mln BOOKLET

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PRINT-FRIENDLY VERSION

MEDICARE FRAUD & ABUSE: PREVENTION, DETECTION, AND REPORTING

Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare). Many of the laws discussed apply to all Federal Health Care Programs (including Medicaid and Medicare Advantage).

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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YOU CAN HELP FIGHT FRAUD — REPORT IT!

The Office of Inspector General (OIG) Hotline accepts tips and complaints from all sources on potential fraud, waste, and abuse. View instructional videos about the OIG Hotline operations, as well as reporting fraud to the OIG.

MEDICARE FRAUD AND ABUSE: A SERIOUS PROBLEM THAT NEEDS YOUR ATTENTION

Although no precise measure of health care fraud exists, those intent on abusing Federal health care programs can cost taxpayers billions of dollars while putting beneficiaries' health and welfare at risk. The impact of these losses and risks magnifies as Medicare continues to serve a growing number of people.

You play a vital role in protecting the integrity of the Medicare Program. To combat fraud and abuse, you need to know how to protect your organization from engaging in abusive practices and/or civil or criminal law violations. This booklet provides the following tools to help protect the Medicare Program, your patients, and yourself:

- Medicare fraud and abuse examples
- Overview of the laws used to fight fraud and abuse
- Descriptions of the partnerships among government agencies dedicated to preventing, detecting, and fighting fraud and abuse
- Resources on how to report suspected fraud and abuse

WHAT IS MEDICARE FRAUD?

Medicare **fraud** typically includes any of the following:

- Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health services

CASE STUDIES

To learn about real-life cases of Medicare fraud and abuse and the consequences for culprits, visit the Medicare Fraud Strike Force webpage.

Anyone can commit health care fraud. Fraud schemes range from solo ventures to broad-based operations by an institution or group. Even organized crime has infiltrated the Medicare Program and masqueraded as Medicare providers and suppliers. Examples of Medicare fraud include:

- Billing Medicare for appointments the patient failed to keep
- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the file
- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items
- Paying for referrals of Federal health care program beneficiaries

Defrauding the Federal Government and its programs is **illegal**. Committing Medicare fraud exposes individuals or entities to potential criminal and civil liability, and may lead to imprisonment, fines, and penalties.

Criminal and civil penalties for Medicare fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate intervention. Providers and health care organizations involved in health care fraud risk exclusion from participating in all Federal health care programs and risk losing their professional licenses.

WHAT IS MEDICARE ABUSE?

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice inconsistent with providing patients with medically necessary services meeting professionally recognized standards.

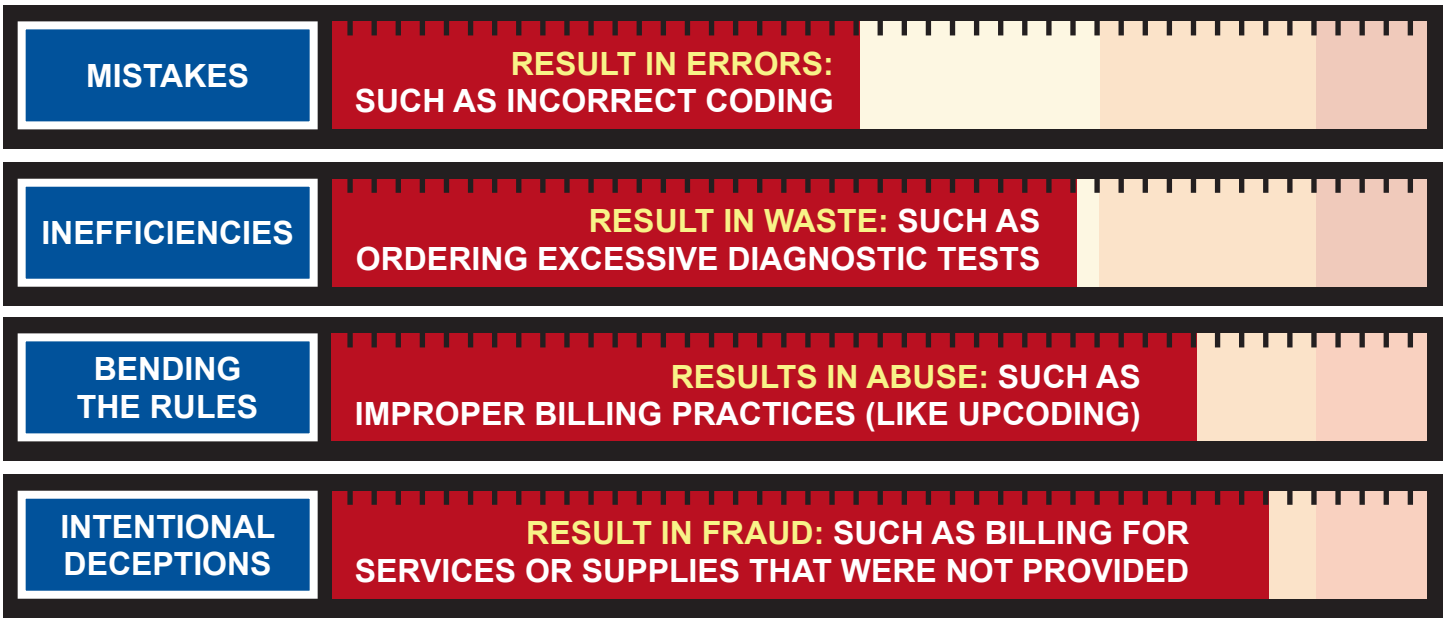
Examples of Medicare abuse include:

- Billing for unnecessary medical services
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes

Medicare abuse can also expose providers to criminal and civil liability.

Program integrity encompasses a range of activities targeting various causes of improper payments. Figure 1 shows examples along the spectrum of causes of improper payments.

Figure 1. Types of Improper Payments*



* The types of improper payments in Figure 1 are strictly examples for educational purposes, and the precise characterization of any type of improper payment depends on a full analysis of the particular facts and circumstances. Providers who engage in incorrect coding, ordering excessive diagnostic tests, upcoding, or billing for services or supplies not provided may be subject to administrative, civil, or criminal liability.

MEDICARE FRAUD AND ABUSE LAWS

Federal laws governing Medicare fraud and abuse include all of the following:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)
- Social Security Act
- United States Criminal Code

These laws specify the criminal, civil, and administrative remedies the government may impose on individuals or entities that commit fraud and abuse in the Medicare Program, including Medicare Parts C and D, as well as the Medicaid Program.

Violating these laws may result in nonpayment of claims, Civil Monetary Penalties (CMPs), exclusion from all Federal health care programs, and criminal and civil liability.

Federal False Claims Act (FCA)

The civil FCA protects the Federal Government from being overcharged or sold substandard goods or services, and imposes civil liability on any person who **knowingly** submits, or **causes** the submission of, a false or fraudulent claim to the Federal Government.

The terms "knowing" and "knowingly" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. **No proof of specific intent to defraud is required to violate the civil FCA.**

Example: A physician knowingly submits claims to Medicare for a higher level of medical services than actually provided or higher than the medical record documents.

Penalties: Civil penalties for violating the FCA may include recovery of up to **three** times the amount of damages sustained by the Government as a result of the false claims, plus penalties up to $21,916 (in 2017) per false claim filed.

Additionally, a criminal FCA statute exists by which individuals or entities submitting false claims may face fines, imprisonment, or both.

Anti-Kickback Statute (AKS)

The AKS makes it a crime to **knowingly and willfully** offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program. When a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the AKS.

Example: A provider receives cash or below fair market value rent for medical office space in exchange for referrals.

Penalties: Civil penalties for violating the AKS may include **three** times the amount of the kickback plus up to $74,792 (in 2017) per kickback. Criminal penalties for violating the AKS may include fines, imprisonment, or both.

If certain types of arrangements satisfy regulatory safe harbor regulations, they may not violate the AKS.

ANTI-KICKBACK STATUTE VS. STARK LAW

Refer to the Comparison of the Anti-Kickback Statute and Stark Law handout.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from referring certain designated health services payable by Medicare or Medicaid to an **entity** in which the physician (or an immediate family member) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

WHAT IS AN ENTITY?

Refer to the Code of Federal Regulations (CFR) for more information about the definition of an entity.

Example: A provider refers a beneficiary for a designated health service to a business in which the provider has an investment interest.

Penalties: Penalties for physicians who violate the Stark Law may include fines, CMPs up to $24,253 (in 2017) for each service, repayment of claims, and potential exclusion from all Federal health care programs.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits **knowingly and willfully** executing, or attempting to execute, a scheme or artifice connected to the delivery of or payment for health care benefits, items, or services to either:

- Defraud any health care benefit program
- Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary claims for power wheelchairs.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Additional Medicare Fraud and Abuse Penalties

Aside from the civil and criminal actions brought by law enforcement agencies, the Medicare Program has additional administrative remedies applicable for certain fraud and abuse violations.

Exclusion Statute

Under the Exclusion Statute, the OIG must exclude providers and suppliers convicted of any of the following from participation in all Federal health care programs:

- Medicare fraud, as well as any other offenses related to the delivery of items or services under Medicare
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances

OIG may also impose permissive exclusions on other grounds, including:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud, or misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard services
- Submitting false or fraudulent claims to a Federal health care program
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

Excluded providers may not participate in Federal health care programs for a designated period. With very limited exception, an excluded provider may not bill Federal health care programs (including, but not limited to, Medicare, Medicaid, and State Children's Health Insurance Program [SCHIP]) for services he or she orders or performs. Additionally, an employer or a group practice may not bill for an excluded provider's services. At the end of an exclusion period, an excluded provider must seek reinstatement; reinstatement is not automatic.

The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE).

Civil Monetary Penalties Law

The Civil Monetary Penalties Law authorizes CMPs for a variety of health care fraud violations. Different amounts of penalties and assessments may be authorized based on the type of violation. CMPs also may include an assessment of up to **three** times the amount claimed for each item or service, or up to **three** times the amount of remuneration offered, paid, solicited, or received. Violations that may justify CMPs include:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or that is false and fraudulent
- Presenting a claim you know, or should know, is for an item or service for which Medicare will not pay
- Violating the AKS

CMP INFLATION ADJUSTMENT

Each year, the Federal Government adjusts all CMPs for inflation. The adjusted amounts apply to civil penalties assessed after August 1, 2016, and violations after November 2, 2015. Refer to 45 CFR 102.3 for the yearly adjustments for inflation.

MEDICARE ANTI-FRAUD AND ABUSE PARTNERSHIPS

Government agencies partner to fight fraud and abuse, uphold the Medicare Program's integrity, save and recoup taxpayer funds, reduce health care costs, and improve the quality of health care.

Health Care Fraud Prevention Partnership (HFPP)

The HFPP is a voluntary public-private partnership among the Federal Government, State agencies, law enforcement, private health insurance plans, and health care anti-fraud associations. The HFPP fosters a proactive approach to detect and prevent health care fraud through data and information sharing.

Centers for Medicare & Medicaid Services (CMS)

CMS is the Federal agency within the U.S. Department of Health and Human Services (HHS) that administers the Medicare, Medicaid, SCHIP, Clinical Laboratory Improvement Amendments (CLIA), and several other health-related programs.

To prevent and detect fraud and abuse, CMS works with individuals, entities, and law enforcement agencies, including:

- Accreditation Organizations (AOs)
- Medicare beneficiaries and caregivers
- Physicians, suppliers, and other health care providers
- State and Federal law enforcement agencies, including the OIG, Federal Bureau of Investigation (FBI), Department of Justice (DOJ), State Medicaid Agencies, and Medicaid Fraud Control Units (MFCUs)

To support its efforts to prevent, detect, and investigate potential Medicare fraud and abuse, CMS also partners with an array of contractors.

Table 1. Contractor Efforts to Prevent, Detect, and Investigate Fraud and Abuse

Contractor	Role
Comprehensive Error Rate Testing (CERT) Contractors	Help calculate the Medicare Fee-For-Service (FFS) improper payment rate by reviewing claims to determine if they were paid properly
Medicare Administrative Contractors (MACs)	Process claims and enroll providers and suppliers
Medicare Drug Integrity Contractors (MEDICs)	Monitor fraud, waste, and abuse in the Medicare Parts C and D Programs
Recovery Audit Program Recovery Auditors	Reduce improper payments by detecting and collecting overpayments and identifying underpayments
Zone Program Integrity Contractors (ZPICs) Formerly called Program Safeguard Contractors (PSCs)	Investigate potential fraud, waste, and abuse for Medicare Parts A and B; Durable Medical Equipment Prosthetics, Orthotics, and Supplies; and Home Health and Hospice
Unified Program Integrity Contractor (UPIC)	Combine and integrate functions of Medicare and Medicaid Program Integrity audit and investigation work into a single contract

Within CMS, the Center for Program Integrity (CPI) promotes the integrity of Medicare through audits, policy reviews, and identifying and monitoring program vulnerabilities. CPI oversees CMS' collaboration with key stakeholders on program integrity issues related to detecting, deterring, monitoring, and combating fraud and abuse. Visit the CMS Blog for the latest CPI news.

In 2010, HHS and CMS launched a national effort known as the Fraud Prevention System (FPS), a state-of-the-art predictive analytics technology that runs predictive algorithms and other analytics nationwide on all Medicare FFS claims prior to payment to detect potentially suspicious claims and patterns that may constitute fraud and/or abuse.

In 2012, CMS created the Program Integrity Command Center to bring together Medicare and Medicaid officials, clinicians, policy experts, CMS fraud investigators, and the law enforcement community, including the OIG and FBI. The Command Center gathers these experts to, among other things, develop and improve intricate predictive analytics that identify fraud and mobilize a rapid response. CMS is able to connect instantly with its field offices to evaluate fraud allegations through real-time investigations. Previously, finding substantiating evidence of a fraud allegation took days or weeks; now it takes mere hours.

Office of Inspector General (OIG)

The OIG protects the integrity of HHS' programs, including Medicare, and the health and welfare of its beneficiaries. The OIG operates through a nationwide network of audits, investigations, inspections, and other related functions. The Inspector General is authorized to, among other things, exclude individuals and entities who engage in fraud or abuse from participation in Medicare, Medicaid, and other Federal health care programs, and to impose CMPs for certain violations related to Federal health care programs.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

The DOJ, OIG, and HHS established HEAT to build and strengthen existing programs combatting Medicare fraud while investing new resources and technology to prevent fraud and abuse. HEAT expanded the DOJ-HHS Medicare Fraud Strike Force, which targets emerging or migrating fraud schemes, including fraud by criminals masquerading as health care providers or suppliers.

General Services Administration (GSA)

The GSA consolidated several Federal procurement systems into one new system: the System for Award Management (SAM). SAM includes information on entities that are:

- Debarred or proposed for debarment
- Disqualified from certain types of Federal financial and non-financial assistance and benefits
- Disqualified from receiving Federal contracts or certain subcontracts
- Excluded
- Suspended

REPORT SUSPECTED FRAUD

Table 2. Where Should You Report Fraud and Abuse?

If You Are a…	Report Fraud to…
Medicare Beneficiary	For any complaint: • CMS Hotline: Phone: 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048 AND • OIG Hotline: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950 Fax: 1-800-223-8164 Online: Forms.oig.hhs.gov/hotlineoperations/index.aspx Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 For Medicare Part C (Managed Care) or Part D (Prescription Drug Plans) complaints: • 1-877-7SafeRx (1-877-772-3379)
Medicare Provider	• OIG Hotline: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950 Fax: 1-800-223-8164 Online: Forms.oig.hhs.gov/hotlineoperations/index.aspx Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 OR • Your local MAC

Table 2. Where Should You Report Fraud and Abuse? (cont.)

If You Are a…	Report Fraud to…
Medicaid Beneficiary or Provider	• OIG Hotline Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950 Fax: 1-800-223-8164 Online: Forms.oig.hhs.gov/hotlineoperations/index.aspx Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 OR • Your Medicaid State Agency: State MFCUs are listed in the National Association of Medicaid Fraud Control Units (NAMFCU)

If you prefer to submit your complaint **anonymously** to the OIG Hotline, the OIG record systems collect no information that could trace the complaint to you. However, lack of contact information may prevent OIG's comprehensive review of the complaint, so the OIG encourages you to provide contact information for possible follow-up.

Medicare and Medicaid beneficiaries can learn more about protecting themselves and spotting fraud by contacting their local Senior Medicare Patrol (SMP) program.

For questions about Medicare billing procedures, billing errors, or questionable billing practices, contact your MAC.

RESOURCES

For more information about the OIG and fraud, visit the OIG website. For more information regarding preventing, detecting, and reporting fraud and abuse, as well as other Medicare information, refer to the resources listed in Table 3.

Table 3. Fraud and Abuse Resources

Resource	Website
CMS	CMS.gov
CMS Fraud and Abuse Products	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf

Table 3. Fraud and Abuse Resources (cont.)

Resource	Website
CMS Fraud Prevention Toolkit	CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
Can Someone Change My CPT Codes?	Medscape.com/viewarticle/872465 **Note:** To access this article, you need to create a free account.
Frequently Asked Questions: Medicare Fraud and Abuse	Questions.CMS.gov/faq.php?id=5005&rtopic=1887
Help Fight Medicare Fraud	Medicare.gov/Forms-Help-and-Resources/Report-Fraud-and-Abuse/Fraud-and-Abuse.html
HHS	HHS.gov
Medicaid Program Integrity Education	CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html
Medicaid Program Integrity: Safeguarding Your Medical Identity Products	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf
Medicare Learning Network® Electronic Mailing Lists: Keeping Health Care Professionals Informed Listing	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243324.html
MLN Provider Compliance	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
OIG Advisory Opinions	OIG.HHS.gov/Compliance/Advisory-Opinions
OIG Compliance 101	OIG.HHS.gov/Compliance/101
OIG Email Updates	OIG.HHS.gov/Contact-Us
OIG Fraud Information	OIG.HHS.gov/fraud
Physician Self Referral	CMS.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral

Table 3. Fraud and Abuse Resources (cont.)

Resource	Website
The Basics of Medicare Web-Based Training (WBT) Series: • Part One: History, program overview, enrollment • Part Two: Billing, reimbursement, appeals • Part Three: Claim review programs, fraud and abuse, outreach and education	Learner.MLNLMS.com

Table 4. Hyperlink Table

Embedded Hyperlink	Complete URL
45 CFR 102.3	https://www.ecfr.gov/cgi-bin/text-idx?SID=f3da2968a38d247521cada756ad2ad4f&mc=true&node=pt45.1.102&rgn=div5
AKS	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7b.pdf
Civil FCA	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title31/pdf/USCODE-2016-title31-subtitleIII-chap37-subchapIII.pdf
Civil Monetary Penalties Law	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7a.pdf
CMS	https://www.cms.gov
CMS Blog	https://blog.cms.gov/category/cms-center-for-program-integrity
Code of Federal Regulations	https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol2/pdf/CFR-2016-title42-vol2-sec411-351.pdf
Comparison of the Anti-Kickback Statute and Stark Law	https://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf
Contact Your MAC	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Criminal FCA	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap15-sec287.pdf

Table 4. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Criminal Health Care Fraud Statute	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1347.pdf
Exclusion Statute	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7.pdf
HFPP	https://hfpp.cms.gov
List of Excluded Individuals/Entities	https://oig.hhs.gov/exclusions/exclusions_list.asp
Local MAC	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Medicare Fraud Strike Force	https://oig.hhs.gov/fraud/strike-force
National Association of Medicaid Fraud Control Units	http://www.namfcu.net/medicaid-fraud-control-unit1.php
OIG Hotline Operations	https://www.youtube.com/watch?v=Wlsnd1DYG6Y
OIG Website	https://oig.hhs.gov
Physician Self-Referral Law	https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXVIII-partE-sec1395nn.pdf
Reporting Fraud to the OIG	https://www.youtube.com/watch?v=nH7p30j7dOw
Safe Harbor Regulations	https://oig.hhs.gov/compliance/safe-harbor-regulations
Senior Medicare Patrol	http://www.smpresource.org
System for Award Management	https://www.sam.gov