Resource Guide

Laws Against Health Care Fraud Resource Guide

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Although most health care providers work hard to deliver quality care and submit correct claims for payment, some providers seek to exploit government health care programs for illegal personal gain. Health care fraud remains a serious problem for these programs. The U.S. Government Accountability Office has designated Medicaid as a program that is at high risk for improper payments. 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."[1] There are a number of Federal and State laws to deter and punish those who fraudulently seek to obtain improper payments from Medicaid. Federal laws include, but are not limited to, the following:

- 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,[2] New York,[3] and Texas,[4] have State false claims acts that punish false claims made to State Medicaid programs.[5] These three States also have anti-kickback statutes.[6, 7, 8] Providers who engage in fraud or abuse in violation of these laws can be subject to serious consequences ranging from monetary fines and damages to prison time and exclusion from Federal health care programs, including Medicaid. By becoming familiar with these laws, providers will be in a better position to avoid violations and to identify and report others who are in violation.

This resource guide gives an overview of some of the major Federal laws. This guide is not intended to be exhaustive, and the reader should keep in mind that there are other Federal and State laws that apply to health care fraud.

Health Care Fraud Statute

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years.[9] It is also subject to criminal fines of up to $250,000.[10] Specific intent to violate this section is not required for conviction.

False Claims Act

The False Claims Act establishes civil liability for offenses related to certain acts, including knowingly presenting a false or fraudulent claim to the government for payment, and making a false record or statement that is material to the false or fraudulent claim.[11] "Knowingly" includes not only actual knowledge but also deliberate ignorance or reckless disregard for the truth or falsity of the information. No specific intent to defraud the government is required.[12] Depending on the circumstances, some examples of potential False Claims Act violations in the health care fraud context include upcoding, billing for unnecessary services, billing for services or items that were not rendered, and billing for services performed by an excluded individual.[13]

Individuals and entities that make false claims are subject to civil penalties of up to $11,000 for each false claim, plus three times the amount of damages the government sustains by reason of each claim.[14] Violation of the False Claims Act may lead to exclusion from Federal health care programs.[15]

Civil legal actions for penalties and damages under the False Claims Act may be brought not only by the government, but by private persons, such as competitors or employees of a provider, on behalf of the government. If the legal action is successful, the private person is entitled to a percentage of the recovery. The False Claims Act protects all persons from retaliation for reporting false claims or bringing legal actions to recover money paid on false claims.[16]

Failure to return overpayments may lead to liability under the False Claims Act. Under section 1128J(d) of the Social Security Act, persons who have received an overpayment from a Federal health care program must report and return the overpayment within 60 days of the date the overpayment was identified. Failure to do so may make the overpayment a false claim.[17]

False claims made knowingly may also be subject to criminal prosecution. Persons who knowingly make a false claim may be subject to criminal fines up to $250,000[18] and imprisonment of up to 5 years.[19]

Anti-Kickback Statute

The Anti-Kickback Statute, found in Section 1128B(b) of the Social Security Act, prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, in cash or in kind, to induce or in return for referring an individual for the furnishing or arranging of any item or service for which payment may be made under a Federal health care program. Remuneration means anything of value and can include gifts, under-market rent, or payments that are above fair market value for the services provided. Criminal penalties for violation are a fine of up to $25,000 and imprisonment for up to 5 years.[20]

Compliance with the Anti-Kickback Statute is a condition of payment in Federal health care programs. Claims that include items or services resulting from a violation are not payable and may constitute false or fraudulent claims under the False Claims Act.[21]

Under the Civil Monetary Penalties Law, Social Security Act Section 1128A(a)(7), the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) may impose civil penalties for violations of the Anti-Kickback Statute. The penalties are up to $50,000 per violation plus three times the amount of the remuneration.[22] Violation of the Anti-Kickback Statute may also lead to exclusion from Federal health care programs.

The Anti-Kickback Statute provides safe harbors for certain arrangements, such as personal services and rental agreements, investments in ambulatory surgery centers, and payments to bona fide employees. Physicians with questions about the Anti-Kickback Statute and these safe harbor arrangements should consult the regulations and guidance documents available from HHS-OIG.[23]

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 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 related to patient abuse, felony convictions related to health care fraud, and felony convictions related to controlled substances. Exclusion is discretionary for loss of license due to professional competence or financial integrity, convictions related to fraud, convictions related to obstruction of an investigation or audit, misdemeanor convictions related to controlled substances, and participation in prohibited conduct such as kickbacks and false statements.[24]

Generally, Federal health care programs will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity.[25]

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,[26] practitioners should exercise caution here. A professional who contracts with or employs "a person that the provider knows or should know is excluded by 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."[27] 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.[28] 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. Any person who has received an overpayment must return the money within 60 days of the date on which the overpayment was identified.[29] Failure to do so may subject the person to liability under the False Claims Act and the Civil Monetary Penalties Law.[30]

Under the Civil Monetary Penalties Law, Social Security Act Section 1128A, HHS-OIG may impose civil monetary penalties of up to $10,000 per item or service claimed while excluded. HHS-OIG may also impose an assessment of up to three times the amount claimed.[31]

It is in the best interest of physicians and other providers to screen potential employees and contractors prior to employment or hiring 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 report any exclusion information discovered immediately.[32] 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 Estract, which can be accessed by visiting https://www.sam.gov/ on the System for Award Management website.

Civil Monetary Penalties Law

As previously noted, the Civil Monetary Penalties Law, Section 1128A of the Social Security Act, authorizes HHS-OIG to impose civil penalties for violations of the Anti-Kickback Statute as well as a range of other violations. Penalties range from $10,000 to $50,000 per violation. These violations include, but are not limited to, the following:

- Submitting false claims;

- Violating Medicare assignment provisions or the physician agreement;
- Providing false or misleading information expected to influence a decision to discharge a patient;
- Failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency condition or in labor; and
- Making false statements on applications or contracts to participate in a Federal health care program. [33, 34]

All of these laws, 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.

To see the electronic version of this resource guide 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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