

## Examples of Medicare Fraud, Waste and Abuse

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### Definitions:

|              |                                                                                                                                                                                                                                       |
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| <b>Fraud</b> | Intentional deception or misrepresentation made to gain unauthorized benefits. <ul style="list-style-type: none"><li>• Example: Billing for services not rendered.</li></ul>                                                          |
| <b>Waste</b> | Overuse or inefficient use of resources not caused by criminal intent. <ul style="list-style-type: none"><li>• Example: Ordering excessive tests without medical justification.</li></ul>                                             |
| <b>Abuse</b> | Practices inconsistent with sound medical, business, or fiscal practices that lead to unnecessary costs. <ul style="list-style-type: none"><li>• Example: Providing services at a frequency not supported by clinical need.</li></ul> |

### Key Indicators of Fraud, Waste and Abuse:

|                                        |                                                                                                                                                                                                                                                             |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Billing Red Flags</b>               | <ul style="list-style-type: none"><li>• Excessive billing compared to peers</li><li>• Services not medically necessary</li><li>• Billing inconsistent with specialty/taxonomy</li><li>• Unbundling of services</li><li>• Impossible day scenarios</li></ul> |
| <b>Beneficiary Indicators</b>          | <ul style="list-style-type: none"><li>• Complaints of services not rendered</li><li>• Complaints of unsolicited or unwanted services</li><li>• Reports of suspicious contact or solicitation</li></ul>                                                      |
| <b>Operational/Compliance Concerns</b> | <ul style="list-style-type: none"><li>• Non-operational or sham business sites</li><li>• Lapses in licensing or certification</li><li>• Excessive changes of ownership (CHOW)</li><li>• High hospice live discharge rate or length of stay</li></ul>        |
| <b>Provider Risk Factors</b>           | <ul style="list-style-type: none"><li>• Affiliation with suspect providers or owners</li><li>• Prior investigative history</li><li>• Patient harm or concerning clinical patterns.</li></ul>                                                                |

Below are examples of fraud that are outlined in the PIM. This list is not all-inclusive:

## **CMS Program Integrity Manual (PIM)**

### **Chapter 4**

#### **Subsection 4.2.1 – Examples of Medicare Fraud**

Fraud may take such forms as (this is not an exhaustive list):

- Incorrect reporting of diagnoses or procedures to maximize payments;
- Billing for services not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;
- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies, billing both Medicare and the beneficiary for the same service, or billing both Medicare and another insurer in an attempt to get paid twice;
- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount;
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment);
- Unbundling or “exploding” charges;
- Completing Certificates of Medical Necessity for patients not personally and professionally known by the provider;
- Participating in schemes that involve collusion between a provider and a beneficiary, or between a supplier and a beneficiary;
- Participating in schemes that involve collusion between a provider and a MAC employee where the claim is assigned (e.g., the provider deliberately overbills for services, and the MAC employee then generates adjustments with little or no awareness on the part of the beneficiary);
- Billing based on “gang visits,” (e.g., a physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients);
- Misrepresenting dates and descriptions of services furnished or the identity of the beneficiary or the individual who furnished the services;
- Billing non-covered or non-chargeable services as covered items;
- Repeatedly violating the participation agreement, assignment agreement, or the limitation amount;
- Knowingly allowing a beneficiary to use another person's Medicare card to obtain medical care;
- Giving false information about provider ownership; or
- Using the adjustment payment process to generate fraudulent payments.