UNDERSTANDING FRAUD, ABUSE AND WASTE

We are committed to protecting the integrity of the program we offer and the efficiency of our operations by preventing, detecting and investigating fraud, abuse, and waste. Combating fraud, abuse and waste begins with knowledge and awareness.

**Fraud** is any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to him- or herself or some other person. The attempt itself is fraud, regardless of whether or not it is successful.

**Abuse** is any practice that is inconsistent with sound fiscal, business or medical practices, and results in an unnecessary cost to the Medicaid program including administrative costs from acts that adversely affect providers or members.

**Waste** is generally defined as activities involving careless, poor or inefficient billing or treatment methods causing unnecessary expenses and/or mismanagement of resources.

**Examples of Physician and other Professional Provider Fraud, Abuse and Waste**

These are typical examples of provider fraud and abuse:

- Billing for services not provided
- Billing for medically unnecessary tests
- Unbundling/upcoding
- Misrepresentation of diagnosis or services
- Under-utilization and over-utilization
- Soliciting, offering or receiving kickbacks or bribes
- Billing professional services performed by untrained personnel
- Altering medical records

**Examples of Member Fraud, Abuse and Waste**

These are examples of member fraud, abuse and waste:

- Frequent emergency room visits with non-emergent diagnoses
- Obtaining controlled substances from multiple providers
- Violation of pain management contract
- Using more than one physician or professional provider to obtain similar treatments and/or medications
- Using physicians or professional providers not approved by the primary care provider (PCP)
- Forging, altering or selling prescriptions
- Loaning insurance identification (ID) cards
- Disruptive or threatening behavior
- Relocating to out-of-service area
REPORTING PHYSICIAN AND PROFESSIONAL PROVIDER OR RECIPIENT FRAUD, ABUSE OR WASTE

If you suspect a member (a person who received benefits) or a provider (for example, doctor, dentist, counselor and so on) has committed fraud, abuse or waste, you have a responsibility and a right to report it.

Providers can report allegations of fraud, abuse or waste to us by telephone at:

- Medicaid Managed Care (STAR) Program: 877-560-8055
- Children’s Health Insurance Program (CHIP): 877-560-8055

Or, you may complete a Fraud Referral Form and mail or fax it to:

BCBSTX
Special Investigations Department
1001 E. Lookout Drive, Building A
Richardson, Texas 75082
Fax: 972-996-9211

Do you want to report waste, abuse, or fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law.

For example, tell us if you think someone is:

- Getting paid for services that weren’t given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid (STAR) or CHIP ID.
- Using someone else’s Medicaid (STAR) or CHIP ID.
- Not telling the truth about the amount of money or resources a member has to qualify for benefits.
To report waste, abuse, or fraud, choose one of the following:

Call the Office of the Inspector General (OIG) Hotline at 800-436-6184;

Visit https://oig.hhsc.state.tx.us/ and under the box labeled ‘I Want To’ click ‘Report Waste, Abuse, and Fraud’ to complete the online form; or

Report waste, abuse or fraud to BCBSTX:

Website: www.bcbstx.com/ut/resources/fraud.html
Phone: 800-543-0867
Address: BCBSTX
Special Investigations Department
1001 E. Lookout Drive, Building A
Richardson, Texas 75082

To report waste, abuse or fraud, gather as much information as possible.

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

• 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, if you have it.
• Type of provider (doctor, dentist, therapist, pharmacist, etc.).
• Names and phone numbers of other witnesses who can help in the investigation.
• Dates of events.
• Summary of what happened.

When reporting about someone who receives benefits, include:

• The person’s name.
• The person’s date of birth, Social Security Number, or case number if you have it.
• The city where the person lives.
• Specific details about the waste, abuse or fraud.

Anonymous Reporting of Suspected Fraud, Abuse and Waste

Although you may report the incident to us anonymously, we must know the following information should there be any question or missing information in the report:

• Name of the person reporting and their relationship to the person suspected
• A call-back phone number for the person reporting the incident
What Happens After Reporting an Incident of Fraud, Abuse or Waste?

BCBSTX thoroughly investigates all fraud, abuse and waste referrals. We report all referrals to regulatory agencies and appropriate law enforcement agencies.

Reporting Fraud, Abuse or Waste to the State

If you have access to the Internet, go to the Texas Health and Human Services Commission (HHSC) Office of the Inspector General (OIG) website at [www.hhs.state.tx.us](http://www.hhs.state.tx.us) and select Reporting Waste, Abuse and Fraud. The site provides information on the types of waste, abuse and fraud to report.

If you do not have Internet access or prefer to talk to a person, call the HHSC Office of the Inspector General (OIG) Fraud Hotline at: **800-436-6184** or, you may send a written statement to the following addresses:

Address to Report Providers:  
**Office of Inspector General  
Medicaid Provider Integrity**  
Mail Code 1361  
P.O. Box 85200  
Austin, TX 78708-5200

To Report Clients (Recipients):  
**Office of Inspector General  
Investigations M a i l Code**  
1362  
P.O. Box 85200  
Austin, TX 78708-5200

ROLE OF THE FRAUD, ABUSE AND WASTE DEPARTMENT

We do not tolerate acts that adversely affect our physicians or professional providers or members. We investigate all reports of fraud, abuse and waste. Allegations and the investigative findings are reported to the HHSC regulatory and law enforcement agencies. In addition to reporting, we take corrective action, such as:

- **Written warning and/or education:** We send certified letters to the physician or professional provider or member documenting the issues and the need for improvement. Letters may include education or request for recoveries, or may advise of further action.

- **Medical record audit:** We may review medical records to substantiate allegations or validate claims submission.

- **Special claims review:** Special claims review places payment or system edits on the file to prevent automatic claim payment; this requires a medical reviewer evaluation.

- **Recoveries:** We recover overpayments directly from the provider within a reasonable time frame of receiving notice of the error or overcharge.
QUALITY OF CARE

We refer physicians or other professional providers who compromise patient care to the Quality Management department. The Physicians or other professional providers may be presented to the credentials committee and/or peer review committee for disciplinary action, which may include any of the following:

- **Provider termination**: Failure to comply with program policies and procedures or any violation of the contract will result in termination from our plan.

- **Member disenrollment**: Fraud, threatening behavior or failure to correct issues may result in involuntary disenrollment from our health plan (with state approval). See the PCP-initiated Member Transfers section.

- **Referral to law enforcement**: We refer criminal activity to the appropriate local and/or regulatory enforcement agency.

FALSE CLAIMS ACT

We are committed to complying with all applicable federal and state laws including the Federal False Claims Act (FCA).

The FCA is a federal law that provides the federal government with the means to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages, or loss, to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam or ‘whistleblower’ provisions. A ‘whistleblower’ is an individual who in good faith reports an act of fraud, abuse, or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.