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Originated Department	Clinical Operations

Fraud, Waste, and Abuse

Audience
<ul style="list-style-type: none"> • Wipro Health Plan Services • Personify • Mountain Health Co-Op • Members Providers • Brokers

Purpose
<p>The purpose of this policy is to explain Mountain Health Co-Ops' commitment to conducting its activities in a lawful and ethical manner. Mountain Health Co-Op controls fraud, waste, and abuse of its and others' assets through prevention, detection, and correction of any violation of applicable Federal or State law, regulatory requirement, contractual obligation, or organizational policy reference.</p> <p>Anyone who suspects fraud, waste, or abuse, or other wrongdoing should report it to the Plan as described below.</p>

Definition
<p>Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit, unlawful gain, or unfair gain. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)</p> <p>Waste: The overutilization of services or practices that result in unnecessary costs. Waste also refers to useless consumption or expenditure without adequate return.</p> <p>Abuse: provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are</p>

not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid programs. (42 CFR § 455.2)

Policy/Procedure

1. Introduction

Healthcare fraud, waste, and abuse affect all of us. It costs taxpayers millions of dollars each year and is estimated to account for 3%-10% of annual health care expenditures in the United States. Health care fraud is a crime. It is the policy of the Plan that detecting and preventing fraud, waste, and abuse is the responsibility of everyone, including members, providers, and their delegates. It is further the policy of the Plan to protect its corporate assets and the interests of its members, brokers, and providers, against those who knowingly and willfully commit fraud or other wrongful acts.

2. Scope of Program

Mountain Health Co-Op operates a Fraud, Waste, and Abuse Program in the following markets. The FWA program applies to all services and programs provided by these markets.

- a. On exchange Individual
- b. Off-exchange Individual
- c. On-exchange Small Group
- d. Off-exchange Small Group
- e. Off-exchange Large Group

3. Fraud, Waste, and Abuse Program Goals and Purpose

The Purpose of the FWA Program, Mountain Health Co-Op (The Plan), is to protect its corporate assets and the interests of its members, brokers, and providers against those who knowingly and willingly commit fraud or other wrongful acts. The Plan will identify, resolve, and recover funds; when appropriate, report suspected fraud, waste, and/or abuse; and, if necessary, take legal action.

The Compliance division, along with FWA employees, has established a set of standards for the Plan based on state and federal rules, laws, and regulations. The Plan will uphold those regulations. The FWA Program will be reviewed and modified as needed.

The responsibilities of the FWA team include, but are not limited to

- a. Prevent, detect, and investigate FWA
- b. Educate employees, members, brokers, and providers about FWA and this Program
- c. Report suspect FWA to the appropriate law enforcement agencies and regulatory bodies, state or federal
- d. Pursue recoupment for financial loss caused by FWA, when appropriate
- e. Assist law enforcement by providing information as needed to develop a successful prosecution
- f. Collaborate with the Departments of Insurance and report suspected trending fraud in a geographic region to prevent bad actors in a large area of care.

4. Regulations

Providers must understand the statutory and regulatory requirements relating to health care fraud. Some examples include, but are not limited to, the following:

a. The False Claims Act (31 USC §§ 3729–3733)

A federal statute that covers fraud involving any federally funded contract or program, including, but not limited to, the Affordable Care Act, Medicare, and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

- i. The term “knowing” is defined to mean that a person, with respect to information:
 - has actual knowledge of the falsity of information in the claim,
 - acts in deliberate ignorance of the truth or falsity of the information in a claim,
 - or acts in reckless disregard of the truth or falsity of the information in a claim.
- ii. Health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as the following:
 - Knowingly making false statements,
 - Falsifying records,
 - Double billing for items or services,
 - Submitting bills for services never performed or items never furnished, or otherwise causing a false claim to be submitted.

b. Whistleblower Protection Under the False Claims Act.

An employer cannot retaliate against an employee for exercising their right to report possible fraud or a violation under the False Claims Act, discrimination, harassment, suspension, or termination of employment

c. Anti-Kickback Statute.

The anti-kickback statute is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare, Medicaid and the Affordable Care Act patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

d. Stark Law (42 U.S.C. § 1395nn)

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if you invest in an imaging center, the Stark law requires the resulting financial relationship to fall within an exception; otherwise, you may not refer patients to the facility, and the entity may not bill for the referred imaging services.

e. Exclusion Statute [42 U.S.C. § 1320a-7]

Office of Inspector General (OIG) is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses:

- a. Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Federal health care programs such as Medicare, Medicaid, or the Affordable Care Act.
- b. Patient abuse or neglect.
- c. Felony convictions for other health-care-related fraud, theft, or other financial misconduct. And
- d. Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

OIG has discretion to exclude individuals and entities on several other grounds, including misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud or misdemeanor convictions in connection with the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; and defaulting on health education loan or scholarship obligations.

If a provider is excluded by OIG from participating in the Federal health care programs, then Medicare, Medicaid, and other Federal health care programs, such as the Affordable Care Act, TRICARE, and the Veterans Health Administration, will not pay for items or services that you furnish, order, or prescribe.

f. Criminal Health Care Fraud Statute (18 USC § 1347)

The Criminal Health Care Fraud Statute prohibits anyone who knowingly and willfully executes, or attempts to execute a scheme to defraud any health care benefit program or to obtain by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

5. Types of Fraud

A provider that contracts with Mountain Health Co-Op and provides services to its members is subject to both federal and state laws (1,2,3). Both federal and state contract requirements have also been designed to prevent FWA in government programs such as the Affordable Care Act, Medicare, Medicaid, and private insurance. A provider's submission of a claim for payment also constitutes the provider's representation that the claim is not submitted as a form of, or

part of, fraud and abuse as listed below, and is submitted in compliance with all federal and state laws (1,2,3) and regulations.

Providers are responsible for, and these provisions likewise apply to, the actions of their staff members and agents. Any amount billed by a provider in violation of this policy and paid by the Plan constitutes overpayment and is subject to recovery. A provider may not bill members for any amounts due as a result of a violation of this policy.

Providers must understand, recognize, and prevent fraud and abuse. The following is a list of examples of potential fraud and abuse from a provider:

- a. Billing for services not rendered
- b. Not medically necessary is performing (and billing for) services that are not medically necessary just to obtain an insurance payment
- c. Editing a claim to get it paid is changing the rendering physician and/or services to get the claim paid (after the claim was denied)
- d. Waiving a patient's copay or deductible and over-billing the insurance company
- e. Falsifying records is falsifying a diagnosis to support testing or services not otherwise necessary/covered
- f. Kickback - Soliciting, offering, or receiving referral fees or waiving members' deductibles, coinsurance, or copayments (i.e., kickbacks)
- g. Referring patients in exchange for other services
- h. Over prescribing is prescribing a prescription that has no legitimate or medical purpose
- i. Practicing "defensive medicine" by ordering medical tests or procedures as a safeguard against possible malpractice liability, not to ensure a patient's health
- j. Overcharging is charging excessively for services, procedures, or supplies
- k. Over-treating is submitting for services that are not medically necessary, or services not medically necessary to the extent rendered (for instance, a panel of tests is ordered when, based upon the patient's diagnosis, only a few of the tests, if any at all, within the panel were actually necessary)
- l. Unbundling is billing each stage of a procedure as if it were a separate procedure
- m. Upcoding is billing for a more expensive service than the one actually performed
- n. Duplicate billing is billing multiple times for the same service

A person with the intent to deceive and defraud may violate the Insurance Fraud statute or the Fraudulent Insurance Act if they:

- a. Provide false, incomplete, or misleading information material to an insurance application, either in writing or orally
- b. Provide false, incomplete, or misleading information in order to obtain insurance benefits or damages related to a civil claim for personal or bodily injury or property damage
- c. Accept a benefit from insurance fraud proceeds
- d. Intentionally or recklessly devise a scheme or device to obtain professional service fees or anything of value through false or fraudulent pretenses, representations, promises, or material omissions
- e. Aide, solicit, or conspire with another person to commit insurance fraud

- f. Supply false or fraudulent material information in a document or statement required by the insurance department
- g. Fail to forward a premium to an insurer
- h. Employ, use, or acts as a "runner" or "body broker" for the purpose of committing insurance fraud

The Fraudulent Insurance Act also includes insurers violating this statute with the intent to deceive or defraud when they:

- a. Knowingly withholding information or providing false or misleading information with
- b. respect to an application, coverage, benefits, or claims under a policy or
- c. certificate
- d. Assist, abet, solicit, or conspire with another to commit a fraudulent insurance act
- e. Knowingly accept a benefit from the proceeds derived from a fraudulent
- f. insurance act
- g. Knowingly supply false or fraudulent material information in any document or
- h. statement required by the department

6. Other Types of Fraud

a. Drug Fraud

A few common types of drug fraud and abuse: drug pricing fraud, counterfeit drug fraud, and drug diversion abuse.

- a. Drug pricing fraud is when a physician dishonestly prescribes unnecessary medication to a patient in order to profit from the sale.
- b. Counterfeit drug fraud is when a physician knowingly pushes stolen, expired or altered or fake prescription drugs.
- c. Drug diversion abuse is when a health care worker does not administer a patient's medication but keeps it for personal profit.

b. Home Health Care Fraud

Home health care fraud is when home health agencies bill insurers, government benefit programs, or homebound patients for unnecessary services or for services that were never delivered.

This may also constitute Medicare or Medicaid fraud if the homebound patient receives home care under either program. It is fraud if claims are submitted that are not compliant with government program requirements.

7. Mandatory Reporting of Fraudulent Insurance Acts

A person shall report a fraudulent insurance act to the Department of Insurance Fraud Division if:

- a. The person has a good faith belief in the preponderance of the evidence that a fraudulent insurance act is being, will be, or has been committed by a person other than the person making the report.
- b. The person is an insurer or, in relation to the business of title insurance, an auditor that is employed by a title insurer.

- c. The report will be in writing and submitted through the National Insurance Crime Bureau fraud reporting system. Detailed information will be provided on the fraudulent insurance act, the perpetrator, and whether this was also reported to the attorney general, a state law enforcement agency, a criminal investigative department, or agency of the United States, the district attorney, or a prosecuting attorney of a municipality or county.

Detecting and preventing fraud, waste, and abuse (FWA) is the responsibility of everyone, including members, providers, and delegates. Anyone who knows of or suspects fraud and abuse activity should report such activity in one of the following ways:

1. **Call** the Plan's Customer Service on 1-800-781-6260,
2. **Email** Internal Compliance, compliance@mhc.coop
3. Report **anonymously** at 1-855-780-0066
4. **Email** anonymously to reports@lighthouse-services.com
5. Report anonymously **online** www.lighthouse-services.com/mhc
6. **Report to the Office of Inspector General (OIG)**
Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
Fax: 1-800-223-8164
Online: <https://oig.hhs.gov/fraud/report-fraud/>

Mail: U.S. Department of Health & Human Services
Office of Inspector General
ATTN: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

Mountain Health Co-Op (The Plan) will protect its corporate assets and the interests of its members, brokers, and providers against those who knowingly and willingly commit fraud or other wrongful acts. The Plan will identify, resolve, and recover funds; when appropriate, report suspected fraud, waste, and/or abuse; and, if necessary, take legal action.

The Plan will not retaliate against anyone who makes a good faith report of potential fraud or other wrongful acts. Various state and federal laws protect those who make a good-faith reports of potential fraud.

8. Documentation Requirements

Consistent with Centers for Medicare & Medicaid Services standards, medical records must contain information to justify treatment, admission, or continued hospitalization, support the diagnosis, and document the patient's progress and response to medications and services.

- a. Medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.
- b. All records must document relevant medical history, updated examination of the patient, admitting diagnosis, consultative evaluations, complications, informed consent, discharge summary, and final diagnosis with completion of medical records within 30 days following consultation or discharge.

- c. All corrections of medical records must be made within 30 days following consultation or discharge.
 - a. When an error is made in a medical record entry, proper error correction procedures must be followed for both paper and electronic records.
 - i. For paper records, a thin pen line should be drawn through the incorrect entry to ensure that the inaccurate information is still legible.
 - ii. The provider must state the reason for the error, document the correct information, and sign and date the correction. The original entry must not be obliterated or otherwise altered by blacking out with marker, using white-out, writing over an entry, or by other means.
 - iii. For electronic records, use an addendum to identify corrections due to errors. The addendum must be signed and dated by the provider.
 - iv. Documentation should include only acceptable standard abbreviations from Jablonski's Dictionary of Medical Acronyms and Abbreviations, 5th Edition, or other nationally accepted standard abbreviations. Facility- or provider-based acronyms are not acceptable.

9. Program Oversight

a. Medical Director

The Mountain Health Co-Ops Medical Director is responsible for the executive oversight and sponsorship of the FWA program.

b. Assistant Vice President (AVP) Clinical Operations

The AVP of Clinical Operations is responsible for leadership oversight of the program and its strategic plan. The AVP of Clinical Operations reports directly to the SVP of Provider Contracting. The AVP frequently reports to the leadership and executive team on the SIU department's activities, findings, and outcomes.

c. Special Investigations Unit (SIU) Investigator/Nurse

The Plan contracts with a registered Nurse with a background in SIU and FWA investigations. The contractor supports medical records review and FWA lead identification and serves as the subject-matter expert for the Co-Op. The Contractor reports directly to the AVP of Clinical Operations. The contractor works with internal teams to resolve investigations. Some actions may include, but are not limited to the following

- a. Pursuing financial recoupment of an overpayment
- b. Placing the provider's claims on a prepay pend status
- c. Providing or coordinating education
- d. Terminating a provider's participating agreement

d. The FWA team reports to the Compliance Department, which is overseen by the Senior Vice President (SVP) of External Affairs. The SVP of External Affairs reports directly to the Chief Operating Officer (COO) of Mountain Health Co-Op. The Compliance Department also includes the AVP of Organizational Accountability.

10. FWA Program Plan

The Plan will maintain the integrity of the FWA program through multiple internal controls to prevent, detect, investigate, resolve, monitor, and report suspected FWA activities.

a. Pended claim process

Mountain Health Co-Op or its delegate has provisions in place to suspend payments to providers and members when a credible allegation of FWA is made. The claims are pended for manual review by the SIU investigator, coder, and/or clinical staff.

b. Credentialing

Mountain Health Co-Op has partnered with a vendor to conduct provider credentialing, which involves verifying and screening applicants for the Mountain Health Co-Op network. The vendor also provides monitoring services to ensure providers consistently meet the quality standard set forth in The Plans' Credentialing panel policy.

c. Pharmacy FWA monitoring

The Plans' Pharmacy Benefit Manager (PBM) monitors the Prescription (RX) claim report, which generates monthly pharmacy and physician data used to detect potential drug fraud cases.

d. Case management

Case Management works with members who raise concerns about FWA cases. Referrals are made to The Plans' FWA department. Medical Necessity post-payment reviews.

e. Pre-Payment claim review

Claims for services that have reached predetermined financial thresholds are routed to a delegated vendor for high-dollar bill review, itemized bill audit, and outpatient claims clinical editing.

f. Pre-payment SIU reviews.

Claims for services deemed to pose a risk to FWA are routed to The Plan's SIU investigator for review.

g. Pre- and post-payment integrity

Claims for services are edited against the National Correct Coding Initiative (NCCI) and the Centers for Medicare & Medicaid Services (CMS) coding guidelines to ensure they are processed in accordance with the fundamentals of payment accuracy and integrity.

h. CMS issued Fraud Alerts

The Plan reviews CMS-issued Fraud alerts identified alleged fraud schemes for which parties have not yet been found responsible.

i. Partner with law enforcement

The Plan will partner with local, state, and federal law enforcement agencies if cases of fraud, waste, and abuse warrant notification of and involvement.

j. Partner with payer community

The Plan partners with the payer community to identify suspicious activity, prevent market trends, and fight FWA as one, protecting the community from bad actors.

k. Enrollment

Enrollment verifications are completed. If enrollment verification is suspected of being fraudulent, an investigation will be conducted. Recission requests are submitted to CMS.

11. Reporting

Internal reporting is performed to detect and identify suspected fraud, waste, and abuse in the Plans' claim system data. The OIG Workplan, alerts, and exclusion list drive some of the reports for investigation.

References

1. MCA 33-1-1202
2. Mont. Admin. r. 6.6.1914
3. ID Code § 41-293 (2024)
4. <https://www.justice.gov/civil/false-claims-act>
5. <https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/>
6. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fraud-abuse-mln4649244>
7. <https://oig.hhs.gov/fraud/>

Review/Revision/Approval History

Date	Description
09/01/2024	Policy Adopted
02/09/2026	The Policy Committee reviewed and passed the policy

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract.

Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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