Medicare Fraud
Medicare loses billions of dollars annually in fraud—an estimated $60 billion in 2012 alone. In addition to outright criminal activity, the Dartmouth Atlas of Health Care (which studies links between health care spending and outcomes) estimates that up to 30 percent of current health care spending is wasteful. This includes what is called “excessive” care: services that are costly but provide no measurable benefit to patients, or services that are needlessly duplicated. While patterns vary across the country, it has been shown that in many cases, a higher volume of care does not produce significantly better health outcomes.

The Centers for Medicare & Medicaid Services (CMS) share responsibility for ensuring Medicare program integrity with the Department of Health and Human Services’ Office of Inspector General (HHS OIG), the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

Medicare program integrity and antifraud activities are funded through the Health Care Fraud and Abuse Control (HCFAC) Program and Medicare Integrity Program (MIP).

HCFAC funds are directed to enforcement and prosecution of health care fraud and abuse, and MIP funds support the program integrity activities of CMS contractors.

Health Care Fraud and Abuse Control (HCFAC)

Efforts to combat fraud were consolidated and strengthened under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

HCFAC coordinates federal, state and local law enforcement activities to fight fraud, and it has returned more than $20 billion to the Medicare Trust Funds since its inception, with half of that amount—$10.7 billion—recovered in the three years between passage of the Affordable Care Act in March 2010 and February 2013 because of the new powers and penalties the ACA set in motion.

Programs supported by HCFAC have returned more money to the Medicare Trust Funds than the dollars spent to combat the fraud.

In 2013, the Attorney General certified $294.8 million in mandatory funding as necessary for the HCFAC to run the program and Congress appropriated an additional $309.7 million for a total of $604.6 million.
Medicare Integrity Program (MIP)

The CMS Medicare Integrity Program (MIP) works through its administrative contractors to identify and address fraud, waste, and abuse, which are all causes of improper payments.

Before 1996, contractors were expected to review claims and conduct audits, but funding constraints reduced their ability to do so. The Department of Health and Human Services (HHS) advocated for a dedicated program so that could retain experienced staff and be managed on a multi-year basis.

The Medicare Integrity Program (MIP) was established in 1997 by the Health insurance Portability and Accountability Act (HIPPA) of 1996 to meet these concerns.

CMS pays MIP funds to its Medicare contractors to conduct five activities to safeguard Medicare payments. These activities include 1) audits of required annual cost reports; 2) reviews of medical claims to determine whether services are medically reasonable and necessary; 3) determinations of who, between Medicare and other insurance sources, have primary and secondary responsibility for payment; 4) benefit integrity, which is identification and investigation of potential fraud cases; and 5) education to inform providers about appropriate billing procedures.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

In 2009, HHS and the DOJ created a special Health Care Fraud Prevention and Enforcement Action Team (HEAT). HEAT was organized to crack down on people and organizations that financially abuse the health care system, taking the fight against Medicare fraud to a Cabinet-level priority.

From its beginning to 2011, HEAT actions have led to a 75 percent increase in individuals charged with criminal health care fraud. In 2011, HEAT coordinated the largest-ever federal health care fraud takedown, involving $530 million in fraudulent billing.

Medicare Fraud Strike Force

The Medicare Fraud Strike Force was created 2007 as a multijurisdictional team bringing together federal, state and local investigators. Each Medicare Fraud Strike Force team is led by a federal prosecutor from the local U.S. Attorney's office or the HHS OIG Criminal Division’s Fraud Section, and includes the investigative support of the FBI and the OIG.

The largest take down by the strike force happened in May 2012 and involved $452 million in false billings. The government charged 107 individuals, including doctors and nurses in seven cities. HHS also suspended or took other administrative action against 52 providers.
In 2012 overall, the strike force achieved 251 guilty pleas and guilty verdicts against 29 defendants in jury trials. The average prison sentence in these cases was over four years.

Medicare fraud is more prevalent in certain metropolitan areas and the strike force has set up operations in nine of them. South Florida/Miami Dade area has the highest rate of fraud and is considered Ground Zero for Medicare fraud. South Florida/Miami-Dade became the first designated “hot spot” for Medicare fraud in 2007. Other cities followed as designated hot spots: Los Angeles in 2008; Detroit, Houston, Brooklyn, Tampa Bay and Baton Rouge in 2009; and Dallas and Chicago in 2011.

**Senior Medicare Patrols**

While HEAT and the Strike Force investigate and prosecute active abuse, the Senior Medicare Patrols (SMP) work on fraud prevention at the recipient level.

The SMP program empowers seniors through increased awareness and understanding of health care programs. The patrols include groups of highly trained volunteers who teach Medicare and Medicaid recipients how to detect and report fraud and protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error and abuse.

SMP members also work to resolve beneficiary complaints of potential fraud in partnership with state and national fraud control/consumer protection entities, including Medicare administrative contractors, state Medicaid fraud control units, state attorneys general, the OIG and the CMS.

From the inception of the program in 1997 through December 2011:

- More than 3.5 million beneficiaries have been educated over more than 94,000 group education sessions led by SMP staff or SMP projects;
- More than 1.2 million one-on-one counseling sessions were held with or on behalf of a beneficiary
- Nearly 27 million people are estimated to have been reached by SMP community education events;
- 1,913,909 media outreach events have been conducted;
- More than 1,545,000 inquiries, including one-on-one counseling and complaints regarding potential fraud, error or abuse, have been received from beneficiaries, their families or caregivers as a result of educational efforts; and
- Nearly $106 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings and other savings have been attributed to the project as a result of documented complaints.
Medicare Fraud

Four Approaches to Antifraud Activities

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services, organizes its antifraud activities into four categories:

• Fraud Prevention: The National Fraud Prevention Program provides enrollment and screening, engages Medicare beneficiaries, educates state Medicaid program integrity staff, markets antifraud efforts and works to improve payment accuracy.

• Fraud Detection: The CMS partners with providers and law enforcement on Parts C and D compliance, data analytics and audit activities and other enhanced analytics.

• Transparency and Accountability: These activities work toward increased coordination and collaboration with law enforcement, the private sector and states.

• Recovery: Collaboration with law enforcement (HEAT) and implementation of the Medicaid and Medicare Part C/D Recovery Audit Contractor (RAC) programs.

Common Forms of Medicare Fraud

Medicare and Medicaid fraud can take many forms. Common schemes include:

• Phantom billing, which is billing for tests that are not actually performed;

• Performing inappropriate or unnecessary procedures;

• Charging for equipment and supplies that were never ordered;

• Substituting used durable medical equipment for new;

• Billing for more expensive equipment than supplied;

• Certificates of Medical Necessity (CMN) completed by drug or equipment suppliers rather than physicians;

• “Reflex testing,” which is testing that is automatically ordered by the results of another test, rather than by physician request;

• “Defective Testing,” which is billing for a test or part of a test that was not performed because of technical issues, such as insufficient or destroyed samples or machine malfunction;

• “Code jamming,” which occurs when laboratories or providers insert or “jam” fake diagnosis codes into billing for extra Medicare/Medicaid reimbursement;

• Offering free services or supplies in exchange for a recipient’s Medicare or Medicaid number
• “Unbundling,” which is using two or more billing codes instead of one inclusive code for a defined panel of services where rules and regulations require “bundling” of such claims; or submitting multiple bills for tests and services that were performed within a specified time period and that should have been submitted as a single bill.

• “Double Billing,” which is charging more than once for the same service; for example, by billing using an individual code and again as part of an automated or bundled set of tests;

• “Up-Coding,” which is inflating bills by using billing codes that indicate the patient experienced medical complications and/or needed more expensive treatments. Examples would be billing for complex services when only simple services were performed, billing for brand-name drugs when generic drugs were provided, or listing treatment as having been for a more complicated diagnosis than was actually the case;

• Submitting charges for “phantom employees,” which are employees who do not exist;

• Submitting “improper cost reports,” which are false cost reports seeking higher Medicare reimbursements than facts permit; and

• Seeking Medicare reimbursement for substandard skilled nursing home care.

**Supply and Service Categories Most Frequently Abused**

Reimbursement abuse is most prevalent among certain categories of supplies and services. These include durable medical equipment (DME), such as wheelchairs, walkers, portable oxygen tanks; orthotics and other foot related supplies; prosthetics, aerosol medications, HIV infusion therapy, occupational and physical therapy; and community mental health centers and home health agencies.