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Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or C-M-S. These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for Medicare Fee-For-Service Providers.

If you are a Medicare Fee-For-Service Provider, you will benefit from this podcast! Medicare fraud and abuse is a serious problem that requires your attention. In this podcast, you will learn the key elements of Medicare fraud and abuse and how to detect, report, and prevent suspicious activity. As a Medicare Fee-For-Service Provider, you play a vital role in protecting the integrity of the Medicare Program. You should know what to do to combat fraud and abuse and protect yourself and your organization from potentially abusive or fraudulent activities.

This podcast is based on the Medicare Learning Network®, or M-L-N, fact sheet titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting." The fact sheet is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse. It includes key definitions and information on laws, partnerships with other organizations and resources for additional information.

First, let's discuss the key elements and differences between Medicare fraud and abuse.

Most health care providers are honest and well-intentioned, but there are some who intentionally abuse the system. Such actions cost taxpayers billions of dollars and threaten the health and welfare of Medicare beneficiaries.

Medicare Fraud involves making false statements or misrepresenting facts to obtain a benefit or payment that would not otherwise exist. These acts may be committed either for a person's own benefit or for the benefit of some other party.

Fraudulent schemes range from individual to broad-based operations by an institution or group. Anyone can commit health care fraud. You may even know someone who has committed fraud. Examples of Medicare fraud may include:

- Billing for services and/or supplies that you know were not furnished or provided; and

- Altering claims forms and/or receipts to receive a higher payment amount.

It is a crime to defraud the Federal Government and its programs. Punishment may involve imprisonment, significant fines, or both. In some states, providers and health care organizations can lose their licenses. Medicare fraud may also result in civil liability and suspension from the Medicare Program for a specified length of time. For more information on fraud, visit oig.hhs.gov/fraud on the Internet.

Medicare Abuse is any action that, either directly or indirectly, results in unnecessary costs to the Medicare Program. It includes any practice that does not provide Medicare beneficiaries with services that are medically necessary, fairly priced, and meet professionally-recognized standards.

Examples of Medicare abuse may include:

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

Both Medicare fraud and abuse can expose you and your organization to criminal and civil liabilities.

Now that you understand the basic key elements of Medicare fraud and abuse, we will now discuss the statutes and laws used to protect the integrity of the Medicare Program. There are three main laws that address fraud and abuse:

1. The False Claims Act,
2. The Anti-Kickback Statute, Physician Self-Referral Law (or Stark Law), and
3. The Social Security Act and U.S. Criminal Code.

Violating these laws may result in nonpayment of claims, Civil Monetary Penalties (or C-M-Ps), exclusion from the Medicare Program, and criminal and civil liability. Please note, fraudulent conduct addressed by these laws also applies to Medicare Part C and Part D and Medicaid. This includes “dual eligibles,” or those individuals who are entitled to, or enrolled in, Medicare Part A or B and also eligible for Medicaid.

The Department of Health and Human Services (H-H-S) Office of Inspector General (O-I-G) imposes exclusions on certain health care providers and suppliers from participating in all Federal health care programs. For a designated period of time, Medicare and other Federal health care programs will not pay for services performed or ordered by excluded providers and suppliers.  This includes:

those who have been convicted of the following offenses:

1. Patient abuse or neglect;
2. Felonies of other health care related fraud, theft, or other financial misconduct; or
3. Felonies of unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Please note, the O-I-G may decide to impose permissive exclusions for other reasons.

Civil Monetary Penalties (C-M-Ps) may be imposed for a variety of reasons, and different amounts of penalties and assessments are authorized based on the type of violation. Penalties range from 10 to 50 thousand dollars per violation. They can also be up to 3 times the amount claimed for each item or service, or the amount of remuneration offered, paid, solicited, or received. Examples of C-M-P violations may include the following:

1. Presenting a claim that you know, or should know, is for an item or service not provided as claimed or is false and fraudulent;
2. Presenting a claim that you know, or should know, is for an item or service for which payment may not be mad;, and
3. Violating the Anti-Kickback Statute.

We will now discuss partnerships that have been established to maintain the integrity of the Medicare Program. Government agencies have formed partnerships to fight Medicare fraud and abuse, protect taxpayer funds, and maintain health care costs and quality of care.

CMS administers the Medicare and Medicaid programs and partners with the following entities to prevent and detect fraud and abuse:

- Program Safeguard Contractors (P-S-Cs)/Zone Program Integrity Contractors (Z-PICs),
- Medicare Drug Integrity Contractors (MEDICs),
- State and Federal law enforcement agencies,
- Medicare beneficiaries and caregivers,
- Senior Medicare Patrol (S-M-P) program,
- Physicians, suppliers, and other providers,
- Medicare Carriers, Fiscal Intermediaries (F-Is), and Medicare Administrative Contractors (MACs) who pay claims and enroll providers and suppliers;
- Accreditation Organizations;
- Recovery Audit Program Recovery Auditors; and
- Comprehensive Error Rate Testing (CERT) Contractors.

The Center for Program Integrity (C-P-I), within C-M-S, promotes the integrity of Medicare by:

- conducting audits and policy reviews;
- identifying and monitoring program vulnerabilities; and
- providing assistance to states.

C-P-I also oversees interactions between C-M-S and key stakeholders intended to support program integrity efforts and detect, deter, monitor, and combat fraud and abuse.

The O-I-G protects the integrity of H-H-S' programs, including Medicare, and the health and welfare of its beneficiaries. The O-I-G operates through a national network of audits, investigations, inspections, and other functions. The Inspector General may prohibit individuals and entities who have engaged in fraud or abuse from participating in Medicare, Medicaid, and other Federal health care programs. The Inspector General may also impose C-M-Ps for certain misconduct related to Federal health care programs. The OIG maintains a list of excluded parties. This list is called the List of Excluded Individuals/Entities. For more information, please visit oig.hhs.gov/exclusions on the Internet.

The Department of Justice (D-O-J) and H-H-S established Health Care Fraud Prevention and Enforcement Action Team (HEAT) to strengthen existing programs to combat Medicare fraud while investing in new resources and technology to prevent fraud and abuse. HEAT expanded the DOJ-HHS Medicare Fraud Strike Force to fight fraud and create the Stop Medicare Fraud website. This website provides information about how you can identify and report fraudulent activity and protect yourself and your organization against Medicare fraud. For more information, visit www.stopmedicarefraud.govon the Internet.

The General Services Administration (G-S-A) maintains the Excluded Parties List System (E-P-L-S). This list includes information on entities debarred, suspended, or proposed for debarment. The list also includes those entities that have been excluded, or disqualified from receiving Federal contracts, certain subcontracts, and certain types of Federal assistance and benefits. For more information, visit www.epls.gov on the Internet.

If you suspect fraudulent activity, you may file your complaint anonymously to the OIG Hotline. No information will be entered in OIG record systems that could trace the complaint to you. However, lack of contact information may prevent a comprehensive review of the complaint. Therefore, the O-I-G encourages you to provide your contact information in case they have any questions or need to contact you for more information.

For questions about billing procedures, billing errors, or questionable billing practices, contact your Medicare Carrier, FI, or MAC.

CMS and the OIG offer a wealth of information about preventing, detecting, and reporting Medicare fraud and abuse. For a complete list of resources, please download the MLN fact sheet titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" by visiting the CMS website at www.cms.gov. Click on Outreach and Education from the menu at the top right of the page. From that page, scroll down to the Medicare Learning Network section and click on the MLN Products link.

More questions? To learn more about Medicare fraud and abuse, contact your Medicare Contractor or visit the CMS website at www.cms.gov. Click on Outreach and Education from the menu at the top right of the page. Scroll down to the Medicare Learning Network® section and click on the MLN Products link. From that page, click on MLN Provider Compliance from the left menu.

Be on the lookout for future MLN podcasts on subjects of interest to you.

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