DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Fraud & Abuse: Prevention, Detection, and Reporting

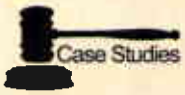
FACT SHEET

Medicare fraud and abuse is a serious problem requiring your attention. Although there is no precise measure of health care fraud and the majority of health care providers are honest and well-intentioned, a minority of providers who are intent on abusing the system can cost taxpayers billions of dollars and put beneficiaries' health and welfare at risk. The impact of these losses and risks is magnified by the growing number of people served by Medicare and the increased strain on Federal and state budgets.

You play a vital role in protecting the integrity of the Medicare Program. To combat fraud and abuse, you need to know what to watch for to protect your organization from potential abusive practices, civil liability, and perhaps criminal activity. This fact sheet gives you some of the tools you need to protect the Medicare Program, including the definitions of Medicare fraud and abuse, laws used to address fraud and abuse, overviews of partnerships among government agencies engaged in fighting fraud and abuse, and resources on how you can report suspected fraud and abuse.

What Is Medicare Fraud?

In general, **fraud** is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of material facts.



To learn about real-life cases of Medicare fraud and abuse and the consequences for culprits, visit http://www.stopmedicarefraud.gov/HEATnews on the Internet.

Fraud schemes range from solo to broad-based operations by an institution or group. Anyone can commit health care fraud. You may even know someone who has committed fraud. Organized crime also is infiltrating the Medicare Program and masquerading as Medicare providers and suppliers. Examples of Medicare fraud **may** include:

- Knowingly billing for services that were not furnished and/or supplies not provided, including billing Medicare for appointments that the patient failed to keep; and
- Knowingly altering claims forms and/or receipts to receive a higher payment amount.

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It is a crime to defraud the Federal Government and its programs. Punishment may involve imprisonment, significant fines, or both. Criminal penalties for health care fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate fraud prevention. In some states, providers and health care organizations may lose their licenses. Convictions also may result in exclusion from Medicare participation for a specified length of time. Medicare fraud may also result in civil liability.

What Is Medicare Abuse?

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

Examples of Medicare abuse **may** include:

- Misusing codes on a claim,
- Charging excessively for services or supplies, and
- Billing for services that were not medically necessary.

Both fraud and abuse can expose providers to criminal and civil liability.

Medicare Fraud and Abuse Laws

The False Claims Act, Anti-Kickback Statute, Physician Self-Referral Law (Stark Law), Social Security Act, and the U.S. Criminal Code are used to address fraud and abuse. Violations of these laws may result in nonpayment of claims, Civil Monetary Penalties (CMPs), exclusion from the Medicare Program, and criminal and civil liability.

NOTE: The fraudulent conduct addressed by these laws is also prohibited in Medicare Part C and Part D and in Medicaid, including fraud and abuse related to "dual eligibles." "Dual eligibles" refers to individuals who are entitled to or enrolled in Medicare Part A or enrolled in Part B, and who are eligible for Medicaid.

False Claims Act (FCA)

The FCA (31 United States Code [U.S.C.] Sections 3729-3733) protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. An example may be a physician who submits claims to Medicare for medical services he or she knows were not provided. Civil penalties for violating the FCA may include fines and up to 3 times the amount of damages sustained by the Government as a result of the false claims. There also is a criminal FCA (18 U.S.C. Section 287). Criminal penalties for submitting false claims may include fines, imprisonment, or both. For more information on fraud, visit http://oig.hhs.gov/fraud on the Internet.

Anti-Kickback Statute

The Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Where remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by a Federal health care program, the Anti-Kickback Statute is violated. If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute. The safe harbor regulations are set forth at 42 Code of Federal Regulations (CFR) Section 1001.952. Criminal penalties for violating the Anti-Kickback Statute may include fines, imprisonment, or both. For more information, visit http://oig.hhs.gov/compliance/safe-harbor-regulations on the Internet.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (Stark Law) (42 U.S.C. Section 1395nn) prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an immediate member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties for physicians who violate the Physician Self-Referral Law (Stark Law) include fines as well as exclusion from participation in all Federal health care programs. For more information, visit http://www.cms.gov/PhysicianSelfReferral on the Centers for Medicare & Medicaid Services (CMS) website.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits 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;

in connection with the delivery of or payment for health care benefits, items, or services. Proof of actual knowledge or specific intent to violate the law is **not** required. Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Exclusions

Under 42 U.S.C. Section 1320a-7, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) is required to impose exclusions from participation in all Federal health care programs on health care providers and suppliers who have been convicted of:

- Medicare fraud;
- Patient abuse or neglect;
- Felony convictions for other health care related fraud, theft, or other financial misconduct; or
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Exclusion means that, for a designated period, Medicare, Medicaid, and other Federal health care programs will not pay the provider for services performed or for services ordered by the excluded party. Note that the OIG has discretion to impose permissive exclusions on a number of other grounds.

Civil Monetary Penalties (CMPs)

Under 42 U.S.C. Section 1320a-7a, CMPs may be imposed for a variety of conduct, and different amounts of penalties and assessments may be authorized based on the type of violation at issue. Penalties range from up to $10,000 to $50,000 per violation. CMPs can also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received. Examples of CMP violations include:

- Presenting a claim that the person knows or should know is for an item or service that was not provided as claimed or is false and fraudulent,
- Presenting a claim that the person knows or should know is for an item or service for which payment may not be made, and
- Violating the Anti-Kickback Statute.

Medicare Fraud and Abuse Partnerships

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

Centers for Medicare & Medicaid Services (CMS)

CMS is a Federal agency within HHS that administers and oversees the Medicare and Medicaid Programs. CMS partners with the following entities and law enforcement agencies, among others, to prevent and detect fraud and abuse:

- Program Safeguard Contractors (PSCs)/Zone Program Integrity Contractors (ZPICs);
- Medicare Drug Integrity Contractors (MEDICs);
- State and Federal law enforcement agencies, such as the OIG, Federal Bureau of Investigation (FBI), Department of Justice (DOJ), and State Medicaid Fraud Control Units (MFCUs);
- Medicare beneficiaries and caregivers;
- Senior Medicare Patrol (SMP) program;
- Physicians, suppliers, and other providers;
- Medicare Carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (MACs) who pay claims and enroll providers and suppliers;
- Accreditation Organizations (AOs);
- Recovery Audit Program Recovery Auditors; and
- Comprehensive Error Rate Testing (CERT) Contractors.

Center for Program Integrity (CPI)

CPI promotes the integrity of Medicare through audits and policy reviews, identification and monitoring of program vulnerabilities, and support and assistance to states. CPI oversees those CMS interactions and collaborations with key stakeholders that relate to program integrity for the purposes of detecting, deterring, monitoring, and combating fraud and abuse.

Office of Inspector General (OIG)

The OIG protects the integrity of the HHS' programs, including Medicare, and the health and welfare of its beneficiaries. The OIG carries out its duties through a nationwide network of audits, investigations, inspections, and other related functions. The Inspector General has the authority to exclude individuals and entities who have engaged in fraud or abuse from participation in Medicare, Medicaid, and other Federal health care programs, and to impose CMPs for certain misconduct related to Federal health care programs. The OIG maintains a list of excluded parties called the List of Excluded Individuals/ Entities (LEIE). For more information, visit http://oig.hhs.gov/exclusions on the Internet.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

The DOJ and HHS established HEAT to build and strengthen existing programs to combat Medicare fraud while investing new resources and technology to prevent fraud and abuse. HEAT efforts have included expansion of the DOJ-HHS Medicare Fraud Strike Force that has been successful in fighting fraud. HEAT created the Stop Medicare Fraud website, which provides information about how to identify and protect against Medicare fraud and how to report it. For more information, visit http://www.stopmedicarefraud.gov on the Internet.

General Services Administration (GSA)

The GSA maintains the Excluded Parties List System (EPLS) that includes information on entities debarred, suspended, proposed for debarment, excluded, or disqualified throughout the U.S. Government from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non-financial assistance and benefits. For more information, visit https://www.epls.gov on the Internet.

Report Suspected Fraud

Where Should I Report Fraud and Abuse?

I am a ...	Report to ...
Medicare Beneficiary	For any complaints: CMS Hotline: 1-800-MEDICARE (1-800-633-4227) or TTY 1-800-486-2048 OR For Medicare Managed Care or Prescription Drugs: 1-877-7SafeRx (1-877-772-3379)
Medicare Provider	OIG Hotline Phone: 1-800-HHS-TIPS (1-800-447-8477) Fax: 1-800-223-8164 E-mail: HHSTips@oig.hhs.gov TTY: 1-800-377-4950 http://oig.hhs.gov/fraud/report-fraud/report-fraud-form.asp Mail: Office of Inspector General Department of Health and Human Services Attn: Hotline P.O. Box 23489 Washington, DC 20026 OR your local Medicare Carrier, FI, or MAC
Medicaid Beneficiary or Provider	OIG Hotline 1-800-HHS-TIPS (1-800-447-8477) Fax: 1-800-223-8164 E-mail: HHSTips@oig.hhs.gov TTY: 1-800-377-4950 http://oig.hhs.gov/fraud/report-fraud/report-fraud-form.asp Mail: Office of Inspector General Department of Health and Human Services Attn: Hotline P.O. Box 23489 Washington, DC 20026 OR your Medicaid State Agency (State Agency Fraud Units are listed at http://www.cms.gov/FraudAbuseforConsumers)

If you prefer, you may provide your complaint anonymously to the OIG Hotline. No information will be entered in OIG record systems that could trace the complaint to you. In many cases, however, the lack of contact information for the source prevents a comprehensive review of the complaint. The OIG encourages you to provide information on how to contact you for additional information.

Medicare and Medicaid beneficiaries can learn more about protecting themselves and spotting fraud by contacting their local SMP program. For more information about SMP or to find the local SMP, visit the SMP Locator at http://www.smpresource.org on the Internet.

For questions about billing procedures, billing errors, or questionable billing practices, contact your Medicare Carrier, FI, or MAC. For Medicare Carrier, FI, or MAC contact information, including toll-free telephone numbers, visit http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Resources

The OIG and CMS offer a wealth of information regarding prevention, detection, and reporting of Medicare fraud and abuse.

For more information about the OIG and fraud, visit http://oig.hhs.gov/fraud on the Internet.

For more information about OIG e-mail updates, visit http://www.oig.hhs.gov/contact-us on the Internet.

For more information about CMS, visit http://www.cms.gov on the CMS website.

For the CMS Fraud Prevention Toolkit, which contains information for providers and information providers can give to beneficiaries, visit http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp on the CMS website.

For more information about HEAT, visit http://www.stopmedicarefraud.gov/heattaskforce on the Internet.

For more information about CMS Electronic Mailing Lists, visit http://www.cms.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf on the CMS website.

For provider compliance educational materials, visit http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp on the CMS website.

For more information about OIG Advisory Opinions, visit http://www.oig.hhs.gov/compliance/advisory-opinions on the Internet.

For more information about CMS Advisory Opinions, visit http://www.cms.gov/PhysicianSelfReferral/95_advisory_opinions.asp on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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