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FRAUD AND ABUSE

When Medicare first came into being in 1965 there was only a general prohibition in the Social Security Act against making false statements in applications for benefits. Since then, due to reports that healthcare providers were routinely abusing both the Medicare and Medicaid programs and an estimate by the General Accounting Office that as much as 10% of the cost of healthcare in the United States was going to reimburse fraudulent claims, the laws pertaining to Medicaid and Medicare fraud and abuse have multiplied and become increasingly specific, and enforcement has increased as well. Today it is vital that every physician be aware of the laws governing the concepts of fraud and abuse and know how to avoid even the appearance of being in conflict with them.

DEFINITIONS

Fraud

Fraud is defined as "knowingly or willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program or to obtain by means of false and fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody of or control of any healthcare benefit program."

The types of activities currently governed by federal law on healthcare fraud are:

- False claims and other fraudulent billing practices;
- Illegal referrals under the Medicare/Medicaid antikickback statute; and
- Physician self-referral practices proscribed by the Stark legislation

Abuse

Abuse is defined as unintentionally following practices that violate the guidelines of the Medicare or Medicaid programs, which may directly or indirectly result in unnecessary costs to the program. If the abuse persists after a practitioner has been warned, the abuse may come to be considered fraud.

FALSE CLAIMS AND FRAUDULENT BILLING PRACTICES

Under the current statutes, false claims and billing practices include billing for services that were known to be medically unnecessary, or were not rendered at all; consistently using CPT codes that describe more extensive services than those that were actually provided; falsifying information on applications, medical records, or billing statements; and consistently failing to collect coinsurance

payments in order to induce beneficiaries to use your services. You are expected to know the rules and to abide by them.

In fact, if a claim is returned for coding corrections, this officially constitutes a warning that abuse is being committed. If claims continue to be filed with coding errors, those errors may be considered fraud (a felony) rather than abuse since a warning had been issued when your claims were returned for correction.

ILLEGAL REFERRALS UNDER THE ANTI-KICKBACK STATUTE

The issues of illegal referrals and kickbacks were first dealt with in the 1989 Ethics in Patient Referrals Act, known fondly as Stark I. In 1993 the law was expanded to cover more healthcare services under what is known as Stark II. Because of this anti-kickback statute, many arrangements between healthcare providers that would have previously been considered ordinary (i.e., joint ventures, discounts on goods and services, space and equipment leases) now must be evaluated to be certain they don't violate the law. Although there are some exceptions defined within the law itself, basically, anyone who solicits or receives any remuneration for a referral or for the purchase of goods that are covered by a federal healthcare program can be found guilty of violating the anti-kickback statute. Violations can result in both criminal penalties and civil sanctions, including imprisonment, fines, and exclusion from federal healthcare programs.

SELF-REFERRAL PRACTICES

Under Stark, doctors are also forbidden to refer patients to any facility in which they or any members of their immediate families have financial interests. The AMA has published recommendations on the issue of self-referrals as an ethical issue as well. The AMA recommendations state that physicians should not refer to a facility at which they do not directly provide care or services when they have a financial interest in that facility. However, they make an exception for cases where there is a demonstrated need in the community for the facility and there is no alternative financing available.

ENFORCEMENT

The federal government has put into law several mechanisms for policing fraud and abuse: 1.) the Fraud and Abuse Control Program, a joint project of the Health and Human Services (HHS) Office of the Inspector General (OIG) and the Department of Justice; 2.) the Health Care Fraud and Abuse Control Account, which provides funds for the administration of healthcare fraud and abuse control

programs; 3.) the Medicare Integrity Program, which authorizes HHS to contract with private organizations to review the activities of healthcare professionals and entities who receive federal payments for their services, and generally set standards for Medicare and provide investigative, enforcement, and educational assistance to HHS; and 4.) the Beneficiary Incentive Program, which establishes a bounty system to encourage individuals to turn in information on any healthcare professionals or entities they suspect of committing fraud and abuse. A central database to record final adverse actions against healthcare professionals, providers, and suppliers has also been established under the Health Care Fraud and Abuse Data Collection Program.