

FRAUD AND ABUSE PRIMER

This summary has been prepared to help UCMC employees, contractors, and vendors gain a better understanding of the terms Fraud and Abuse. If you have any questions, please call the Office of Medical Center Compliance at (773) 834-4588. You may also call our confidential, toll-free Resource Line at 1-877-440-5480.

WHAT IS FRAUD?

Intentional deception or misrepresentation that,

- An individual *knows or should know* to be false, or
- Is made knowing that the deception *could result* in some unauthorized benefit such as reimbursement from the Medicare program.

“Know or Should Know”,

- A term of art
 - Actual Knowledge of the truth or falsity of a claim, or
 - Deliberate Ignorance of the truth or falsity of a claim, or
 - Reckless Disregard of the truth or falsity of a claim.

WHAT IS ABUSE?

Practices which are inconsistent with accepted sound medical, business or fiscal practices, directly or indirectly resulting in unnecessary costs to the Medicare program, improper reimbursement, or program reimbursement for services which fail to meet professionally recognized standards of care or which are medically unnecessary.

- Abusive billing or reporting practices can lead to allegations of fraud.

WHAT IS A BILLING ERROR OR OVERPAYMENT?

Neither fraud nor or abuse

- Usually isolated incidents for which payments are returned when mistake is identified, and
- Measures are implemented to ensure that mistake is not repeated.
- May convert to fraud or abuse if overpayments resulting from isolated mistakes or repeated mistakes are
 - kept with no intent to return to the government, and
 - measures to rectify and prevent reoccurrence are not implemented.

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COMMON TYPES OF FRAUD AND ABUSE

- Altering claim forms to ensure or enhance reimbursement (Diagnosis codes, CPT-4/HCPCS codes, dates of service, units of service, charges, site of service, demographic data),
- Billing for services or supplies that were not furnished or not furnished as claimed,
- Billing for services that are not medically necessary to diagnose and/ or treat illness or injury (Most “screening” services, preventative care services),
- Billing a non-covered service as a covered service (self-administered drugs in the outpatient setting, less complex services v. complex/covered services),
- Routinely waiving co-payments or charges without evaluation of financial need,
- Falsifying or signing blank certificate of medical necessity, treatment plan, medical records,
- Soliciting, offering, or receiving payment in exchange for referrals,
- Billing Medicare as the primary payer when another payer is responsible,
- Failing to return credit balances,
- Billing PPS transfers or qualified discharges as discharges,
- Billing outpatient services provided within 72 hours of a related inpatient admission,
- Billing with incorrect provider numbers,
- Billing beneficiaries for non-covered services without obtaining an ABN prior to service,
- Billing Medicare for services covered by research grants,
- Billing beneficiaries for contractual balances – “balance billing”.
- Billing for items or services in excess of what is medically necessary for a particular patient,
 - Lab equipment calibrated to run a predetermined set of indices, regardless of what physician orders,
 - Hospital protocol requires EKG, Chest X-Ray, Urinalysis and Lab Panel for all patients who present to the Emergency Department, regardless of the patient’s medical condition.
- Routinely filing duplicate or inaccurate claims even if no duplicate payment results,
 - Electronic billing system automatically refiles claims if payment is not received within three weeks of submission,
 - Unbundling or exploding charges when there is a single code that represents the service provided.
- Filing inaccurate information on cost reports,
 - Claiming unallowable costs or misstating costs,
 - Not identifying as “protested amounts”, costs previously disallowed at audit,
 - Failing to gross up charges to compensate for inpatient and outpatient charge differentials.
- Collecting excess co-pay amounts or requiring a deposit as a condition for admission, continued care, or provision of services.