



Fraud & Abuse: Frequently Asked Questions

What is Fraud and Abuse?

In general, “fraud” means a deliberate or intentional deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation will result in an unauthorized benefit or financial gain. The term includes any act that constitutes fraud under applicable federal or state law. “Abuse” means any practice that is inconsistent with generally accepted business or medical practices or standards and that results in unnecessary cost or reimbursement for goods or services that are not medically necessary, or fail to meet professionally recognized standards for health care, or recipient practices that result in unnecessary cost.

What are some of the common types of health care fraud?

- Submitting claims for services, treatments, procedures, equipment and/or supplies that were not provided
- Providing payment or other inducements to a health plan member in exchange for the use of his/her identification card or using health plan member identification information with or without the permission of the health plan member to submit claims for the purpose of obtaining wrongful payment
- Unlawful kickbacks, gratuities or other inducements to providers, members or others
- Any intentional misrepresentation of a material fact or facts regarding the provision of health care services for the purpose of obtaining wrongful payment such as (1) any information provided verbally or in writing used for the purpose of obtaining an authorization for service; (2) the nature of services, procedures, and/or supplies provided; (3) the dates on which services or treatments were rendered; (4) the medical record of service and/or treatment provided; (5) the condition treated or the diagnosis made; (6) the charges or reimbursement for services, procedures, and/or supplies; (7) the identity of the provider, recipient of services, procedures, and/or supplies; (8) nondisclosure of waived co-payments or deductibles in schemes; or (9) falsifying clinical records, notes, and other documents used to validate services

What are some examples of health care abuse?

- Failing to adequately document services provided according to accepted medical record and documentation standards
- Providing treatment or services that are inconsistent with the diagnosis or appropriate medical/clinical indications
- Withholding medically necessary services to avoid cost or performing repetitive or excessive tests, visits, supplies, drugs and treatments not meeting medical necessity criteria
- Failure to establish and maintain adequate financial records



What is an error?

An error is an isolated, unintentional event resulting from a mistake or misunderstanding of rules, policies or generally accepted guidelines. Errors may occur as the result of miscommunication, misunderstanding, assumptions, outdated reference guidelines, inexperienced personnel, or other administrative problems.

What are some examples of an error?

- Honest billing mistakes, such as inadvertent transposition of numbers, charges, missing data, or identifying information
- Isolated instances of billing more than once for the same service for the same patient on the same date, up-coding, or unbundling
- Use of outdated or discontinued diagnostic and procedure codes or the occasional incorrect use of modifiers

What is the Special Investigations Unit?

The Special Investigations Unit (SIU) was established to investigate incidents of fraud and abuse for the health plan. The SIU is located at the corporate headquarters in Tampa, Florida. The mission of the SIU is to:

- comply with State and Federal statutory, regulatory, and contractual requirements regarding fraud and abuse;
- effectively prevent, detect, investigate, and report suspected fraud and abuse;
- identify and recover lost funds through negotiation and/or litigation, including criminal prosecution when warranted; and
- provide fraud and abuse training to providers, members and associates.

Reported incidents of suspected fraud and abuse are investigated by the SIU and coordinated with the health plan, corporate Legal Services, Regulatory Affairs and Corporate Compliance, Government agencies, law enforcement, prosecutors and others as required. If you suspect fraud or abuse, please call 1-866-678-8355 toll free, or use the link on the Fraud and Abuse page of our website to report suspected fraud or abuse.