Common Types of Health Care Fraud

Fraud, waste, and abuse pose major risks for the Medicaid program. “Fraud means 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.” “Abuse means 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.”[1]

Providers who engage in fraud and abuse are subject to sanctions under a number of Federal and State laws. Sanctions under Federal law, for example, can take the form of administrative,[2] civil,[3] and criminal[4] penalties. These penalties range from monetary fines and damages to prison time and exclusion from the Federal health care programs, including Medicaid. Becoming familiar with common types of fraud, waste, and abuse, will better position providers to ensure they are not involved in such conduct. Providers will also be better equipped to identify and report others who may be engaged in fraud, waste, and abuse.

This fact sheet provides a brief overview of some common types of Medicaid fraud, waste, and abuse involving providers. Although the examples involve violation of Federal laws, many States have similar laws against fraud, waste, and abuse. This list is not intended to be complete.

- **Medical Identity Theft**

  Medical identity theft involves the misuse of a person’s medical identity to wrongfully obtain health care goods, services, or funds.[5] 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.”[6] Stolen physician identifiers can be used to fill fraudulent prescriptions, refer patients for unnecessary additional services or supplies, or bill for services that were never provided.

Some people use beneficiary medical identifiers to fraudulently bill services or items not provided, or to enable an ineligible person to receive services by impersonating a beneficiary. Providers should take steps to protect their identifying information and that of their patients from unauthorized use. Health care professionals may obtain more information on medical identity theft by reviewing the "Medicaid Program Integrity: Understanding and Preventing Provider Medical Identity Theft" booklet posted to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Med-ID-Theft-Booklet-ICN908264.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

- **Billing for Unnecessary Services or Items**

  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."[7] States may "place appropriate limits on a service based on such criteria as medical necessity."[8] Providers are responsible for ensuring authorized services meet the definition of medical necessity in the States where they practice. Intentional billing of unnecessary services or items can lead to the serious consequences mentioned earlier.

- **Billing for Services or Items Not Furnished**

  To be covered by Medicaid, the billed service or supply must be provided. Some providers bill Medicaid for a covered service or item but do not deliver the service or item. These providers may create false records in an attempt to justify the bills. For example, a physician might sign charts and submit bills for examinations and tests that never took place. Providers should only bill for the medically necessary or otherwise authorized services or items provided to beneficiaries, and should ensure that proper documentation is in place. Health care professionals should exercise appropriate caution when evaluating offers of payment in exchange for reviewing medical records written by others.[9]

- **Upcoding**

  Upcoding is a term that is not defined in the regulations but is generally understood as billing for services at a higher level of complexity than the service actually provided or documented in the file.[10] For example, a supplier of durable medical equipment might bill for motorized scooters while supplying less expensive manual wheelchairs. As another example, a physician might bill simple office visits at the higher rate for complex visits. These practices are illegal. Providers should only bill for the level of services or items provided.

- **Unbundling**

  According to the Federal Bureau of Investigation, unbundling "is the practice of submitting bills in a fragmented fashion in order to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost."[11] For example, a laboratory might receive an order for a panel of blood tests on a patient. Instead of billing for the panel, the laboratory might attempt to increase its income by billing for each test separately. This is like ordering a value meal at a fast-food restaurant and then being charged the higher individual prices for each item. Providers who bill Medicaid are responsible for knowing which procedures are subject to bundling requirements and billing accordingly.

- **Kickbacks**

  Kickbacks can be defined as offering, soliciting, paying, or receiving remuneration (in kind or in cash) to induce, or in return for referral of patients or the generation of business involving any item or service for which payment may be made under Federal health care programs.[12, 13] Rewarding sources of new business may be acceptable in some industries, but not when Federal health care programs and beneficiaries are involved. For example, it would be illegal for a physician to accept payments from a medical imaging facility for referring patients. Kickbacks in health care can lead to overutilization, increased program costs, corruption of medical decision-making, patient steering, and unfair competition.

Specific examples of provider prosecutions and settlements resulting from these types of fraud are updated frequently and posted to https://oig.hhs.gov/fraud/enforcement/criminal/ on the U.S. Department of Health and Human Services, Office of Inspector General website.

To see the electronic version of this fact sheet and the other products included in the "Fraud, Waste, and Abuse" Toolkit posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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