UF Ped-I-Care
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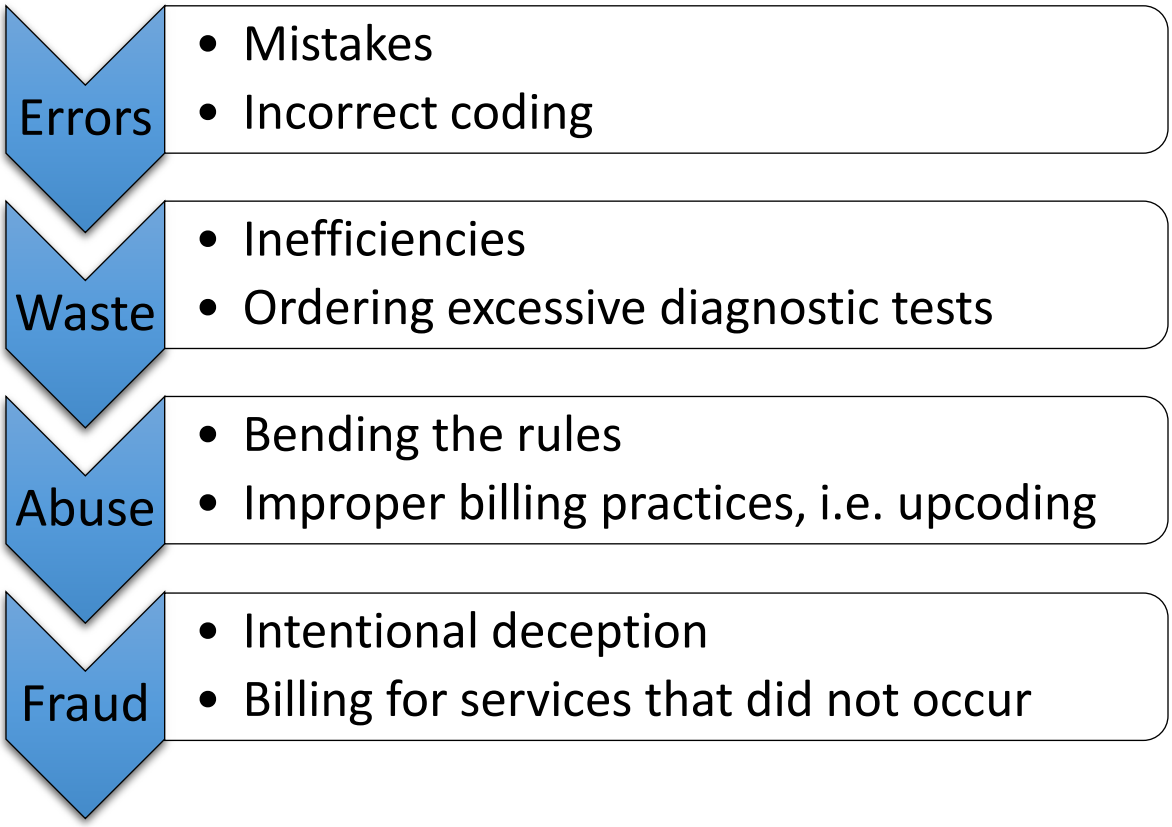
Definitions and Examples of Abuse, Fraud, Overpayment, Waste



Abuse (for program integrity functions)**:** Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care, or member practices that result in unnecessary costs.

Examples of Provider Abuse:

- Provider billing irregularities
- Over-utilization of health care services
- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Improper billing practices
- Inaccurate coding

Examples of Member Abuse:

- Residing out-of-state
- Tampering with prescriptions
- Drug-seeking behaviors
- Failure to report third-party liability

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Examples of Provider Fraud:

- Billing for an office visit when there was none, or adding additional family members' names to bills
- Billing for services that were not provided, e.g., a chest x-ray that was not taken
- Billing for more time than was actually provided, i.e., counseling, anesthesia, etc.
- Ordering unnecessary x-rays, blood work, etc.
- Upcoding (billing for a more involved or time-consuming service than was actually provided), e.g., providing a simple office visit and billing for a comprehensive visit
- Billing for transportation that is not medically necessary or is not related to health care
- Billing for services that are not medically necessary, or are not for a medical purpose
- Accepting payment from someone, including sharing in the reimbursement paid by the health plan, as a result of services that were not rendered, not legal, or for referring a patient to another provider
- Duplicate billing such as billing Medicaid and another payer and/or the member for the same service
- Misrepresentation of professional credentials/licensing/status of licensure
- Having an unlicensed person perform services that only a licensed professional should render, and billing as if the professional provided the service
- Intentionally submitting claims using another provider's Medicaid # or National Provider Identification (NPI).
- Unbundling codes (billing separately for each component of the code) which results in increased payment, when one comprehensive code includes all related services at a lesser reimbursement rate. This also includes incidental procedures that are typically performed as part of a larger procedure and, because they take little extra effort, are not usually reimbursed separately. Examples include laboratory blood test panels, surgical procedures, etc.

Examples of Member Fraud:

- Intentionally under-reporting income, assets, resources, etc.
- Loaning a Medicaid Identification card to another person
- Using multiple ID cards and/or Medicaid/member numbers
- Forging or altering a prescription or fiscal order
- Selling items paid for by the health plan
- Intentionally receiving duplicative, excessive, contraindicated, or conflicting health care services or supplies
- Misrepresentation of a medical condition

Overpayment: Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Examples of Overpayment:

- Payment for provider, supplier, or physician services after benefits have been exhausted, or where the member was not entitled to benefits
- Payment for non-covered items and services, including medically unnecessary services or custodial care furnished to a member
- Payment based on a charge that exceeds the reasonable charge
- Duplicate processing of charges/claims

- Payment to a physician on a non-assigned claim or to a member on an assigned claim (payment made to wrong payee)
- Primary payment for items or services for which another entity is the primary payer
- Payment for items or services rendered during a period of non-entitlement

Waste: It not defined in the rules, but "is generally understood to encompass the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act." Examples of waste by a beneficiary could include making excessive office visits or accumulating more prescription medications than necessary for the treatment of specific conditions. Waste by a provider could include ordering excessive laboratory tests such as a comprehensive metabolic panel; ordering a group of blood tests, when only one test is needed; or ordering magnetic resonance imaging (MRI) instead of a mammogram for preventive care.

Additional Examples of Waste:

- **Failures of care delivery** – Poor execution or lack of widespread adoption of best practices, such as effective preventive care practices or patient safety best practices, which can result in patient injuries, worse clinical outcomes, and higher costs
- **Failures of care coordination** – Fragmented and disjointed care can lead to unnecessary hospital readmissions, avoidable complications, and declines in functional status, especially for the chronically ill
- **Overtreatment**
    - Excessive use of antibiotics
    - Care that is rooted in outmoded habits
    - Ordering clinical procedures, tests, medications, and other services that may not benefit patients
    - Providers' preferences for treatment that is beyond/outside of that considered necessary and appropriate by industry standards
    - Scheduling more visits than is medically necessary
    - Ordering unnecessary tests or diagnostic procedures to guard against liability in malpractice lawsuits
    - Over-diagnosis stemming from efforts to identify and treat disease in its earliest stages when the disease might never actually progress and when a strategy such as watchful waiting may have been preferred. For example, in July 2012 the US Preventive Services Task Force recommended against prostate-specific antigen-based screening for prostate cancer because of "substantial over-diagnosis" of tumors, many of which are benign. Excessive treatment of these tumors, including surgery, leads to unnecessary harms, the task force said.