharge planning process to increase the likelihood they will understand their discharge plan and to attend post-discharge appointments.

Social determinants of health
Another key area for behavioral health staff to consider during discharge planning is whether a member has any social determinants of health (SDH) to address. Social determinants of health are defined as "the economic and social conditions that influence individual and group differences in health status. This includes, but is not limited to homelessness, lack of transportation, low income, and language barriers. Identifying what supports people might need and planning for such is essential to their recovery.

The bottom line
Helping your members attend their follow-up appointments can help you catch the warning signs that can lead the member back to the hospital. Not only are follow-up appointments necessary for member recovery, but it's also important to consider that hospital readmission rates are costly. Reducing the amount of people that return to the hospital will not only improve member outcomes, but it will also support the funding needed to provide quality care.

Systems of Care

Children & Adult Autism Spectrum Disorder (ASD) Services and Assessments

For contracted B-UHP providers that offer ASD services or assess and diagnose for ASD, AHCCCS recently conducted a provider secret shopper audit across the state to inquire about availability of evaluations, timeliness to receive an assessment/intake and availability of ASD services.

Please ensure that the staff that are scheduling appointments or providing information about your agency's services are familiar with the services and criteria that are listed on the documents on the B-UHP ASD webpage. Also, please ensure that the information provided for the ASD AHCCCS deliverable within the following documents are accurate:

1. Provider List for Diagnosing Autism Spectrum Disorder
2. Provider List for Autism Spectrum Disorder Services

These documents can be found at: https://www.banneruhp.com/resources/autism-spectrum-disorder

If you would like to provide feedback for edits or do not see your agency listed, please contact Jennifer Blau at Jennifer.Blau@bannerhealth.com. If you have any additional questions related to the audit or other children's service matters, please contact Cameron Cobb at Cameron.Cobb@bannerhealth.com.

We hope that the results of this audit and ongoing efforts will continue to enhance the quality of work that we all strive for to ensure the highest-quality services for our members. Thank you for all the work that you do for our members and families every day!

Children's System of Care

The Child and Family Support page includes the following updated resources for behavioral health providers: https://www.banneruhp.com/resources/child-and-family-support.

- Children's Specialty BH Provider Directory for specialty services in Central and Southern Arizona
- School-Based BH Service lists for Southern Arizona
- Birth to Five resources
- Birth to Five High Needs Determination Tool
- Transition Age Youth (TAY) resources
- TAY Tool for transition planning
- TAY Checklist for transitioning to adulthood
- Anti-Human Trafficking treatment and resources
- LGBTQ+ resources
- Adopted child and family resources
- Suicide prevention resources
- Family and community resources and more

If you are not currently listed in the Children's Specialty BH Provider Directory or the School-Based BH Service lists and would like to be added, please contact Program Coordinator, Jennifer Blau, at Jennifer.blau@bannerhealth.com. For questions regarding resource guides or Transition Age Youth, contact Program Coordinator, Mayra Lopez, at Mayra.lopez@bannerhealth.com. If you have other questions, please contact Associate Director, Cameron Cobb, at Cameron.cobb@bannerhealth.com

Adult System of Care

Adult Recovery Team (ART)

ART: means a defined group of individuals that includes, at a minimum, the member, their family, a behavioral health representative, and any individuals important in the member's life that are identified and invited to participate by the member. This may include system partners such as extended family members, friends, family support partners, healthcare providers, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like the Department of Developmental Disabilities (DDD), Probation, or the Administrative Office of the Courts (AOC). The size, scope and intensity of involvement of the team members are determined by the objectives established for the adult, the needs of the family in providing for the adult, and by which individuals are needed to develop an effective service plan and can therefore expand and contract as necessary to be successful on behalf of the adult should this be needed or required.

ART is key component to assessment and service planning in receiving input from individual, support system and clinical team.

B-UHP contracted behavioral health providers must coordinate with members Adult Recovery Team to make appropriate referrals to assess members needs during coordination of care. We remind providers of The Adult Recovery Team process that can be facilitated by telehealth, phone and/or in-person to affectively engaged in members' services and road to recovery.

Through the ART process, B–UHP endorses and requires for all contracted providers to comply with the **Arizona Adult Service System's Nine Guiding Principles**.

1. Respect

2. Persons in recovery choose services and are included in program decisions and program development efforts.
3. Focus on individual person, while including and/or developing natural supports.
4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure.
5. Integration, collaboration, and participation with the community of one's choice.
6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust.
7. Persons in recovery define their own success.
8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences.
9. Hope is the foundation for the journey towards recovery

For additional information, refer to the B-UHP Behavioral Health Comprehensive Provider Manual Supplement (https://www.banneruhp.com/-/media/files/project/uahp/provider-manuals/buhp_comprehensive-provider-manual_11172020.ashx?la=en)

Office of Individual and Family Affairs (OIFA)

Stigma Stops Here campaign

May is Mental Health Awareness month. The way we talk about mental illness and the things we express publicly through media, social media, in our homes and in our workplaces can make a difference. Let's be Change Agents! Let's change the conversation!

Join with BUHP to build Mental Health Awareness and support and spotlight the ways in which you already do this. OIFA and BUHP are launching a Stigma Free with BUHP Campaign: #stigmafreewithBUHP

Let's highlight how we support our members and families by building Mental Health Awareness and Stop Stigma. Social media campaigns are about bringing us ALL together through sharing our stories, learning from and with each other and taking a journey together to create awareness and change.

Here is how:

1. Keep an eye out for an upcoming email blast with ideas on how you can highlight how your agency is already showcasing how you are #stigmafreewithBUHP
2. Visit the Banner University Health Plans Facebook, Twitter and Instagram pages frequently for upcoming challenges that encourage you and community partners to spotlight personal stories, member stories, videos, quizzes, educational information and inspiration highlighting the ways in which together we are increasing Mental Health Awareness and Stopping Stigma.

Maternal & Child Health

Breast pumps available for BUHP members

Breast pumps are one of the many benefits available to members of the Banner University Health Plans. With breastfeeding having many associated health benefits for both mother and baby, BUHP encourages our pregnant and postpartum members to breast feed their newborns. We provide many options of breast pumps and ordering them is easy for our members.

Breast pumps are usually ordered at 34 weeks of pregnancy and shipped directly to their home. Members can order breast pumps earlier if they are at risk of having a premature delivery.

Providers can expect breast pump vendors to call for verification of pregnancy and gestational age.

If your office or the member needs any help with ordering a breast pump, please contact our Maternal Child Health team by email at BUHPMaternalChildHealth@bannerhealth.com or call our Customer Care Department at 1-800-582-8686.

Summer Well Visit/EPSDT Child and Adolescent Member Incentive

To help increase well-visits this summer, BUHP is offering a $15 gift card to members if they complete their child or adolescent well-visit between June and September. Member households who qualify for the promotion will receive a letter and flyer. The parent/member will bring the flyer to your office during the visit. Please sign and fax the form back to BUHP as outlined in flyer. Thank you for supporting this project.

News of Note

Evidence-based guidelines: Providers receive information related to B – UCA;s use of evidence-based guidelines through the provider manual, newsletters, policies and procedures and BUHP website postings (www.banneruhp.com). Several resources are posted on the provider website, including the provider manual and provider newsletters. The newsletters include information on chronic diseases, such as diabetes and asthma, adult care and case management services. For additional information, the direct link to pre-service authorization information is: **https://www.banneruhp.com/materials-and-services/prior-authorizations-and-referrals#Prior-Authorization-Grids**.

Coding Update from AHCCCS: AHCCCS will cover U0005 for our Medicare only population. AHCCCS will continue to pay $100 for U0003/U0004 and not implement U0005 at this time for our AHCCCS only members.

Pharmacy Update

Retrospective Drug Utilization Reviews

A Retrospective Drug Utilization Review (DUR) is an important part of our Banner Health Plan quality assurance programs. A retrospective review utilizes health plan medical claims and prescription claims data to identify utilization patterns and trends and translate them into **actionable opportunities to help promote quality and cost-effective drug therapy for our members.**

Some providers have recently received patient specific faxes that are part of the retrospective DUR for quarter one. The purpose of this DUR is to inform and educate providers about the importance of statin prescribing in target populations and the documentation required to exclude patients from the Statin use in Persons with Diabetes (SUPD) and/or Statin Therapy for Patients with Cardiovascular Disease (SPC) quality measures who are not able to take statins. This is a new and very important change that has just recently occurred for SUPD. The new exclusion criteria can improve measurements of quality if properly documented.

Please take the time to review the patient specific DUR letters you may receive. **If these letters are placed in the patient charts, then they can be properly addressed at the next appointment time.** Thank you for your continued support of our quality assurance programs.

Provider Relations

Member Rosters

To access member enrollment information and obtain member rosters, please visit https://eservices.uph.org/. For more information about eServices, contact your Provider Relations Representative.

For inquiries related to obtaining information regarding the provider's assigned membership, please send to our dedicated inbox at BUHPProviderNotifications@bannerhealth.com

Access to Timely Care

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks patients to report on and evaluate their experiences with health care and their provider. One important component focuses on getting appointments and care quickly. AHCCCS also has a set of required appointment standards. Ensuring your office meets these standards increases the patients positive experience with your office and healthcare. Ease of getting needed care impacts overall health care quality for our members.

BUHP has made a commitment to meet appointment availability standards as set forth by AHCCCS, Medicare and community standards; see chart of standards below. In accordance with AHCCCS and Medicare standards, appointment standards/wait time audits are conducted regularly to ensure members have timely access to care. Should providers not meet appointment or wait time standards, a Corrective Action Plan will be issued.

Note: BUHP utilizes a contracted vendor (Contact One) to conduct appointment availability surveys on a quarterly basis. Please share the appointment standards below with your staff. You may designate a representative in your office to complete the quarterly appointment availability survey with Contact One to alleviate confusion.

If you have any questions on implementing this in your office, please reach out to your Provider Relations Representative.

Appointment Standards		
PROVIDER TYPE	**URGENT**	**ROUTINE**
Primary Care Provider (PCP)	No later than 2 business days of request	Within 7 calendar days for non-urgent but in need of attention (SNP) only. Within 21 calendars of request for routine physicals or health maintenance visits
Specialty Provider Referrals	No later than 2 business days of request	Within 45 calendar days of referral
Dental (AHCCCS Oral Health Care is a covered service for AHCCCS members between birth and age 21)	No later than 3 business days of request	Within 45 calendar days of referral
Maternity	High risk pregnancies – no later	Initial prenatal care appointments

	than 3 business days of identification of high risk by contractor or immediately if an emergency exists	1st trimester – within 14 calendar days of request 2nd trimester – within 7 calendar days of request 3rd trimester – within 3 business days of request Within 45 calendar days for routine care (SNP) Uncomplicated pregnancy – every 4 weeks for the first 28 weeks and every 2 – 3 weeks until 36 weeks of pregnancy and weekly thereafter One postpartum visit at approximately 6 weeks after delivery.
Behavioral Health Providers	No later than 24 hours from identification of need	Initial assessment within 7 calendar days of referral or request for service For members 18 years or older – 1st service following assessment no later than 23 calendar days after initial assessment For members under the age of 18, no later than 21 days after the initial assessment All following services no later than 45 calendar days from identification of need
Psychotropic Medications	Urgency will be assessed immediately	Appointment within a timeframe that ensures member does not run out of needed medication or decline in behavioral health condition, but no later than 30 days from the identification of needs

Provider Manuals: All Banner University Health Plans provider manuals can be accessed on the Health Plans website: https://www.banneruhp.com/.

A printed copy of the manuals will be provided upon request, please contact your Provider Relations Representative.

Notify the Health Plan Data Department of the below updates: According to provider standards and responsibilities, providers must notify plan with any changes to:

- Provider and Provider Group Adds
- Provider or Group Location demographic updates (except terms)
- Provider Panel Changes

- Telephone numbers

This notification should occur within 30 days of any of the above noted changes. Please send all updates and changes via the online Provider Update Form located at https://www.banneruhp.com/materials-and-services/provider-data-update-form or you may email to BUHPDataTeam@bannerhealth.com.

Notify the Health Plan Provider Relations Department of the below updates: According to provider standards and responsibilities, providers must notify plan with any changes to:

- Practitioner or Provider (Group) Termination
- Key contacts
- Tax Identification Numbers
- Corporate structure

This notification should occur as soon as possible, please send your request to BUHPProviderNotifications@bannerhealth.com.

Compliance Corner

The Banner Insurance Division recently updated their Compliance Program and FWA Plan. The document can be located on the website at the following link: https://www.banneruhp.com/materials-and-services/compliance-program for Banner University Health Plans and at https://www.bannerhealth.com/medicare/for-healthcare-providers/compliance-program for Banner Medicare Advantage Plans.

Exclusion Screening

Banner University Health Plans and Banner Medicare Advantage Plans require its First Tier, Downstream and Related Entities (FDRs), Providers, and Administrative Contractors to screen all employees and downstream entities prior to hire/contract and on a monthly basis by reviewing the following lists or databases: List of Excluded Individuals and Entities - LEIE (https://exclusions.oig.hhs.gov/); SAM (https://www.sam.gov/portal/SAM/), formerly known as the Excluded Parties List (EPLS); state exclusion data bases and any other data bases as directed by AHCCCS or Medicare. Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP). To avoid CMP liability, health care entities should routinely check the list to ensure that new hires and current employees or downstream entities are not on it. The Office of the Inspector General (OIG) has the authority to exclude individuals and entities from Federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded can receive no payment from Federal health care programs for any items or services they furnish, order, or prescribe. This includes those that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan). CMS publishes a Preclusion List and any person or entity on the list cannot be paid by the Medicare Health Plans.

FDRs/Providers/Administrative Contractors are required to report any confirmed excluded party to the Insurance Division Compliance Department and directly to AHCCCS OIG and Medicare. This includes any State Medicaid exclusion as the Banner Credentialing Policy prohibits exclusion from any Federal Health Care Program and that is inclusive of State Medicaid Exclusions.

Offshore Activities:

Health Plan Activities that involve protected health information (PHI) must not be completed offshore for Medicaid. If used for Medicare, Banner Medicare Advantage Plans and Banner-University Care Advantage must notify the Centers for Medicare & Medicaid Services (CMS) of the offshore activities. Common offshore activities include the following examples:

- Billing company
- Call center
- Clearinghouse
- Coding company
- Transcription services, etc.

The term "Offshore" refers to work not performed within one of the fifty United States or one of the United States Territories. AHCCCS does not allow any Medicaid activities involving Protected Health Information (PHI) to be performed offshore. This includes the accessing, receiving, processing, transferring, handling, or storing of Banner-University Family Care Medicaid member PHI offshore.

The following information is contained in AHCCCS's minimum subcontract provisions:
19. OFFSHORE PERFORMANCE OF WORK PROHIBITED
Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to secure or sensitive data or personal client data shall be performed within the defined territories within the borders of the United States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by Subcontractors at all tiers.

As a reminder, if you enter into a contract with another entity, you are required to enforce AHCCCS's Off-Shore prohibition. For Medicare, Banner Medicare Advantage Plans and Banner-University Family Care are required to report offshore activities to CMS. If you engage in offshore activities, you must complete and submit an offshore attestation to the Banner Insurance Division Compliance Department. This attestation is CMS's assurance that you have taken the appropriate steps to address the risks associated with the use of subcontractors operating outside of the U.S.

Organizations must submit one attestation for each offshore subcontractor that you have engaged to perform Medicare related activities. Given the unique risks associated with the use of subcontractors operating outside of the US, you must take extraordinary measures to ensure that offshore arrangements protect PHI, including oversight requirements and audits of the offshore activities.

If you identify or suspect offshore activities, immediately notify the Banner Insurance Division Compliance Department:

ComplyLine 24-hour hotline (anonymous reporting): 888-747-7989

Email: BHPCompliance@BannerHealth.com

Secure Fax: 520-874-7072
Compliance Department Mail:
Banner Medicaid and Medicare Health Plans Compliance Department
2701 E Elvira Rd
Tucson, AZ 85756

Contact the Medicaid Compliance Officer Terri Dorazio via phone 520-874-2847(office) or 520-548-7862 (cell) or email Theresa.Dorazio@BannerHealth.com

Contact the Medicare Compliance Officer Linda Steward via phone 520-874-2553 or email Linda.Steward@BannerHealth.com

Banner University Health Plans Contact Information

BUHP Customer Care
Banner - University Family Care – ACC 800-582-8686
Banner - University Family Care – LTC 833-318-4146
Banner - University Care Advantage – SNP 877-874-3930
BUHP Compliance Officers
520-548-7862 (Medicaid) or 520-874-2553 (Medicare)
BUHP Compliance Department FAX 520-874-7072
BUHP Compliance Department Email
BHPCompliance@BannerHealth.com

BUHP Compliance Department Mail:
BUHP Compliance Dept
2701 E Elvira Rd
Tucson, AZ 85756

Confidential and Anonymous Compliance Hotline (ComplyLine)
888-747-7989

Banner Medicare Advantage Customer Care

Prime HMO – 844-549-1857

Plus PPO – 844-549-1859

AHCCCS Office of the Inspector General
Providers are required to report any suspected FWA directly to AHCCCS OIG

Provider Fraud
602-417-4045

888-487-6686

Member Fraud
602-417-4193
888-487-6686

Website
www.azahcccs.gov (select **Fraud Prevention**)

Mail:
Inspector General
701 E Jefferson St.
MD 4500
Phoenix, AZ 85034

Medicare
Providers are required to report all suspected fraud, waste and abuse to the Health Plan or to Medicare

Phone: 800-HHS-TIPS (800-447-8477)
FAX: 800-223-8164
TYY: 800-377-4950

Website:
https://forms.oig.hhs.gov/hotlineoperations

Mail:
US Department of Health & Human Services
Office of the Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026