Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Fraud, Waste, and Abuse

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

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 Point32Health 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, providers may not routinely waive, cap, or otherwise reduce members' deductibles, coinsurance, or co-payment obligations.

Any amount billed by a provider in violation of this policy, if paid by Point32Health, constitutes an overpayment by Point32Health 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.

Prerequisites

Applicable Point32Health referral, notification, and authorization policies may apply. Refer to the appropriate sections within the Provider Manuals for more information.

Definition

Point32Health will protect the interests of its constituents (including members, employers, and providers) and Point32Health corporate assets against those who knowingly and willingly commit fraud. Point32Health is committed to detecting, investigating, and preventing wrongful acts committed by providers, members, and any other entity against the organization. Point32Health 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 Point32Health. 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 or Related Policies

Point32Health 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, Point32Health will expect the provider/facility to refund all payments related to noncompliance. Please refer to the following policies for more information:

- Harvard Pilgrim Audit Policy
- Tufts Health Plan Payment Policies and Audit Program

Providers who know of or suspect fraud and abuse activity should call Point32Health's Compliance and Fraud, Waste and Abuse Hotline: 1-877-824-7123 or submit an email to FraudAndAbuse@point32health.org

Related Policies and Resources

- Point32Health Payment Policies
- Point32Health Medical Necessity Guidelines

Publication History

05/01/2026:	Annual policy review; administrative edits
02/28/2025:	Annual policy review; revised applicable laws and regulations; added example under definition of fraud; added email to report suspected fraud and abuse; administrative updates
04/01/2024:	Annual review; administrative updates
03/31/2023:	Policy moved to new template; includes all lines of business

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. 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.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.