Medicare Fraud & Abuse: Prevent, Detect, Report

Introduction

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Welcome Cassie!
The Medicare Fraud & Abuse: Prevent, Detect, Report course is brought to you by the Medicare Learning Network®

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The Medicare Learning Network® (MLN) offers free educational materials for health care professionals on Centers for Medicare & Medicaid Services (CMS) programs, policies, and initiatives. Get quick access to the information you need.

- MLN Publications & Multimedia *(on the web at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts)*
- MLN Events & Training *(on the web at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Events-and-Training.html)*
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Navigating and Completing This Course

This course consists of lessons, a Post-Assessment, and an evaluation. Successfully completing this course requires:

- Completing the lessons
- Scoring 70 percent or higher on the Post-Assessment
- Completing the course evaluation

This course uses cues at various times to provide additional information and functionality. For more information on using these cues, adjusting your screen resolution, and suggested browser settings, select "HELP".

You do not have to complete this course in one session; however, you must complete at least one lesson before exiting the course. Do not click the "X" button in the upper right-hand corner of the window or the course will close without properly saving your progress. You can complete the entire course in about 90 minutes. After you successfully complete this course, you'll get instructions on how to print your certificate.

Visit the Reference page for disclaimers, a list of helpful websites, and frequently asked questions (FAQs). You may find this information useful as you go through this course.

Watch the embedded videos or read the transcripts. Information in the videos helps you meet course learning objectives.

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Welcome to the Medicare Fraud & Abuse: Prevent, Detect, Report Course!

This course educates health care professionals about how to prevent, detect, and report Medicare fraud & abuse.

Although there is no precise measure of health care fraud, those who exploit 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 beneficiaries.

The Federal government aggressively cracks down on fraud & abuse, but it needs your help. All health care professionals must do their part to prevent fraud & abuse.

Please note: The information in this course focuses on the Medicare FFS Program (also known as Original Medicare). Many of the laws discussed apply to all Federal health care programs (including Medicaid and Medicare Parts C and D). See Job Aid C *(on the web at ../009-resources/009JobAidC.html)* for information on fraud & abuse in Medicaid and Medicare Parts C and D.

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Do Your Part, Get Informed!

Committing Fraud Is Not Worth It

Medicare Trust Fund recovered approximately **$1.2 billion**

$232 million recovered in Medicaid Federal money transferred to the Treasury

The Federal government convicted **497 defendants** of health care fraud

Department of Justice (DOJ) opened **1,139 new criminal** health care fraud investigations

DOJ opened **918 new civil** health care fraud investigations

NOTE: All statistics cover FY 2018 unless otherwise noted.

Consequences

HHS OIG Criminal Actions

HHS OIG Civil Actions

2,712 Exclusions

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Course Objectives

After completing this course, you should correctly:

- Identify what Medicare considers fraud & abuse
- Identify Medicare fraud & abuse provisions and penalties
- Recognize Medicare fraud & abuse prevention methods
- Recognize entities that detect Medicare fraud & abuse
- Recognize how to report Medicare fraud & abuse

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Course Overview

This course consists of five lessons:

- **Lesson 1: Medicare Fraud & Abuse** explains fraud & abuse basics
- **Lesson 2: Medicare Fraud & Abuse Laws and Penalties** outlines the laws and sanctions used to fight fraud & abuse
- **Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors** describes methods to prevent Medicare fraud & abuse
- **Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies** identifies the entities charged with detecting Medicare fraud & abuse
- **Lesson 5: Report Suspected Medicare Fraud & Abuse** describes how to report suspected Medicare fraud & abuse, how to self-disclose violations, and the rewards available for reporting fraud & abuse

Select the "NEXT LESSON" button to return to the WBT Main Menu. Then, select "Lesson 1: Medicare Fraud & Abuse" to begin the course.

Print Disclaimer

Statutory and Regulatory Provisions
Under section 1140 of the Social Security Act (the Act), there are restrictions regarding the use of certain words, letters, emblems and symbols in connection with advertisements, solicitations or other productions. Specifically, the words "Social Security," "Social Security Account," "Social Security System," "Social Security Administration," "Medicare," "Health Care Financing Administration," "Department of Health and Human Services," "Health and Human Services," "Supplemental Security Income Program," or "Medicaid" may not be used in a manner that gives (or could give) the impression that the solicitation, advertisement or other production is endorsed, authorized, affiliated with or approved by the Centers for Medicare and Medicaid Services or by the Department of Health and Human Services.

Similarly, letters such as "SSA," "HCFA,"[1] "DHHS," "HHS," "SSI," or other combinations or variations also may not be used to imply approval or involvement by the Department of Health and Human Services or CMS. The same rules apply to the use of symbols and emblems associated with the Department of Health and Human Services or with the Centers for Medicare and Medicaid Services, such as the design of the social security card, the Medicare card, or envelopes or stationary used by either entity. State agencies or political subdivisions of state agencies are exempt from these restrictions.

Government publications are not subject to copyright law.[2] However, section 1140(a)(2)(B) of the Act prohibits the reproduction, reprinting or distribution of items consisting of forms, applications or other publications of the Social Security Administration or the Department of Health and Human Services for a fee unless specific, written authorization is obtained as prescribed by regulations published by the Commissioner of Social Security or the Secretary of the Department of Health and Human Services.[3] Violations of Section 1140 are punishable by a civil money penalty of $5,000 for each piece of advertisement, solicitation or other production, and up to $25,000 for each instance where a broadcast or telecast is used as the means of transmission for the solicitation or advertisement. See 42 C.F.R. § 1003.102(b)(7). Section 1140 is enforced by the Office of the Inspector General. It should be noted that the use of a disclaimer to inform the public that a given solicitation or advertisement is not endorsed or approved of by any governmental entity does not waive the requirements of section 1140.

Analysis
CMS information may be used in an advertisement or solicitation if certain words, letters, emblems and symbols are not used in a manner that could conceivably give the impression that the advertisement has been approved, authorized or sanctioned by either the Department of Health and Human Services or CMS. The information CMS makes public on its web site can be incorporated into another web site for without prior authorization if the commercial entity does not charge a fee for reproductions of forms, applications or other government publications. If an individual wishes to copy a CMS publication, form or application verbatim in order to sell it to the public, CMS may refuse to grant written authorization for reproduction. However, it would be permissible for an individual to retrieve information from CMS' website, incorporate or synthesize that information into his own publication, and sell the publication to the public. Arguably, CMS' website constitutes a "publication" that cannot simply be copied by an individual who wishes to sell the information.

[1]We would also expect that the initials "CMS" would be included in this list in light of the agency's new name.

[2]17 U.S.C. § 105.

[3]The Department has yet to publish regulations pursuant to subsection 1140(a)(2)(B); however, we believe that CMS has the authority to disapprove reproduction of its publications.

Medicare Fraud & Abuse: Prevent, Detect, Report

Lesson 1: Medicare Fraud & Abuse

Page 1

Lesson 1: Medicare Fraud & Abuse

This lesson introduces the basic Medicare fraud & abuse concepts and what you must know to detect it within your organization. Fraud is a crime with serious consequences, including exclusion from Federal health care programs, fines, and prison. It should take about 10 minutes to complete this lesson.

In this lesson, you'll learn about:

- Medicare fraud
- Medicare abuse

This lesson includes Medicare fraud & abuse examples.

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Lesson 1: Learning Objectives

After completing this lesson, you should correctly:

- Identify Medicare fraud basics
- Identify Medicare abuse basics
- Recognize Medicare fraud & abuse instances

Page 3

Medicare Fraud & Abuse: A Serious Problem Requiring Your Attention

Health care fraud can cost taxpayers billions of dollars. The dollars lost to Medicare fraud & abuse increase the strain on the Medicare Trust Fund. The impact of these losses and risks magnifies as Medicare continues to serve a growing number of people.

Schemes and fraudulent billing practices not only cost taxpayers, they endanger the health and welfare of beneficiaries. For example, dozens of patients got medically unnecessary cardiac pacemakers implanted because of a cardiologist-involved scam. The doctor convinced his patients to get the pacemakers by telling them they would die, even though they had a non-fatal diagnosis. Thanks to anti-fraud efforts and education, law enforcement caught and prosecuted the doctor. He was sentenced to 42 months in prison and ordered to pay over $300,000.00 in fines and restitution.

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Medicare Fraud & Abuse: A Serious Problem Requiring Your Attention (continued)

To combat fraud & abuse, you must know how to protect your organization from potential abusive practices, civil liability, and possible criminal activity. You play a vital role in protecting the integrity of the Medicare Program. Watch the video for more information.

If you are unable to access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html).*

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What is Medicare Fraud?

- Knowingly submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain a Federal health care payment (in other words, fraud includes obtaining something of value through misrepresentation or concealment of material facts)
- 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

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Examples of Medicare Fraud

Examples of actions that **may** constitute Medicare fraud include:

- Knowingly billing services not given or supplies not provided, including billing Medicare appointments patients fail to keep
- Knowingly altering claim forms, medical records, or receipts to get a higher payment
- Paying for referrals of Federal health care program beneficiaries

To learn about real cases of Medicare fraud and its consequences, select the "CASE STUDIES" button.

Fraud in Practice

Anyone can commit Medicare fraud, including people you know. Examples of fraud cases include (select an example to read more):

Fraud Example 1

A hospital paid $8 million to settle allegations it knowingly kept patients hospitalized, beyond the time considered medically necessary, to increase its Medicare payments and maintain its classification as a long-term acute care facility.

Fraud Example 2

A Durable Medical Equipment (DME) business owner served 70 months in prison and paid $1.9 million in restitution after pleading guilty to conspiracy to commit health care fraud and aggravated identity theft. The DME company owner created several different companies and submitted more than 1,500 false and fraudulent claims to Medicare for unnecessary medical equipment.

Fraud Example 3

An oncologist and his wife paid $3.1 million to resolve allegations they jointly defrauded Medicare and other Federal health care programs by overbilling medications and services and billing medications and services not provided.

Fraud Example 4

A court sentenced a home health provider to 168 months in prison for his role as one of the owners of a home health agency that submitted about $45 million in false claims to Medicare. Almost all his insulin claims billed twice-daily injections to purportedly homebound diabetic patients. The investigation revealed most patients were not homebound or insulin-dependent diabetics.

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Fraud in Practice (continued)

Medicare fraud extends beyond medical professionals. Corporations and organized crime networks commit Medicare fraud, unlawfully getting millions of Medicare Program dollars.

A major pharmaceutical manufacturer pled guilty to misbranding and paid $600 million to resolve criminal and civil liability from promoting a certain drug. Part of the settlement resolved allegations the company misled doctors about the drug's safety and success and instructed them to miscode claims to ensure Federal health care payments. The company also allegedly paid doctors kickbacks.

In another case, the government charged 73 defendants when investigators uncovered an organized crime ring's scheme that allegedly involved more than $163 million in fraudulent billings and identity theft impacting thousands of beneficiaries and doctors.

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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 medically necessary services, meeting professionally recognized standards, and charging fair prices.

Both fraud & abuse can expose providers to criminal, civil, and administrative liabilities.

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Examples of Abuse

Examples of actions that **may** constitute Medicare abuse include:

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

To learn about real Medicare abuse cases and its consequences, select the "CASE STUDIES" button.

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Program Integrity

Program Integrity includes a range of activities to target the various causes of improper payments beyond fraud & abuse. Select the vulnerability on the left to see the severity of the consequences.

MISTAKES

INEFFICIENCIES

BENDING THE RULES

INTENTIONAL DECEPTIONS

Reset Meters

NOTE: The types of improper payments are examples for educational purposes. Providers who engage in these practices may be subject to administrative, civil, or criminal liability.

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Lesson 1: Summary

- Fraud & abuse drain billions of dollars from the Medicare Program each year and put beneficiaries' health and welfare at risk by exposing them to unnecessary services, taking money away from care, and increasing costs.
- Fraud & abuse jeopardize quality health care and services and threaten the integrity of the Medicare Program by fostering the misconception that Medicare means easy money.
- Fraud & abuse cost you as a health care provider and taxpayer. Fraud & abuse result in waste and unintentionally financing criminal activities.
- Fraud includes, but is not limited to, knowingly submitting false statements or making misrepresentations of material facts to get a Federal health care payment for which no entitlement would otherwise exist.
- Abuse describes practices that, either directly or indirectly, result in unnecessary Medicare Program costs.

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Review Questions

After selecting an answer for a question, select the "SUBMIT ANSWER" button for feedback on the correct answer.

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Review Question 1

Select the correct answer.

If you knowingly submit a false statement of material fact to get a Medicare payment when no entitlement would otherwise exist for someone other than yourself, you did not commit Medicare fraud.

A. True

B. False **- CORRECT ANSWER**

RESET QUESTION

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Review Question 2

Select the correct answer.

Medicare abuse describes practices that directly or indirectly result in unnecessary Medicare Program costs.

A. True **- CORRECT ANSWER**

B. False

RESET QUESTION

Page 16

Review Question 3

Select the correct answer.

A physician regularly bills Medicare X-rays never provided to beneficiaries. This is considered Medicare ________.

A. Mistakes

B. Inefficiencies **- CORRECT ANSWER**

C. Abuse

D. Fraud **- CORRECT ANSWER**

RESET QUESTION

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You've completed Lesson 1: Medicare Fraud & Abuse.

Now that you've learned about Medicare fraud & abuse, let's look at relevant Medicare fraud & abuse laws. Lesson 2 explains provisions and penalties used to fight and punish fraud & abuse and preserve Medicare Program integrity.

Select the "NEXT LESSON" button to return to the Main Menu. Then, select "Lesson 2: Medicare Fraud & Abuse Laws and Penalties" to begin Lesson 2.

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Medicare Fraud & Abuse: Prevent, Detect, Report

Lesson 2: Medicare Fraud & Abuse Laws and Pe...

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Lesson 2: Medicare Fraud & Abuse Laws and Penalties

In this lesson, you'll learn about laws the Centers for Medicare & Medicaid Services (CMS) and its partners use to address fraud & abuse. Knowledge of fraud & abuse laws helps you partner in preventing these activities, which drains billions of dollars from the Medicare Program, endangers its integrity, drives up health care costs, and compromises beneficiary health care services. This lesson should take you about 35 minutes to complete.

In this lesson, you'll learn about:

- Federal laws governing fraud & abuse
- Penalties for fraud & abuse

Page 2

Lesson 2: Learning Objectives

After completing this lesson, you should correctly:

- Identify these fraud & abuse Federal laws:
    - Federal Civil False Claims Act (FCA)
    - Anti-K ickback Statute (AKS)
    - Physician Self-Referral Law (Stark Law)
    - Criminal Health Care Fraud Statute
    - Exclusion Statute
    - Civil Monetary Penalties Law (CMPL)
- Recognize civil and criminal fraud penalties

Use Job Aid F *(on the web at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN4649244.html)* as a resource for the laws discussed in this lesson.

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Medicare Fraud & Abuse Laws

The FCA, AKS, Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statue, Social Security Act, which includes the Exclusion Statute, and CMPL, are the main laws that address Medicare fraud & abuse and specify the criminal, civil, and administrative penalties the government imposes on those committing fraud & abuse. Violations may result in:

- Medicare-paid claims recoupment
- Civil Monetary Penalties (CMPs)
- Exclusion from Federal health care programs participation
- Criminal and civil liability

These laws prohibit Medicare Part C and Part D and Medicaid fraud & abuse.

Let's take a closer look at Medicare fraud & abuse laws.

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False Claims Act

The FCA (31 United States Code [U.S.C.] Sections 3729–3733 *(on the web at https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title31-section3731&num=0&edition=prelim)*) protects the Federal 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 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.

Example: A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than provided.

Watch the video for more information about the FCA. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html)*.

There is also a criminal FCA (18 U.S.C. Section 287 *(on the web at https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title18-section287&num=0&edition=prelim)*). Criminal penalties for submitting false claims may include prison, fines, or both.

Anti-Kickback Statute

The AKS (42 U.S.C. Section 1320a–7b(b) *(on the web at https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1320a-7b&num=0&edition=prelim)*) 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. Remuneration includes anything of value such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultations.

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

Watch the video for more information about the AKS. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html)*.

Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participating in Federal health care programs.

The Code of Federal Regulations (CFR) at 42 CFR Section 1001.952 *(on the web at https://www.ecfr.gov/cgi-bin/text-idx?SID=77c822f9ba84345d648e53df5015c3ed&mc=true&node=se42.5.1001_1952&rgn=div8)* sets the safe harbor regulations and describes various payments and business practices that may satisfy regulatory requirements and may not violate AKS. Go to the Safe Harbor Regulations *(on the web at https://oig.hhs.gov/compliance/safe-harbor-regulations)* webpage for more information.

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Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (Stark Law (42 U.S.C. Section 1395nn *(on the web at https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1395nn&num=0&edition=prelim)*) prohibits a physician from referring certain "designated health services" (for example, clinical laboratory services, physical therapy, and home health services), payable by Medicare or Medicaid, to an entity where the physician (or an immediate family member) has an ownership/investment interest or has a compensation arrangement, unless an exception applies.

Example: A provider refers a patient for a designated health service to a clinic where the physician (or an immediate family member) has an investment interest.

Watch the video for more information about the Stark Law. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html)*.

Penalties for physicians who violate the Stark Law include fines, repayment of claims, and potential exclusion from participation in Federal health care programs.

Review the Code List for Certain Designated Health Services (DHS) *(on the web at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List_of_Codes.html)* webpage and request an advisory opinion *(on the web at https://oig.hhs.gov/compliance/advisory-opinions)* if you have questions on specific scenarios.

Review the Comparison of the Anti-Kickback Statute and Stark Law *(on the web at https://oig.hhs.gov/compliance/provider-compliance-training/files/starkandakscharthandout508.pdf)* for a simplified overview of the two laws.

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Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347 *(on the web at https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title18-section1347&num=0&edition=prelim)*) prohibits **knowingly and willfully** executing, or attempting to execute, a scheme or lie about the delivery of, or payment 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) the money or property owned by, or under the custody or control of, a health care benefit program

Example: Several doctors and medical clinics conspired to defraud the Medicare Program by submitting claims for medically unnecessary power wheelchairs.

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

Now, let's review Medicare fraud & abuse penalties for violating the FCA, AKS, Stark Law, or the Criminal Fraud Statute.

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Medicare Fraud & Abuse Penalties

Beyond paying restitution to CMS for money acquired fraudulently, Medicare fraud & abuse penalties may include exclusions, CMPs, and sometimes criminal sanctions—including fines and prison—against health care providers and suppliers who violate the FCA, AKS, Physician Self-Referral Law (Stark Law), or Criminal Health Care Fraud Statute.

Now, let's look at Medicare Program exclusions and how they affect providers.

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Exclusion Statute

The Exclusion Statute (42 U.S.C. Section 1320a-7 *(on the web at https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1320a-7&num=0&edition=prelim)*) requires the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) to exclude health care providers and suppliers convicted of certain offenses from participating in Federal health care programs. OIG may also impose permissive exclusions on several other grounds.

Watch the video for more information about the Exclusion Statute. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html)*.

Visit the OIG Exclusions Program *(on the web at https://oig.hhs.gov/exclusions)* webpage for more information.

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Exclusion Statute: Referrals

Excluded providers may not participate in Federal health care programs for a designated period but may refer a patient to a non-excluded provider if the excluded provider does not furnish, order, or prescribe services for the referred patient. In this case, the non-excluded provider must treat the patient and independently bill Federal health care programs for items or services provided. Covered items or services from a non-excluded provider to a Federal health care program beneficiary are payable, even when an excluded provider referred the patient.

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Mandatory Exclusions

For certain offenses, the OIG **must** impose an exclusion. Mandatory exclusions stay in effect for a minimum of 5 years; however, aggravating factors may lead to an even longer or permanent exclusion. Providers and suppliers face mandatory exclusions if convicted of these offenses:

- Medicare or Medicaid fraud and criminal offenses related to the delivery of items or services under a Federal or State health care program
- 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 the delivery of a health care item or service
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances

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Permissive Exclusions

The OIG may impose exclusions for offenses not under a mandatory exclusion. Permissive exclusions vary in length.

The OIG may issue permissive exclusions for various actions. Some examples include:

- Misdemeanor health care fraud convictions other than Medicare or Medicaid fraud
- Misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances
- Revocation, suspension, or health care license surrender for reasons of professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard service
- Convictions for obstructing an investigation or audit
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

For a complete list of permissive exclusions, review 42 U.S.C. Section 1320a-7 *(on the web at https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1320a-7&num=0&edition=prelim).*

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OIG List of Excluded Individuals/Entities

The OIG List of Excluded Individuals/Entities (LEIE) publicly lists individuals and entities currently excluded from participation in all Federal health care programs. Providers and contracting entities must check the program exclusion status of individuals and entities in the LEIE before entering employment or contractual relationships.

Health care providers that knowingly hire an excluded party are subject to potential FCA liability and CMPs. Medicare will not pay for services by an excluded party, with certain exceptions. Prior to hiring an individual, purchasing supplies, or contracting with an entity (and periodically thereafter), health care providers should use the OIG LEIE to check program exclusion status.

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Search the List of Excluded Individuals/Entities

The LEIE is accessible through a searchable online database. It identifies parties excluded from Medicare reimbursement. The list includes information about the provider's specialty, exclusion type, and exclusion date. Watch the video for tips on searching the LEIE.

Watch the video for information on searching the LEIE. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html)*.

Access the LEIE *(on the web at https://oig.hhs.gov/exclusions)* on the OIG website.

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General Services Administration's System for Award Management

The General Services Administration (GSA) consolidated several Federal procurement systems into one new system—the System for Award Management (SAM) *(on the web at https://www.sam.gov/)*. SAM incorporated the Excluded Parties List System (EPLS) and includes information on entities:

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

OIG compliance guidance encourages health care providers to check the SAM prior to hiring an individual, purchasing durable medical equipment (DME), supplies, or contracting with an entity (and periodically thereafter). Read the GSA fact sheet How do I search for an exclusion? *(on the web at https://www.fws.gov/northeast/refuges/agreements/Documents/SAM_Exclusions_how_do_i_search_exclusions.pdf)* for detailed instructions.

Remember, health care providers should check the LEIE and the SAM before making employment and contract decisions. You cannot get Federal payment or compensation for services provided by individuals and organizations listed on the LEIE and the SAM.

Now, let's look closer at the exclusion payment denial.

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Exclusion: Denial of Payment

An OIG exclusion means Federal health care programs do **not** pay for items or services given, ordered, or prescribed by an excluded individual or entity. Federal health care programs also make no payment to the excluded individual, anyone who employs or contracts with the excluded individual, and a hospital or other provider where the excluded individual provides services.

The exclusion applies **regardless** of who submits the claims for payment and applies to all administrative and management services given by the excluded individual.

For example, Federal health care programs do not make payment if:

- A hospital employs an excluded nurse who provides items or services to Federal health care program beneficiaries, even if the nurse's services are not separately billed and are paid as part of a Medicare diagnosis-related group payment the hospital gets
- 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 individual or entity may face additional penalties for submitting or causing the submission of claims to a Federal health care program. The excluded individual or entity is susceptible to CMP liability as well as reinstatement denial to the Federal health care programs, including Medicare. Exceptions to payment denial apply in specific situations.

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Exclusion: Denial of Payment Exceptions

If a beneficiary submits claims for items or services given, ordered, or prescribed by an excluded individual or entity in any capacity after the effective date of the exclusion:

- Medicare pays the first claim submitted by the beneficiary and immediately gives the beneficiary notice of the exclusion
- Medicare makes no payment for the beneficiary items or services given more than 15 days after the date of the notice or after the effective date of the exclusion, whichever is later

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

There are also exceptions for certain inpatient hospital, skilled nursing facility, home health, and emergency services detailed in the Medicare Program Integrity Manual, Chapter 4 *(on the web at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf)*, Section 4.19.2.6.

Page 18

Exclusion: Reinstatement

Reinstating excluded entities and individuals is not automatic once the specified exclusion period ends. Those who want to participate in all Federal health care programs must apply for reinstatement and get authorized notice from the OIG they granted reinstatement. If the OIG denies reinstatement, the excluded party is eligible to re-apply after 1 year.

Now, let's look at CMPs.

Page 19

Civil Monetary Penalties

CMPs apply to a variety of health care fraud violations, and assessment of the CMP depends on the type of violation. The CMP authorizes penalties up to $100,000 (in 2018) per violation, and assessments 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. Violations that justify CMPs include:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or is false and fraudulent
- Violating the AKS
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs

Watch the video for an example of where CMPs applied in a kickback scheme. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html)*.

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 *(on the web at https://www.ecfr.gov/cgi-bin/text-idx?SID=78a3e90ced07ef07cb7593828bfa1cb8&mc=true&node=pt45.1.102&rgn=div5#se45.1.102_13)* for the yearly inflation adjustments.

Now, let's look at civil prosecutions and penalties.

Civil Prosecutions and Penalties

Depending on the severity of the violation, a civil suit or settlement may include any combination of the following:

Civil Prosecutions and Penalties - Example 1

A CMP for each item or service in non-compliance (or higher amounts where applicable by statute)

Civil Prosecutions and Penalties - Example 2

Payment up to 3 times the amount claimed for each item or service instead of damages sustained by the Federal government

Civil Prosecutions and Penalties - Example 3

Exclusion from all Federal health care programs for a specified period

Civil Prosecutions and Penalties - Example 4

An OIG Corporate Integrity Agreement (CIA), which requires an individual or entity to carry out a compliance program (including, for example, hiring a compliance officer, developing written standards and policies, carrying out an employee training program, and conducting annual audits and reviews)

In addition to civil prosecutions and penalties, law enforcement may prosecute health care fraud and pursue criminal convictions. Under the Affordable Care Act, the U.S. Sentencing Commission may add offense levels for health care fraud crimes with more than $1 million in losses. It is also a crime to obstruct fraud investigations.

Stay updated on the latest enforcement actions on the OIG Criminal and Civil Enforcement *(on the web at https://oig.hhs.gov/fraud/enforcement/criminal)* webpage.

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Lesson 2: Summary

- The FCA, AKS, Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statute, the Social Security Act which includes, the Exclusion Statute, and the CMPLs, are the main Federal laws that address Medicare fraud & abuse. Select a law to read more.

FCA

The FCA imposes civil liability on a 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.

Anti-Kickback Statute

The AKS prohibits knowingly and willfully offering, paying, soliciting, or getting remuneration in exchange for Federal health care program business referrals.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (Stark Law) prohibits physicians from referring Medicare beneficiaries for designated health services to an entity where the physician (or an immediate family member) has an ownership/investment interest or a compensation arrangement, unless an exception applies.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie for delivering, or paying for, health care benefits, items, or services to defraud a health care benefit program, or to get (by means of false or fraudulent pretenses, representations, or promises) the money or property owned by, or under the custody or control of, a health care benefit program.

Exclusion Statute

The Exclusion Statute prohibits the excluded individual or entity from participating in all Federal health care programs. The exclusion means no Federal health care program pays for items or services given, ordered, or prescribed by an excluded individual or entity.

Civil Monetary Penalties (CMPs)

CMPs apply to a variety of conduct violations, and assessing the CMP amount depends on the violation. Penalties up to $100,000 (in 2018) per violation may apply. CMPs may also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount offered, paid, solicited, or got.

- Providers and contracting entities must check for program exclusion status prior to entering employment or contractual relationships using the OIG LEIE. OIG recommends checking SAM as well.
- Civil and criminal prosecutions can result in a variety of fines, exclusion, CIAs, and even prison in criminal cases.

Page 22

Review Questions

After selecting an answer for a question, select the "SUBMIT ANSWER" button for feedback on the correct answer.

Page 23

Review Question 1

Select the correct answer.

The Federal fraud & abuse laws are the False Claims Act (FCA), the Anti-Kickback Statute, the Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statute, Social Security Act, and the Civil Monetary Penalties Law (CMPL).

A. True **- CORRECT ANSWER**

B. False

RESET QUESTION

Page 24

Review Question 2

Select the correct answer.

Which of the following is **NOT** a possible penalty for Medicare fraud or abuse?

A. Exclusion from participating in all Federal health care programs

B. Imprisonment in criminal cases

C. Civil Monetary Penalties (CMPs) up to $500,000 per violation **- CORRECT ANSWER**

RESET QUESTION

Page 25

You've completed Lesson 2: Medicare Fraud & Abuse Laws and Penalties.

Now that you've learned about Medicare fraud & abuse basic laws and penalties, let's look at preventing Medicare fraud & abuse.

Select the "NEXT LESSON" button to return to the Main Menu. Then, select "Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors" to begin Lesson 3.

Print Disclaimer

Statutory and Regulatory Provisions
Under section 1140 of the Social Security Act (the Act), there are restrictions regarding the use of certain words, letters, emblems and symbols in connection with advertisements, solicitations or other productions. Specifically, the words "Social Security," "Social Security Account," "Social Security System," "Social Security Administration," "Medicare," "Health Care Financing Administration," "Department of Health and Human Services," "Health and Human Services," "Supplemental Security Income Program," or "Medicaid" may not be used in a manner that gives (or could give) the impression that the solicitation, advertisement or other production is endorsed, authorized, affiliated with or approved by the Centers for Medicare and Medicaid Services or by the Department of Health and Human Services.

Similarly, letters such as "SSA," "HCFA,"[1] "DHHS," "HHS," "SSI," or other combinations or variations also may not be used to imply approval or involvement by the Department of Health and Human Services or CMS. The same rules apply to the use of symbols and emblems associated with the Department of Health and Human Services or with the Centers for Medicare and Medicaid Services, such as the design of the social security card, the Medicare card, or envelopes or stationary used by either entity. State agencies or political subdivisions of state agencies are exempt from these restrictions.

Government publications are not subject to copyright law.[2] However, section 1140(a)(2)(B) of the Act prohibits the reproduction, reprinting or distribution of items consisting of forms, applications or other publications of the Social Security Administration or the Department of Health and Human Services for a fee unless specific, written authorization is obtained as prescribed by regulations published by the Commissioner of Social Security or the Secretary of the Department of Health and Human Services.[3] Violations of Section 1140 are punishable by a civil money penalty of $5,000 for each piece of advertisement, solicitation or other production, and up to $25,000 for each instance where a broadcast or telecast is used as the means of transmission for the solicitation or advertisement. See 42 C.F.R. § 1003.102(b)(7). Section 1140 is enforced by the Office of the Inspector General. It should be noted that the use of a disclaimer to inform the public that a given solicitation or advertisement is not endorsed or approved of by any governmental entity does not waive the requirements of section 1140.

Analysis
CMS information may be used in an advertisement or solicitation if certain words, letters, emblems and symbols are not used in a manner that could conceivably give the impression that the advertisement has been approved, authorized or sanctioned by either the Department of Health and Human Services or CMS. The information CMS makes public on its web site can be incorporated into another web site for without prior authorization if the commercial entity does not charge a fee for reproductions of forms, applications or other government publications. If an individual wishes to copy a CMS publication, form or application verbatim in order to sell it to the public, CMS may refuse to grant written authorization for reproduction. However, it would be permissible for an individual to retrieve information from CMS' website, incorporate or synthesize that information into his own publication, and sell the publication to the public. Arguably, CMS' website constitutes a "publication" that cannot simply be copied by an individual who wishes to sell the information.

[1]We would also expect that the initials "CMS" would be included in this list in light of the agency's new name.

[2]17 U.S.C. § 105.

[3]The Department has yet to publish regulations pursuant to subsection 1140(a)(2)(B); however, we believe that CMS has the authority to disapprove reproduction of its publications.

Medicare Fraud & Abuse: Prevent, Detect, Report

Lesson 3: Physician Relationships with Payers, ...

Page 1

Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors

In this lesson, you'll learn how physician relationships with payers, other providers, and vendors can prevent Medicare fraud & abuse. It should take about 15 minutes to complete.

In this lesson, you'll learn about:

- How you can help prevent Medicare fraud & abuse
- How compliance with Medicare laws, regulations, and policies prevent fraud & abuse
- Continuing education available on Medicare laws, regulations, and polices about fraud & abuse prevention

Page 2

Lesson 3: Learning Objectives

After completing this lesson, you should correctly:

- Identify ways your relationships with payers, other providers, and vendors prevent fraud & abuse
- Identify ways to comply with Medicare laws, regulations, and policies to prevent fraud & abuse
- Identify continuing education available on Medicare laws, regulations, and policies

Page 3

Physician Relationships with Payers, Other Providers, and Vendors

The U.S. health care system relies on third party payers to pay most medical bills on behalf of patients. These payers understand Federal fraud & abuse laws apply when the government covers items or services provided to Medicare and Medicaid beneficiaries. This lesson focuses on:

- Physician Relationships with Payers
- Physician Relationships with Other Providers
- Physician Relationships with Vendors
- Continuing Medical Education on Medicare laws, regulations, and policies

Page 4

You Can Help Prevent Medicare Fraud & Abuse

As a health care provider, you play a vital role in the fight against Medicare fraud & abuse. Help prevent Medicare fraud & abuse by:

- Checking the List of Excluded Individuals/Entities (LEIE) and System for Award Management (SAM) before making hiring and contracting decisions
- Providing only medically necessary, high quality Medicare beneficiary
- Accurately coding and billing Medicare services
- Maintaining accurate and complete Medicare beneficiary medical records
- Understanding and complying with the Anti-Kickback Statute and Physician Self-Referral Law (Stark Law) when making investments or doing business with vendors

Page 5

You Can Help Prevent Medicare Fraud & Abuse (continued)

Fraud & abuse also exist in Medicare Part C, Part D, and Medicaid, especially involving "dual eligibles."

Watch the video, which focuses on fraud in Medicare Part D. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html)*.

For more information, see Job Aid C *(on the web at ../009-resources/009JobAidC.html)* and Job Aid D *(on the web at ../009-resources/009JobAidD.html)*.

Now let's look at physicians' relationships with payers related to accurate coding, billing, documentation, investments, and physician recruitment.

Page 6

Accurate Coding and Billing

As a physician, payers trust you to provide medically necessary, cost-effective, quality care. When you submit claims for Medicare services, you certify you earned the payment and complied with billing requirements. If you knew, or should have known, you submitted a false claim, this is an illegal attempt to collect payment.

Examples of improper claims include:

- Examples of improper claims include:
- Billing medically unnecessary services
- Billing services not provided
- Billing services performed by an improperly supervised or unqualified employee
- Billing services performed by an employee excluded from participation in Federal health care programs
- Billing services of such low quality they are 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

Page 7

Physician Documentation

Maintain accurate and complete records of the services you provide. Make sure your documentation supports your claims for payment. Good documentation practices help ensure your patients get appropriate care and allow other providers to rely on your records for patients' medical histories.

The Medicare Program may review beneficiaries' medical records. Good documentation helps address any challenges raised about the integrity of your claims. You may have heard the saying regarding malpractice litigation: "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.

Page 8

Physician Documentation (continued)

Medicare pays for many physician services using E/M codes. These codes identify the level of service and pay new patient codes at a higher level than established patients. Billing an established patient follow-up visit using a higher-level E/M code is upcoding.

Another 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 of a procedure or other service. Upcoding occurs when a provider uses modifier –25 to claim payment for a medically unnecessary E/M service, an E/M service not distinctly separate from the procedure provided, or an E/M service not above and beyond the care usually associated with the procedure.

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Page 9

Physician Investments in Health Care Business Ventures

Some physicians who invest in business ventures with outside parties (for instance, imaging centers, laboratories, equipment vendors, or physical therapy clinics) refer more patients for services provided by those parties than physicians who do not invest. These business relationships may improperly influence or distort physician decision-making and result in improper patient-steering to a therapy or service where a physician has a financial interest.

Excessive and medically unnecessary referrals waste Federal government resources and can expose Medicare beneficiaries to harmful, unnecessary services. Many of these investment relationships have legal risks under the AKS and Stark Law.

If a health care business invites you to invest and might be a place where you would refer your patient, investigate the relationship thoroughly before proceeding.

Page 10

Physician Recruitment

Hospitals and other health systems may provide a physician-recruitment incentive to induce providers or practices to join their medical staff. Often, such 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 which cross the line into an illegal arrangement with legal consequences for the provider and the hospital.

A hospital may pay a provider a fair market-value salary as an employee or pay them a fair market value for specific services they provide to the hospital as an independent contractor. The hospital may **not** offer money, free or below-market rent for a medical office, or engage in similar activities designed to influence referral decisions.

Now let's look at physician relationships with vendors related to transparency and conflict of interest.

Page 11

Physician Relationships with Vendors

Many drug and biologic companies provide free product samples to physicians. It is legal to give these samples to patients free of charge, but it is illegal to sell the samples. The Federal government prosecutes physicians for billing Medicare for free samples. Implement reliable systems to safely store free samples and ensure they remain separate from your commercial stock.

Some pharmaceutical and device companies use sham consulting agreements and other arrangements to buy physician loyalty. If you have opportunities to work as a consultant for the drug or device industry, evaluate the link between the services you provide and the compensation you get. Test the appropriateness of any proposed relationship by asking yourself:

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

Page 12

Federal Open Payments Program

The Federal Open Payments Program is a national disclosure program that promotes healthcare transparency by making financial relationships between health care providers and drug and medical device companies available to the public. The Open Payments data includes payments and other transfers of value such as gifts, honoraria, consulting fees, research grants, travel reimbursements, and other payments drug or device companies provide to physicians and teaching hospitals. The data also includes ownership and investment interests held by physicians or their immediate family members in reporting entities.

Data from a given year must be reported by drug and device companies by March 31 of the following year. CMS posts Open Payments data on or by June 30 each year. The public data is accessible via the Open Payments Search Tool *(on the web at https://openpaymentsdata.cms.gov/)*. CMS closely monitors this process to ensure reported data integrity.

Visit Open Payments *(on the web at https://www.cms.gov/OpenPayments)* for more information.

Page 13

Conflict-of-Interest Disclosures

Rules about disclosing and managing conflicts of interest come from a variety of sources, including grant funders, such as States, universities, and the National Institutes of Health (NIH), and from the U.S. Food and Drug Administration (FDA) when you submit data to support marketing approval for new drugs, devices, or biologics.

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

Page 14

Education on Medicare Laws, Regulations, and Policies

The Medicare Learning Network® (MLN) offers a variety of health care training and educational materials explaining Medicare policy. The MLN delivers planned and coordinated provider education through various media, including MLN Matters® Articles, fact sheets and booklets, web-based training courses, videos, and podcasts. Visit the MLN *(on the web at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo)* or the MLN Catalog *(on the web at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf)* for a list of educational products.

The MLN Provider Compliance *(on the web at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html)* webpage contains educational products informing Medicare Fee-For-Service (FFS) Providers how to avoid common Medicare Program billing errors and other improper activities.

The OIG Compliance *(on the web at https://oig.hhs.gov/compliance)* webpage provides education, compliance guidance, advisory opinions, and training resources.

Medicare Administrative Contractor (MAC *(on the web at https://go.cms.gov/MAC-website-list)*) Provider Outreach and Education (POE) Programs offer providers and suppliers education on the fundamentals of the Medicare Program.

Page 15

Lesson 3: Summary

You play a vital role in detecting fraud. Your actions can help protect the Medicare Trust Fund. Be sure to review:

- Your relationships with payers related to accurate coding, billing, and documentation
- Your relationships with other providers related to investments and recruitment
- Your relationships with vendors related to transparency and conflict of interest
- Training available related to Medicare laws, regulations, and policies

Page 16

Review Questions

After selecting an answer for a question, select the "SUBMIT ANSWER" button for feedback on the correct answer.

Page 17

Review Question 1

Select the correct answer.

You can help prevent Medicare fraud & abuse by _______.

A. Providing only medically necessary, high quality services to Medicare beneficiaries

B. Properly documenting all services provided to Medicare beneficiaries

C. Correctly billing and coding services provided to Medicare beneficiaries

D. All of the above **- CORRECT ANSWER**

RESET QUESTION

Page 18

Review Question 2

Select the correct answer.

The Medicare Learning Network® provides a variety of ________ for health care professionals.

A. Coding Rules

B. Training and educational products **- CORRECT ANSWER**

C. Regulations

D. Enrollment forms

RESET QUESTION

Page 19

You've completed Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors.

Now that you've learned how your relationships with payers, other providers, and vendors prevent fraud & abuse, let's look at Medicare anti-fraud partnerships and agencies.

Select the "NEXT LESSON" button to return to the Main Menu. Then, select "Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies" to begin Lesson 4.

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Medicare Fraud & Abuse: Prevent, Detect, Report

Lesson 4: Medicare Anti-Fraud and Abuse Partn...

Page 1

Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies

In this lesson, you'll learn about the entities and methods used to detect fraud & abuse. It should take about 15 minutes to complete this lesson.

In this lesson, you will learn about:

- Efforts by the Centers for Medicare & Medicaid Services (CMS) to detect fraud & abuse in the Medicare program
- Data analysis, the Fraud Prevention System (FPS), and the Integrated Data Repository (IDR)
- Entities that conduct pre-payment and/or post-payment claims review to detect Medicare fraud & abuse
- Entities that investigate suspected Medicare fraud & abuse

Page 2

Lesson 4: Learning Objectives

After completing this lesson, you should correctly:

- Recognize efforts by CMS to detect fraud & abuse in the Medicare program
- Recognize entities conducting pre-payment and/or post-payment claims review
- Recognize entities investigating suspected Medicare fraud & abuse

Page 3

Health Care Fraud Prevention Partnership

The Health Care Fraud Prevention Partnership *(on the web at https://hfpp.cms.gov/)* (HFPP) is a voluntary, public-private partnership including 132 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.

Page 4

The Centers for Medicare & Medicaid Services

CMS *(on the web at https://www.cms.gov/)* is the Federal agency within the Department of Health and Human Services (HHS) that administers the Medicare and Medicaid programs. To prevent fraud & abuse, CMS works with individuals, entities, and law enforcement agencies, including:

- Accreditation Organizations
- Medicare beneficiaries and caregivers
- Physicians, suppliers, and other health care providers
- Office of Inspector General (OIG)
- Federal Bureau of Investigation (FBI)
- Contractors

Let's review the contractors that assist with CMS efforts to prevent and detect fraud.

Page 5

Claim-Reviewing Entities

CMS authorizes several different contractors to conduct pre-payment and/or post-payment reviews of claims. These include:

- Comprehensive Error Rate Testing (CERT) Contractors
- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractors (UPICs)

If one of these entities contacts you, respond within the specified timeframe and with all requested documentation supporting the claim service(s) medical necessity. This ensures accurate payment of the claim(s) under review and prevents payment recoupment for claims correctly paid. Contact your MAC *(on the web at http://go.cms.gov/MAC-website-list)* to find contact information for your review contractors.

Page 6

Comprehensive Error Rate Testing Program

The CERT Program *(on the web at https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/cert)* produces a national Medicare Fee-For-Service (FFS) error rate. CERT randomly selects a statistically valid, random sample of Medicare FFS claims and reviews those claims' and related medical records' compliance with Medicare coverage, payment, coding, and billing rules.

To accurately measure the MACs' performance and gain insight into error causes, CMS calculates a national Medicare FFS paid claims error rate and an improper payment rate by claim type and publishes the results of these reviews annually. For example, here are the improper payment rate and projected improper payment amounts by claim type for Fiscal Year (FY) 2018. If you see your provider type on this list, refer to Job Aid D *(on the web at ../009-resources/009JobAidD.html)* for tips on avoiding fraud & abuse.

Service Type	Improper Payment Rate	Improper Payment Amo unt
Inpatient Hospitals	4.29%	$4.96B
Durable Medical Equipme nt	35.54%	$2.59B
Physician/Lab/Ambulance	10.68%	$10.47B
Non-Inpatient Hospital Fa cilities	8.07%	$13.60B
Overall	8.12%	$31.62B

Page 7

CERT Program FFS Improper Payment Rate

The Medicare FFS Improper Payment Rate is a good indicator of how Medicare FFS claims errors impact the Medicare Trust Fund. CMS and MACs educate providers and suppliers on CERT-identified high-risk areas.

For more information, visit the CERT Documentation Contractor *(on the web at https://certprovider.admedcorp.com/)* website. The CERT Outreach and Education Task Force *(on the web at https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-Outreach-and-Education-Task-Force.html)* provides consistent, accurate provider outreach and education to help reduce the improper payment rate.

Page 8

Medicare Administrative Contractors

CMS, MACs, and other claim review contractors identify suspected billing problems through error rates produced by the CERT Program, vulnerabilities identified through the Recovery Audit Program, analysis of claims data, and evaluation of other information (for example, complaints).

CMS, MACs, and other claim review contractors target Medical Review (MR) activities on problem areas based on the severity of the problem. The SMRC conducts nationwide MR as directed by CMS. This includes identifying underpayments and overpayments.

MR may occur before or after the MAC makes a payment on the claim. MACs may review one or multiple claims at the same time.

Some providers may go through probed reviews or placed on Progressive Corrective Action (PCA) plans depending on the extent of their billing errors.

Page 9

Medicare FFS Recovery Audit Program

Medicare FFS Recovery Audit Contractors (RACs) conduct post-payment claim reviews to detect improper underpayments and overpayments. RACs may target claim reviews by service. Each RAC website publishes its targeted services. Visit the Recovery Audit Program *(on the web at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program)* webpage for more information, including Medicare Parts A and B Recovery Auditors contact information.

Also review the Quarterly Provider Compliance Newsletter *(on the web at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyCompNL_Archive.pdf)* for common Medicare FFS Recovery Audit and CERT findings and tips for avoiding issues.

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Parts C and D Recovery Audit Program

CMS created the Parts C and D Recovery Audit Program to identify and correct past improper payments to Medicare providers. CMS also implemented procedures to help MACs prevent future improper payments. Communication about audit results and trends leads to continuous process improvement, more accurate payments, and helps plan sponsors correct issues in a timely manner.

CMS designated one Recovery Auditor to review payments for Medicare Part D. CMS will start the Recovery Audit Program for Medicare Part C payments in the future. Visit the Parts C and D Recovery Audit Program *(on the web at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d)* webpage for more information.

Now that you've learned about the entities that review claims, let's discuss entities that provide analytical support to CMS to detect fraud & abuse activities.

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Analytical Entities

Within CMS, the Center for Program Integrity *(on the web at https://www.cms.gov/About-CMS/Components/CPI/CPI-Landing.html)* (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 & abuse issues.

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

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Fraud Prevention System

The FPS uses sophisticated analytics to prevent and detect fraud & abuse in the Medicare FFS Program. It provides a comprehensive view of Medicare FFS provider and beneficiary activities to identify and analyze provider networks, billing patterns, beneficiary usage patterns, and patterns representing a high risk of fraudulent activity.

Examples of these fraudulent activities include:

- A home health agency in Florida billed services never provided. Due to the FPS, CMS placed the home health agency on pre-payment review and payment suspension, referred the agency to law enforcement, and ultimately revoked the agency's Medicare enrollment.
- In Texas, the FPS identified an ambulance company submitting claims for non-covered services and services not given. Medicare revoked the ambulance company's enrollment.
- The FPS identified an Arizona medical clinic with questionable billing practices, such as billing excessive units of service per beneficiary per visit. The physicians delivered repeated and unnecessary neuropathy treatments to beneficiaries. CMS revoked the medical clinic's Medicare enrollment.

The FPS is fully integrated with the Medicare FFS claims processing system and uses other data sources, such as the Integrated Data Repository (IDR).

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Integrated Data Repository

The IDR creates an integrated data environment from Medicare and Medicaid claims, beneficiaries, providers, Medicare Advantage (MA) plans, Part D Prescription Drug Events (PDEs), and other data.

The IDR provides greater information sharing, broader and easier access, enhanced data integration, increased security and privacy, and strengthened query and analytic capability by building a unified data repository for reporting and analytics.

Now let's review the entities that help CMS investigate fraud & abuse activities.

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Investigating Entities

The following entities review claims **and** more extensively investigate specific health care providers:

- UPICs
- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Federal Bureau of Investigation (FBI)

These entities work with the claim reviewing entities and CMS to protect the Medicare Program against fraud & abuse.

Medicare Advantage (MA) plans also investigate Medicare Part C fraud & abuse. Prescription Drug Plans (PDPs) investigate Medicare Part D fraud & abuse. Medicare Drug Integrity Contractors (MEDICs) investigate Medicare Part C and Part D fraud & abuse.

Page 15

Unified Program Integrity Contractors

UPICs identify suspected fraud & abuse cases and refer them to the OIG. UPICs may also act to minimize potential losses to the Medicare Trust Fund and protect Medicare beneficiaries from potential adverse effects. Appropriate action varies from case to case. For example, when a provider's employee files a complaint, the UPIC immediately advises the OIG.

For more information, go to the Medicare Program Integrity Manual, Chapter 4 *(on the web at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf)*.

Page 16

Office of Inspector General

The OIG *(on the web at https://oig.hhs.gov/)* 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 OIG can exclude individuals and entities who engaged in fraud or abuse from participation in all Federal health care programs and impose Civil Monetary Penalties (CMPs) for certain Federal health care program misconduct.

Watch the video for a snapshot of the OIG's work. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html)*.

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Department of Justice

The DOJ investigates and prosecutes fraud & abuse in Federal government programs. The DOJ's investigators partner with the OIG; the FBI; and other Federal, State, and local law enforcement offices through HEAT to investigate and prosecute Medicare fraud & abuse. DOJ attorneys, through the U.S. Attorney's Offices, handle the civil and criminal prosecutions

Page 18

Health Care Fraud Prevention and Enforcement Action Team

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 & abuse. HEAT investigators use new state-of-the-art technology to fight fraud with unprecedented speed and efficiency.

Page 19

Medicare Fraud Strike Force

The DOJ-HHS Medicare Fraud Strike Force also fights fraud. Each Medicare Fraud Strike Force team combines the FBI's investigative and analytical resources with HHS-OIG's Criminal Division's Fraud Section and the U.S. Attorney's Offices prosecutorial resources.

Page 20

Lesson 4: Summary

- Medicare fraud & abuse data helps guide claims reviewers and investigators to high-risk fraud & abuse areas.
- MACs and UPICs conduct pre-payment claims reviews.
- MACs, the SMRC, UPICs, CERT Contractors, and RAC Auditors conduct post-payment claims reviews.
- UPICs, OIG, DOJ, and HEAT investigate Medicare fraud & abuse.

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Review Questions

After selecting an answer for a question, select the "SUBMIT ANSWER" button for feedback on the correct answer.

Page 22

Review Question 1

Select the correct answer.

Which of the following entities conduct claims Medical Review (MR)?

A. Medicare Administrative Contractors (MACs)

B. Comprehensive Error Rate Testing (CERT) Contractors

C. Recovery Audit Program Recovery Auditors

D. All of the above **- CORRECT ANSWER**

RESET QUESTION

Page 23

Review Question 2

Select the correct answer.

Which of the following entities investigate health care providers suspected of Medicare fraud & abuse?

A. Office of Inspector General (OIG)

B. Department of Justice (DOJ)

C. Unified Program Integrity Contractors (UPICs)

D. B and C

E. A, B, and C - **CORRECT ANSWER**

RESET QUESTION

Page 24

You've completed Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies.

Now that you've learned about the basic concepts of Medicare fraud & abuse detection, let's look at how to report Medicare fraud & abuse.

Select the "NEXT LESSON" button to return to the Main Menu. Then, select "Lesson 5: Report Suspected Medicare Fraud & Abuse" to begin Lesson 5.

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Analysis

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Medicare Fraud & Abuse: Prevent, Detect, Report

Lesson 5: Report Suspected Medicare Fraud & A...

Page 1

Lesson 5: Report Suspected Medicare Fraud & Abuse

In this lesson, you'll learn about reporting fraud & abuse. It should take about 5 minutes to complete.

In this lesson, you'll learn about:

- How you can report suspected Medicare fraud & abuse
- How you can self-disclose Medicare fraud & abuse
- The Medicare Incentive Reward Program (IRP)

Page 2

Lesson 5: Learning Objectives

After completing this lesson, you should correctly:

- Recognize how to report suspected Medicare fraud & abuse
- Recognize how to self-disclose Medicare fraud & abuse

Page 3

How to Report Suspected Medicare Fraud & Abuse: OIG

The Office of Inspector General (OIG) maintains a hotline and webpage that accepts and reviews tips from all sources, such as Medicare and Medicaid beneficiaries and providers. You can report suspected fraud & abuse anonymously by phone (OIG Hotline), email, fax, mail, and on the OIG website. The OIG collects no information that could trace the complaint to you; however, lack of contact information may prevent a comprehensive review of the complaint. OIG encourages you to provide contact information for follow-up.

Watch this video for more information. If you cannot access the video, read the transcript in Job Aid G *(on the web at ../009-resources/009JobAidG.html).*

Use Job Aid E *(on the web at ../009-resources/009JobAidE.html)* to report fraud & abuse to the appropriate authorities.

Page 4

How to Report Suspected Medicare Fraud & Abuse: MAC

For questions about Medicare billing procedures, billing errors, or questionable billing practices, contact your Medicare Administrative Contractor *(on the web at http://go.cms.gov/MAC-website-list)* (MAC).

Page 5

What to do if you Suspect you have Problematic Relationships or Inappropriate Billing Practices:

- Stop submitting problematic bills
- Seek legal counsel
- Determine money collected in error from patients and from Federal health care programs and report and return refunds
- Cease involvement in a problematic investment
- Get out of the problematic relationship(s)
- Consider self-disclosing the issues

Page 6

How to Self-Disclose Medicare Fraud & Abuse to the OIG

Providers who wish to voluntarily disclose evidence of potential fraud, where it may trigger Civil Monetary Penalties (CMPs), may do so under the OIG Provider Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to minimize the costs and disruptions associated with a government-directed investigation and civil or administrative litigation.

The OIG works cooperatively with forthcoming, thorough, and transparent providers in their disclosures to resolve these matters. While the OIG does not speak for the Department of Justice (DOJ) or other agencies, the OIG consults with these agencies, as appropriate, regarding SDP issues resolution.

Visit the OIG Self-Disclosure Information *(on the web at https://oig.hhs.gov/compliance/self-disclosure-info)* webpage for more information or to complete your self-disclosure online.

Page 7

How to Self-Disclose Actual or Potential Violations of the Physician Self-Referral Law (Stark Law)

For Physician Self-Referral Law (Stark Law) actual or potential violations, Centers for Medicare & Medicaid Services (CMS) Self-Referral Disclosure Protocol *(on the web at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Self_Referral_Disclosure_Protocol.html)* (SRDP) allows health care providers and suppliers to self-disclose them through a separate OIG process.

The physician cannot use the SRDP to get a CMS determination as to whether an actual or potential violation of the Physician Self-Referral Law (Stark Law) occurred. Providers and suppliers should submit their overpayment liability exposure to the SRDP to resolve the conduct they identify.

Under certain circumstances, CMS can reduce the amount due. However, fraud & abuse self-disclosure does not protect health care providers from sanctions and prosecutions.

Page 8

Medicare Incentive Reward Program

CMS established the Medicare IRP to encourage reporting suspected fraud & abuse.

The IRP rewards information on Medicare fraud & abuse or other punishable activities. The information must lead to a minimum Medicare recovery of $100 from individuals and entities CMS determines committed fraud.

For more information, go to the Medicare Program Integrity Manual, Chapter 4 *(on the web at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf)*, Section 4.9.

Page 9

Lesson 5: Summary

- You may report suspected Medicare fraud & abuse by phone, email, fax, mail, and on the OIG website.
- You may self-disclose fraud & abuse to the OIG using the Provider SDP. You may self-disclose actual or potential violations of the Physician Self-Referral Law (Stark Law) to CMS using the Medicare SRDP.
- The Medicare IRP provides rewards for Medicare fraud & abuse information or other punishable activities.

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Review Questions

After selecting an answer for a question, select the "SUBMIT ANSWER" button for feedback on the correct answer.

Page 11

Review Question 1

Select the correct answer.

You may report suspected fraud & abuse anonymously by phone, email, fax, mail, and on the Office of Inspector General (OIG) website.

A. True **- CORRECT ANSWER**

B. False

RESET QUESTION

Page 12

Review Question 2

Select the correct answer.

Health care providers who self-disclose fraud & abuse violations are protected from sanctions and prosecutions.

A. True

B. False **- CORRECT ANSWER**

RESET QUESTION

Page 13

You've completed Lesson 5: Report Suspected Medicare Fraud & Abuse.

Now that you've learned about Medicare fraud & abuse prevention, detection, and reporting, let's take a Post-Assessment to see how much you've learned.

Select the "Post-Assessment" button to return to the Main Menu. Then, select "Post-Assessment" to begin the Post-Assessment.

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