

Fraud, Waste and Abuse

Definition

Harvard Pilgrim Health Care will protect the interests of its constituents (including members, employers, and providers) and Harvard Pilgrim corporate assets against those who knowingly and willingly commit fraud. Harvard Pilgrim is committed to detecting, investigating, and preventing wrongful acts committed by providers, members, and any other entity against the organization. Harvard Pilgrim will identify, investigate, recover funds, report, and when appropriate, take legal actions, if suspected fraud, waste, and/or abuse has occurred.

Fraud

In the healthcare context, fraud occurs when a person(s)¹

- knowingly and willfully makes or causes to be made any false statement or misrepresentation of a material fact in any application for a payment of a health care benefit.
- knowingly and willfully presents or causes to be presented an application for a health care benefit containing any false statement or misrepresentation of a material fact, or
- knowingly and willfully makes or causes to be made any false statement or misrepresentation of a material fact for use in determining rights to a health care benefit, including whether services were medically necessary in accordance with professionally accepted standards.

Abuse

Abuse describes practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, does not meet industry accepted and/or professionally recognized standards, or is not fairly priced. Abuse also occurs when a person(s) obtains or attempts to obtain payment for items or services when there is no legal entitlement to that payment, but without knowingly and/or intentionally misrepresenting facts to obtain payment.

Waste

Waste generally involves the overutilization or underutilization of services or other practices, or the inefficient and ineffective utilization of practices, systems, or controls.

Fraud and abuse may include, but are not limited to, the following:

- Performing an unnecessary or inappropriate service.
- Billing services, procedures and/or supplies that were not provided.
- Billing a higher level procedure code than is supported by the record (upcoding).
- Billing duplicate claims.
- Unbundling claims.
- Charging in excess of usual, customary and reasonable fees.
- Soliciting or accepting referral fees or waiving member's deductibles, coinsurance or copayments (i.e., kickbacks).
- Collecting monies except for deductible amounts, coinsurance amounts, copayment amounts, and non-covered items as permitted pursuant to Harvard Pilgrim's final notification of payment or published policies.

Policy²

All members and providers must comply with all federal and state laws and regulations prohibiting fraudulent acts and false reporting, specifically including but not limited to M.G.L. c. 175H, s. 1-7 and U.S. Code Title 18.³

Likewise, a provider's submission of a claim for payment constitutes a representation by the provider that the services or supplies reflected on the claim, including all quantities set forth on that claim:

- Were medically necessary in the provider's reasonable judgment (except with respect to cosmetic services)
- Were actually performed by the provider or services were performed under a clinician's supervision as allowed by Harvard Pilgrim policy
- Were submitted accurately, using appropriate coding
- Have been properly documented in the member's medical records

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 described above, and is submitted in compliance with all federal and state laws and regulations. Additionally, a provider may not routinely agree to waive members' deductibles, coinsur-

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PAYMENT POLICIES

Fraud, Waste and Abuse (*cont.*)

ance, and copayments. Providers are responsible for, and these provisions likewise apply to, the actions of their staff members and agents.

Any amount billed by a provider in violation of this policy, if paid by Harvard Pilgrim, constitutes an overpayment by Harvard Pilgrim that is subject to denial, recovery, retraction, or off-set.

Any amounts billed to and paid by members in violation of this policy, must be immediately refunded to such members. A provider may not bill members for any amounts due resulting from a violation of this policy.

Providers who know of or suspect fraud and abuse activity should call Harvard Pilgrim's Special Investigations Unit at 617-509-1029.

PUBLICATION HISTORY

07/08/08	original documentation
05/15/09	annual review; no changes
06/15/10	annual review; minor edit for clarity
06/15/11	annual review; no changes
01/01/12	removed First Seniority Freedom information from header
09/15/12	annual review, reformatted policy
03/15/16	annual review; administrative edits

¹Fraud is not limited to these contexts. See M.G.L. c. 175H, §1-7, M.G.L. c. 12 §5, 5A-O and U.S. Code Title 18 for statutory descriptions of fraud in health insurance and the potential consequences of fraudulent acts.

¹This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

³Medicare Advantage products are subject to all applicable Medicare Program statutes, rules and regulations.