KOVA IPA CMS Standardized Fraud, Waste & Abuse (FWA) Training Program

Prepared for: KOVA IPA
Version: 3
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This manual fulfills CMS Section 50.3.2 FWA Training requirements for First Tier, Downstream, and Related Entities (FDRs) under Medicare Parts C & D. It includes training elements required by CMS for FWA prevention, detection, and correction.

Part I – Purpose and Scope

The KOVA IPA CMS Standardized Fraud, Waste & Abuse (FWA) Training Program educates employees, contractors, and downstream entities about preventing, detecting, and reporting FWA in Medicare Advantage and Part D programs. This training aligns with CMS requirements under Chapter 21, Section 50.3.2 and must be completed within 90 days of hire or contract execution, and annually thereafter.

Part II – Laws and Regulations Related to FWA

The following laws govern the prevention of FWA within the Medicare program:

- **False Claims Act (31 U.S.C. §§ 3729–3733):** Prohibits knowingly submitting false or fraudulent claims to the Federal Government.
- **Anti-Kickback Statute (42 U.S.C. §1320a-7b):** Prohibits offering, paying, soliciting, or receiving remuneration for referrals or business related to Federal health care programs.
- **HIPAA/HITECH:** Protects patient privacy and ensures the security of health information.
- **Civil Monetary Penalties Law:** Establishes monetary penalties for improper claims and fraudulent activities.
- **CMS Requirement:** CMS's standardized FWA training module may be used by FDRs to meet this requirement.

Part III – FDR Responsibilities and Policies

FDRs must have and maintain written policies and procedures to detect, prevent, and correct FWA. These policies must define internal reporting processes, investigation steps, corrective actions, and documentation standards. All training and investigations must be recorded and retained for audit readiness.

Part IV – Reporting Suspected FWA

FDR employees must report suspected or detected FWA directly to the sponsor or to their employer's Compliance Officer, who must then report it to the sponsor. Reports should be submitted confidentially and without fear of retaliation.

FDRs must ensure reporting systems are well-publicized and easily accessible to all employees. Clear guidance must be available through posters, intranet links, and communication updates.

Part V – Protections for Employees Who Report FWA

Employees who report suspected FWA in good faith are protected from retaliation under Federal and State law. KOVA IPA and its FDRs enforce strict confidentiality and non-retaliation standards for all whistleblowers.

Part VI – Types of Fraud, Waste, and Abuse

Fraud: Knowingly and willfully submitting false information to obtain payment or benefits.
Waste: Overuse or misuse of services, resulting in unnecessary costs.
Abuse: Practices inconsistent with sound fiscal, business, or medical practices that result in unnecessary costs.

Examples include:
- Billing for services not provided.
- Providing medically unnecessary services.
- Falsifying documentation or credentials.
- Misusing patient or Medicare beneficiary information.

Part VII – Training and Proof of Completion

All FDR employees must complete FWA training within 90 days of hire or contract execution, and annually thereafter. Proof of completion must be maintained for 10 years and may include sign-in sheets, attestation forms, or LMS certifications.

Documentation must be made available to CMS or the plan sponsor upon request, even if the standardized CMS module is used.

Part VIII – Communication and Oversight

FDRs must communicate compliance information effectively throughout the organization. Information from the Compliance Officer should be shared promptly through email, internal postings, meetings, or websites.

The Compliance Officer ensures timely dissemination of FWA-related updates to all employees. The reporting system for FWA issues must be well-publicized and easily accessible.

Part IX – Review Questions (10 FWA Knowledge Test)

1. What does FWA stand for?

2. How often must FWA training be completed?

3. Who should employees report suspected FWA to?

4. Name one Federal law addressing FWA.

5. What protections are available for employees who report FWA?

6. List the three categories of FWA.

7. Provide one example of FWA in a healthcare setting.

8. What is the minimum documentation retention period for FWA training?

9. How should the Compliance Officer communicate updates?

10. When must new hires complete their initial FWA training?

KOVA Healthcare, Inc.	
Policy: Utilization Management	**Subject: Fraud, Waste and Abuse Program**
Effective Date: 6/01/2018	**Number: 2**
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Lines of Business: Medicare, Medi-Medi, Commercial	**Last Revision Date: 2/25/2025**

Fraud, Waste and Abuse Program

POLICY:

A. KOVA believes that Compliance with fraud prevention and reporting is everyone's responsibility.

B. KOVA has developed a Fraud, Waste and Abuse (FWA) Program to comply with certain requirements set forth in the Deficit Reduction Act of 2005 with regard to federal and state false claims laws, the Department of Managed Health Care (DMHC) and in accordance with Health and Safety Code, Section 1348, enacted in 1998 through SB 956, as well as to meet the expectations of the federal and state government in preventing and detecting fraud in federal or state funded programs such as Medi-Cal.

C. The objective of the KOVA FWA Program is to identify and reduce costs caused by fraudulent activities and to protect consumers, Members, health care providers and others in the delivery of health care services.

D. Providers, First Tier Entities, Downstream Entities, and Contractors are educated regarding the federal and state false claims statutes and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

E. KOVA has created a Compliance Committee (CC) and a Special Investigation Unit (SIU) That reports to the Compliance Officer to oversee its FWA Program and to manage all instances of suspected fraud.

F. All activities of the CC and SIU are confidential to the extent permitted by law.

G. KOVA reports its fraud prevention activities and suspected fraud to regulatory and law enforcement agencies as required by law and contractual obligations.

H. Providers, First Tier Entities, Downstream Entities, and Contractors must adhere to Federal and California State laws, including but not limited to False Claims laws.

I. Providers, First Tier Entities, Downstream Entities, and Contractors with KOVA will comply with Federal and California State laws in regard to the detection, reporting, and investigation of suspected fraud and abuse.

J. Providers, First Tier Entities, Downstream Entities, and Contractors with KOVA will participate in investigations as needed.

DEFINITIONS:

A. Providers, First Tier Entities, Downstream Entities, and Contractors must adhere to Federal and California State laws, including but not limited to False Claims laws.

B. Providers, First Tier Entities, Downstream Entities, and Contractors with KOVA will comply with Federal and California State laws in regard to the detection, reporting, and investigation of suspected fraud and abuse.

C. Providers, First Tier Entities, Downstream Entities, and Contractors with KOVA will

participate in investigations as needed.

REFERENCES:

A. Code of Federal Regulations, Title 42, §438.608 and §455.2
B. Federal False Claims Act, US Code, Title 31
C. California Code of Regulations, Title 22, §53891
D. Health and Safety Code §1348
E. DHCS Contract 04-35765
F. Welfare & Institution Code, §14043.1

PROCEDURES:

A. **KOVA FWA Program**; is designed to deter, identify, investigate, and resolve potentially fraudulent activities that may occur in KOVA daily operations, both internally and externally.

B. **Responsibilities of KOVA's Compliance Officer;** for ensuring that the objectives of KOVA FWA Program are carried out, and for preventing, detecting, and investigating fraud-related issues in a timely manner. To accomplish this, the Compliance Officer designates and oversees the Compliance Department to perform the following responsibilities:
    1. Developing fraud, waste, and abuse training programs to educate staff, Providers, practitioners, Members, First Tier Entities, Downstream Entities, and Contractors on prevention, deterrence and detection of fraud, waste, and abuse.
    2. Identifying, detecting, thoroughly investigating, managing, and resolving all suspected instances of fraud, waste, and abuse, internally and externally.
    3. Cooperating with, reporting, and referring suspected fraud, waste, and abuse to the appropriate governmental and law enforcement agencies, as applicable, including exchange of information as appropriate.

KOVA Responsibilities for Fraud Prevention.

A. **KOVA Responsibilities** include, but are not limited to the following:

    1. Training KOVA staff, Providers, practitioners, First Tier Entities, Downstream Entities, and Contractors on fraud; KOVA Fraud, Waste and Abuse Program, and fraud prevention activities at least annually.

    2. Communicating its FWA and efforts through KOVA's website, the KOVA Provider Policy and Procedure Manual, KOVA Provider Newsletter, Joint Operation Meetings, targeted mailings, or in-service meetings.

    3. Continuous monitoring and oversight, both internally and externally, of daily operational activities to detect and/or deter fraudulent behavior. Such activities include, but are not limited to:
        1. Monitoring of Member grievances
        2. Monitoring of Provider and physician grievances
        3. Claims Audits and monitoring activities, including audits of the P4P Program and other direct reimbursement programs to physicians
        4. Review of Providers' financial statements
        5. Medical Management Audits
        6. Utilization Management monitoring activities
        7. Quality Management monitoring activities
        8. Case Management Oversight activities
        9. Pharmacy Audits
        10. Encounter Data Reporting Edits
        11. Chart Audits

12. Clinical Audits

4. Investigating and resolving all reported and/or detected suspected instances of fraud and taking action against confirmed suspected fraud, waste or abuse, including but not limited to reporting to law enforcement agencies, termination of the KOVA contract (if a Provider, direct contracting practitioner, First Tier Entities, Downstream Entities, and Contractors), and/or removal of a participating practitioner from the KOVA network.
5. KOVA reports suspected fraud, waste or abuse to the following entities, as deemed appropriate and required by law:
    1. The California Department of Justice, Bureau of Medi-Cal Fraud
    2. The California Department of Health Care Services (DHCS), Investigations Branch
    3. The Centers for Medicare and Medicaid Services (CMS) through the Medicare
    4. Drug Integrity Contractor (MEDIC).
    5. Department of Managed Health Care (DMHC)
    6. Local law enforcement agencies
    7. Office of Inspector General (OIG)
    8. Submitting periodic reports to DHCS, DMHC, or CMS as required by law.
    9. Encouraging and supporting Provider activities related to fraud prevention and detection.

The Providers, First Tier Entities, Downstream Entities, and Contractor's Responsibilities

A. **Fraud Prevention and Detection Include**, but are not limited to, the following:

1. Training staff, on KOVA and Provider's Fraud, Waste and Abuse (FWA) Program and fraud, waste and abuse prevention activities and false claims laws upon initial employment and at least annually thereafter;
2. Verifying and documenting the presence/absence of office staff and contracted individuals and/or entities by accessing the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE); the General Services Administration Excluded Parties List (GSA); and/ or the California Medi-Cal exclusion list, available online, prior to hire or contracting and monthly thereafter:
3. Terminating the KOVA Medi-Cal network participation of individuals and/or entities who appear on any of the exclusion lists. Developing a FWA Program, implementing fraud, waste and abuse prevention activities and communicating such program and activities to staff, contractors, and subcontractors.
4. Communicating awareness, including:
    1. Identification of fraud, waste, and abuse schemes.
    2. Detection methods and monitoring activities to contracted and subcontracted entities and KOVA.
    3. Notifying KOVA of suspected fraudulent behavior and asking for assistance in completing investigations.
    4. Participating in the investigation process as needed.
    5. Taking action against suspected or confirmed fraud, waste and abuse including referring such instances to MEDIC, DHCS and/or law enforcement and reporting activity to KOVA.

6. Policing and/or monitoring own activities and operations to detect, deter and correct fraudulent behavior.
7. Cooperating with KOVA in fraud, waste and abuse detection and awareness activities, including monitoring, reporting, etc., as well as cooperating with KOVA in fraud, waste or abuse investigations to the extent permitted by law.
8. Return of identified overpayments of state and/or federal claims within federal timelines.

B. Reporting Concerns Regarding Fraud, Waste Abuse and False Alarms

1. KOVA takes issues regarding false claims and fraud, waste and abuse seriously. KOVA providers, and their contractors or agents of KOVA's providers are to be aware of the laws regarding fraud, waste and abuse and false claims and to identify and resolve any issues immediately. Affiliated providers' employees, managers, and contractors are to report concerns to their immediate supervisor when appropriate.
2. KOVA provides the following ways in which to report alleged and/or suspected fraud, waste and/or abuse directly to the plan:
    1. In writing to:

        Compliance Officer
        KOVA Healthcare, Inc.
        7061 N. Whitney Ave. Suite 102
        Fresno, Ca. 93720

    2. By E-mail to: amym@kovahealth.com
    3. By fax to: (559) 207-3901
3. The Suspected Noncompliance/Fraud Report Form is to be completed when reporting concerns regarding fraud, waste, abuse, and false claims
4. The following information is needed in order for KOVA to investigate suspected fraud, waste and/or abuse:
    1. Your name. title and organization name. Although you may choose to report anonymously. If you choose to give your name, please provide a contact number and a date and time for a return call at a time and place confidential for you.
    2. The name(s) of the party/parties/departments involved in the suspected fraud.
    3. Where the suspected fraud may have occurred.
    4. Details on the suspected activity.
    5. When the suspected fraud took place, for example over what period of time. A description of any documentation in your possession that may support the allegation of fraud, waste and/or abuse.
    6. Information reported to the KOVA Compliance Department or
    7. Special Investigation Unit will remain confidential to the extent allowable by law.
5. KOVA expressly prohibits retaliation against those who, in good faith, report potential fraud, waste, and abuse to the Fraud, Waste and Abuse Program. Information of Whistleblower Protections and the False Claims Act is included in the annual Compliance Training Program available to Providers, First Tier Entities, Downstream Entities, and Contractors

mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

Medicare Fraud & Abuse: Prevent, Detect, Report

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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Updates

- Note: No substantiative content updates.

Medicare Fraud and Abuse: A Serious Problem That Needs Your Attention

Although no precise measure of health care fraud exists, those who exploit Federal health care programs can cost taxpayers billions of dollars while putting beneficiaries' health and welfare at risk. The impact of these losses and risks magnifies as Medicare continues to serve a growing number of beneficiaries.

Most physicians try to work ethically, provide high-quality patient medical care, and submit proper claims. Trust is core to the physician-patient relationship. Medicare also places enormous trust in physicians. Medicare and other Federal health care programs rely on physicians' medical judgment to treat patients with appropriate, medically necessary services, and to submit accurate claims for Medicare-covered health care items and services.

You play a vital role in protecting the integrity of the Medicare Program. To combat fraud and abuse, you must know how to protect your organization from engaging in abusive practices and violations of civil or criminal laws. This booklet provides the following tools to help protect the Medicare Program, your patients, and yourself:

- Medicare fraud and abuse examples
- Overview of fraud and abuse laws
- Government agencies and partnerships dedicated to preventing, detecting, and fighting fraud and abuse
- Resources for reporting suspected fraud and abuse

Help Fight Fraud by Reporting It

The Office of Inspector General (OIG) Hotline accepts tips and complaints from all sources on potential fraud, waste, and abuse. View instructional videos about the OIG Hotline operations, as well as reporting fraud to the OIG.

Health care professionals who exploit Federal health care programs for illegal, personal, or corporate gain create the need for laws that combat fraud and abuse and ensure appropriate, quality medical care.

Physicians frequently encounter the following types of business relationships that may raise fraud and abuse concerns:

- Relationships with payers
- Relationships with fellow physicians and other providers
- Relationships with vendors

These key relationships and other issues addressed in this booklet apply to all physicians, regardless of specialty or practice setting.

What Is Medicare Fraud?

Medicare **fraud** typically includes any of the following:

- Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering, or paying remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health services

Case Studies

To learn about real-life cases of Medicare fraud and abuse and the consequences for culprits, visit the Medicare Fraud Strike Force webpage.

Anyone can commit health care fraud. Fraud schemes range from solo ventures to widespread activities by an institution or group. Even organized crime groups infiltrate the Medicare Program and operate as Medicare providers and suppliers. Examples of Medicare fraud include:

- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the medical records
- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items
- Knowingly ordering medically unnecessary items or services for patients
- Paying for referrals of Federal health care program beneficiaries
- Billing Medicare for appointments patients fail to keep

Defrauding the Federal Government and its programs is illegal. Committing Medicare fraud exposes individuals or entities to potential criminal, civil, and administrative liability, and may lead to imprisonment, fines, and penalties.

Criminal and civil penalties for Medicare fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate intervention. Providers and health care organizations involved in health care fraud risk being excluded from participating in all Federal health care programs and losing their professional licenses.

What Is Medicare Abuse?

Abuse describes practices that may directly or indirectly result in unnecessary costs to the Medicare Program. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care.

The difference between "fraud" and "abuse" depends on specific facts, circumstances, intent, and knowledge.

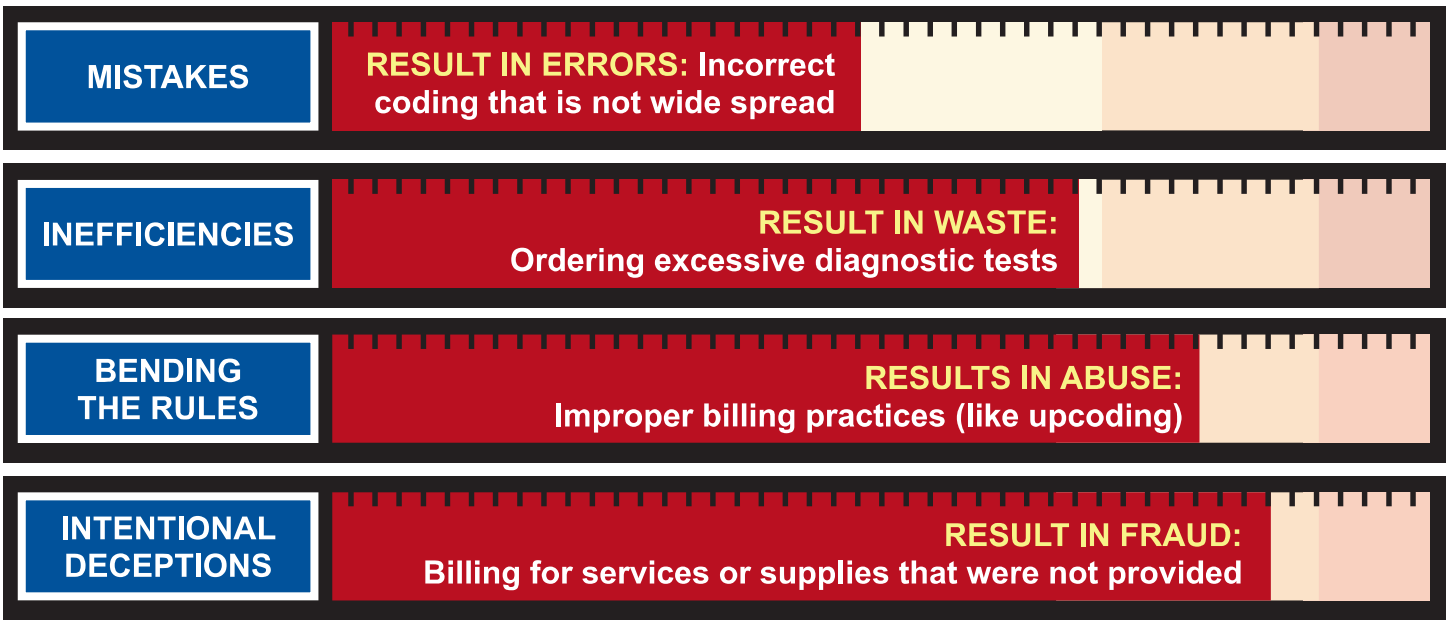
Examples of Medicare abuse include:

- Billing for unnecessary medical services
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes. Upcoding is when a provider assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement.

Medicare abuse can also expose providers to criminal and civil liability.

Program integrity includes a range of activities targeting various causes of improper payments. Figure 1 shows examples along the range of possible types of improper payments.

Figure 1. Types of Improper Payments*



*The types of improper payments in Figure 1 are strictly examples for educational purposes, and the precise characterization of any type of improper payment depends on a full analysis of specific facts and circumstances. Providers who engage in incorrect coding, ordering excessive diagnostic tests, upcoding, or billing for services or supplies not provided may be subject to administrative, civil, or criminal liability.

Medicare Fraud and Abuse Laws

Federal laws governing Medicare fraud and abuse include the:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)
- Social Security Act, which includes the Exclusion Statute and the Civil Monetary Penalties Law (CMPL)
- United States Criminal Code

Fraud and Abuse in Medicare Part C, Part D, and Medicaid

In addition to Medicare Part A and Part B, Medicare Part C and Part D and Medicaid programs prohibit the fraudulent conduct addressed by these laws.

These laws specify the criminal, civil, and administrative penalties and remedies the government may impose on individuals or entities that commit fraud and abuse in the Medicare and Medicaid Programs.

Violating these laws may result in nonpayment of claims, Civil Monetary Penalties (CMP), exclusion from all Federal health care programs, and criminal and civil liability.

Government agencies, including the U.S. Department of Justice (DOJ), the U.S. Department of Health & Human Services (HHS), the HHS Office of Inspector General (OIG), and the Centers for Medicare and Medicaid Services (CMS), enforce these laws.

Federal Civil False Claims Act (FCA)

The civil FCA, 31 United States Code (U.S.C.) Sections 3729–3733, protects the Federal Government from being overcharged or sold substandard goods or services. The civil FCA imposes civil liability on any person who **knowingly** submits, or **causes** the submission of, a false or fraudulent claim to the Federal Government.

The terms “knowing” and “knowingly” mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. **No specific intent to defraud is required to violate the civil FCA.**

Examples: A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than actually provided.

Penalties: Civil penalties for violating the civil FCA may include recovery of up to **three** times the amount of damages sustained by the Government as a result of the false claims, plus financial penalties per false claim filed.

Additionally, under the criminal FCA, 18 U.S.C. Section 287, individuals or entities may face criminal penalties for submitting false, fictitious, or fraudulent claims, including fines, imprisonment, or both.

Anti-Kickback Statute (AKS)

The AKS, 42 U.S.C. Section 1320a-7b(b), makes it a crime to **knowingly and willfully** offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward patient referrals or the generation of business involving any item or service reimbursable by a Federal health care program. When a provider offers, pays, solicits, or receives unlawful **remuneration**, the provider violates the AKS.

Anti-Kickback Statute vs. Stark Law

Refer to the Comparison of the Anti-Kickback Statute and Stark Law handout.

NOTE: Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

Example: A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals.

Penalties: Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participation in the Federal health care program. Under the CMPL, penalties for violating the AKS may include **three** times the amount of the kickback.

The "safe harbor" regulations, 42 Code of Federal Regulations (C.F.R.) Section 1001.952, describe various payment and business practices that, although they potentially implicate the AKS, are not treated as offenses under the AKS if they meet certain requirements specified in the regulations. Individuals and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their businesses.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, 42 U.S.C. Section 1395nn, often called the Stark Law, prohibits a physician from referring patients to receive "designated health services" payable by Medicare or Medicaid to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applies.

Example: A physician refers a beneficiary for a designated health service to a clinic where the physician has an investment interest.

Penalties: Penalties for physicians who violate the Stark Law may include fines, CMPs for each service, repayment of claims, and potential exclusion from participation in the Federal health care programs.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute, 18 U.S.C. Section 1347 prohibits **knowingly and willfully** executing, or attempting to execute, a scheme or lie in connection with the delivery of, or payment for, health care benefits, items, or services to either:

- Defraud any health care benefit program
- Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary claims for power wheelchairs.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Exclusion Statute

The Exclusion Statute, 42 U.S.C. Section 1320a-7, requires the OIG to exclude individuals and entities convicted of any of the following offenses from participation in all Federal health care programs:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances

The OIG also may impose permissive exclusions on other grounds, including:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud, or misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard services
- Submitting false or fraudulent claims to a Federal health care program
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

Excluded providers may not participate in the Federal health care programs for a designated period. If you are excluded by OIG, then Federal health care programs, including Medicare and Medicaid, will not pay for items or services that you furnish, order, or prescribe. Excluded providers may not bill directly for treating Medicare and Medicaid patients, and an employer or a group practice may not bill for an excluded provider's services. At the end of an exclusion period, an excluded provider must seek reinstatement; reinstatement is not automatic.

The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE).

Civil Monetary Penalties Law (CMPL)

The CMPL, 42 U.S.C. Section 1320a-7a, authorizes OIG to seek CMPs and sometimes exclusion for a variety of health care fraud violations. Different amounts of penalties and assessments apply based on the type of violation. CMPs also may include an assessment of up to **three** times the amount claimed for each item or service, or up to **three** times the amount of remuneration offered, paid, solicited, or received. Violations that may justify CMPs include:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or that is false and fraudulent
- Violating the AKS
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs

CMP Inflation Adjustment

Each year, the Federal Government adjusts all CMPs for inflation. The adjusted amounts apply to civil penalties assessed after August 1, 2016, and violations after November 2, 2015. Refer to 45 C.F.R. Section 102.3 for the yearly inflation adjustments.

Physician Relationships With Payers

The U.S. health care system relies heavily on third-party payers to pay the majority of medical bills on behalf of patients. **When the Federal Government covers items or services rendered to Medicare and Medicaid beneficiaries, the Federal fraud and abuse laws apply.** Many similar State fraud and abuse laws apply to your provision of care under state-financed programs and to private-pay patients.

Accurate Coding and Billing

As a physician, payers trust you to provide medically necessary, cost-effective, quality care. You exert significant influence over what services your patients get. You control the documentation describing services they receive, and your documentation serves as the basis for claims you submit. Generally, Medicare pays claims based solely on your representations in the claims documents.

When you submit a claim for services provided to a Medicare beneficiary, you are filing a bill with the Federal government and certifying you earned the payment requested and complied with the billing requirements. If you knew or should have known the submitted claim was false, then the attempt to collect payment is illegal. Examples of improper claims include:

- Billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided
- Billing medically unnecessary services
- Billing services not provided
- Billing services performed by an improperly supervised or unqualified employee
- Billing services performed by an employee excluded from participation in the Federal health care programs
- Billing services of such low quality they are virtually worthless
- Billing separately for services already included in a global fee, like billing an evaluation and management service the day after surgery

Physician Documentation

Maintain accurate and complete medical records and documentation of the services you provide. Ensure your documentation supports the claims you submit for payment. **Good documentation practices help to ensure your patients get appropriate care and allow other providers to rely on your records for patients' medical histories.**

The Medicare Program may review beneficiaries' medical records. Good documentation helps address any challenges raised about the integrity of your claims. You may have heard the saying regarding malpractice litigation: "If you didn't document it, it's the same as if you didn't do it." The same can be said for Medicare billing.

Accuracy of Medical Record Documentation

For more information on physician documentation, refer to the Evaluation and Management Services guide, Complying With Medical Record Documentation Requirements fact sheet, and an OIG video on the Importance of Documentation.

Upcoding

Medicare pays for many physician services using Evaluation and Management (E/M) codes. New patient visits generally require more time than established patient follow-up visits. Medicare pays new patient E/M codes at higher reimbursement rates than established patient E/M codes.

Example: Billing an established patient follow-up visit using a higher-level E/M code, such as a comprehensive new-patient office visit.

Another example of E/M upcoding is misusing modifier –25. Modifier –25 allows additional payment for a significant, separately identifiable E/M service provided on the same day of a procedure or other service. Upcoding occurs when a provider uses modifier –25 to claim payment for a medically unnecessary E/M service, an E/M service not distinctly separate from the procedure or other service provided, or an E/M service not above and beyond the care usually associated with the procedure.

Physician Relationships With Other Providers

Anytime a health care business offers you something for free or below fair market value, ask yourself, "**Why?**"

Physician Investments in Health Care Business Ventures

Some physicians who invest in health care business ventures with outside parties (for instance, imaging centers, laboratories, equipment vendors, or physical therapy clinics) refer more patients for the services provided by those parties than physicians who do not invest. These business relationships may improperly influence or distort physician decision-making and result in the improper steering of patients to a therapy or service where a physician has a financial interest.

Excessive and medically unnecessary referrals waste Federal Government resources and can expose Medicare beneficiaries to harm from unnecessary services. Many of these investment relationships have serious legal risks under the AKS and Stark Law.

Physician Investments

For more information on physician investments, refer to the OIG's:

- Special Fraud Alert: Joint Venture Arrangements
- Special Fraud Alert: Physician-Owned Entities
- Special Advisory Bulletin: Contractual Joint Ventures

If someone invites you to invest in a health care business whose products you might order or to which you might refer your patients, ask yourself the following questions. If you answer "yes" to any of them, you should carefully consider the reasons for your investment.

- Is the investment interest offered to you in exchange for a nominal capital contribution?
- Is the ownership share offered to you larger than your share of the aggregate capital contributions made to the venture?
- Is the venture promising you high rates of return for little or no financial risk?
- Is the venture, or any potential business partner, offering to loan you the money to make your capital contribution?

- Are you promising or guaranteeing to refer patients or order items or services from the venture?
- Are you more likely to refer patients for the items and services provided by the venture if you make the investment?
- Does the venture have sufficient capital from other sources to fund its operations?

Physician Recruitment

Hospitals and other health systems may provide a physician-recruitment incentive to induce you to relocate to the hospital's geographic area, join its medical staff, and establish a practice to help serve a community's medical needs. Often, such recruitment efforts fill a legitimate "clinical gap" in a medically underserved area where attracting physicians may be difficult in the absence of financial incentives.

However, in some communities, especially ones with multiple hospitals, hospitals fiercely compete for patients. To gain referrals, some hospitals may offer illegal incentives to you or to the established physician practice you join in the hospital's community. This means the competition for your loyalty can cross the line into an illegal arrangement with legal consequences for you and the hospital.

A hospital may pay you a fair market-value salary as an employee or pay you fair market value for specific services you render to the hospital as an independent contractor. However, the hospital may **not** offer you money, provide you free or below-market rent for your medical office, or engage in similar activities designed to influence your referral decisions. **Admit your patients to the hospital best suited to care for their medical conditions or to the hospital your patients select based on their preference or insurance coverage.**

Within very specific parameters of the Stark Law and subject to compliance with the AKS, hospitals may provide relocation assistance and practice support under a properly structured recruitment arrangement to assist you in establishing a practice in the hospital's community. If a hospital or physician practice separately or jointly recruit you as a new physician to the community, they may offer a recruitment package. Unless you are a hospital employee, you cannot negotiate for benefits in exchange for an implicit or explicit promise to admit your patients to a specific hospital or practice setting. Seek knowledgeable legal counsel if a prospective business relationship requires you to admit patients to a specific hospital or practice group.

Physician Relationships With Vendors

Free Samples

Many drug and biologic companies provide free product samples to physicians. It is legal to give these samples to your patients free of charge, but it is illegal to sell the samples. The Federal Government has prosecuted physicians for billing Medicare for free samples. If you choose to accept free samples, you need reliable systems in place to safely store the samples and ensure samples remain separate from your commercial stock.

Pharmaceutical and Medical Device Industries Codes of Ethics

Both the pharmaceutical industry, through the Pharmaceutical Research and Manufacturers of America (PhRMA), and the medical device industry, through the Advanced Medical Technology Association (AdvaMed), adopted codes of ethics regarding relationships with health care professionals. For more information, visit the PhRMA Code on Interactions With Health Care Professionals and the AdvaMed Code of Ethics.

Relationships With the Pharmaceutical and Medical Device Industries

Some pharmaceutical and device companies use sham consulting agreements and other arrangements to buy physician loyalty to their products. As a practicing physician, you may have opportunities to work as a consultant or promotional speaker for the drug or device industry. For every financial relationship offered to you, evaluate the link between the services you can provide and the compensation you will get. Test the appropriateness of any proposed relationship by asking yourself the following questions:

- Does the company **really** need **your** specific expertise or input?
- Does the company's monetary compensation to you represent a **fair, appropriate,** and **commercially reasonable** exchange for your services?
- Is it possible the company is paying for **your loyalty,** so you prescribe its drugs or use its devices?

If your contribution is your time and effort or your ability to generate useful ideas and the payment you receive is fair-market-value compensation for your services without regard to referrals, then, depending on the circumstances, you may legitimately serve as a bona fide consultant. **If your contribution is your ability to prescribe a drug, use a medical device, or refer patients for services or supplies, the potential consulting relationship likely is one you should avoid as it could violate fraud and abuse laws.**

Transparency in Physician-Industry Relationships

Although some physicians believe free lunches, subsidized trips, and gifts do not affect their medical judgment, research shows these types of privileges can influence prescribing practices.

Federal Open Payments Program

The Federal Open Payments Program highlights financial relationships among physicians, teaching hospitals, and drug and device manufacturers. Drug, device, and biologic companies must publicly report nearly all gifts or payments made to physicians.

Industry Relationships

For more information on distinguishing between legitimate and questionable industry relationships, refer to the OIG's Compliance Program Guidance for Pharmaceutical Manufacturers.

The Federal Open Payments Program requires pharmaceutical and medical device manufacturers to publicly report payments to physicians and teaching hospitals. CMS posts Open Payments data on June 30 each year, including payments or other transfers of value and ownership or investment interest reports. CMS closely monitors this process to ensure integrity in the reported data.

Publicly available information about you includes:

- Activities such as speaking engagements
- Educational materials such as text books or journal reprints
- Entertainment
- Gifts
- Meals
- Participation in a paid advisory board
- Travel expenses

CMS does not require physicians to register with, or send information to, Federal Open Payments. However, CMS encourages your help to ensure accurate information by doing the following:

- Register with the Open Payments Program and subscribe to the electronic mailing list for Program updates
- Review the information manufacturers and GPOs submit on your behalf
- Work with manufacturers and GPOs to settle data issues about your Open Payments profile

Conflict-of-Interest Disclosures

Many of the relationships discussed in this booklet are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you may be obligated to disclose their existence. Rules about disclosing and managing conflicts of interest come from a variety of sources, including grant funders, such as states, universities, and the National Institutes of Health (NIH), and from the U.S. Food and Drug Administration (FDA) when you submit data to support marketing approval for new drugs, devices, or biologics.

If you are uncertain whether a conflict exists, ask yourself if you would want the arrangement to appear in the news.

Continuing Medical Education (CME)

You are responsible for your CME to maintain State licensure, hospital privileges, and board certification. Drug and device manufacturers sponsor many educational opportunities for physicians. **It is important to distinguish between CME sessions that are educational and sessions that constitute marketing by a drug or device manufacturer.** If speakers recommend prescribing a drug when there is no FDA approval or prescribing a drug for children when the FDA has approved only adult use, independently seek out the empirical data supporting these recommendations.

NOTE: Although physicians may prescribe drugs for off-label uses, it is illegal under the Federal Food, Drug, and Cosmetic Act for drug manufacturers to promote off-label drug use.

FDA Bad Ad Program

Drugs, biologics, medical devices, and other promotional advertisements must be truthful, not misleading, and limited to approved uses. The FDA requests physicians' assistance in identifying misleading advertisements through its Bad Ad Program. If you spot advertising violations, report them to the FDA by calling 877-RX-DDMAC (877-793-3622) or by emailing BadAd@fda.gov.

Watch What To Do About Misleading Drug Ads for more information.

Compliance Programs for Physicians

Physicians treating Medicare beneficiaries should establish a compliance program. Establishing and following a compliance program helps physicians avoid fraudulent activities and submit accurate claims. The following seven components provide a solid basis for a physician practice compliance program:

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards
3. Designate a compliance officer or contact
4. Conduct appropriate training and education
5. Respond appropriately to detected offenses and develop corrective action
6. Develop open lines of communication with employees
7. Enforce disciplinary standards through well-publicized guidelines

Compliance Programs for Physicians

For more information on compliance programs for physicians, visit the OIG Compliance webpage or watch this Compliance Program Basics video.

Medicare Anti-Fraud and Abuse Partnerships and Agencies

Government agencies partner to fight fraud and abuse, uphold the integrity of the Medicare Program, save and recoup taxpayer funds, reduce health care costs, and improve the quality of health care.

Health Care Fraud Prevention Partnership (HFPP)

The HFPP is a voluntary public-private partnership among the federal government, State agencies, law enforcement, private health insurance plans, and health care anti-fraud associations. The HFPP fosters a proactive approach to detect and prevent health care fraud through data and information sharing.

Centers for Medicare & Medicaid Services (CMS)

CMS is the Federal agency within HHS that administers the Medicare Program, Medicaid Program, State Children's Health Insurance Program (SCHIP), Clinical Laboratory Improvement Amendments (CLIA), and several other health-related programs.

To prevent and detect fraud and abuse, CMS works with individuals, entities, and law enforcement agencies, including:

- Accreditation Organizations (AO)
- Medicare beneficiaries and caregivers
- Physicians, suppliers, and other health care providers
- State and Federal law enforcement agencies, including the OIG, Federal Bureau of Investigation (FBI), DOJ, State Medicaid Agencies, and Medicaid Fraud Control Units (MFCU)

To support its efforts to prevent, detect, and investigate potential Medicare fraud and abuse, CMS also partners with a selection of contractors.

Table 1. Contractor Efforts to Prevent, Detect, and Investigate Fraud and Abuse

Contractor	Role
Comprehensive Error Rate Testing (CERT) Contractors	Help calculate the Medicare Fee-For-Service (FFS) improper payment rate by reviewing claims to determine if they were paid properly
Medicare Administrative Contractors (MAC)	Process claims and enroll providers and suppliers
Medicare Drug Integrity Contractors (MEDIC)	Monitor fraud, waste, and abuse in the Medicare Parts C and D Programs. Beginning January 2, 2019, the Centers for Medicare & Medicaid Services (CMS) will have two Medicare Drug Integrity Contractors (MEDICs), the National Benefit Integrity (NBI MEDIC) and the Investigations (I-MEDIC).
Recovery Audit Program Recovery Audit Contractors (RACs)	Reduce improper payments by detecting and collecting overpayments and identifying underpayments
Zone Program Integrity Contractors (ZPIC) Formerly called Program Safeguard Contractors (PSC)	Investigate potential fraud, waste, and abuse for Medicare Parts A and B; Durable Medical Equipment Prosthetics, Orthotics, and Supplies; and Home Health and Hospice
Unified Program Integrity Contractors (UPIC)	Combine and integrate Medicare and Medicaid Program Integrity audit and investigation work functions into a single contract

Within CMS, the Center for Program Integrity (CPI) promotes the integrity of Medicare through audits, policy reviews, and identifying and monitoring program vulnerabilities. CPI oversees CMS' collaboration with key stakeholders on program integrity issues related to detecting, deterring, monitoring, and combating fraud and abuse.

In 2010, HHS and CMS launched the Fraud Prevention System (FPS), a state-of-the-art predictive analytics technology that runs predictive algorithms and other analytics nationwide on all Medicare FFS claims prior to payment to detect potentially suspicious claims and patterns that may constitute fraud and abuse.

In 2012, CMS created the Program Integrity Command Center to bring together Medicare and Medicaid officials, clinicians, policy experts, CMS fraud investigators, and the law enforcement community, including the OIG and FBI. The Command Center gathers these experts to develop and improve intricate predictive analytics that identify fraud and mobilize a rapid response. CMS connects instantly with its field offices to evaluate fraud allegations through real-time investigations. Previously, finding substantiating evidence of a fraud allegation took days or weeks; now it can take only hours.

Office of the Inspector General (OIG)

The OIG protects the integrity of HHS' programs and the health and welfare of program beneficiaries. The OIG operates through a nationwide network of audits, investigations, inspections, evaluations, and other related functions. The Inspector General is authorized to, among other things, exclude individuals and entities who engage in fraud or abuse from participation in all Federal health care programs, and to impose CMPs for certain violations.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

The DOJ, OIG, and HHS established HEAT to build and strengthen existing programs combatting Medicare fraud while investing new resources and technology to prevent and detect fraud and abuse. HEAT expanded the DOJ-HHS Medicare Fraud Strike Force, which targets emerging or migrating fraud schemes, including fraud by criminals masquerading as health care providers or suppliers.

General Services Administration (GSA)

The GSA consolidated several Federal procurement systems into one new system: the System for Award Management (SAM). SAM includes information on entities that are:

- Debarred or proposed for debarment
- Disqualified from certain types of Federal financial and non-financial assistance and benefits
- Disqualified from receiving Federal contracts or certain subcontracts
- Excluded or suspended from the Medicare Program

Report Suspected Fraud

Table 2. Where Should You Report Fraud and Abuse?

If You Are a…	Report Fraud to…
Medicare Beneficiary	For any complaint: • **CMS Hotline**: Phone: 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048 AND • **OIG Hotline**: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950 Fax: 1-800-223-8164 Online: Forms.oig.hhs.gov/hotlineoperations/index.asp Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 For Medicare Part C (Medicare Advantage) or Part D (Prescription Drug Plans) complaints: • 1-877-7SafeRx (1-877-772-3379)
Medicare Provider	• **OIG Hotline**: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950 Fax: 1-800-223-8164 Online: Forms.oig.hhs.gov/hotlineoperations/index.asp Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 OR • Contact your MAC

Table 2. Where Should You Report Fraud and Abuse? (cont.)

If You Are a…	Report Fraud to…
Medicaid Beneficiary or Provider	• **OIG Hotline**: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950 Fax: 1-800-223-8164 Online: Forms.oig.hhs.gov/hotlineoperations/index.asp Mail: U.S. Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026 OR • Your Medicaid State Agency: State MFCUs are listed in the National Association of Medicaid Fraud Control Units (NAMFCU)

If you prefer to report fraud and abuse **anonymously** to the **OIG Hotline**, the OIG record systems collect no information that could trace the complaint to you. However, lack of contact information may prevent OIG's comprehensive review of the complaint, so the OIG encourages you to provide contact information for possible follow-up.

Medicare and Medicaid beneficiaries can learn more about protecting themselves and spotting fraud by contacting their local Senior Medicare Patrol (SMP) program.

For questions about Medicare billing procedures, billing errors, or questionable billing practices, contact your MAC.

Where to Go for Help

When considering a billing practice; entering into a particular business venture; or pursuing any employment, consulting, or other personal services relationship, evaluate the arrangement for potential compliance problems. Consider the following list of resources to assist with your evaluation:

Medical Identity Theft

For more information, refer to the Medical Identity Theft & Medicare Fraud brochure.

Legal Counsel

- Experienced health care lawyers can analyze your issues and provide a legal evaluation and risk analysis of the proposed venture, relationship, or arrangement.
- The Bar Association in your state may maintain a directory of local attorneys who practice in the health care field.

Professional Organizations

- Your state or local medical society may be a good resource for issues affecting physicians and may keep listings of health care attorneys in your area.
- Your specialty society may have information on additional risk areas specific to your type of practice.

CMS

- MAC medical directors are a valuable source of information on Medicare coverage policies and appropriate billing practices. Contact your MAC for more information.
- CMS issues advisory opinions to parties seeking advice on the Stark Law. For more information, visit the CMS Advisory Opinions webpage.

OIG

- For more information on OIG compliance recommendations and discussions of fraud and abuse risk area, refer to OIG's Compliance Program Guidance. Visit OIG's Compliance Education Materials for more information.
- OIG issues advisory opinions to parties who seek advice on the application of the Anti-Kickback Statute, Civil Monetary Penalties Law, and Exclusion Statute. For more information, visit the OIG Advisory Opinions webpage.

What to Do if You Think You Have a Problem

If you think you are engaged in a problematic relationship or have been following billing practices you now realize are wrong:

- Immediately stop submitting problematic bills
- Seek knowledgeable legal counsel
- Determine what money you collected in error from patients and from the Federal health care programs and report and return overpayments
- Unwind the problematic investment by freeing yourself from your involvement
- Separate yourself from the suspicious relationship
- Consider using OIG's or CMS' self-disclosure protocols, as applicable

OIG Provider Self-Disclosure Protocol

The OIG Provider Self-Disclosure Protocol is a vehicle for providers to voluntarily disclose self-discovered evidence of potential fraud. The protocol allows providers to work with the Government to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.

CMS Self-Referral Disclosure Protocol (SRDP)

The SRDP enables health care providers and suppliers to self-disclose actual or potential Stark Law violations.

Resources

- CMS Fraud Prevention Toolkit
- Center for Program Integrity: Protecting the Medicare & Medicaid Programs from Fraud, Waste & Abuse
- Help Fight Medicare Fraud
- Medicaid Program Integrity Education
- OIG Contact Information
- OIG Fraud Information
- Physician Self-Referral