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MEDICAL PRACTICE CONSULTANTS, INC.

Series of Medicaid Fraud and Abuse, Part Two

Below are excerpts from the "Health Care Fraud and Program Integrity: An Overview for Providers (Fraud, Waste, and Abuse Toolkit)"

Definitions and Comparison

Before considering common types of health care fraud, waste, and abuse, reviewing term definitions may be helpful. Waste is not defined in the rules, but "is generally understood to encompass the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act." 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; ordering a group of blood tests, when only one test is needed; or ordering magnetic resonance imaging (MRI) instead of a mammogram for preventive care.

Abuse is defined in the Medicaid rules as:

> 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.

A provider can abuse the Medicaid program even if there is no intent to deceive. Fraud is different and involves intent.

Providers, beneficiaries, corporate officials, and others can commit health care fraud. The rules governing Medicaid define "fraud" as:

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.

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 of the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim." 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.

Fraud Detection, Prosecution, Recovery

U.S. Department of Justice and Office of Inspector General

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 (FY) 2015, the combined health care fraud enforcement efforts of the U.S. Department of Justice and the U.S. Department of Health and Human Services recovered $1.6 billion in taxpayer dollars for the Medicare Trust Fund and another $800 million to the Treasury and private individuals affected by fraud.

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A total of 613 defendants were convicted of health care fraud related crimes, and Federal prosecutors charged 888 defendants in 463 separate cases with health care fraud related crimes, which was also a record. In addition, of the over 4,100 individuals and entities HHS -OIG excluded in FY 2015, more than 1,300 were excluded because of Medicare- or Medicaid-related criminal convictions.

Medicaid Fraud Control Units

States actively enforce health care fraud laws in Medicaid cases through their respective MFCUs. The HHS-OIG MFCU Statistical Data sheet for FY 2015 showed 1,553 criminal convictions and 795 civil settlements and judgments against providers. The SMAs recovered more than $744 million for the Medicaid program in FY 2015.

Monitoring and Auditing

Investigations that lead to criminal charges often start with the identification of improper payments. There are a number of ways 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;
-Audit Medicaid Integrity Contractors (Audit MICs), which contract with CMS to perform audits and identify overpayments; and
-Medicaid Recovery Audit Contractors (RACs), which contract with States to audit providers and identify overpayments.

CMS, through its Center for Program Integrity, 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.

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