

Chapter 12 ***Fraud and Abuse***

Molina seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members, and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

A. Definitions

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in 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 cost to the Medicaid program. (42 CFR §455.2)

“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 CFR § 455.2)

B. Federal False Claims Act, 31 USC Section 3279

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including 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.

The term “knowing” is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- 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.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, 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 knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

C. Deficit Reduction Act

On February 8, 2006, President Bush signed into law the Deficit Reduction Act (“DRA”). The law, which became effective on January 1, 2007 aims to cut fraud, waste and abuse from the Medicare and Medicaid programs over the next five years.

Health care entities like Molina who receive or pay out at least \$5 million in Medicaid funds per year must comply with DRA. As a contractor doing business with Molina, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protected rights as whistleblowers.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it;
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use;
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program;
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer’s inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina will take steps to monitor Molina contracted providers to ensure compliance with the law.

D. Health Care Fraud Is

Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

Examples of Fraud and Abuse

By a Member	By a Provider
Lending an ID card to someone who is not entitled to it.	Billing for services, procedures and/or supplies that have not been actually been rendered
Altering the quantity or number of refills on a prescription	Providing services to patients that are not medically necessary
Making false statements to receive medical or pharmacy services	Balancing Billing a Medicaid member for Medicaid covered services
Using someone else's insurance card	Double billing or improper coding of medical claims
Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits	Intentional misrepresentation of manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment , "upcoding", and billing for services not provided
Pretending to be someone else to receive services	Concealing patients misuse of Molina Health card
Falsifying claims	Failure to report a patient's forgery/alteration of a prescription

F. Other Provider Crimes

- Knowingly and willfully solicits or receives payment of kickbacks or bribes in exchange for the referral of Medicare or Medicaid patients.
- A physician knowingly and willfully referring Medicare or Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)
- Balance billing – asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.

G. Reporting Fraud and Abuse

You may report suspected cases of fraud and abuse to Molina's Compliance Officer. You have the right to have your concerns reported anonymously to either Molina and/or the Health and Human Services Commission Office of Inspector General. Remember to include the following information when reporting suspected fraud or abuse:

When reporting a provider (e.g., doctor, dentist, counselor, etc.) provide the following:

- Name, address, and phone number of provider;
- Name and address of the facility (hospital, nursing home, home health agency, etc.);
- Medicaid number of the provider and facility
- Type of provider (physician, physical therapist, pharmacist, etc.);
- Names and phone numbers of other witnesses who can aide in the investigation;
- Dates of events; and
- Summary of what happened.

When reporting a recipient (a person who receives benefits) provide the following:

- The person's name;
- The person's date of birth, social security number, or case number if available;
- The city where the person resides; and
- Specific details about the waste, abuse or fraud.

Where to Report Suspected Fraud and Abuse

Molina Healthcare of Texas Confidential Compliance Hotline Voice Mail: 866-887-1748

Email: mhtcompliance@Molinahealthcare.com

To submit written report via mail or fax:

Mail:

Compliance Officer
Molina Healthcare of Texas
84 NE Loop 410, Suite 200
San Antonio, TX 78216
Fax: 866-887-1749

You may also report suspected fraud and abuse directly to the Texas Health and Human Services Commission Office of Inspector General

When reporting providers:

Office of Inspector General
Medicaid Provider Integrity
Mail Code 1361
P.O. Box 85200
Austin, TX 78708-5200

When reporting recipients:

Office of Inspector General
General Investigations
Mail Code 1362
P.O. Box 85200
Austin, TX 78708-5200