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

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Medicare Fraud & Abuse

Prevention, Detection, and Reporting

Please note:

The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Medicare Fraud and Abuse: A Serious Problem that Requires Your Attention

Although no precise measure of health care fraud exists, those intent on abusing the system can cost taxpayers billions of dollars while putting beneficiaries' health and welfare at risk. Medicare fraud and abuse increases the strain on the Medicare Trust Fund. The impact of these losses and risks magnify 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 what to watch for to protect your organization from potential abusive practices, civil liability, and criminal activity. This fact sheet gives you some of the tools you need to protect the Medicare Program, your patients, and yourself, including:

- Examples of Medicare fraud and abuse;
- Overview of the laws used to fight fraud and abuse;
- Descriptions of the partnerships among government agencies engaged in preventing, detecting, and fighting fraud and abuse; and
- Resources on how you can report suspected fraud and abuse.

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Click the image to play the video.

You Can Help Fight Fraud – Report It!

For a short video on reporting Medicare fraud to the Office of Inspector General (OIG), visit http://www.youtube.com/watch?v=nH7p30j7dOw or click the image on the left.

What Is Medicare Fraud?

Medicare **fraud** is typically characterized by:

- Knowingly submitting false statements or making misrepresentations of fact to obtain a federal health care payment for which no entitlement would otherwise exist;
- Knowingly soliciting, paying, and/or accepting remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs; or
- 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 http://www.stopmedicarefraud.gov/newsroom on the Internet.

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:

- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items or billing Medicare for appointments that the patient failed to keep; and
- Knowingly billing for services at a level of complexity higher than the service actually provided or documented in the file.

Defrauding the Federal government and its programs is **illegal**. Committing Medicare fraud exposes individuals or entities to potential criminal and civil remedies, including 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 that commit health care fraud risk exclusion from participation in Federal health care programs and the loss of 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 that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and priced fairly.

Examples of Medicare abuse include:

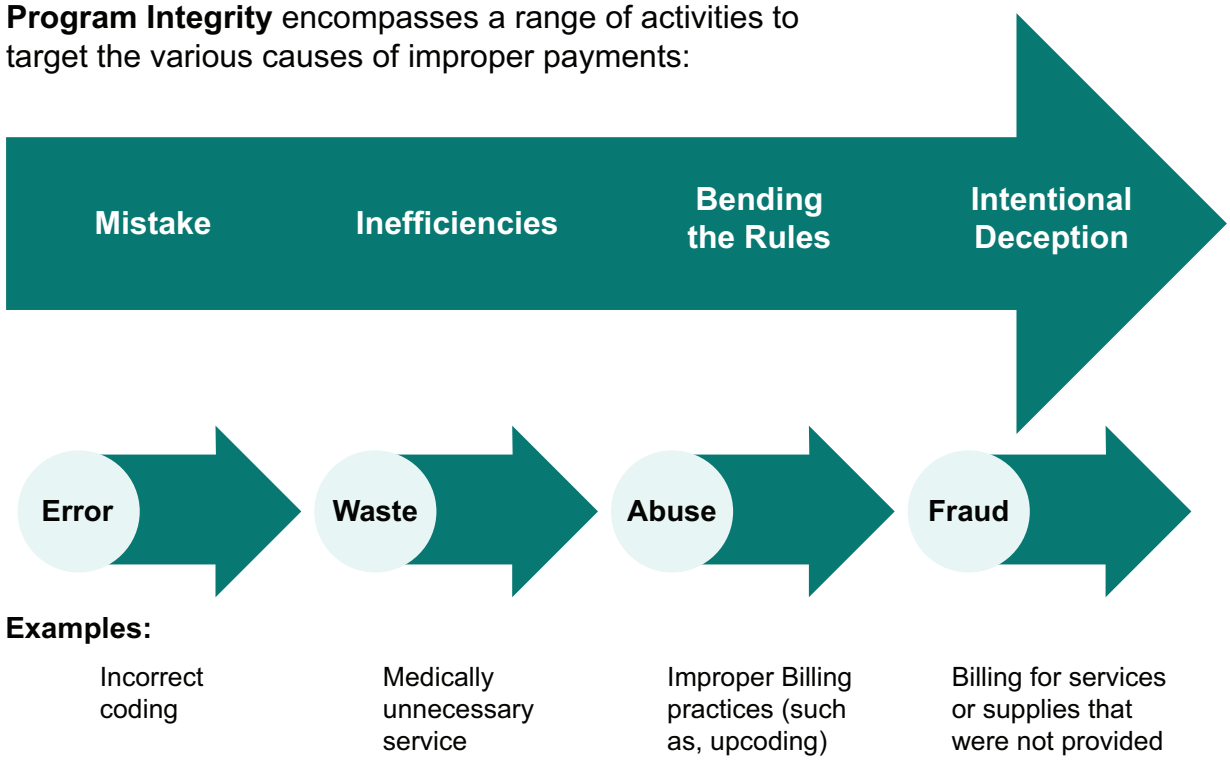
- Billing for services that were not medically necessary;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.

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

Figure 1 shows examples along the spectrum of causes of improper payments.

Figure 1. Types of Improper Payments

Program Integrity encompasses a range of activities to target the various causes of improper payments:



Medicare Fraud and Abuse Laws

Federal laws governing Medicare fraud and abuse include the:

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

These bodies of law specify the criminal and/or civil remedies the government can impose upon individuals or entities that commit fraud and abuse in the Medicare Program, including Medicare Parts C and D, as well as the Medicaid Program. Violations of these laws may result in nonpayment of claims, Civil Monetary Penalties (CMPs), exclusion from participation in Federal health care programs, and criminal and civil liability. Liability can exist without proof of actual knowledge or a specific intent to violate the law. We briefly summarize each law below, and you can find hyperlinks to the text of the laws at the end of this section in Table 1.

False Claims Act (FCA)

The FCA 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 the submission of, 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.

> **Example:** A physician submits claims to Medicare for a higher level of medical services than actually provided or that the medical record documents.
>
> **Penalties:** Civil penalties for violating the FCA can include fines of $5,500–$11,000 per false claim and up to three times the amount of damages sustained by the government as a result of the false claims.

There is also a criminal FCA statute by which individuals or entities that submit false claims can face criminal penalties.

Anti-Kickback Statute (AKS)

The AKS makes it a criminal offense 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.

> **Example:** A provider receives cash or below fair market value rent for medical offices in exchange for referrals.

> **Penalties:** Civil penalties for violating the AKS can include fines up to three times the amount of kickback. Criminal penalties for violating the AKS can include fines, imprisonment, or both.

Find More Information about the AKS and the Stark Law

For a comparison of the AKS and Stark Law, refer to http://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf on the OIG website.

If certain types of arrangements satisfy regulatory safe harbors, the AKS will not treat these arrangements as offenses. For more information on safe harbors, visit the United States (U.S.) Department of Health & Human Services (HHS) Office of Inspector General's (OIG) website at https://oig.hhs.gov/compliance/safe-harbor-regulations on the OIG website.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or member of his or her immediate family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

What Is an Entity?

For more information about the definition of an entity, refer to http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol2/pdf/CFR-2013-title42-vol2-sec411-351.pdf on the GPO website.

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 include fines, repayment of claims, and potential exclusion from participation in all Federal health care programs.

For more information, visit http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral on the CMS website.

Criminal Health Care Fraud Statute

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

- Defraud any health care benefit program; or
- 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.

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting claims for power wheelchairs that were not medically necessary.

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.

Exclusions

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

- Medicare fraud;
- Patient abuse or neglect;
- Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service; or
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG also has the discretion to impose exclusions on a number of other grounds. Excluded providers cannot participate in Federal health care programs for a designated period. 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. At the end of an exclusion period, an excluded provider must affirmatively seek reinstatement; reinstatement is not automatic. The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE), at https://oig.hhs.gov/exclusions on the OIG website.

Civil Monetary Penalties Law (CMPL)

Under the CMPL, Civil Monetary Penalties (CMPs) apply for a variety of conduct. The CMPL authorizes penalties of up to $50,000 per violation, and assessments 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 give rise to CMPs include:

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

Table 1. Table of Statutes

Statute	Reference
Civil FCA 31 United States Code (U.S.C.) Sections 3729-3733	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title31/pdf/USCODE-2012-title31-subtitleIII-chap37-subchapIII.pdf
Criminal FCA 18 U.S.C. Section 287	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title18/pdf/USCODE-2012-title18-partI-chap15-sec287.pdf
AKS 42 U.S.C. 1320A-7b(b)	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXI-partA-sec1320a-7b.pdf
Regulatory Safe Harbors 42 Code of Federal Regulations (CFR) Section 1001.952	http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol5/pdf/CFR-2013-title42-vol5-sec1001-952.pdf
Physician Self-Referral Law 42 U.S.C. Section 1395nn	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXVIII-partE-sec1395nn.pdf
Criminal Health Care Fraud 18 U.S.C. Section 1347	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title18/pdf/USCODE-2012-title18-partI-chap63-sec1347.pdf
Exclusion 42 U.S.C. Section 1320a-7	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXI-partA-sec1320a-7.pdf
CMPL 42 U.S.C. Section 1320a-7a	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXI-partA-sec1320a-7a.pdf

Medicare 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 care.

Public-Private Health Care Fraud Prevention Partnership

The Health Care Fraud Prevention Partnership (Partnership) is a public-private forum for the Federal government and private and state organizations, including insurers, to prevent health care fraud on a national scale. Public and private sector partners exchange information and best practices to detect and prevent fraudulent claims and payments. The partnership also performs analytics on industry-wide data to detect and predict fraud schemes. For more information on the partnership, visit http://www.stopmedicarefraud.gov/aboutfraud/public-private on the Internet.

Centers for Medicare & Medicaid Services (CMS)

CMS is the Federal agency responsible for administering the Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Health Insurance Portability and Accountability Act of 1996 (HIPAA), Clinical Laboratory Improvement Amendments (CLIA), and several other health-related programs. For more information about CMS and its programs, visit http://www.cms.gov on the CMS website.

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

- Accreditation Organizations (AOs);
- Medicare beneficiaries and caregivers;
- Physicians, suppliers, and other health care providers; and
- 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 contracts with an array of contractors, including:

- Comprehensive Error Rate Testing (CERT) Contractors;
- Medicare Administrative Contractors (MACs) which pay claims and enroll providers and suppliers;
- Medicare Drug Integrity Contractors (MEDICs);
- Recovery Audit Program Recovery Auditors; and
- Zone Program Integrity Contractors (ZPICs), formerly called Program Safeguard Contractors (PSCs), which investigate potential fraud and abuse.

The Center for Program Integrity (CPI), within CMS, promotes the integrity of Medicare through audits, policy reviews, and identification and monitoring of program vulnerabilities. CPI oversees CMS' collaborative interactions with key stakeholders on program integrity issues related to the detecting, deterring, monitoring, and combating fraud and abuse. For the latest CPI news, visit http://blog.cms.gov/category/cms-center-for-program-integrity on the CMS website.

In 2010, HHS and CMS launched an ambitious national effort to obstruct criminals at every step in the act of committing fraud. The Fraud Prevention System (FPS) is the state-of-the-art predictive analytics technology that runs predictive algorithms and other analytics nationwide on all Medicare Fee-For-Service (FFS) claims prior to payment. For the first time in Medicare history, CMS systematically applies advanced analytics to the Medicare FFS claims on a streaming, nationwide basis.

In 2012, CMS created the Program Integrity Command Center to bring together officials, experts, and investigators from Medicare, Medicaid, and the law enforcement community, including the OIG and FBI. The Command Center gathers experts in one room to develop intricate predictive analytics identifying fraud and mobilizing a rapid fraud response. CMS uses this technology to connect instantly with its field offices and 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)

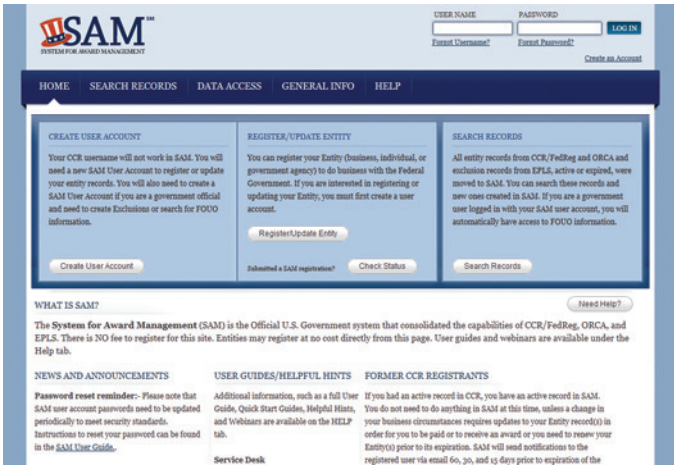
The OIG protects the integrity of HHS' programs, including Medicare, and the health and welfare of its beneficiaries. The OIG carries out its duties through a nationwide network of audits, investigations, inspections, and other related functions. The Inspector General has the authority to exclude individuals and entities who engage 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.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

The DOJ 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 efforts included expansion of the DOJ-HHS Medicare Fraud Strike Force, which successfully fights 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 on HEAT, visit http://www.stopmedicarefraud.gov on the Internet.

General Services Administration (GSA)

The GSA consolidated several Federal procurement systems into one new system—the System for Award Management (SAM). SAM incorporated the formerly maintained Excluded Parties List System (EPLS). SAM includes information on entities debarred, suspended, proposed for debarment, excluded, or disqualified from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non-financial assistance and benefits. For more information on excluded parties, visit https://www.sam.gov on the Internet.



Report Suspected Fraud

The following table tells you how to report Medicare 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; or • OIG Hotline: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950; Fax: 1-800-223-8164; Email: HHSTips@oig.hhs.gov Online: https://forms.oig.hhs.gov/hotlineoperations Mail: U.S. Department of Health & Human Services Office of Inspector General Attn: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 OR For Medicare Part C (Managed Care) or Part D (Prescription Drug Plans) complaints: • 1-877-7SafeRx (1-877-772-3379)

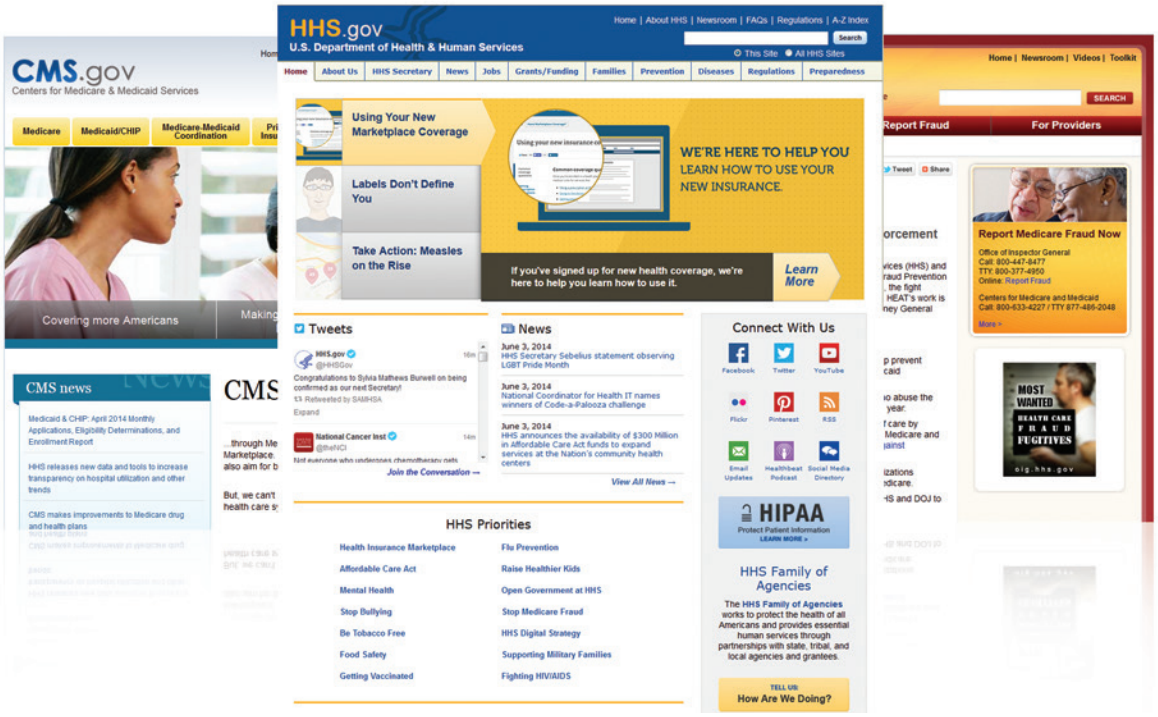
Table 2. Where Should You Report Fraud and Abuse? (cont.)

If You Are a…	Report Fraud to…
Medicare Provider	• OIG Hotline: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950; Fax: 1-800-223-8164; Email: HHSTips@oig.hhs.gov Online: https://forms.oig.hhs.gov/hotlineoperations 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 For MAC contact information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.
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 Email: HHSTips@oig.hhs.gov Online: https://forms.oig.hhs.gov/hotlineoperations 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 at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Report_Fraud_and_Suspected_Fraud.html on the CMS website.

If you prefer, you can give your complaint **anonymously** to the OIG Hotline; the OIG record systems will contain no information that could trace the complaint to you. This lack of contact information, however, 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 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 Medicare billing procedures, billing errors, or questionable billing practices, contact your MAC. For MAC contact information, including toll-free telephone numbers, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.



Resources

For more information about the OIG and fraud, visit https://oig.hhs.gov/fraud on the OIG website, or scan the Quick Response (QR) code on the right with your mobile device. For more information regarding preventing, detecting, and reporting Medicare fraud and abuse, refer to the resources listed below.

Table 3. Fraud and Abuse Resources

Resource	Website
HHS	http://www.hhs.gov
CMS	http://www.cms.gov
HEAT Task Force	http://www.stopmedicarefraud.gov/aboutfraud/heattaskforce
OIG	http://oig.hhs.gov
"CMS Electronic Mailing Lists: Keeping Health Care Professionals Informed" fact sheet	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf
CMS Fraud and Abuse Products	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf

Resource	Website
CMS Fraud Prevention Toolkit	http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
Frequently Asked Questions (FAQ): Medicare Fraud and Abuse	https://questions.cms.gov/faq.php?id=5005&rtopic=1887
"How CMS Is Fighting Fraud: Major Program Integrity Initiatives"	http://www.medscape.org/viewarticle/764791 **NOTE:** To access this program, you need to create a free account.
"Medicaid Program Integrity: Safeguarding Your Medical Identity" Products	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf
Medicare Learning Network® (MLN) Provider Compliance	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
OIG Advisory Opinions	https://oig.hhs.gov/compliance/advisory-opinions
OIG Compliance 101	https://oig.hhs.gov/compliance/101
OIG Email Updates	https://oig.hhs.gov/contact-us
"Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients"	http://www.medscape.org/viewarticle/764496 **NOTE:** To access this program, you need to create a free account.

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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