Fraud, Waste, and Abuse Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

Policy

All members and providers must comply with all applicable federal and state laws and regulations prohibiting fraudulent acts, kickbacks, and false reporting, specifically including but not limited to M.G.L. c. 175H, §§ 1-7; N.H. Rev. Stat. § 638:20; Conn. Gen. Stat §§ 53a – 215 and 53 – 440; 24-A M.R.S. § 2436-A, and 18 U.S.C. § 1033.

Likewise, a provider's submission of a claim for payment constitutes a representation by the provider that the services or supplies reflected on the claim, including all quantities set forth on that claim:

- Were medically necessary in the provider's reasonable judgment
- Were actually performed by the provider or services were performed under a clinician's supervision as allowed by CarePartners of Connecticut policy
- Were submitted accurately, using appropriate coding
- Have been properly documented in the member's medical records

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 described above, and is submitted in compliance with all federal and state laws and regulations. Additionally, a provider may not routinely agree to waive members' deductibles, coinsurance, or co-payment obligations.

Any amount billed by a provider in violation of this policy, if paid by CarePartners of Connecticut, constitutes an overpayment by CarePartners of Connecticut that is subject to denial, recovery, retraction, or offset.

Any amounts billed to and paid by members in violation of this policy, must be immediately refunded to such members. A provider may not bill members for any amounts due resulting from a violation of this policy.

Definition

CarePartners of Connecticut will protect the interests of its constituents (including members, employers, and providers) and CarePartners of Connecticut corporate assets against those who knowingly and willingly commit fraud. CarePartners of Connecticut is committed to detecting, investigating, and preventing wrongful acts committed by providers, members, and any other entity against the organization. CarePartners of Connecticut will identify, investigate, recover funds, report, and when appropriate, take legal actions, if suspected fraud, waste, and/or abuse has occurred.

Fraud

In the healthcare context, fraud occurs when a person(s):

- Knowingly and willfully makes, or causes to be made, any false statement or misrepresentation of a material fact in any application for a payment of a health care benefit.
- Knowingly and willfully presents or causes to be presented an application for a health care benefit containing any false statement or misrepresentation of a material fact, or
- Knowingly and willfully makes or causes to be made any false statement or misrepresentation of a material fact for use in determining rights to a health care benefit, including whether services were medically necessary in accordance with professionally accepted standards.
- Soliciting or receiving any remuneration, directly or indirectly, for the purchasing, leasing, ordering, or arranging for any services payable by CarePartners of Connecticut. This includes the routine waiving or capping of member's cost-sharing obligations.

Abuse

Abuse describes practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, does not meet industry accepted and/or

professionally recognized standards, or is not fairly priced. Abuse also occurs when a person(s) obtains or attempts to obtain payment for items or services when there is no legal entitlement to that payment, but without knowingly and/or intentionally misrepresenting facts to obtain payment.

Waste

Waste generally involves the overutilization or underutilization of services or other practices, or the inefficient and ineffective utilization of practices, systems, or controls.

Fraud and abuse may include, but are not limited to, the following:

- Performing an unnecessary or inappropriate service
- Billing services, procedures and/or supplies that were not provided
- Billing a higher-level procedure code than is supported by the record (upcoding)
- Billing duplicate claims
- Unbundling claims
- Charging in excess of usual, customary, and reasonable fees
- Soliciting or accepting referral fees or waiving member's deductibles, coinsurance, or copayments (i.e., kickbacks)
- Collecting monies except for deductible amounts, coinsurance amounts, copayment amounts, and non-covered items as permitted.

Additional Resources

Providers must comply with federal and state laws and regulations designed to prevent, identify, and correct fraud, waste, and abuse. CarePartners of Connecticut reserves the right to audit claims for FWA.

If a practitioner becomes aware of a questionable practice by a CarePartners of Connecticut provider or member that may indicate possible health care fraud, CarePartners of Connecticut established a hotline to help CarePartners of Connecticut's members, providers and vendors who have questions, concerns and/or complaints related to possible wasteful, fraudulent, or abusive activity.

Providers can call the CarePartners of Connecticut Compliance and Fraud Hotline to report concerns 24 hours a day, 7 days a week at 877-824-7123 or submit an email to FraudAndAbuse@point32health.org. Callers may self-identify or choose to remain anonymous.

Providers who care for CarePartners of Connecticut members are required to comply with CMS certification requirements.

Document History

- February 2025: Annual policy review; revised applicable laws and regulations; added example under definition of fraud; added email to report suspected fraud and abuse, administrative updates
- April 2024: Policy created to support existing claims processes and reimbursement guidelines

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.