mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

Medicare Fraud & Abuse: Prevent, Detect, Report

What's Changed?

Note: No substantive content updates.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

Table of Contents

While no precise measure of health care fraud exists, those who exploit federal health care programs cost taxpayers billions of dollars while putting Medicare patients' health and welfare at risk. The impact of these losses and risks increases as Medicare continues to serve a growing number of patients.

In this booklet, unless otherwise stated, **you** refers to anyone billing Medicare and **we** refers to CMS.

Most physicians work ethically, provide their patients with high-quality medical care, and submit accurate claims. Trust is core to the physician-patient relationship. CMS also places enormous trust in you. Medicare and other federal health care programs rely on your medical judgment to treat patients with appropriate, medically necessary services and to submit accurate claims for Medicare-covered health care items and services.

You play an important role in protecting the Medicare Program's integrity. To combat fraud and abuse, know how to protect your organization from potential abusive practices, civil liability, and possible criminal activity. This booklet provides these tools to help protect the Medicare Program, your patients, and yourself:

- Medicare fraud and abuse examples
- An overview of fraud and abuse laws
- Government agencies and partnerships dedicated to preventing, detecting, and fighting fraud and abuse
- Resources for reporting suspected fraud and abuse

Help Fight Fraud by Reporting It

The Office of Inspector General (OIG) Hotline accepts tips and complaints from all sources on potential fraud and abuse.

The federal government created laws to combat fraud and abuse while ensuring appropriate, quality medical care because of people who exploit federal health care programs for illegal, personal, or corporate gain.

You may frequently encounter these business relationships that may raise fraud and abuse concerns:

- Payer relationships
- Fellow physician and other provider relationships
- Vendor relationships

These key relationships and other issues addressed in this booklet apply to all providers, regardless of specialty or practice setting.

What's Medicare Fraud?

Medicare **fraud** typically includes:

- Knowingly submitting, or causing to be submitted, false claims or misrepresenting facts to get a federal health care payment where no entitlement would otherwise exist.
- Knowingly soliciting, getting, offering, or paying remuneration to induce or reward referrals for items or services paid for by federal health care programs. Remuneration can be money (for example, discounts, kickbacks, or bribes) or providing items or services for free or for other than fair market value.
- Making prohibited referrals for certain designated health services.

Case Studies

To examine real-life Medicare fraud and abuse cases and offender consequences, visit the Medicare Fraud Strike Force.

Anyone can commit health care fraud. Fraud schemes range from solo ventures to widespread institutional or group activities. Even organized crime groups infiltrate the Medicare Program and operate as Medicare providers and suppliers.

Medicare fraud examples include:

- Knowingly billing for services at a higher complexity level than the services provided or documented in medical records (upcoding)
- Knowingly billing for services or supplies not provided, including falsifying records to show items were delivered
- Knowingly ordering items or services the patient doesn't need
- Billing Medicare for appointments patients don't keep
- Paying for federal health care program patient referrals

Defrauding the federal government and its programs is illegal. Committing Medicare fraud exposes people or entities to potential administrative, civil, and criminal liability and may lead to imprisonment, fines, and penalties.

Civil and criminal penalties for Medicare fraud reflect the serious harms from health care fraud and the need for aggressive and appropriate intervention. Providers and health care organizations involved in health care fraud risk being excluded from all federal health care programs and losing their professional licenses.

What's Medicare Abuse?

Abuse describes practices that may directly or indirectly result in unnecessary Medicare Program costs. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized care standards.

The difference between fraud and abuse depends on specific facts, circumstances, intent, and knowledge.

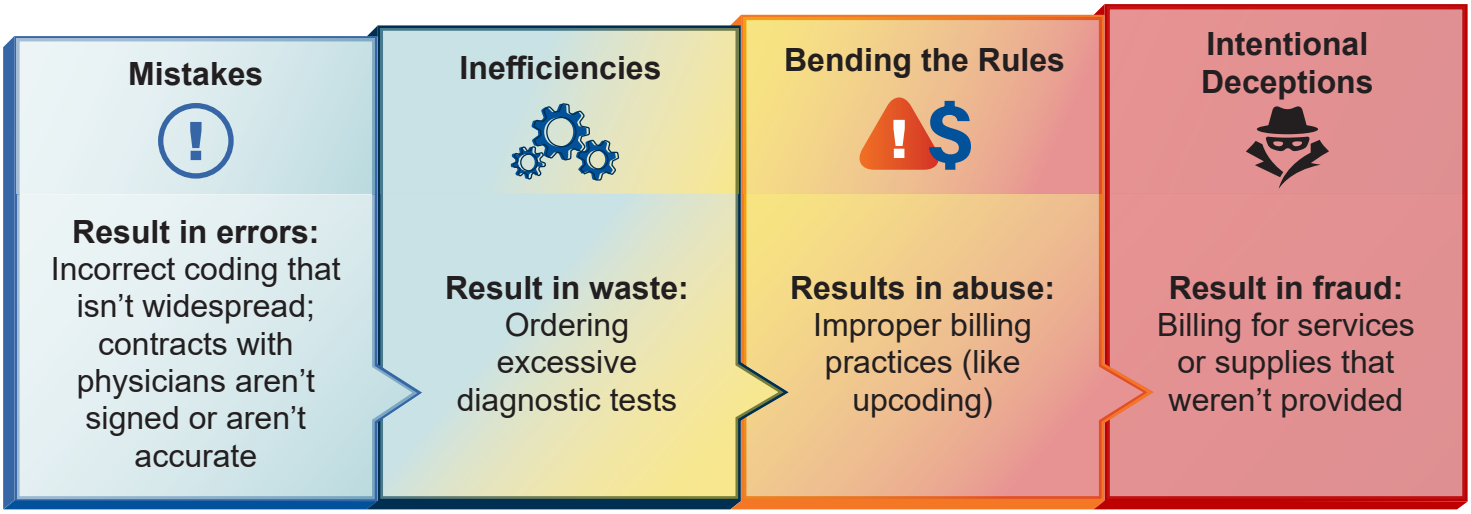
Medicare abuse examples include:

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

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

Program Integrity

Program integrity includes a range of activities targeting improper payment causes. This figure shows possible causes of improper payments.



Causes of Improper Payments

The causes of improper payments in this figure are examples for educational purposes, and the precise characterization of any improper payment depends on a full analysis of specific facts and circumstances. Providers who engage in incorrect coding, ordering excessive diagnostic tests, upcoding, or billing for services or supplies they didn't provide may be subject to administrative, civil, or criminal liability.

Medicare Fraud & Abuse Laws

Federal laws about Medicare fraud and abuse include the:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark law)
- Criminal Health Care Fraud Statute
- Exclusion Statute
- Civil Monetary Penalties Law (CMPL)

Other CMS Programs

The Medicare Part C, Medicare Part D, and Medicaid programs also prohibit the fraudulent conduct these laws address.

These laws specify the administrative, civil, and criminal penalties and actions the federal government may impose on people or entities that commit fraud and abuse in the Medicare and Medicaid programs.

Violating these laws may result in us not paying claims, civil monetary penalties (CMPs), exclusion from all federal health care programs, and civil and criminal liability.

In addition to CMS, federal government agencies like the U.S. Department of Justice (DOJ), HHS, and the HHS Office of Inspector General (OIG) enforce these laws.

Note: CMS also works with states to enforce Title XXVII of the Public Health Service Act (PHS Act). If a state informs CMS that it doesn't have authority to enforce 1 or more of the applicable provisions of the PHS Act, and the state hasn't entered a collaborative arrangement, we're directly responsible for enforcing the relevant provisions in the state regarding health insurance issuers in the group and individual markets.

Federal False Claims Act

The civil FCA protects the federal government from overcharges and buying substandard goods or services. The civil 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 terms "knowing" and "knowingly" mean a person knows the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. **Specific intent to defraud isn't required to violate the civil FCA.**

Example:	A physician knowingly submits claims to Medicare for medical services they didn't provide or for a higher level of medical services than they provided.
Penalties:	Civil penalties for violating the civil FCA may include recovering up to 3 times the amount of damages sustained by the federal government because of the false claims, plus financial penalties per false claim filed.

Also, under the criminal FCA, people or entities who submit false, fictitious, or fraudulent claims may face criminal penalties, including fines, imprisonment, or both.

Anti-Kickback Statute

The AKS makes it a crime to knowingly and willfully offer, pay, solicit, or get remuneration directly or indirectly to induce or reward patient referrals or generate business involving items or services payable by a federal health care program. When a provider offers, pays, solicits, or gets unlawful remuneration, they violate the AKS.

Remember:	Remuneration includes anything of value, like cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.
Example:	A provider gets cash or below fair market value rent for medical office space in exchange for referrals.
Penalties:	Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from all federal health care programs. Under the CMPL, penalties for violating the AKS may include 3 times the amount of the kickback.

Safe harbor regulations describe various payment and business practices that, although they potentially implicate the AKS, aren't treated as AKS offenses if they meet certain requirements specified in the regulations. People and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their businesses. OIG's Safe Harbor Regulations webpage has more information.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, often called the Stark law, both:

- Prohibits a physician from making referrals for certain designated health services (for example, inpatient and outpatient hospital services, clinical lab services, physical therapy, DMEPOS, and home health services), payable by Medicare, to an entity with which the physician or a member of their immediate family has a financial relationship, unless the requirements of an applicable exception are satisfied
- Prohibits the entity providing designated health services (which can be, for example, a physician organization) from filing claims with Medicare (or billing another individual, entity, or third-party payor) for any improperly referred designated health services

It's important to note that even if an entity doesn't know that a designated health service was improperly referred or doesn't intend to file a claim for an improperly referred designated health service, filing a claim for such a service is still prohibited under the Physician Self-Referral Law. It doesn't matter if you didn't intend to violate the law because the Physician Self-Referral Law is a strict-liability statute.

A financial relationship may be an ownership or investment interest in the entity providing designated health services or a compensation arrangement with the entity. Financial relationships can be direct or indirect.

Examples:	• A physician refers a patient for a designated health service to a clinic where the physician has an investment interest • A contract between a hospital and a physician group has technical errors; for example, compensation to the physician increases but the contract isn't updated • A physician group leases office space from a hospital for much less than fair market value
Penalties:	If an entity violates the Physician Self-Referral Law by filing a claim for a designated health service that was improperly referred and Medicare pays the claim, then the entity got an overpayment. An overpayment is an amount that you have been paid by Medicare to which you're not entitled. Per section 1128J of the Social Security Act, the entity has an obligation to report and return the overpayment within 60 days of identifying it (also called the 60-Day Overpayment Rule) or the entity faces FCA liability under U.S. Code section 3729(a)(1)(g) and potential whistleblower actions under 42 CFR 401.305. In addition, violations of the Physician Self-Referral Law may result in fines, CMPs, and potential exclusion from all federal health care programs.
How to Avoid Violations:	• Review the statute and related regulations, CMS advisory opinions, and the Code List for certain designated health services for more information on the Physician Self-Referral Law • Submit general questions about the Physician Self-Referral Law to 1877CallCenter@cms.hhs.gov • Review the Medicare Overpayments fact sheet and Medicare Financial Management Manual, Chapter 3 for more information on overpayments • Review the Industry Segment-Specific Compliance Program Guidance to make sure you avoid any technical mistakes that could lead to massive debt

Differences Between the AKS & Physician Self-Referral Law

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

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:

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

Example:	A group of doctors and medical clinics conspired to defraud the Medicare Program by submitting medically unnecessary power wheelchair claims.
Penalties:	Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Exclusion Statute

The Exclusion Statute requires OIG to exclude health care providers and suppliers from participating in all federal health care programs if they're convicted of certain offenses. OIG may also impose permissive exclusions on several other grounds.

OIG List of Excluded Individuals & Entities

The OIG List of Excluded Individuals & Entities publicly lists people and entities currently excluded from participating in all federal health care programs. Providers and contracting entities must check each person's and entity's exclusion status before entering employment or contractual relationships.

Mandatory Exclusions

For certain offenses, OIG must impose exclusions. Mandatory exclusions are effective for a minimum of 5 years, but aggravating factors may lead to a longer or permanent exclusion. Providers and suppliers face mandatory exclusions if they're convicted of these offenses:

- Medicare or Medicaid fraud, as well as any other offenses related to delivering items or services under Medicare or Medicaid
- Criminal offenses related to patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct connected to delivering a health care item or service
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances

Permissive Exclusions

OIG may impose exclusions for offenses not under a mandatory exclusion. Permissive exclusions vary in length, and OIG may issue them for various actions, including:

- Misdemeanor health care fraud convictions other than Medicare or Medicaid fraud
- Misdemeanor convictions for the unlawful manufacture, distribution, prescription, or dispensing of controlled substances
- Health care license revocation, suspension, or surrender for reasons of professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard services
- Convictions for obstructing an investigation or audit
- Engaging in unlawful kickback arrangements
- Submitting false or fraudulent claims to a federal health care program
- Defaulting on health education loan or scholarship obligations

Exclusion: Payment Denial

An OIG exclusion means federal health care programs don't pay for items or services provided, ordered, or prescribed by an excluded person or entity. Federal health care programs also don't pay the excluded person or anyone who employs or contracts with them, including hospitals or other providers where the excluded person provides services.

The exclusion applies regardless of who submits the claims and applies to all administrative and management services that the excluded person provides.

For example, federal health care programs don't make payment:

- If a hospital employs an excluded nurse who provides items or services to federal health care program patients—even if the nurse's services aren't separately billed and paid as part of a Medicare Diagnosis-Related Group payment to the hospital
- If the excluded nurse violates their exclusion, thereby causing the hospital to submit claims for items or services they provide

During an exclusion period, the excluded person or entity may face additional penalties for submitting, or causing the submission of, claims to a federal health care program. The excluded person or entity may experience CMP liability as well as federal health care program reinstatement denial. Payment denial exceptions apply in specific situations.

Exclusion: Reinstatement

Reinstating excluded people and entities isn't automatic after the specified exclusion period ends. Those who want to participate again in all federal health care programs must apply for reinstatement and get authorized notice from OIG granting reinstatement. If OIG denies reinstatement, the excluded party is eligible to re-apply after 1 year.

Exclusion: Payment Exceptions Denial

If a patient submits claims for items or services provided, ordered, or prescribed by an excluded person or entity in any capacity after the exclusion's effective date:

- We pay the patient's first submitted claim and immediately give them notice of the exclusion
- We don't pay for patient items or services provided more than 15 days after the notice date or after the exclusion's effective date, whichever is later

The same process applies when labs or DME suppliers submit item or service claims that an excluded person or entity ordered or prescribed.

There are also exceptions for certain inpatient hospital, skilled nursing facility, home health, and emergency services.

Civil Monetary Penalties Law

The CMPL authorizes OIG to seek CMPs and sometimes exclusion for a variety of health care fraud violations. Different penalty and assessment amounts apply based on the violation. Penalties can be approximately $10,000–$100,000 per violation. CMPs may also include an assessment of up to 3 times the remuneration amount offered, paid, solicited, or obtained.

Violations that may justify CMPs include:

- Arranging for services or items from an excluded person or entity
- Failing to grant OIG timely records access
- Filing a claim you know, or should know, is for an item or service not provided as claimed or is false or fraudulent
- Filing a claim you know, or should know, is for an item or service we can't pay for
- Violating the AKS
- Violating Medicare assignment provisions
- Violating the Medicare physician agreement
- Providing false or misleading information expected to influence a discharge decision
- Failing to provide an adequate medical screening exam for patients who come to a hospital emergency department with an emergency medical condition or in labor
- Making false statements or misrepresentations on applications or contracts to participate in federal health care programs

Section 1128A(a) of the Social Security Act has more information.

CMP Inflation Adjustment

Each year, the federal government adjusts CMPs for inflation. 45 CFR 102.3 has the yearly inflation adjustments.

Medicare Fraud & Abuse Penalties

Beyond repaying us the money acquired fraudulently, Medicare fraud and abuse penalties may include exclusions, CMPs, and sometimes criminal sanctions—including fines and imprisonment—against health care providers and suppliers who violate the FCA, AKS, Physician Self-Referral Law, or Criminal Health Care Fraud Statute.

People who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000
- Imprisonment for up to 20 years

If the violations resulted in death, the person may be imprisoned for any term of years or for life.

Organizations who knowingly make a false claim may be subject to a criminal fine up to $500,000.

Physician Relationships With Payers

The U.S. health care system relies heavily on third-party payers to pay most medical bills on a patient's behalf. When the federal government covers items or services provided to Medicare and Medicaid patients, federal fraud and abuse laws apply. Many similar state fraud and abuse laws apply to care provided under state-financed programs and to private-pay patients.

Accurate Coding & Billing

Payers trust physicians to provide medically necessary, cost-effective, quality care. When a physician submits claims for services provided to a patient, they're filing a bill with the federal government and certifying that they earned the payment requested and complied with the billing requirements. If a physician knew or should have known the submitted claim was false, then the attempt to collect payment is illegal. Improper claim examples include:

- Billing codes reflecting a more severe illness than existed or a more expensive treatment than provided (upcoding)
- Billing for medically unnecessary services
- Billing for services not provided
- Billing for services performed by an improperly supervised or unqualified employee
- Billing for services performed by an employee excluded from participating in federal health care programs
- Billing for services of such low quality that they're virtually worthless
- Billing separately for services already included in a global fee, like billing an evaluation and management (E/M) service the day after surgery (unbundling)

Physician Documentation

Physicians must maintain accurate and complete medical records and documentation of the services they provide. Make sure their documentation supports the claims they submit for payment. Good documentation practices help patients get appropriate care and allow other providers to rely on physician records for patients' medical histories.

We may review patients' medical records. Good documentation helps address any challenges to the integrity of the claims. A common saying about malpractice litigation is: "If you didn't document it, it's the same as if you didn't do it." The same can be said for Medicare billing.

Accuracy of Medical Record Documentation

Find more information in:

- Evaluation and Management Services
- Complying with Medical Record Documentation Requirements
- Importance of Documentation video

Upcoding for E/M Services

We pay for many physician services using E/M codes. New patient visits generally require more time than established patient follow-up visits. We pay new patient E/M codes at higher payment rates than established patient E/M codes.

An example of E/M upcoding is misusing modifier 25, which allows additional payment for a significant, separately identifiable E/M service provided on the same day as a procedure or other service. Upcoding occurs when the provider uses modifier 25 to claim payment for:

- A medically unnecessary E/M service
- An E/M service not distinctly separate from the procedure or other service provided
- An E/M service not above and beyond the care usually associated with the procedure

Physician Relationships With Other Providers

Anytime a health care business offers you something for free or below fair market value, ask yourself, **"Why?"**

Physician Investments in Health Care Business Ventures

Some physicians who invest in health care business ventures with outside parties (for example, imaging centers, labs, equipment vendors, or physical therapy clinics) refer more patients for services provided by those parties than physicians who don't invest. These business relationships may improperly influence or distort physician decision-making and result in steering patients to a particular therapy or service source in which a physician has a financial interest.

Excessive and medically unnecessary referrals waste federal government resources and can expose patients to harm from unnecessary services. Many of these investment relationships have legal risks under the AKS and Physician Self-Referral Law.

If someone invites a physician to invest in a health care business where they might refer their patients, they should investigate the relationship thoroughly before proceeding. Physicians should ask these questions:

- Is the investment interest offered in exchange for a nominal capital contribution?
- Is the ownership share offered larger than a share of the aggregate capital contributions made to the venture?
- Is the venture promising high rates of return for little or no financial risk?
- Is the venture, or any potential business partner, offering to loan the money to make the capital contribution?
- Is the venture asking for promises or guarantees of patient referrals or ordering of items or services?
- Is it more likely that patients are referred for the items and services provided by the venture if the investment is made?
- Does the venture have sufficient capital from other sources to fund its operations?

Note: For more information on physician investments, refer to OIG Special Fraud Alerts, Bulletins, and Other Guidance.

Hospital Physician Recruitment

Hospitals and other health systems may provide a convincing physician-recruitment incentive for relocating to their geographic area, joining their medical staff, and establishing a practice to help serve a community's medical needs. Often, these recruitment efforts fill a legitimate clinical gap in a medically underserved area where attracting physicians may be difficult without financial incentives.

Some hospitals, however, may offer incentives that cross the line into an illegal arrangement with legal consequences for the physician and the hospital.

A hospital may pay you (the physician) a fair market value salary as an employee or pay you fair market value for specific services you provide to the hospital as an independent contractor. However, the hospital can't incentivize physicians to relocate their practices to its service area based on the physicians' referrals to the hospital, nor can they prevent physicians from referring patients to other providers or health systems. Hospitals can't offer you money, provide you free or below market value medical office rent, or engage in similar activities designed to influence your referral decisions. Admit patients to the hospital best suited to caring for their medical conditions or to the hospital that patients select based on their preference or insurance coverage.

Within specific Physician Self-Referral Law parameters and subject to AKS compliance, hospitals may provide relocation assistance and practice support under a properly structured recruitment arrangement to help you establish a practice in the hospital's community. If a hospital or physician practice separately or jointly recruits you as a new provider to the community, they may offer a recruitment package. You can't negotiate for benefits in exchange for any promise to admit your patients to a specific hospital or practice. Get knowledgeable legal counsel if a prospective business relationship requires this.

Physician Relationships With Vendors

Free Samples

Many drug and biologic companies provide free product samples to physicians. It's legal to give these samples to your patients free of charge, but it's illegal to sell them. The federal government prosecutes physicians for billing Medicare for free samples. If you choose to accept free samples, use reliable systems to safely store them and make sure they remain separate from commercial stock.

Industry Relationships

OIG's Compliance Program Guidance for Pharmaceutical Manufacturers has more information on distinguishing between legitimate and questionable industry relationships.

Pharmaceutical & Medical Devices

Some pharmaceutical and device companies use sham consulting agreements and other arrangements to buy physician loyalty. As a practicing physician, you may have opportunities to work as a consultant or promotional speaker for the drug or device industry. For every financial relationship offered to you, evaluate the link between the services you can provide and the compensation you'll get. Test the appropriateness of any proposed relationship by asking yourself:

- Does the company really need **my** specific expertise or input?
- Does the company's monetary compensation represent a **fair**, **appropriate**, and **commercially reasonable** exchange for my services?
- Is it possible the company is paying for **my loyalty** so I prescribe its drugs or use its products?

If the physician's contribution is their time and effort and they get fair market value compensation for their services without regard to referrals, then they may legitimately serve as a consultant. If their contribution is their ability to prescribe a drug, use a medical device, or refer patients for services or supplies, they should consider avoiding the consulting relationship as it could violate fraud and abuse laws.

Pharmaceutical & Medical Device Industries Codes of Ethics

Both the pharmaceutical industry, through the Pharmaceutical Research and Manufacturers of America (PhRMA), and the medical device industry, through the Advanced Medical Technology Association (AdvaMed), adopted codes of ethics regarding relationships with health care professionals. PhRMA Code on Interactions With Health Care Professionals and AdvaMed Code of Ethics have more information.

Physician-Industry Relationship Transparency

Although some physicians believe free lunches, subsidized trips, and gifts don't affect their medical judgment, research shows these privileges can influence prescribing practices.

Open Payments Program

The Open Payments Program highlights financial relationships among physicians, certain non-physician practitioners (NPPs), teaching hospitals, and drug and device manufacturers. Drug, device, and biologic companies must publicly report nearly all recipient gifts or payments.

The Open Payments Program requires pharmaceutical and medical device manufacturers to publicly report physician, NPP, and teaching hospital payments. We post Open Payments data by June 30 each year, including payments or other transfers of value and ownership or investment interest reports. We closely monitor this process to ensure the reported data's integrity.

Publicly available Open Payments information includes:

- Activities, like speaking engagements
- Educational materials, like textbooks or journal reprints
- Entertainment
- Gifts
- Meals
- Paid advisory board participation
- Travel expenses

Note: Medical companies make a variety of payments to hospitals and health care providers.

We don't require covered recipients to register with, or send information to, Open Payments. However, we encourage them to make sure their information is accurate by:

- Registering with the Open Payments Program and subscribing to the electronic mailing list for program updates
- Reviewing the information manufacturers and group purchasing organizations submit on their behalf
- Working with manufacturers and group purchasing organizations to settle data issues about their Open Payments profile

Conflict of Interest Disclosures

Many relationships discussed in this booklet are subject to conflict of interest disclosure policies. Even if the relationships are legal, there may be an obligation to disclose them. Rules about disclosing and managing conflicts of interest come from a variety of sources, including grant funders like states, universities, and the National Institutes of Health, and from FDA when data is submitted to support marketing approval for new drugs, devices, or biologics.

If you're uncertain whether a conflict exists, ask yourself if you would want the arrangement to appear in the news.

Continuing Medical Education

Physicians are responsible for continuing medical education (CME) to maintain state licensure, hospital privileges, and board certification. Drug and device manufacturers sponsor many educational opportunities for physicians. It's important to distinguish between educational CME sessions and marketing sessions by a drug or device manufacturer. If speakers recommend prescribing a drug when there's no FDA approval or prescribing a drug for children when FDA has approved only adult use, they must independently seek the actual data supporting these recommendations.

Note: Although physicians may prescribe drugs for off-label uses, it's illegal under the Federal Food, Drug, and Cosmetic Act for drug manufacturers to promote off-label drug use.

FDA Bad Ad Program

Promotional advertisements for drugs, biologicals, and medical devices must be truthful, not misleading, and limited to approved uses. FDA requests physicians' assistance in identifying misleading advertisements through its Bad Ad Program.

Physician Compliance Programs

Physicians treating patients should establish and follow a compliance program to help avoid fraudulent activities and submit accurate claims. These 7 components provide a solid basis for a physician practice compliance program:

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards
3. Designate a compliance officer or contact
4. Conduct appropriate training and education
5. Respond appropriately to detected offenses, and develop corrective actions
6. Develop open communication lines with employees
7. Enforce disciplinary standards through well-publicized guidelines

OIG Compliance has more information.

Medicare Anti-Fraud & -Abuse Partnerships and Agencies

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 health care quality.

Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership that includes key partners from the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations. Their goal is to identify and reduce fraud, waste, and abuse across the health care sector through collaboration, data and information sharing, and cross-payer research studies. The HFPP also performs sophisticated industry-wide analytics to detect and predict fraud schemes.

CMS

CMS is the federal agency within HHS that administers the Medicare Program, Medicaid Program, State Children's Health Insurance Program (SCHIP), Clinical Laboratory Improvement Amendments (CLIA), and other health-related programs.

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

- Accreditation organizations (AOs)
- Patients and caregivers
- Physicians, suppliers, and other health care providers
- State and federal law enforcement agencies, including OIG, the Federal Bureau of Investigation (FBI), DOJ, state Medicaid Agencies, and Medicaid Fraud Control Units (MFCUs)

To help prevent, detect, and investigate potential Medicare fraud and abuse, CMS also partners with review contractors.

Table 1. Review Contractor Efforts to Prevent, Detect & 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.
Division of Prescription Drug Audits (DPDA)	Serve as the focal point for fraud, waste, and abuse oversight of Parts C and D plans. Perform oversight of other contractors.
Medicare Administrative Contractors (MACs)	Process claims and enroll providers and suppliers.
Medicare Drug Integrity Contractors (MEDICs)	Monitor fraud, waste, and abuse in the Parts C and D Programs and prescription drug plan benefits (specific to providers, prescribers, and pharmacies).
Recovery Audit Program Recovery Audit Contractors (RACs)	Reduce improper payments by detecting and collecting overpayments and identifying underpayments.
Supplemental Medical Review Contractor (SMRC)	Perform Medicare medical review activities as directed by CMS.
Unified Program Integrity Contractors (UPICs)	Investigate potential fraud, waste, and abuse for Parts A and B, DMEPOS, and home health and hospice. Combine and integrate Medicare and Medicaid Program Integrity audit and investigation work functions into a single contract.

Center for Program Integrity

Our Center for Program Integrity (CPI) promotes Medicare integrity through audits, policy reviews, and identifying and monitoring program vulnerabilities. CPI oversees CMS collaboration with key stakeholders on detecting, deterring, monitoring, and combating fraud and abuse issues.

HHS and CMS manage 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 before payment to detect potentially suspicious claims and patterns that may constitute fraud and abuse.

The FPS is fully integrated with the Medicare FFS claims processing system and uses other data sources like the Integrated Data Repository (IDR). The IDR creates an integrated data environment from Medicare and Medicaid claims, patients, providers, Medicare Advantage (MA) plans, Part D prescription drug events, and other data.

OIG

OIG protects the integrity of HHS programs (including Medicare) and the health and welfare of the patients those programs serve. OIG operates through a nationwide network of audits, investigations, inspections, evaluations, and related functions. OIG can exclude people and entities who engaged in fraud or abuse from participating in all federal health care programs and impose CMPs for certain violations.

DOJ

DOJ investigates and prosecutes fraud and abuse in federal government programs. DOJ's investigators partner with OIG; FBI; and other federal, state, and local law enforcement offices through the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to investigate and prosecute Medicare fraud and abuse. DOJ attorneys prosecute civil and criminal cases through the U.S. Attorney's Offices.

Health Care Fraud Prevention and Enforcement Action Team

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

General Services Administration

General Services Administration (GSA) consolidated several federal procurement systems into 1 system, the System for Award Management (SAM). SAM incorporated the Excluded Parties List System and includes information on entities:

- Debarred or proposed for debarment
- Disqualified from getting certain types of federal financial and non-financial assistance and benefits
- Disqualified from getting federal contracts or certain subcontracts
- Excluded or suspended from the Medicare Program

Report Suspected Fraud

Table 2. Where Should I Report Fraud & Abuse?

I am a...	Report to...
Patient	**CMS Hotline:** Phone: 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048 **OIG Hotline:** Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY: 1-800-377-4950 Fax: 1-800-223-8164 Online: oig.hhs.gov/fraud/report-fraud Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 **Medicare Part C (Medicare Advantage) Complaints:** Refer to your plan's general contact or fraud reporting information **Medicare Part D (Prescription Drug Plans) Complaints:** 1-877-7SafeRx (1-877-772-3379)
Medicare provider or a member of the general public	**OIG Hotline:** Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY: 1-800-377-4950 Fax: 1-800-223-8164 Online: oig.hhs.gov/fraud/report-fraud Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 or Contact your MAC

Table 2. Where Should I Report Fraud & Abuse? (cont.)

I am a...	Report to...
Medicaid patient 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: oig.hhs.gov/fraud/report-fraud Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 or **Contact your Medicaid state agency:** National Association of Medicaid Fraud Control Units lists state MFCUs.

Anyone can report fraud and abuse anonymously. However, lack of contact information may prevent a comprehensive complaint review, so OIG encourages you to provide contact information for possible follow-up.

Medicare and Medicaid patients can learn more about protecting themselves and spotting fraud by contacting their local Senior Medicare Patrol program.

For questions about Medicare billing procedures, billing errors, or questionable billing practices, find your MAC's website.

Where to Go for Help

When considering a billing practice; entering a particular business venture; or pursuing employment, consulting, or another personal services relationship, evaluate the arrangement for potential compliance problems. Consider these resources to help with your evaluation:

Legal Counsel

- Experienced health care lawyers can analyze your issues and provide a legal evaluation and risk analysis of the proposed venture, relationship, or arrangement
- The bar association in your state may maintain a directory of local attorneys who practice in the health care field

Professional Organizations

- Your state or local medical society may be a good resource for issues affecting physicians and may keep listings of health care attorneys in your area
- Your specialty society may have information on more risk areas specific to your practice type

CMS

- MAC medical directors are a valuable source of information on Medicare coverage policies and appropriate billing practices
- CMS provides responses to general questions about the Physician Self-Referral Law, which can be submitted to 1877CallCenter@cms.hhs.gov

OIG

- OIG issues compliance guidance and has other resources
- OIG issues advisory opinions about the AKS, CMPL, and Exclusion Statute

What to Do If You Think You Have a Problem

If you think you're engaged in a problematic relationship or have been following billing practices you now realize are wrong:

- Immediately stop submitting problematic bills
- Seek knowledgeable legal counsel
- Determine what money you collected from patients and federal health care programs in error, and report and return overpayments
- Free yourself from any problematic investments
- Separate yourself from any suspicious relationship
- Consider using OIG's or CMS's self-disclosure protocols, as applicable

OIG Provider Self-Disclosure Protocol

Providers can voluntarily disclose potential fraud evidence through the OIG Provider Self-Disclosure Protocol. Self-disclosure helps providers minimize the costs and disruptions of a federal government-directed investigation and civil or administrative litigation.

OIG works cooperatively with transparent providers to resolve these matters. While OIG doesn't speak for DOJ or other agencies, it consults with these agencies, as appropriate, about self-disclosure issues.

Self-Referral Disclosure Protocol

CMS's Self-Referral Disclosure Protocol (SRDP) allows health care providers and suppliers to self-disclose actual or potential Physician Self-Referral Law violations, and it authorizes the Secretary of HHS to reduce the amount due and owed in overpayments arising from violating this law.

Providers and suppliers can't use the SRDP to get a CMS determination about whether an actual or potential violation of the Physician Self-Referral Law occurred or to circumvent an ongoing inquiry by another government entity. The SRDP is intended to facilitate the resolution of matters that, in the disclosing party's reasonable assessment, are actual or potential violations of the Physician Self-Referral Law. Providers and suppliers should make submissions to the SRDP in good faith with the intention of resolving their overpayment liability exposure for the conduct they identify.

In processing self-disclosures to the SRDP, we may coordinate with OIG and DOJ. We may conclude that the disclosed matter warrants a referral to law enforcement for consideration under our civil or criminal authorities. While we're authorized to settle overpayment liability for Physician Self-Referral Law violations under the SRDP, we may not provide a release to parties for violations of other laws, including the AKS and FCA, under the SRDP.

At the time we acknowledge receipt of the SRDP submission, the obligation to return the disclosed overpayment within 60 days will be suspended until a settlement agreement is entered, the provider or supplier withdraws from the SRDP, or we remove the provider or supplier from the SRDP.

A disclosing party should make a submission to the SRDP with the intention of resolving its overpayment liability exposure for the conduct it identified. We'll review the circumstances surrounding the matter disclosed to determine an appropriate resolution. In some cases, Medicare contractors may be responsible for processing any identified overpayment.

Only use the SRDP to report overpayments in Medicare Parts A and B.

Resources

- CMS Fraud Prevention Toolkit
- Eye on Oversight - The New HHS OIG Hotline
- Medicaid Integrity Program - Educational Resources
- OIG Contact Information
- OIG Fraud Information
- Physician Self-Referral
- U.S. Criminal Code