



## What are Fraud, Waste and Abuse?

**Fraud** is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare 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 healthcare benefit program (18 U.S.C. § 1347).

**Waste** is overutilization of services or other practices that, directly or indirectly, results in unnecessary costs to the healthcare system, including Medicare and Medicaid. It generally is not considered to be caused by criminally negligent actions, but by the misuse of resources.

**Abuse** is payment for items or services when there is no legal entitlement to that payment, but the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.

### How to report fraud, waste and abuse

**If you suspect fraud, waste or abuse (FWA) in the healthcare system, you must report it to CarePlus or Humana** (CarePlus' parent company), and the Humana Special Investigations Unit (SIU) will investigate. Your actions may help to improve the healthcare system and reduce costs for our customers, business partners and CarePlus-covered patients.

To report suspected fraud, waste or abuse, you can contact us in one of these ways:

- **Phone:** 1-800-614-4126
- **Fax:** 1-920-339-3613
- **Email:** [siureferrals@humana.com](mailto:siureferrals@humana.com)
- **Mail:** Humana, Special Investigation Unit, 1100 Employers Blvd., Green Bay, WI 54344
- **Ethics Help Line:** 1-877-5-THE-KEY (1-877-584-3539)
- **Ethics Help Line Reporting website:** [www.ethicshelpline.com](http://www.ethicshelpline.com)

You have the option to remain anonymous. All information received or discovered by SIU will be treated as confidential, and the results of investigations will be discussed only with people having a legitimate reason to receive the information (e.g., state and federal authorities, the Humana corporate law department, market medical directors and/or Humana senior management).

Another option is to complete and submit the Special Investigations Referral Form online at the link below.

### [Investigations Referral Form](#)

If you are a medical, dental or pharmacy provider and previously reported a concern to SIU, you can follow up by completing the Request to Contact SIU form.

### [Request to Contact SIU form](#)

### SIU tools and resources

Humana's SIU supports CarePlus with software tools that help find and prevent healthcare fraud. This fraud-detection software enables us to review claims for possible fraud before payment.

SIU references the following resources to support its investigations:

- [Medical and Pharmacy Coverage Policies](#)
- [Medicare Coverage Database – Centers for Medicare & Medicaid Services National Coverage Determinations \(NCDs\) and Local Coverage Determinations \(LCDs\)](#)
- American Medical Association (AMA) Current Procedural Terminology (CPT®), International Classification of Diseases, Ninth Revision (ICD-9) and 10th Revision (ICD-10) and Healthcare Common Procedure Coding System (HCPCS) coding references

### What SIU does

SIU's investigation process varies, depending on the situation and allegation. Its investigational steps may include the following:

- **Contact with relevant parties to gather information.** This may include contacting CarePlus-covered patients to get a better understanding of the situation. For example, we may contact a patient to ask about a visit with his or her physician. We may ask the patient to describe the services provided, who provided the care, how long the patient was at the office, etc.
- **Requests for medical or dental records.** We do this to validate that the records support the services billed. It is important that the healthcare provider submit complete records, as requested. We rely on this information to make a fair and appropriate decision.
- **Notification of suspected fraud and abuse to law enforcement and CMS,** if applicable, including the appropriate Medicare Drug Integrity Contractor (MEDIC) for Medicare Part C (medical) and Part D (prescriptions) and any other applicable state and/or federal agencies.

### Most common coding and billing issues

Some of the most common coding and billing issues are:

- Billing for services not rendered
- Billing for services at a frequency that indicates the provider is an outlier as compared with his/her peers
- Billing for noncovered services using an incorrect CPT, HCPCS and/or diagnosis code in order to have services covered
- Billing for services performed by another provider
- Up-coding
- Modifier misuse; for example, modifiers 25 and 59
- Unbundling
- Billing for more units than rendered
- Lack of documentation in the records to support the services billed
- Services performed by an unlicensed provider but billed under a licensed provider's name
- Alteration of records to get services covered