



Fraud and Abuse

Neighborhood recognizes that fraud and abuse has a high impact upon the health care industry. In our efforts to combat fraud and abuse as a partner in health care, we are committed to building and maintaining a proactive program that detects and prevents fraud and abuse while complying with our obligations under federal and state laws, as well as our Medicaid contractual responsibilities.

How do we define “Fraud and Abuse”?

Fraud: Fraud is defined as an intentional deception or misrepresentation done by an individual with the knowledge that it will result in an unauthorized benefit to themselves or others.

Abuse: Abuse is defined as a practice that is inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid program, or in reimbursement from services that are not medically necessary or fail to meet professionally recognized standards for health care.

The following are common examples we recognize as fraud and abuse by providers:

- Billing for services that were not
- Misrepresenting the diagnosis to justify the services
- Altering claims forms to receive a higher level of payment
- Soliciting, offering, or receiving a kickback for referral of patients in exchange for other services
- Concealing ownership of related companies (i.e., the physician also owns the radiological service)
- Deliberate duplicate billing to more than one payor source
- Unbundled or exploded charges in which the provider bills for components of a procedure instead of using a comprehensive code
- Providing Certificates of Medical Necessity for members ineligible
- Falsifying plans of treatment or medical records
- Misrepresenting the services provided or the person receiving the care
- Billing for non-covered benefits by using a different diagnosis
- Billing services provided on one date over a period of
- Gang visit billing at a skilled nursing facility or other group domicile for members that did not receive any care
- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Over-utilization of medical or health care services
- Underutilization of services
- Solicitation for payment for covered services outside of co-payment amounts
- Duplicate billing defined as repetitive billing less than 30 days from original submission date and/or after a claim has already been adjudicated and finalized



The following are common examples we recognize as fraud and abuse by members:

- Excessive use or overuse of benefits
- Using another individual's benefits card or information
- Lending, altering or duplicating a benefit card or information
- Altering or forging prescriptions
- Providing incorrect eligibility information to obtain services
- Simultaneously receiving benefits in Rhode Island and other states
- Knowingly assisting providers in furnishing services to defraud Medicaid

Publication date:

10/8/2010