FEHB - PSHB Fraud, Waste, and Abuse Definitions

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice 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. Fraud can be committed by a contractor, a subcontractor, a large provider, a provider, and a FEHB/PSHB Program enrollee. It includes any act that constitutes fraud under applicable Federal and/or state law.

Examples include but are not limited to the following:

- billing for services that were never rendered,
- misrepresenting who provided the services,
- altering claim forms, electronic claim records or medical documentation, or
- falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary.

Waste is the expenditure, consumption, mismanagement, or misuse of resources, practice of inefficient or ineffective procedures, systems, and/or controls to the detriment or potential detriment of entities. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Waste can be committed by a contractor, a subcontractor, a large provider, a provider, and a FEHB/PSHB Program enrollee.

Examples include but are not limited to the following:

- performing a large number of laboratory tests on a patient when the standard of care indicates that only a few tests were sufficient for treatment and/or diagnosis,
- medication and prescription refill errors, and
- failure to implement standard industry waste prevention measures.

Abuse includes actions that may directly or indirectly result in unnecessary costs to the FEHB/PSHB Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction

between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors. Abuse can be committed by a contractor, a subcontractor, a large provider,[1] a provider, and/or a FEHB/PSHB Program enrollee.

Examples include but are not limited to the following:

- Misusing procedure or diagnosis codes on the claim (e.g., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered);
- Waiving patient co-pays, coinsurance, or deductibles and over-billing the FEHB/PSHB Program Carrier; and
- Billing for items or services that should not be paid for by the FEHB/PSHB Program, such as "never events."

Allegation/Complaint: An FWA allegation or complaint can include anything from a hotline call from a member or provider to an internal report or referral from another department within the Carrier to a report or lead generated by the Carrier's Proactive Fraud Detection Software vendor or other appropriate tools used by the Carrier or Plan. At this point, there may be no evidence to support that the reported allegations or complaint have potential to be related to FWA. All allegations received within the Carrier's anti-fraud unit or SIU must be thoroughly vetted with an Initial Assessment prior to being considered a potential reportable FWA issue to OPM or OPM OIG. Some exceptions include subpoenas received from a law enforcement or government regulatory agency, a law enforcement request for assistance, or other outside agency referral from a source that would otherwise be consistent with an already identified FWA issue.

Affirmative Step: The affirmative step is the point at which the Carrier makes a decision that the received allegation is a potential FWA issue. Affirmative steps typically include, but are not limited to, investigative actions or review or a finding of broader fraud schemes by actors against the FEHB/PSHB Program. Affirmative steps do not include education of the FEHB/PSHB member, provider, or staff member regarding allegations or complaints which do not indicate a fraudulent scheme (i.e., human error).

[1] Per FAR 1602.170-16 Large Provider Agreement

Initial Assessment: The Initial Assessment has a 30 working-day time limit and would include a limited or initial request for information, limited or initial medical review, research and/or other limited investigative activities to determine whether an allegation/complaint received by the Carrier's anti-fraud unit or SIU has either real or potential FEHB/PSHB exposure, and therefore is reportable to the OPM-HI team through the monthly ARC Spreadsheet. Activities include, but are not limited to as follows:

- Assessment/review of allegation(s),
- Obtaining claims data exposure,
- Obtaining background on subject(s),
- Reviewing benefit language,
- Determining network status,
- Identification of patterns according to allegation(s), additional suspect patterns,
- Researching Current Procedural Terminology (CPT) definitions, Carrier policies, and state regulations,
- Medical records request to provider(s),
- Questionnaires to member(s)/provider(s),
- Telephone interviews with member(s) or provider(s), and
- Request for information from Carriers support areas.

Member: Any eligible or ineligible subscriber to the FEHB/PSHB Program including the contract holder (i.e., enrollee), spouse, and children.

Other: Anything that does not fit into the provider or member categories, such as a Carrier employee, vendor employee, medical identity theft, or other thefts that occur by third parties, not associated with a provider of service or member.

Provider: Any medical practitioner that acts and is licensed as a provider of medical services. This may include, but is not limited to, a physician, hospital (inpatient or outpatient), chiropractor, physical therapist, nurse practitioner, physician assistant, laboratory, pharmacy.