



Desk Aid

Fraud, Waste, and Abuse (FWA) Identification, Prevention, and Reporting

Executive Summary

This desk aid is designed to help Indiana Health Coverage Programs (IHCP) providers recognize, prevent, and report Fraud, Waste, and Abuse (FWA). Drawing on best practices from CMS's Medicare Learning Network (MLN), it defines FWA, highlights real-world Indiana Medicaid examples, outlines common schemes, and provides actionable red flags. This resource details reporting channels, emphasizes confidentiality and whistleblower protections, and summarizes key state and federal regulations, including the False Claims Act. Providers are encouraged to use this guide to fulfill their FWA-related responsibilities and maintain program integrity.

To fully support its mission, this desk aid also incorporates recent Indiana Medicaid policy reforms, operationalizes real-world enforcement patterns, and summarizes current best practices in quantitative analytics and self-reporting methods. Providers should be aware that Indiana, reflecting national trends, has moved toward more robust cross-agency coordination, higher penalties for non-compliance, mandatory data transparency, adoption of peer benchmarking, and increased reliance on technology-driven audits to manage FWA risk at unprecedented levels.



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Understanding FWA

FRAUD

Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that individual or some other person (e.g., billing for services not provided).

WASTE

This includes practices that, directly or indirectly, result in unnecessary costs to the Medicaid program, such as overusing services and is a misuse of resources.

ABUSE

Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

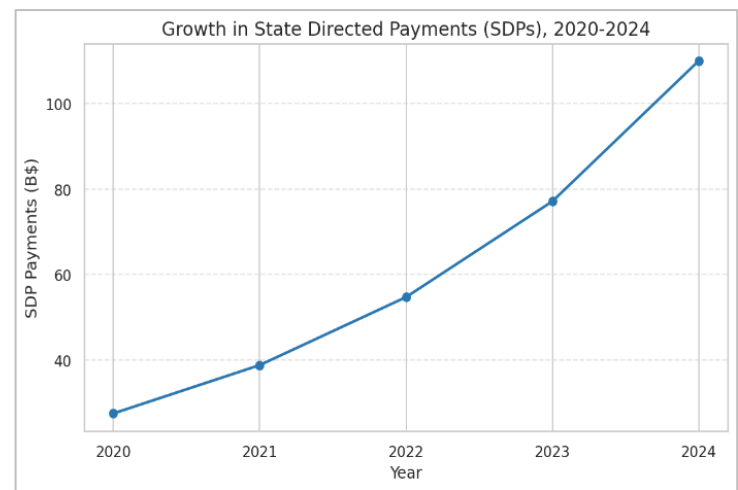
IHCP providers and staff are legally and ethically required to prevent, detect, and report FWA, as noncompliance can lead to serious penalties and Medicaid program exclusion.

In 2025, regulatory updates have increased provider responsibilities, related to increased State Directed Payments (see Figure 1) requiring all Medicaid-financed organizations to submit annual, detailed ownership reports. Accurate self-reporting is essential for compliance and FWA risk prevention. Failure to comply may be considered FWA if federal funds are involved.

Recommended best practices include:

- Conducting frequent peer reviews, internal education programs on FWA
- Implementing strong internal controls, perform regular self-audits
- Providing advanced data analytics for compliance

Figure 1: IHCP State Directed Payments



IHCP has implemented heightened security due to the \$110 billion in State Directed Payments and efforts to align Medicaid payments with Medicaid rates.

Reporting FWA

Acting quickly when FWA is suspected protects patients, providers, and the integrity of Indiana's healthcare system. See Table 1 for guidelines.

Table 1: FWA Reporting and Guidelines

👁️ If You See This...	👍 Do That...
A. Suspicious billing patterns	1. Report immediately (anonymously, if needed)
B. Unreported ownership changes	2. Document what you observed
C. Undisclosed Overpayments	3. Follow Indiana's self-reporting laws



Why it Matters

- **Anonymous & Confidential:** Report suspected FWA without revealing your identity.
- **Protected by Law:** Whistleblowers are legally shielded from retaliation.
- **Powerful Impact:** Over **80% of False Claims Act recoveries** come from whistleblower reports.

Indiana's Compliance Rules

- Providers must self-report FWA, ownership changes, and overpayments.
- Failure to comply can lead to:
 - Penalties up to \$1,000 per day
 - IHCP suspension
 - Federal disciplinary action

FWA Schemes in Indiana Medicaid

To effectively combat healthcare FWA, it's essential for providers to recognize the specific schemes used to exploit payment systems and understand how these behaviors are being detected and prosecuted in Indiana. The following information details the most common FWA behaviors and explain how Indiana's enforcement and reporting reforms have been strengthened to identify and address these fraudulent activities.

Common FWA Schemes

Table 2: Common FWA Schemes in Indiana Medicaid

Scheme	Definition
Upcoding	Charging for a costlier service than the one actually delivered.
Downcoding	Billing for a less expensive service , often done to avoid scrutiny or to manipulate payment rules.
Unbundling	Submitting multiple separate claims for services that should have been grouped and billed together at a single, lower rate.
Kickbacks	Offering or accepting payments or reward in exchange for referring patients or choosing a specific service/product.
Phantom Billing	Charging for services, supplies, or equipment that were never provided to the patient.
Duplicate Billing	Submitting more than one claim for the exact same service or patient visit.
Misrepresentation	Falsifying information about the provider, patient, or medical service that was rendered.

Upcoding can lead to substantial overpayments and is often identified through comparative analytics against peer provider billing patterns.

Kickbacks and Phantom Billing are highly prioritized areas for federal False Claims Act enforcement, as they tend to be complex and result in significant financial loss.

Indiana Specific Reforms

Indiana-specific reforms have expanded the detection net for these schemes.

The state's use of advanced analytics—similar to Medicare's—enables pattern recognition, outlier detection, and audit targeting for claims that deviate from established medical necessity guidelines or service frequency benchmarks.

Whether it's an unusual billing practice or questionable documentation, staying alert to these signs helps safeguard quality and integrity, and appropriately reporting when necessary.


New ownership reporting mandates under HEA 1666 reveal previously obscured conflicts of interest and enable regulatory authorities to scrutinize referral padding or questionable relationships among entities billing Medicaid.¹

1. [IDOI: HEA 1666 Healthcare Ownership Information Reporting](#)


Indiana Medicaid FWA: Investigation and Compliance



Recent enforcement actions in Indiana illustrate the types of FWA that can occur. In 2025, the Indiana Attorney General’s Medicaid Fraud Control Unit (MFCU) conducted 13 criminal investigations, charging healthcare professionals with offenses such as drug diversion, furnishing false information, and billing for services not rendered.² These cases underscore the importance of accurate documentation, vigilant internal controls, and prompt reporting of suspicious activities.



Operational gaps in medication tracking and service documentation, especially in hospice and long term care.



RN’s and personal attendants implicated for failing to maintain accurate records and validate self reported data.

Table 3 below provides an overview of some of the 2025 cases currently under investigation; however, it does not represent the full scope of cases under review.

Table 3: Medicaid FWA Case Types, 2025 [not all-inclusive]

Case Type	Key Documentation Failures
Drug Diversion/Theft	Medication logs, inventory records
False Documentation	Service attestation, timesheets
Billing for Unprovided Care	Visit schedules, patient records
Failure to Produce Records	General administrative

Indiana FSSA Taking Action

Indiana’s participation in the 2025 National Health Care Fraud Takedown—which resulted in nationwide charges related to \$14.6 billion in false billings—demonstrates both the scale of enforcement effort and the increasing use of cross-jurisdictional data sharing to detect FWA.²

Based on recent Indiana Medicaid Fraud Control Unit (MFCU) actions and law enforcement cases, IHCP enrolled providers must now expect the following:

- **Random Audits:** Announced or unannounced reviews of operations and records.
- **Data-Driven Claim Reviews:** Scrutiny of claims based on analysis and shared data to detect large-scale FWA schemes.
- **Strict Timelines for Documentation Submission:** Requests for records must be fulfilled in accordance with the timeline specified in the audit notification.

2. [OPA 2025 National Health Care Fraud Takedown](#)

Real-Life Situations in Healthcare Settings

Everyday operations in healthcare environments can present challenges and risks that aren't always obvious at first glance. Staff and patients may encounter situations that could signal FWA without realizing their significance.

Recognizing common scenarios where FWA might arise is a key step toward maintaining integrity and protecting your organization. Staying alert to these signs helps safeguard quality and integrity.

Figure 2: FWA Question to Ask

Ask Yourself:

- "Have I observed someone billing for a patient who isn't present?"
- "Did a scheduler or biller notice duplicate claims for the same visit time?"
- "Has a pharmacy tech found inventory numbers not matching dispensed medication logs?"
- "Has a staff member been asked to sign off on incomplete documentation?"



Brief Stories: Why a Wrong Never Makes a Right!

1

What Went Wrong:

- A nurse at a hospice care facility was charged with obtaining controlled substances by fraud and falsifying records. The lack of proper medication tracking and peer review contributed to the issue.
- Personal care attendants were submitting claims for home visits that never occurred. Weak reconciliation between timesheets and patient schedules enabled this pattern.



Real-world examples help staff understand FWA risks and prevention, illustrating both potential issues and effective practices that support compliance and patient care, especially in complex situations.

What Right Looks Like:

- Nursing staff reconciles all dispensed medications with inventory records daily and flag discrepancies immediately.
- A billing clerk notices duplicate charges in the system, reports promptly, and an internal audit is initiated—preventing further errors and ensuring compliance.

2

What Went Wrong:

In one facility, a nurse regularly billed for wound care procedures that were never performed. Over several months, internal audit and patient complaints revealed the discrepancy, resulting in an audit, loss of Medicaid billing privileges, and criminal charges.



What Right Looks Like:

At another clinic, a billing clerk spotted multiple duplicate claims in the electronic system for the same date and service. She reported these to the compliance officer, who launched an internal review. The proactive approach prevented an external audit, protected the clinic's funding, and improved training for all staff.

3

What Went Wrong:

A physician was frequently using the highest billing codes for appointments that lasted only a few minutes (known as "upcoding").



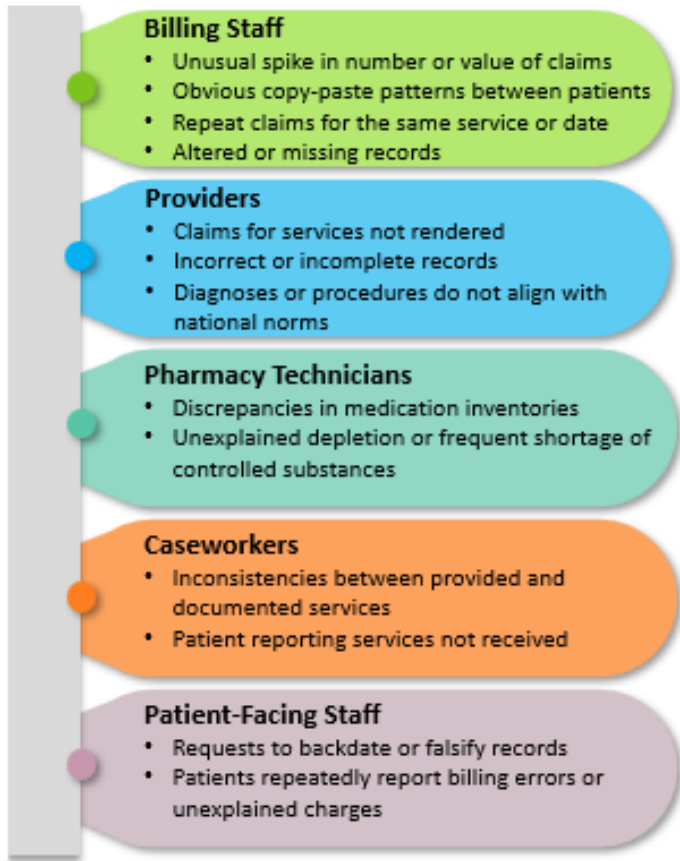
What Right Looks Like:

Instead of assuming fraud or overlooking the pattern, the biller discussed concerns privately with her supervisor, who arranged targeted retraining for the physician and initiated a review.

Actionable Red Flags and Internal Controls

Vigilance and strong internal controls help organizations detect FWA early and reduce risk. Each team member plays a unique part in safeguarding against FWA. Outlined in Figure 3 are key warning signs to be aware of in specific roles.

Figure 3: FWA Warning Signs



Monitoring Red Flags

Robust internal audits and peer reviews are essential for accountability and compliance.

Agencies recommend investing in technology to automate FWA detection and close analytic skill gaps, including network analysis to identify suspicious claims and provider-patient pairings.

Providers should also reconcile inventory, especially for controlled substances, and use automated reviews for high-value claims (see Table 4).

NOTE: Repeat offenses or record gaps signal control weaknesses that require immediate attention. Indiana’s reforms encourage peer benchmarking to flag outliers for review.

Table 4: Internal FWA Detection Controls and Associated Red Flags

Control Area	Common Red Flag	Recommended Action
Billing Data Review	Sudden volume spikes/outlier codes	Routine comparative analytics, peer matching
Documentation Audit	Missing or altered records	Cross-check logs with claims
Medication Inventory	Unexplained depletion/diversion	Reconciliation with administration records
Staff Oversight	Repeated reluctance or noncompliance	Rotation of duties/audit trails
Education and Training	Frequent compliance errors	Regular FWA-focused staff training
Peer Review	Disproportionate service frequency	Inter-provider trend analysis

Key Takeaways

False Claims Act (FCA): Submitting false Medicaid claims is prohibited. Whistleblowers are protected, with strong safeguards against retaliation.

Indiana HEA 1666: All Medicaid-participating entities must file annual ownership reports. Noncompliance carries significant penalties and supports transparency in FWA detection.

Mandatory Self-Disclosure: Providers must report and refund overpayments and cooperate with investigations. Failure to self-report may result in payment suspension or exclusion from IHCP.

Strengthened Enforcement: Indiana has expanded law enforcement authority and requires more comprehensive provider documentation, enabling earlier and more effective audits.

Alignment with Federal Standards: Indiana Medicaid increasingly mirrors CMS best practices, including prior authorization, algorithmic claim review, and peer benchmarking.

Advanced Analytics: AI-driven monitoring is now standard for FWA detection. Providers without these tools face higher risk of audit findings and penalties.

Annual Training Requirement: All staff must complete yearly FWA refresher training. Supervisors are responsible for maintaining training records. Resources are available through CMS MLN Fraud Prevention and IHCP webinars/newsletters.

Call to Action

IHCP Provider and Member Concerns Line
1-800-457-4515

HHS OIG National Hotline
1-800-HHS-TIPS (1-800-447-8477)

Indiana Medicaid Fraud Control Unit (MFCU)
1-800-382-1039

Program Integrity Email
Programintegrity.FSSA@fssa.in.gov

HEA 1666 Healthcare Ownership Information Reporting

[https://www.in.gov/idoi/insurance laws rules and bulletins/hea 1666 healthcare ownership information reporting](https://www.in.gov/idoi/insurance%20laws%20rules%20and%20bulletins/hea%201666%20healthcare%20ownership%20information%20reporting)

References

- [IHCP Program Integrity Page](#)
- [IHCP Webinars and Newsletters](#)
- [Protocol for Voluntary Self-Disclosure of Provider Overpayments](#)
- [CMS Medicare Learning Network \(MLN\) Fraud Prevention](#)

