Fraud, Waste and Abuse Quick Reference Guide

UnitedHealthcare Community Plan of Michigan

Fraud, waste and abuse cost the health care system billions of dollars each year. UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by care providers and plan members. We created this quick reference guide to provide an overview of fraud, waste and abuse, as well as guidelines for reporting it. More information is available in the UnitedHealthcare Community Plan of Michigan Care Provider Manual.

Fraud, Waste and Abuse Definitions

The following definitions are based on state and federal law:

- **Fraud**: Purposely being dishonest or misrepresenting facts to get something of value. Fraud is when a care provider, member or entity is purposely dishonest or misrepresents facts knowing it will result in an inappropriate gain or benefit.
- **Waste**: Using more services than you need, or practices that directly or indirectly result in unnecessary costs to the health care system. Waste is not generally caused by criminal actions, but by overusing resources.
- **Abuse**: An action that may result in unnecessary costs to the health care system. Abuse is when a person or entity has not knowingly or purposely misrepresented facts but receives a payment that they have no legal reason to receive.

Fraud, Waste and Abuse Examples

Common types of fraud, waste and abuse include:

- Billing for medical services not actually performed
- Billing for more expensive services
- Billing for services separately that should be billed together
- Billing more than once for the same service
- Dispensing generic drugs but billing for brand-name drugs
- Falsely charging for missed appointments, unnecessary medical tests or telephoned services
- Falsifying cost reports
- Giving or accepting something of value (cash, gifts, services) in return for medical services, (i.e., kickbacks)
- Providing unnecessary services

Other examples of fraud, waste and abuse include when someone:

- Lies about their medical condition or eligibility for Medicaid
- Forges prescriptions
- Sells their prescription drugs to others
- Loans their Medicaid card to others

Federal and State False Claims Acts

The Federal False Claims Act (31 U.S.C. §§ 3729-3733) prohibits any person from knowingly presenting or causing the presentation of a fraudulent claim for payment. The False Claims Act also protects anyone who reports fraud, waste or abuse from retaliation, including harassment, demotion and wrongful termination.

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In addition, the Michigan Health Care False Claims Act (Act 323 of 1984) was enacted to "prohibit fraud in the obtaining of benefits or payments in connection with health care coverage and insurance; to prohibit kickbacks or bribes in connection with such coverage and insurance; to prohibit conspiracies in obtaining benefits or payments; to provide for certain powers and duties of certain state and local officers and agencies; to provide for and preclude certain civil actions; and to prescribe penalties."

Medical Records Retention Law

Please note that in addition to complying with federal and state false claims laws, Michigan Medicaid care providers must also comply with Michigan Public Health Code Act 368 of 1978, Section 333.16213 by retaining medical records for a minimum of seven years from the date of service.

Penalties for Submitting Fraudulent or Abusive Claims

We take seriously any violations of UnitedHealthcare Community Plan policies, contractual obligations or state and laws, including the Federal False Claims Act and Michigan Health Care False Claims Act. Submitting fraudulent or abusive claims may result in disciplinary action, up to and including legal action and suspension from Michigan Medicaid.

Reporting Fraud, Waste and Abuse to UnitedHealthcare

If you suspect fraud, waste or abuse, you have a responsibility to report it, and may do so anonymously. Retaliation is prohibited if you make a report in good faith. Here's how you can report suspected fraud, waste or abuse to us:

- **Phone:** 844-359-7736
- **Online:** uhc.com/fraud
- **Mail:**
  UnitedHealthcare Community Plan
  Compliance Officer
  3000 Town Center Suite 1400
  Southfield, MI 4075

Reporting Fraud, Waste and Abuse to Michigan Medicaid

You can report suspected fraud, waste and abuse directly to the Michigan Department of Health & Human Services (DHHS) Office of Inspector General, which investigates suspected misuse of Michigan's Medicaid program. Here's how to file a report with DHHS:

- **Phone:** 855-643-7283
- **Online:** Medicaid Fraud and Abuse Online Complaint Form
- **Mail:**
  Office of Inspector General
  P.O. Box 30062
  Lansing, MI 48909

DHHS requests the following information in reports of fraud, waste or abuse:

- Description of the nature of the complaint
- The names of those involved in the suspected fraud, waste and/or abuse, including their address, phone number, Medicaid identification number, date of birth (for beneficiaries) and any other identifying information if available/applicable

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To learn more about the Office of Inspector General, click here.

Reward for Reporting Fraud, Waste or Abuse to Michigan Medicaid

When reporting fraud, waste or abuse to DHHS, you may be eligible for a reward of up to $1,000 if all of these seven conditions are met:

1. You must report the suspected fraud directly to the DHHS Office of the Inspector General. If you reported the fraud to a Medicaid health plan (such as UnitedHealthcare Community Plan), you must also report the fraud to the Office of the Inspector General. The allegation must be specific, not general.
2. The suspected fraud must not have occurred later than six years from the date of the initial report.
3. You are a recipient or an entity providing services to a recipient of a Michigan DHHS program.
4. The suspected fraud must be confirmed as potential fraud by the Office of the Inspector General and formally referred to the Attorney General - Medicaid Fraud Control Unit (AG MFCU) and accepted as a case for investigation.
5. You are not an excluded individual.
6. The person or organization you're reporting isn't already under investigation by the Office of the Inspector General or the AG MFCU for the suspected fraud.
7. Your report leads to criminal or civil action (or any associated settlement) by the AG MFCU **and** the direct recovery of at least $1,000 of State of Michigan Medicaid funds.

The incentive payment will be 10 percent or $1,000, whichever is less, of the state funds recovered. If multiple individuals qualify for a reward, the reward is shared among them. More information is available here.

Provider Self-Disclosure Protocol

Care providers who wish to voluntarily disclose self-discovered evidence of potential fraud to the U.S. Department of Health & Human Services Office of the Inspector General may do so under the Provider Self-Disclosure Protocol. Self-disclosure gives care providers the opportunity to avoid the costs and disruptions associated with a government-directed investigation and civil or administrative litigation. More information is available here.

We're Here to Help

If you have questions, please contact the Compliance Officer , at Jerry.Johnson@uhc.com or **248-331-4209**. Thank you.

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