

Fraud, Waste and Abuse Policy

Purpose

The purpose of this policy is to explain Fallon Health's commitment that its activities be conducted in a lawful and ethical manner. Fallon Health (the Plan) controls fraud, waste, and abuse of its and others' assets through prevention, detection, and correction of any violation of applicable Federal or State law, regulatory requirement, contractual obligation, or organizational policy reference.

Anyone who suspects fraud and abuse activity should report such activity to the Plan as described below.

Definitions

Fraud

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit, unlawful gain, or unfair gain. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Waste

"Waste" includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls. This could be the overutilization of services or other practices that directly or indirectly results in unnecessary costs to the health care system.

Abuse

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Policy

Health care fraud is a crime. It is the policy of the Plan that detecting and preventing fraud, waste, and abuse is the responsibility of everyone including members, providers, and sub-contractors. It is further the policy of the Plan that the Plan will protect its corporate assets and the interests of its members, employers, and providers against those who knowingly and willfully commit fraud or other wrongful acts.

Provisions

1. **Detecting and preventing fraud, waste, and abuse (FWA) is the responsibility of everyone including members, providers, and sub-contractors. Anyone that knows of or suspects fraud and abuse activity should report such activity in one of the following ways:**
 - a. **Call** the Plan's Customer Service at 1-800-868-5200,
 - b. **Email** InternalAudit-FWAInquiries@fallonhealth.org, or
 - c. **Call** the Plan's Compliance Hotline at (888) 203-5295. *All calls to the hotline are anonymous.*

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2. **The Plan will protect its corporate assets and the interests of its members, employers, and providers against those who knowingly and willingly commit fraud or other wrongful acts. The Plan will identify, resolve, and recover funds, as well as potentially reporting, and when appropriate, take legal actions, if suspected fraud, waste, and/or abuse have occurred.**
 - a. The Plan will not retaliate against anyone who makes a good faith report of potential fraud or other wrongful acts.
 - b. Various state and federal laws protect those who make a good faith report of potential fraud.

3. **Providers must understand the statutory and regulatory requirements relating to health care fraud. Some examples include, but are not limited to, the following:**
 - a. False Claims Act
 - i. The False Claims Act is a federal statute that covers fraud involving any Federally funded contract or program, including, but not limited to the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.
 - ii. The term “knowing” is defined to mean that a person with respect to information:
 1. Has actual knowledge of falsity of information in the claim;
 2. Acts in deliberate ignorance of the truth or falsity of the information in a claim; or Acts in reckless disregard of the truth or falsity of the information in a claim.
 - iii. Health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as the following:
 1. Knowingly making false statements,
 2. Falsifying records,
 3. Double-billing for items or services,
 4. Submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.
 - b. Anti-Kickback Statute – This statute provides for criminal and civil penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other Federal health care programs.
 - c. Stark Law – The Stark Law provides penalties for individuals or entities that do not adhere to the regulations regarding financial arrangements between referring physicians (or a member of the physician’s immediate family) and entities that provide certain designated health services payable by Medicare or Medicaid. It does not require any showing of intent on the part of the wrongdoer.

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- 4. As a provider, the services that you offer our members are subject to both federal and state laws.**
 - a. Contract requirements have also been designed to prevent FWA in government programs (such as Medicare and Medicaid) and private insurance.
 - b. A provider's submission of a claim for payment also constitutes the provider's representation that the claim is not submitted as a form of, or part of, fraud and abuse as listed below, and is submitted in compliance with all federal and state laws and regulations.

- 5. Providers are responsible for, and these provisions likewise apply to, the actions of their staff members and agents.**
 - a. Any amount billed by a provider in violation of this policy and paid by the Plan constitutes an overpayment by the Plan that is subject to recovery.
 - b. A provider may not bill members for any amounts due resulting from a violation of this policy.

- 6. Providers must understand, recognize, and prevent fraud and abuse. The following is a list of examples of potential fraud and abuse:**
 - a. Billing for services not rendered
 - b. Billing for services that are more complex than what was actually rendered (upcoding)
 - c. Performing (and billing for) services that are not medically necessary to obtain an insurance payment
 - d. Changing the rendering physician and/or services to get the claim paid (after the claim was denied)
 - e. Falsifying a diagnosis to support testing or services not otherwise necessary/covered
 - f. Soliciting, offering, or receiving referral fees or waiving member's deductibles, coinsurance, or copayments (i.e., kickbacks)
 - g. Referring patients in exchange for other services
 - h. Prescribing a prescription that has no legitimate or medical purpose
 - i. Practicing "defensive medicine" by ordering medical tests or procedures as a safeguard against possible malpractice liability, not to ensure a patient's health
 - j. Charging excessively for services, procedures, or supplies
 - k. Submitting claims for services not medically necessary, or services not medically necessary to the extent rendered (for instance a panel of tests is ordered when based upon the patient's diagnosis only a few of the tests, if any at all, within the panel were actually necessary)
 - l. Unbundling
 - m. Billing multiple times for the same service (duplicate billing)

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- 7. Consistent with The Centers for Medicare and Medicaid Services standards, medical records must contain information to justify treatment, admission or continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.**
- a. Medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.
 - b. All records must document relevant medical history, updated examination of the patient, admitting diagnosis, consultative evaluations, complications, informed consent, discharge summary, final diagnosis with completion of medical records within 30 days following consultation or discharge.
 - c. All corrections of medical records must be made within 30 days following consultation or discharge.
 - i. When an error is made in a medical record entry, proper error correction procedures must be followed for both paper and electronic records.
 - ii. For example, for paper records, a thin pen line should be drawn through the incorrect entry to make sure that that the inaccurate information is still legible.
 - iii. The provider must state the reason for the error, document the correct information, and sign and date the correction. The original entry must not be obliterated or otherwise altered by blacking out with marker, using white out, writing over an entry, or by other means. For electronic records, use an addendum to identify corrections due to errors.
 - iv. Documentation should include only acceptable standard abbreviations from Jablonski's or Dorland's Dictionary of Medical Acronyms & Abbreviations.