Guide to Preventing Fraud, Waste & Abuse

Definitions:

Fraud means 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 C.F.R. § 433.304, 455.2, and W&I, section 14107.11, subdivision (d))

Examples:

- Deliberately claiming for services that were not provided: A staff member spends 20 minutes providing a billable rehabilitation service but documents and bills for 60 minutes.

- Prescribing/ordering/providing unnecessary medications, treatments, labs etc: A provider orders labs for a client every time they have an appointment with no justifiable cause.

- Falsifying records or duplicate billing: A staff member writes that they met with a member for 60 minutes and provided rehabilitation interventions, when they only had a brief five-minute conversation.

- Claiming reimbursement for treating an individual other than the eligible individual: A staff member meets with **Client A**, but documents the service and submits a claim under **Client B** because Client B has active Medi-Cal coverage and Client A does not.

- Intentionally billing for an ineligible individual: A client's Medi-Cal eligibility ended last month. Staff are aware the member is no longer eligible but continue submitting claims to Medi-Cal for services provided after eligibility ended.

Abuse includes actions that may, directly or indirectly, result in: Unnecessary costs or reimbursement to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. (42 C.F.R. § 455.2 and W&I, section 14107.11, subdivision (d))

Examples:

- Billing a non-covered service: A therapist bills for time spent helping a client complete paperwork for a purely administrative task.

- Billing a service which knowingly did not take place: A client cancels their therapy appointment. The clinician documents a completed 60-minute therapy session and submits a claim for reimbursement even though the client was never seen.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Examples:

- Large scale duplicative services: A client attends one 60-minute individual therapy session with a licensed therapist. The therapist bills for the session, but a second clinician who did not provide any service also submits a claim for a 60-minute individual therapy session during the same time period.

- Providing services/procedures/medications that are not medically necessary: A client receives three psychotherapy sessions from three different clinicians on the same day without any documented clinical need or treatment plan supporting the duplication.

Definitions for “fraud", “waste", and “abuse," as those terms are understood in the Medicare context, can also be found in the Medicare Managed Care Manual.

Via: CalAIM-BH-Initiative-FAQ-Compliance

What is NOT Fraud, Waste or Abuse?

- Selecting the incorrect Service Code/CPT Code
- Entering Incorrect service/documentation time
- Billing when the client was a “no show” or session was cancelled
- The service does not meet the definition of a SMHS
- The content of the progress note does not justify the time billed
- The note billed is not present in the chart
- The date of service of the PN does not match the date of service claimed
- Documenting non reimbursable services or including mention of “non billable” interventions during an otherwise billable note
- Service provided was not within scope of person delivering the service
- Documentation was completed but not signed

- Group services not properly apportioned to all clients present

Remember- always consult with QA if you are unsure if something qualifies as FWA.

Red Flags for FWA:

- Repeated pattern of unnecessary services
    - Example: “Assembly line” or non-individualized treatment plans/patterns or “cookie cutter” progress notes
- Pattern of knowingly false statements on billings, or corresponding progress notes
    - Example: Deliberately listing wrong location of service or provider to conceal license/eligibility issues
- Intentional concealment of known errors or overpayments
    - Example: Use of inaccurate statements, or deliberate failure to disclose facts in response to audit questions

Instructions for Programs:

- Any suspected fraud, waste, and/or abuse should be reported **immediately** to Program COR as well as the BHA QA Team at QIMatters.HHSA@sdcounty.ca.gov .
- Please note: DHCS has updated their ‘Reasons for Recoupment’. Programs should not self-disallow services unless specifically instructed to do so by County QA or COR. Evidence found of fraud, waste, and/or abuse:
- Any potential findings of fraud, waste, or abuse must be reported to the DHCS State Medicaid Fraud Control unit by phone, online form, email, or mail by the Program:
    - **Phone:** 1-800-822-6222
    - **Email:** fraud@dhcs.ca.gov
    - **Mail:** Medi-Cal Fraud Complaint – Intake Unit Audits and Investigations: P.O. Box 997413; MS 2500 Sacramento, CA 95899-7413