

## CHAPTER 20 – FRAUD, WASTE, AND ABUSE

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REFERENCES: [42 CFR 455.2](#), [A.R.S. §§ 46-451](#) and [13-3623](#)

The Division is committed to the prevention and detection of fraud, waste and abuse. Providers are responsible to administer internal controls to guard against fraud, waste and abuse.

### **Abuse of the Program**

Abuse is defined by Federal law ([42 CFR 455.2](#)) as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

### **Abuse of a Member**

Abuse of a member, as defined by Arizona law ([A.R.S. §§ 46-451](#) and [13-3623](#)), means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.

### **Fraud**

Fraud is defined by Federal law ([42 CFR 455.2](#)) as 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.

Examples of fraud are:

- A. Falsifying Claims/Encounters: Alteration of a claim; incorrect coding; double-billing; or false data submitted.
- B. Falsifying Services: Billing for services/supplies not provided; misrepresentation of services/supplies; or substitution of services.
- C. Administrative/Financial: Kickbacks; falsifying credentials; fraudulent enrollment practices; fraudulent Third Party Liability (TPL) reporting; or fraudulent recoupment practices.
- D. Member Issues (Fraud) Eligibility Determination Issues: Resource misrepresentation (transfer/hiding); Residency; or household composition.

## **Waste**

Waste is defined as overutilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary cost to a federally-funded or state-funded program.

## **Division Monitoring**

The Division:

- A. Reviews all participating providers during the credentialing/certification process (including re-credentialing).
- B. Monitors providers for non-compliance with Division contracts, rules, policies and procedures, in addition to AHCCCS policies.
- C. Verifies as part of Prior Authorization:
  - 1. Member eligibility
  - 2. Medical necessity
  - 3. Appropriateness of service being authorized
  - 4. Service being requested is a covered service
  - 5. An appropriate provider referral.

The Division's electronic claims processing application executes over 150 pre-payment edits ensuring payment accuracy and guarding against fraud and abuse. Some of these edits include: member eligibility; covered services; prior authorization; appropriate services codes; dates of services; authorized units and units provided; duplicate claims; approved rates; and utilization.

The Division, with the support of the Department's Audit and Management Services Division, conducts post payment reviews. These reviews look retrospectively at a sample of paid claims to ensure provider internal controls are in place. These reviews include the review of provider files, such as timesheets, to ensure proper documentation.

Quality Management conducts regularly scheduled on-site reviews. Additional reviews may be conducted on an as needed basis.

If at any time during the above processes, an unusual incident is suspected or discovered, the matter is referred to the Department's Fraud Coordinator.

## **Provider Requirements**

### A. Training and Education

Providers must ensure all employees receive adequate training addressing fraud, waste, and abuse prevention, recognition and reporting, and encourage employees and Division members to report fraud, waste, and abuse without fear of retaliation.

### B. Reporting Fraud, Waste and Abuse

When a provider becomes aware of an incident of potential/suspected fraud, waste or abuse, the provider must report the incident to the Division within one business day of becoming aware of the incident. To report suspected fraud, waste or abuse of the program, the provider performs one of the following:

1. Call the toll free DES/DDD Hotline at 877-822-5799
2. Report the incident by completing the [on-line referral form](#).

### C. Reporting Abuse of a Member

Providers must:

1. Comply with mandatory reporting requirements in accordance with A.R.S. §13-3620 for children under age 18, and A.R.S. §46-454 for adults, as outlined in [Chapter 6000](#) of the Division's Policy Manual.
2. Report to the Division all incidents of suspected abuse of a member in accordance with the policy and procedures detailed in [Chapter 6000](#).