WASTE, FRAUD & ABUSE

Policy to Prevent Fraud, Waste and Abuse: In standing with the Federal Deficit Reduction Act of 2005 (Public law 109-171), Momentum maintains complete and thorough billing and accounting practices in order to prevent fraud, waste and abuse. The purpose of this policy is to comply with the Federal False Claims Act, as amended by the Deficit Reduction Act of 2005. This Act is applicable to all recipients of $5,000,000 or more in MaineCare funds, which includes Momentum. In brief, the False Claims Act imposes liability on any person who submits a claim for payment to the federal government (e.g. a Medicare or MaineCare [Medicaid] claim) that he or she knows is false. "Knows" means actual knowledge, or acting in reckless disregard or in deliberate ignorance of the truth or falsity of the information.

Any Momentum employee is obligated to report suspected violations or compliance concerns to his/her supervisor. If the employee is not comfortable talking with his/her supervisor, or is not satisfied with the answer received, the employees should contact a higher-level manager. If any abuse, neglect or exploitation of any funds is noticed, it is the policy that each team member at Momentum be mandated reporters of such abuse, neglect or exploitation.

Momentum will make every effort to avoid abuse and or misuse of funds through sound business office operations, periodic Quality Assurance audits, and staff training in the prevention of the following practices:

- Incorrect reporting of diagnosis or procedures to maximize reimbursement
- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies
- Misrepresentation of dates and descriptions of services furnished or of the identity of the beneficiary or the individual who furnished the services
- Claims for non-covered services billed as covered services
- Use of another person's MedicareIMaineCare card/number
- Alteration of claims history to generate fraudulent payment
- Collusion between Intermediary employee acting on behalf of him/herself, and/or beneficiaries or providers

Examples of cost report fraud may include, but are not limited to:

- Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the program through various devices (commissions, fee splitting)to siphon off or conceal illegal profits
- A pattern or history of deliberately billing beneficiaries rather than Medicare for covered services
- Billing Medicare/MaineCare for costs not incurred or which were attributed non-program activities, other enterprises or personal expenses
- Days that have been improperly reported and would result in an overpayment if not adjusted

Examples of abuse may include, but are not limited to:

- Claims for services not medically necessary (Example: progress vs. maintenance therapy)
- Billing for services grossly in excess of those needed by the patient
- A pattern of improper billing practices