



Section 12 – Fraud, Waste and Abuse

Health care fraud, waste and abuse hurts everyone including members, providers, taxpayers and CareSource. As a result, CareSource has a comprehensive fraud, waste and abuse program in our Special Investigations Unit. Please help us by reporting questionable situations.

Definition of Terms

Fraud — Is defined as “An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.” (42 CFR Part 455.2)

Abuse — is defined as “Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost 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 costs to the Medicaid program.” (42 CFR Part 455.2)

Examples of Member Fraud, Waste and/or Abuse Include:

- Doctor shopping for controlled substances.
- Prescription forging or prescription modification to obtain controlled substances, other medications, or more medication than prescribed.
- Members sharing their CareSource ID cards with nonmembers.
- Fraudulent Babies First Coupons submitted for prenatal and well-baby visits (*Medicaid only*).
- Nondisclosed other health insurance coverage.

Examples of Provider Fraud, Waste and/or Abuse Include:

- Lack of medical necessity for medical services and prescription drugs billed.
- Services not provided but billed.
- Up-coding of CPT and DRG codes to obtain a higher rate of reimbursement.
- Inappropriate use of CPT codes and/or modifiers to seek higher reimbursement.
- Unbundling CPT codes to obtain higher reimbursement.
- Not checking member ID's resulting in claims submitted for non-covered persons.
- Prescription drugs that were not dispensed as written.
- Home health care and/or durable medical equipment prescribed when not medically necessary.
- Inappropriate use of unlisted CPT codes.
- Inflating billed charges to seek higher reimbursement.
- Scheduling more frequent return visits than are needed to increased reimbursement.
- Billing for services outside of your medical qualifications.
- Balance billing of members for any balance owed after CareSource has paid the approved state and/or contracted fee for services rendered.
- Fictitious provider operations.
- Purchasing enrollee lists for the purpose for submitting fraudulent claims.



We monitor our claims data and review medical records looking for billing aberrancies. When found, an investigation is initiated and if warranted, a corrective action is taken. Corrective actions can include but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider Termination or Summary Suspension
- Recovery of overpaid funds
- Member disenrollment
- Reporting to one or more applicable state and federal agencies
- Legal action

Reporting Fraud, Waste and Abuse

You can report your suspicions of Fraud, Waste or Abuse to the CareSource Special Investigations Unit utilizing the contact information at the end of this section.

The Federal and State False Claims Acts and other Fraud, Waste and Abuse Laws

Using the False Claims Act (the Act); you can help reduce fraud against the federal government. The Act allows everyday people to bring “whistleblower” lawsuits on behalf of the government – known as “qui tam” suits – against businesses or other individuals that are defrauding the government through programs, agencies, or contracts.

As amended in 2009, the False Claims Act addresses those who:

- a. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
- b. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- c. Conspires to commit a violation of any other section of the False Claims Act;
- d. Has possession, custody or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;
- e. Is authorized to make or deliver a document certifying receipt of property used, or to be used by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or
- g. Knowingly makes, used, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.

“Knowingly” means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

An example would be if a health care provider, such as a hospital or a physician knowingly “upcodes” or overbills; resulting in overpayment of the claim using Medicaid and/or Medicare dollars.



The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CareSource is required to comply with certain provisions of the DRA. One such provision prompted this communication, as it requires us to provide you with information about the Federal False Claims Act, state False Claims Acts, and other state laws regarding Medicare and Medicaid Fraud. **In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste, and abuse when handling CareSource business.**

The time period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the Government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.

Ohio Law

While Ohio has not passed its own false claims statute, there may nevertheless be liability under various Ohio laws regarding false or fraudulent claims with respect to Medicaid program expenditures, including:

- Medicaid Fraud, Ohio Revised Code Sec. 2913.40
- Medicaid Eligibility Fraud, Ohio Revised Code Sec. 2913.401
- Falsification, Ohio Revised Code Sec. 2921.13
- Offenses by Medicaid Providers, Ohio Revised Code Sec. 5111.03

Other Fraud, Waste, and Abuse Laws

- Under the **Federal Anti-Kickback Statute**, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe, or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a Federal health care program. 42 U.S.C. §1320a-7b.
- Under the **Federal Stark Law**, and subject to certain exceptions, physicians are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by Federal health care programs. 42 U.S.C. §1395(a) and §1903(s).
- As part of the **Health Insurance Portability and Accountability Act (HIPAA)**, the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any Federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any Federal health care program. 18 U.S.C. §1347.

Prohibited Affiliations

CareSource is prohibited by federal and/or provider agreements (with the state) from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities. Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that you are a prohibited affiliation, you must notify us immediately.



Protections for Reporters of Fraud, Waste, or Abuse

In addition, federal and state law and CareSource's policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to the Special Investigations Unit.

Additional information on the False Claims Act and our fraud, waste, and abuse policies can be found on our Website, at www.caresource.com.

Fraud, Waste, or Abuse Reporting Process

It is CareSource's policy to detect and prevent any activity that may constitute fraud, waste, or abuse, including violations of the federal False Claims Act or any state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, please contact our Special Investigations Unit using our contact information in this manual.

You can report fraud, waste, and abuse to CareSource by:

Anonymously:

- **Calling 1-800-488-0134** and follow the appropriate menu option for reporting Fraud
- **Writing a letter to:**
CareSource
Attn: Special Investigations Unit
P.O. Box 1940
Dayton, OH 45401-1940

Other means of reporting fraud, waste and/or abuse that are not anonymous:

- Sending an e-mail to: fraud@caresource.com
- Faxing: 1-800-418-0248

Or you may choose to use the **Fraud, Waste and Abuse Reporting Form** located on our Website at www.caresource.com or in the Forms section (Section 14) of this manual.

When you report fraud, waste or abuse, please give as many details as you can, including names and phone numbers. You may remain **anonymous**, but if you do we will not be able to call you back for more information. Your reports will be kept **confidential** to the extent permitted by law.

Thank you for helping CareSource keep fraud, waste and abuse out of health care.