

Understanding Fraud and Abuse

We are committed to protecting the integrity of the programs we offer and the efficiency of our operations by preventing, detecting and investigating fraud and abuse. Combating fraud and abuse begins with knowledge and awareness.

Fraud is any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to a person. The attempt itself is fraud whether or not it is successful.

Abuse is any practice that is inconsistent with sound fiscal, business, medical practices and results in an unnecessary cost to the Medicaid program, including administrative costs from acts that adversely affect providers or members.

Examples of Provider Fraud and Abuse

These are typical examples of provider fraud and abuse:

- Billing for services not provided.
- Billing for medically unnecessary tests.
- Unbundling/upcoding.
- Misrepresentation of diagnosis or services.
- Underutilization and overutilization.
- Soliciting, offering or receiving kickbacks or bribes.
- Billing professional services performed by untrained personnel.
- Altering medical records.

Examples of Member Fraud and Abuse

These are typical examples of member fraud and abuse:

- Frequent emergency room visits with non-emergent diagnoses.
- Obtaining controlled substances from multiple providers.
- Violation of pain management contract.
- Using more than one provider to obtain similar treatments and/or medications.
- Using providers not approved by the Primary Care Provider.
- Forging or selling prescriptions.
- Loaning insurance ID card.
- Disruptive/threatening behavior.
- Relocation out of service area while continuing to use CommunityConnect HealthPlan.

How to Report Healthcare Fraud and Abuse

There are several ways for a provider to report allegations of fraud and abuse:

1. Contact our Provider Services call center at **1-715-552-4300** or **1-877-350-6074** (toll-free).
2. Fax the Fraud Referral Form to **1-715-836-7683**. You can find the Fraud Referral Form in the Forms section on the CommunityConnect HealthPlan website at **www.CommunityConnectHealthPlan.com**.
3. Write to us at the following address:

**Attn: Program Integrity
CommunityConnect HealthPlan
P.O. Box 3157
Eau Claire, WI 54702-3157**

Although you may remain anonymous, we encourage you to provide as much detailed information as possible, including:

- Your name, business and phone number.
- Name, address, license or insurance ID of subject.
- Allegation.
- Date of incident or incidents.
- Supporting documentation.

The more information you provide, the sooner the case can be reviewed and resolved successfully.

Role of the Fraud and Abuse Department

We do not tolerate acts that adversely affect our providers and/or members. We investigate all reports of fraud and abuse. We report allegations and investigative findings to the appropriate regulatory and law enforcement agencies. In addition to reporting, we will take corrective actions, such as:

- Written Warning and/or Education. Certified letters are sent (to the provider/member) documenting the issues and the need for improvement. Letters may include education, request for recoveries or may advise of further corrective action.
- Medical Record Audit. Medical records may be reviewed to substantiate allegations or validate claims submission.
- Special Claims Review. Special Claims Review flags claims to prevent automatic claim payment, requiring a medical reviewer evaluation.

- Recoveries. An overpayment letter will be sent to the provider requesting payment within 30 days. Failure to send payment may reflect in reduced payment of future claims or further legal action.
- Quality of Care. Providers compromising patient care are referred to the Quality Management department. The provider may be presented to the Credentialing Committee and/or Peer Review Committee for disciplinary action.
- Provider Termination. Failure to comply with program policy and procedures or any violation of the contract will result in termination.
- Care Management. Members may be referred to Care Management to assist with access to care, coordination of services, mental health or pain management referrals and community resources.
- Member Disenrollment. Fraud, threatening behavior or failure to correct issues may result in involuntary disenrollment from our health plan (with state approval).
- Referral to Law Enforcement. Criminal activity is referred to the appropriate local and/or regulatory enforcement agency.

False Claims Act

We are committed to complying with all applicable federal and state laws including the Federal False Claims Act (FCA).

The FCA is a federal law that provides the federal government with the means to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages, or loss, to the government plus civil penalties of \$5,500 to \$11,000 per false claim.

The FCA also contains Qui Tam or “whistleblower” provisions. A “whistleblower” is an individual who reports in good faith an act of fraud and abuse to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employers under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.