

# Fraud, Waste, and Abuse Toolkit

## Health Care Fraud and Program Integrity: An Overview for Providers





## Content Summary

This booklet addresses common types of Medicaid fraud and abuse so that providers may recognize, report, and prevent them. The booklet also addresses some of the program integrity measures against such activities. The focus of the discussion is primarily on fee-for-service providers rather than cost-based services such as nursing homes. Examples illustrate different forms of fraud and abuse and the consequences for engaging in these activities. The booklet concludes with how to report fraud and abuse and measures that may be taken to prevent them.

## Health Care Fraud and Program Integrity: An Overview for Providers

Fraud and abuse divert significant resources away from necessary care that is covered by Medicaid program rules. Recent figures on the Medicaid program illustrate the scale of the problem. Every year, Medicaid covers medical expenses for more than 64 million beneficiaries[1] enrolled in 56 State and territory-administered programs. According to the Centers for Medicare & Medicaid Services (CMS), the cost of this coverage in 2014 was \$491 billion.[2] The Government Accountability Office (GAO) has designated Medicaid as a program that is at high risk for improper payments due to vulnerability to fraud, waste, and abuse. Improper payments “include those made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided.”[3]

The U.S. Office of Management and Budget (OMB) estimates that improper payments made under the Medicaid program, including fraud, waste, and abuse, amounted to \$17 billion.[4] This figure is a little over 5 percent of the total cost of the program. By becoming aware of the extent and nature of the problem, health care professionals may put themselves in a better position to help prevent and detect Medicaid fraud and thereby protect their practices while also protecting the Medicaid program.

### Definitions and Comparison

Before considering common types of health care fraud and abuse, it may be helpful to review definitions of the terms “waste,” “abuse,” and “fraud.” Waste is not defined in the rules, but is “generally understood to encompass over-utilization, underutilization or misuse of resources, and typically is not a criminal or intentional act.”[5] Examples of waste by a beneficiary could include making excessive office visits or accumulating more prescription medications than necessary for the treatment of specific conditions. Waste by a provider could include ordering excessive laboratory tests such as a comprehensive metabolic panel, or group of blood tests, when only one test, such as blood urea nitrogen (BUN), is needed, or ordering magnetic resonance imaging (MRI) instead of a mammogram for preventive care.

Abuse is defined in the Medicaid rules as follows:

“... provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.”[6]

A provider can abuse the Medicaid program even if there is no intent to deceive; however, fraud involves intent.

Health care fraud can be committed by providers, beneficiaries, corporate officials and others. The rules governing Medicaid define “fraud” as follows:

“... an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.”[7]

For purposes of enforcement, there is a difference between unintentional mistakes and fraudulent or abusive behavior. For example, submitting an erroneous claim for payment is different from submitting the same claim with actual knowledge, reckless disregard, or deliberate ignorance of its falsity.[8] An honest mistake should lead to the return of funds to Medicaid. Providers who improperly bill for services and beneficiaries who cause unnecessary costs risk losing continued eligibility to participate in the Medicaid program and may face criminal and civil monetary penalties.[9]





## Types of Fraud and Abuse

Fraud and abuse in the Medicaid program may occur in many different forms, including, but not limited to, the following:

- Medical identity theft;
- Billing for unnecessary services or items;
- Billing for services or items not rendered;
- Upcoding;
- Unbundling;
- Billing for non-covered services or items;
- Kickbacks; and
- Beneficiary fraud.

## Medical Identity Theft

Medical identity theft involves the misuse of a person's medical identity to wrongfully obtain health care goods, services, or funds. More specifically, medical identity theft has been defined as "the appropriation or misuse of a patient's or [provider's] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services." [10] Unique medical identifying information for physicians includes the National Provider Identifier, Tax Identification Number, U.S. Drug Enforcement Administration number, and State medical license number. Physician medical identifiers are used for such things as identifying the physician of record on claims and for tracking purposes. Stolen physician identifiers may be used to fill fraudulent prescriptions, refer patients for unnecessary additional services or supplies, or bill for services that were never provided.

Beneficiary medical identifiers include Medicaid cards and numbers. These identifiers may be used to support fraudulent billings for services or items not provided, or to enable an ineligible person to receive services by impersonating the

beneficiary. A person who shares his or her card to help another may not mean to cause harm to the Medicaid program. No matter the intent, card sharing is considered fraud, hurts the Medicaid program, and can also hurt the person who shares their card. The following examples illustrate the issues associated with identity theft:

1. The former director of a medical clinic in Michigan continued to submit claims to Medicaid after the clinic closed in 2005, using the medical identities of physicians who had worked there and the medical identities of former patients. The scheme lasted from 2006 through 2009, and was discovered when one of the former physicians reported that billings were being submitted under his provider identification number for services he did not provide. The director was convicted of Medicaid fraud and sentenced to 4 years in prison in October 2011.[11, 12] This case illustrates how an alert health care professional may help put a stop to a fraudulent scheme.
2. The owner of a prosthetics laboratory in Oklahoma used the names and identification numbers of physicians to submit bills to Medicare and Medicaid for expensive computerized prosthetic limbs that had not been prescribed by the physicians. In May 2012, the owner was sentenced to 4 years and 3 months in prison for health care fraud, and in June 2012 he was ordered to pay more than \$4.6 million in restitution.[13]
3. The ringleader of a criminal group in the Bronx stole prescription pads from doctors and hospitals in the New York City area. Between 2009 and 2011 she used the pads to forge more than 250 prescriptions for painkillers. By using stolen Medicaid cards, she was able to bill the prescriptions to the Medicaid program for a total of more than \$200,000. She received two consecutive 4 to 8 year sentences in prison.[14, 15] Thus, one tip for prevention is that health care professionals should keep their prescription pads in a secure location.

Health care professionals may help prevent identity theft by managing enrollment information with payers (keeping payers updated about their practice location and reimbursement accounts), monitoring billing and compliance processes, controlling unique medical identifiers and prescription pads, educating and training staff, and making patients aware of the risks of medical identity theft. An example of how monitoring billing processes can reveal identity theft comes from one of the cases mentioned above. The scheme of the clinic director who was billing for fictitious services under the names of two providers who formerly worked there was exposed when one of those providers noticed that bills were being submitted under his provider identification number for services he did not provide.[16] Providers may obtain more information by reviewing a booklet on understanding provider identity theft that is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Med-ID-Theft-Booklet-ICN908264.pdf> on the CMS website. In addition, a web-based training course titled “Safeguarding Your Medical Identity,” which is approved for continuing medical education (CME) credit, is available on the CMS website. To register for this course, go to <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WEbBasedTraining.html> on the Medicare Learning Network®.

## Billing for Unnecessary Services or Items

The Federal Medicaid statute authorizes payment for items and services that are included in each State’s approved plan. [17] The included items and services vary from State to State. Only those items and services included in the relevant State’s plan are authorized. Even if an item or service is authorized, it is still not covered under Medicaid unless it is also medically necessary.

Under Section 1902(a)(30)(A) of the Social Security Act, States are required to “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to



safeguard against unnecessary utilization of such care and services ....”[18] Under the regulations implementing this requirement, CMS says, States may “place appropriate limits on a service based on such criteria as medical necessity...”[19] For Medicaid, each State defines medical necessity. Health care professionals are responsible for ensuring that services meet the definition of medical necessity, or are otherwise authorized, in the States in which they practice. When a physician signs billing documents, he or she certifies the truth, accuracy, and completeness of the claims.[20]

Billing for unnecessary services may involve misrepresenting symptoms in the record. For example, from 2003 to 2007 a cardiologist in Maryland inserted unnecessary cardiac stents in his patients during surgery and made false entries in the medical records to justify the unnecessary stents. He defrauded both Medicare and Medicaid. On November 10, 2011, he was sentenced to 8 years and 1 month in prison and ordered to pay \$597,070 in restitution.[21] This example shows how unnecessary services may jeopardize the health of beneficiaries.

Additional examples of billing for unnecessary services or items include the following:

- The owner of a durable medical equipment (DME) company in Texas was sentenced to 1 year and 9 months in prison and ordered to pay \$574,888 in restitution for conspiracy to bill Medicaid for medically unnecessary supplies and for enteral nutrition feeding supply kits that were never delivered;[22]
- A medical laboratory owner in Chicago was sentenced to 2 years and 3 months in prison for billing Medicare and Medicaid for \$70,000 in unnecessary blood tests;[23, 24] and
- An ambulance service owner in Texas was sentenced to 15 years for billing Medicare and Medicaid for transporting patients by ambulance to dialysis appointments even though the medical condition of the patients did not qualify for that level of transportation.[25]

## Billing for Services or Items Not Furnished

To be covered by Medicaid, the billed service or supply is required to be provided. Providing different services or supplies is no justification for submitting a bill for a service or supply that was not provided. Some health care professionals bill Medicaid for a covered service or item but do not provide the service or item. For example, in support of claims submitted to Massachusetts Medicaid, a personal care attendant filled out time sheets stating that he had provided care to a beneficiary for more than 5 months on dates when the beneficiary was in the hospital and on dates after the



beneficiary had died. He pleaded guilty to Medicaid False Claims, was sentenced to 2 years of probation, and was ordered to pay more than \$10,000 in restitution to the Medicaid program.[26] Providers may only bill for the medically necessary or otherwise authorized services or items actually furnished to beneficiaries.

## Upcoding

Upcoding is a term that is not defined in Federal Medicaid regulations, but it is generally understood as billing for services at a level of complexity that is higher than the service actually provided or documented.[27] For example, after a peer review audit found a St. Louis psychiatrist had billed Medicaid for 20-minute sessions after spending 5 minutes or less with patients, the psychiatrist and his employers agreed to pay \$441,870 to Medicaid to settle upcoding allegations. The psychiatrist pleaded guilty to making a false statement during the course of an investigation to the Federal Bureau of Investigation (FBI).[28] He was sentenced to 5 months' imprisonment, forfeiture of \$100,000, and payment of a \$30,000 fine.[29]

Another example of upcoding involves an Idaho dentist who billed Medicaid 67 times for either surgical extractions or post-surgical complications when the procedure was actually the simple removal of a tooth without post-surgical complications. Surgical extractions are reimbursed by Medicaid at a higher rate than simple extractions. The dentist pleaded guilty to provider fraud and was sentenced on March 12, 2013, to 3 years of probation and a \$1,000 fine. He was also ordered to pay restitution to Medicaid and reimburse the Idaho Attorney General's investigative costs. The judge granted a withheld judgment.[30]

A final example of upcoding is billing for complex office visits when only simple office visits were rendered.

Providers may only bill at the level of the services or items actually furnished to beneficiaries.

## Unbundling

According to the National Correct Coding Initiative Manual, "Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code." [31, 32] For example, on January 12, 2012, a dental clinic paid the State of New York \$325,000 to settle allegations that the clinic had billed New York Medicaid from 2005 through 2009 for separate visits during which cleanings, X-rays, and dental examinations were performed. New York Medicaid regulations required that these services be performed in one office visit and billed together rather than separately. The allegations were that the clinic billed separately, or unbundled the claims, to collect more money from the Medicaid program.[33]

Cases of unbundling have also arisen in the context of laboratory providers. In such a scenario, a physician orders a panel of tests for a patient and the laboratory is supposed to seek reimbursement for the entire panel at one price. Instead, the laboratory unbundles the tests and bills for each test individually to increase total reimbursement. Unbundling inflates the cost of Medicaid services and items. Providers should be familiar with their State's Medicaid rules regarding which services and items are to be bundled together when billed, bearing in mind that specific Medicaid requirements may vary from State to State.

## Non-Covered Services or Items

Fraud and abuse may involve services that are provided but are not covered by Medicaid. For example, a Mississippi physician owned a company that from 2002 through 2004 claimed to have provided physical therapy to Medicare and Medicaid beneficiaries in their homes under the supervision of a medical doctor or through a licensed physical therapist.



In fact, services were provided by unlicensed employees without a doctor's supervision. Such services are not covered by Medicare or Medicaid. On August 17, 2012, the physician was sentenced to 14 years in prison for health care fraud and other offenses, and ordered to pay more than \$6.9 million in restitution.[34]

Another example of billing for services that are not covered involves physicians billing for weight loss services. Even though weight loss is not a covered service, the physician may bill this service as a regular office visit for fictitious problems other than weight loss. In this way, the physician seeks payment from Medicaid for a non-covered service. Providers may face consequences billing for services that are not covered, particularly if the bills are disguised in this manner.

## Kickbacks

Rewarding sources of new business may be acceptable in some industries, but not when Federal health care programs are involved.[35, 36] Kickbacks in health care can lead to overutilization, increased program costs, corruption of medical decision-making, patient steering, and unfair competition. For example, the prior owners of a company that provides pharmacy services through home delivery gave gift cards and routinely waived beneficiary copayments to generate referrals or enrollment of Medicare and Medicaid patients as customers. The current owners agreed to a civil settlement of \$5 million for damages and penalties that occurred prior to their ownership.[37] Claims resolved under civil settlement are considered allegations only and therefore no determination of liability was made.

Visit the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) online at <https://oig.hhs.gov/fraud/enforcement/index.asp> to learn about the full range of provider fraud prosecutions and settlements.

## Beneficiary Fraud

Medicaid beneficiaries can also participate in fraud and abuse. Common forms of beneficiary fraud include eligibility fraud, card sharing, doctor shopping, and drug diversion. Eligibility fraud involves misrepresenting one's circumstances in order to obtain program coverage for which one does not qualify. Card sharing occurs when a beneficiary shares his



or her Medicaid identity card with a person who is not covered so the non-covered person may receive services in the beneficiary's name. This practice may expose the beneficiary to the danger of identity theft and compromise the integrity of the beneficiary's medical record. Health care professionals should require an additional form of identification in order to discourage card sharing.

Doctor shopping involves beneficiaries visiting different providers to obtain multiple prescriptions for the same or a similar type of drug. This practice may endanger the beneficiary's health as well as subject the Medicaid program to unnecessary expense. Useful tools to prevent this practice are prescription drug monitoring programs, which are statewide electronic databases that collect information on controlled substance prescriptions. Prescribers in most States have access to such databases.[38] Through access to these databases, a prescriber can see whether another prescriber has already written a prescription that is the same as or similar to the one the patient is requesting. Health care professionals with questions about access to such a database in their State may contact their State professional licensing body or visit the website of the National Alliance for Model State Drug Laws at <http://www.namsdl.org/prescription-monitoring-programs.cfm> for more information.

Drug diversion is the deflection of prescription drugs from medical sources into the illegal market[39] or the use of prescription drugs for illegal or nonmedical purposes. Drug diversion may be accomplished by forging or altering prescriptions, by obtaining prescriptions under false pretenses, or by colluding with a willing prescriber. For example, a Tennessee beneficiary obtained a prescription for the painkiller oxycodone, which Medicaid paid for. Instead of taking the medicine as prescribed, the beneficiary sold a portion of it to a confidential informant. She pleaded guilty to State Medicaid (TennCare) fraud and sale of a controlled substance, was sentenced to concurrent 2 and 3 year sentences, and was fined \$4,000.[40]

By being aware of beneficiary fraud and provider schemes, health care professionals are better equipped to recognize them. Providers who suspect beneficiary fraud should report it to the State Medicaid agency.

## Health Care Fraud Laws

As illustrated by the cases discussed above, there are a variety of Federal and State laws, both civil and criminal, to deter and punish fraud in Medicaid. Major Federal laws include, but are not limited to:

- The Health Care Fraud Statute;
- The False Claims Act;
- The Anti-Kickback Statute;
- Exclusion provisions; and
- The Civil Monetary Penalties Law.

Many States have similar laws. For example, a number of States, including California,[41] New York,[42] and Texas,[43] have State false claims acts that punish false claims made to State Medicaid programs.[44] These three States also have anti-kickback statutes.[45, 46, 47]

All of the Federal laws listed above, except for the Health Care Fraud Statute, are discussed in a web-based training course offered by HHS-OIG titled "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians." The course is approved for continuing education credit. Course information is available at <https://oig.hhs.gov/compliance/101/cme.asp> on the HHS-OIG website.



## Exclusion Provisions

Under Section 1128 of the Social Security Act, HHS-OIG has authority to exclude individuals from participating in Federal health care programs, including Medicaid, for various reasons. Exclusions can be mandatory, meaning the HHS-OIG has no choice about whether to exclude, or discretionary, which means the HHS-OIG does have a choice. Exclusion is mandatory for convictions of program-related crimes, convictions relating to patient abuse, felony convictions relating to health care fraud, and felony convictions relating to controlled substances. Exclusion is discretionary for loss of license due to professional competence or financial integrity, convictions relating to fraud, convictions relating to obstruction of an investigation or audit, misdemeanor convictions relating to controlled substances, and participation in prohibited conduct such as kickbacks and false statements.[48]

As a Federal health care program, Medicaid will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity.[49] If someone on a provider's staff has been excluded from participation in a Federal health care program, the provider should not bill any Federal health care programs for any items or services furnished, ordered, or prescribed by the excluded individual. "Furnished" is a key word that refers to items or services provided or supplied, directly or indirectly, by an excluded individual or entity.[50]

While a health care professional who provides services through Medicaid may employ an excluded individual who does not provide any items or services paid for, directly or indirectly, by Federal health care programs,[51] health care professionals should exercise caution here. A professional who contracts with or employs "a person that the provider knows or should know is excluded by HHS-OIG ... may be subject to CMP [Civil Monetary Penalty] liability if the excluded person provides services payable, directly or indirectly, by a Federal health care program." [52] The prohibition is not limited to items or services involving direct patient care, but extends, for example, to filling prescriptions, providing transportation services, and performing administrative and management services that are not separately billable.[53] If, for example, a biller is excluded from a government health care program, payments on claims submitted by the practice through the biller may be considered overpayments subject to recoupment.

It is in the best interest of providers to screen potential employees and contractors prior to employment or contracting to ensure they are not excluded from participating in Federal health care programs. In addition, providers should regularly check the exclusions database to ensure that none of the practice's employees or contractors have been excluded.

CMS has issued guidance to State Medicaid agencies that they should require providers to screen their employees and contractors for exclusions by checking the database on a monthly basis. The guidance further advises States to require all providers to immediately report any exclusion information discovered.[54] The List of Excluded Individuals/Entities (LEIE) database is available at <http://exclusions.oig.hhs.gov/> on the HHS-OIG website. Both licensed and unlicensed individuals may be excluded, so it is best to check for both. In addition to checking the LEIE, providers should check the Exclusions Extract, which can be accessed by visiting <https://www.sam.gov/> on the System for Award Management website.

## Anti-Fraud Efforts

Through enforcement of the health care fraud laws and other actions, the government has taken significant steps against fraud in health care. In fiscal year 2014, the government's health care fraud enforcement efforts recovered more than \$3 billion in taxpayer dollars.[55] A total of 734 defendants were convicted of health care fraud-related crimes and Federal prosecutors charged 805 defendants with health care fraud-related crimes.[56]

States also actively enforce health care fraud laws in Medicaid cases. The HHS-OIG Medicaid Fraud Control Units Report for 2014 showed 1,318 criminal convictions and 874 civil settlements and judgments against providers. The convictions led to 1,337 provider exclusions. The State Medicaid agencies recovered a total of \$1.9 billion for the Medicaid program in fiscal year (FY) 2014.[57]

Investigations that lead to criminal charges often start with the identification of improper payments. There are a number of ways in which the government may identify improper Medicaid payments, including:

- CMS' Payment Error Rate Measurement (PERM) program, which measures and reports improper payments in Medicaid and identifies common errors;[58]
- Audit Medicaid Integrity Contractors (Audit MICs), which contract with CMS to perform audits and identify overpayments;[59] and
- Medicaid Recovery Audit Contractors (RACs), which contract with States to audit providers and identify overpayments.[60]

CMS, through its Center for Program Integrity (CPI), undertakes or oversees other significant anti-fraud efforts. These include tracking medical identity theft; providing a remediation process for the victims of medical identity theft; using predictive modeling to identify suspect claims before payment; screening providers at enrollment; suspending payments during the investigation of a credible allegation of fraud; and imposing more rigorous requirements on State Medicaid programs for terminating providers for cause across Medicaid programs as discussed in the Reciprocal Termination section later in this booklet.[61]

## Screening of Providers

Medicaid rules require that State Medicaid agencies screen providers before enrollment. This screening searches for certain information depending on an assigned categorical risk of fraud.[62] All providers are screened to ensure current licensure and to determine whether they have been excluded from Federal health care programs or have been terminated from such programs for cause. Providers may fall into a high-risk category because of provider type or adverse actions such as previous exclusions, terminations, or payment suspensions. These providers may be subject to additional screening, including a fingerprint-based criminal background check.[63] The objective is to prevent fraud on the front end rather than paying claims and then chasing providers to recover lost funds.[64]





## Suspension of Payments

Federal regulations became effective in February 2011 that require States to suspend Medicaid payments to providers whenever they determine that a credible allegation of fraud exists and there is a pending investigation.[65] A “credible allegation” is one “which has been verified by the State,” has indicia of reliability, and has been reviewed carefully in light of all the evidence on a case-by-case basis.[66] As a practical matter, a State Medicaid agency’s referral of the allegation to the State Medicaid Fraud Control Unit (MFCU) after such verification and review amounts to a determination that a credible allegation of fraud exists.

## Reciprocal Termination

Before the Affordable Care Act, State actions to terminate providers from Medicaid for cause only applied to the State that took the action. The Affordable Care Act requires a State Medicaid agency to terminate any provider (individual or entity) that has been terminated by Medicare or another State Medicaid program.[67] Through rulemaking, CMS defined termination to only apply to those providers who are terminated for cause—for reasons of fraud, integrity, or quality—and expanded the requirements to include the Children’s Health Insurance Program (CHIP).[68, 69] Therefore, if a provider is terminated for cause by Medicare, or a State’s Medicaid program or CHIP, the provider is required to be terminated by Medicaid and CHIP programs in other States.

To learn about other new means of fighting fraud, visit <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/BackgrounderFraudPreventionInitiative.pdf> on the CMS website.

## How to Report Fraud, Waste, or Abuse

Prevention and detection of fraud, waste, and abuse is not solely the government’s responsibility. Providers play an important role as well. Legitimate providers and the government share the same goal: provision of quality medical care appropriately documented and billed. If a provider learns something that indicates another provider may be engaging in suspect practices, several options are available for reporting. Suspect provider practices may be reported to:

- The State Medicaid agency;
- The MFCU;
  - Contact information for State Medicaid agencies and MFCUs is available at [https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/report\\_fraud\\_and\\_suspected\\_fraud.html](https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/report_fraud_and_suspected_fraud.html) on the CMS website; and
- HHS-OIG
  - 1-800-HHS-TIPS
  - <https://forms.oig.hhs.gov/hotlineoperations/>

You can report fraud anonymously, but it is helpful to provide your telephone number or email address, allowing investigators to contact you for more information, if needed. If you do give your contact information, your identity will be protected to the maximum extent provided by the law. When reporting suspected fraud, waste, and abuse, the provider should include:

- The contact information for the source of the information, suspects, and witnesses;
- The details of the alleged fraud, waste, and abuse;
- Identification of the specific Medicare rules allegedly violated; and
- The suspect's history of compliance, education, training, and communication with your organization or other entities.

A provider who suspects a beneficiary issue, such as card sharing or eligibility fraud, should report the issue to their State Medicaid agency.

## Prevention by Providers

In addition to reporting suspect practices, providers may take steps to prevent fraud and abuse, including:

- Knowing the regulations and laws governing the services offered by the practice;
- Screening potential and existing employees and contractors for current exclusion, or grounds for exclusion, by HHS-OIG; and
- Implementing a compliance program.

Under Section 1128J(d) of the Social Security Act, any provider who has received funds to which he or she is not entitled under the Medicaid program is required to return the funds to the State within 60 days of the date the overpayment was identified.[70]

Providers may benefit from adopting a compliance program. HHS-OIG has recommended seven basic elements of a compliance program:

- Conducting internal monitoring and auditing;
- Implementing written standards and procedures;
- Designating a compliance officer or contact(s) to monitor compliance;
- Conducting training and education on standards and procedures;
- Responding appropriately to detected violations;



- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines.[71]

Implementing a compliance program is voluntary for various providers and suppliers,[72] but the Affordable Care Act [73, 74] requires the Secretary of HHS to establish, as a condition of enrollment in Medicare and Medicaid, a compliance “program” containing core elements for providers or suppliers within a particular industry or category.[75] Recent proposed rules for Medicaid managed care have identified elements of a compliance program which added to the HHS-OIG recommendations. Changes include mandatory reporting to the State of potential fraud, waste, and abuse, and changes in provider circumstances which may affect participation.[76]

Providers who choose to create an internal compliance program to prevent fraud, waste, and abuse may consult guidance from HHS-OIG by visiting <https://oig.hhs.gov/fraud/complianceguidance.asp> on the HHS-OIG website. Guidance is available for different provider types, ranging from hospitals to small or solo physician practices. Additional compliance materials are available at [https://oig.hhs.gov/newsroom/video/2011/heat\\_modules.asp](https://oig.hhs.gov/newsroom/video/2011/heat_modules.asp) on the HHS-OIG website.

## Conclusion

Providers play an important role in preserving the solvency of the Medicaid program, protecting beneficiaries from harm, and preventing fraud and abuse. By understanding common forms of fraud and abuse, providers will be better able to recognize, report, and prevent them. By following the applicable rules, reporting suspected violations, and taking preventive measures in their own practices, providers may help protect their practices and at the same time make a valuable contribution in the fight against fraud and abuse.

To see the electronic version of this booklet and the other products included in the “Fraud, Waste, and Abuse” Toolkit, visit the Medicaid Program Integrity Education page at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website.

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September 2015



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