

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians



**Scan Here to
Report Fraud
Now!**

Table of Contents



I. Introduction	1
II. Fraud And Abuse Laws	1
III. Physician Relationships With Payers	4
Accurate Coding and Billing	4
Physician Documentation	5
IV. Physician Relationships With Other Providers	5
Physician Investments in Health Care Business Ventures	5
Physician Recruitment	6
V. Physician Relationships With Vendors	7
Free Samples	7
Relationships with the Pharmaceutical and Medical Device Industries	7
Transparency in Physician-Industry Relationships	8
Conflict-of-Interest Disclosures	9
Continuing Medical Education	10
VI. Compliance Programs For Physicians	10
VII. Resources	11
Where To Go For Help	11
What to Do if You Think You Have a Problem	12
What to Do if You Have Information About Fraud and Abuse Against Federal Health Care Programs	13
Online Resources	13

CPT only copyright 2013 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS\DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

I. Introduction

Most physicians strive to work ethically, render high-quality medical care to their patients, and submit proper claims for payment. Trust is at the core of the physician-patient relationship. The Federal Government also places enormous trust in physicians. Medicare and other Federal health care programs rely on physicians' medical judgment to treat patients with appropriate services. The Federal Government relies on physicians to submit accurate and truthful claims information when seeking reimbursement for health care services covered by the Medicare Program.

Please note: The information in this publication generally applies to Federal health care programs, specifically the Medicare Program (also known as Original Medicare).

The presence of some dishonest health care professionals who exploit the health care system for illegal personal gain has created the need for laws that combat fraud and abuse and ensure appropriate quality medical care.

This fact sheet assists physicians in understanding how to comply with these Federal laws by identifying "red flags" that could lead to potential liability in law enforcement and administrative actions. During their careers, physicians frequently encounter the following three types of business relationships raising fraud and abuse considerations:

1. Relationships with payers;
2. Relationships with fellow physicians and other providers; and
3. Relationships with vendors.

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

II. Fraud And Abuse Laws

Federal fraud and abuse laws that apply to physicians include the Federal False Claims Act (FCA), the Anti-Kickback Statute, the Physician Self-Referral Law (Stark Law), the Social Security Act, and the U.S. Criminal Code. Violations of these laws may result in nonpayment of claims, Civil Monetary Penalties (CMPs), exclusion from all Federal health care programs (including Medicare), and criminal and civil liability. We briefly summarize each law below, and you can find hyperlinks to the text of the laws in Table 2.

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



The Federal False Claims Act (FCA)

protects the Federal Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who **knowingly** submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The “knowing” standard includes acting in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. An example may be a physician who knowingly submits claims to Medicare for medical services not provided. Civil penalties for violating the FCA may include fines of up to **three** times the amount of damages sustained by the Government as a result of the false claims plus \$11,000 per claim filed. Under the Federal criminal statutes, FCA criminal penalties for submitting false claims may include fines, imprisonment, or both.

The Anti-Kickback Statute makes it a criminal offense to **knowingly and willfully** offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Where a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the Anti-Kickback Statute. Remuneration includes anything of value such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. If an arrangement, however, satisfies certain regulatory safe harbors, it may not implicate the Anti-Kickback Statute. Civil penalties for violating the Anti-Kickback Statute may include penalties of up to \$50,000 per kickback plus **three** times the amount of kickback. Criminal penalties for violating the Anti-Kickback Statute may include fines, imprisonment, or both.

For more information on safe harbor regulations, visit <http://oig.hhs.gov/compliance/safe-harbor-regulations> on the OIG website.

The Physician Self-Referral Law (Stark Law) prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an immediate member) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties for physicians who violate the Stark Law may include fines as well as exclusion from participation in all Federal health care programs.

More Information: Fraud and Abuse in Medicare Part C and Part D and Medicaid

The fraudulent conduct addressed by these laws also is prohibited in Medicare Part C and Part D and in Medicaid. For more information, refer to the “Medicare Parts C and D Fraud, Waste, and Abuse Training” in the Downloads Section at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html> on the Centers for Medicare & Medicaid Services (CMS) website.

More Information: Anti-Kickback Statute and the Stark Law

For a comparison of the Anti-Kickback Statute and Stark Law, refer to <http://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf> on the OIG website.

The Criminal Health Care Fraud Statute prohibits **knowingly and willfully** executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to:

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

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

The Exclusion Statute requires OIG to impose exclusions from participation in all Federal health care programs on health care providers and suppliers who have been convicted of:

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

OIG also has discretion to impose permissive exclusions on a number of other grounds.

**More Information:
Exclusion From Participation in All
Federal Health Care Programs**

Exclusion means that, for a designated period, Medicare, Medicaid, and other Federal health care programs will not pay the provider for items or services furnished, ordered, or prescribed by the excluded party. For more information, refer to the OIG's Special Advisory Bulletins discussing the effect of exclusion at <http://oig.hhs.gov/exclusions/advisories.asp> on the OIG website.

Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.

The Civil Monetary Penalties (CMP) Law imposes CMPs for a variety of health care fraud violations, and different amounts of penalties and assessments may be authorized based on the type of violation at issue. Penalties range from \$10,000 to \$50,000 per violation. CMPs can also 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.

III. Physician Relationships With Payers

The U.S. health care system relies heavily on third-party payers, and, therefore, your patients often are not the ones who pay most of their medical bills. Third-party payers include commercial insurers and the Federal and state governments. **When the Federal Government covers items or services rendered to Medicare beneficiaries, the Federal fraud and abuse laws apply.** Many similar state laws apply to your provision of care under state-financed programs and to private-pay patients. The issues discussed here may apply to the care you provide to all insured patients.

Accurate Coding and Billing

Payers trust you, as a physician, to provide necessary, cost-effective, and quality care. You exert significant influence over what services your patients receive. You control the documentation describing what services they actually received, and your documentation serves as the basis for bills sent to insurers for services you provided. Generally, the Federal Government pays claims based solely on your representations in the claims documents.

When you submit a claim for services performed for a Medicare patient, you are filing a bill with the Federal Government and certifying that you earned the payment requested and complied with the billing requirements. If you knew or should have known that the submitted claim was false, then the attempt to collect unearned money constitutes a violation. Examples of improper claims include:

- Billing for services that you did not actually render;
- Billing for services that were not medically necessary;
- Billing for services performed by an improperly supervised or unqualified employee;
- Billing for services performed by an employee excluded from participation in Federal health care programs;
- Billing for services of such low quality that they are virtually worthless; and
- Billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery.



More Information: Upcoding

Medicare pays for many physician services using Evaluation and Management (E/M) codes. New patient visits generally require more time than follow-up visits for established patients, and therefore E/M codes for new patients command higher reimbursement rates than E/M codes for established patients. An example of upcoding is an instance when you provide a follow-up office visit or subsequent hospital visit but bill using a higher level E/M code as if you had provided a comprehensive new patient office visit or an initial hospital visit.

Another example of upcoding related to E/M codes is the misuse of modifier -25. Modifier -25 allows additional payment for a separate E/M service rendered on the same day as a procedure. Upcoding occurs if a provider uses modifier -25 to claim payment for an E/M service when the patient care rendered was not significant, was not separately identifiable, and was not above and beyond the care usually associated with the procedure.

Physician Documentation

Physicians should maintain accurate and complete medical records and documentation of the services they provide. Physicians also should ensure that the claims they submit for payment are supported by the documentation. The Medicare Program may review beneficiaries' medical records. **Good documentation practice helps ensure that your patients receive appropriate care from you and other providers who may rely on your records for patients' past medical histories.** It also helps you address challenges raised against the integrity of your bills. 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.

More Information: Physician Documentation

For more information on physician documentation, refer to the "Evaluation and Management Services Guide" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf on the CMS website.

IV. Physician Relationships With Other Providers

Any time a health care business offers something to you for free or at below fair market value, you always should 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. This disproportionate utilization partly reflects the physicians' belief in the value of the services or technology, prompting the investments in the first place. However, these business relationships can sometimes unduly influence or distort physician

decision-making and result in the improper steering of a patient to a particular therapy or source of services in which a physician has a financial interest. **Excessive and medically unnecessary referrals cost the Federal Government and Medicare beneficiaries and can expose the beneficiaries to harm from unnecessary services.** Many of these investment relationships have serious legal risks under the Anti-Kickback Statute and the Physician Self-Referral Law (Stark Law).

If you get an invitation to invest in a health care business whose products you might order or to which you might refer your patients, you should ask the following questions. If you answer “yes” to any of them, you should consider carefully the legitimacy of the reasons for your investment.

- Are you being offered an investment interest for a nominal capital contribution?
- Will your ownership share be 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 being asked to promise or guarantee that you will refer patients or order items or services from the venture?
- Do you believe you will be more likely to refer more patients for the items and services provided by the venture if you make the investment?
- Do you believe you will be more likely to refer to the venture just because you made the investment?
- Will the venture have sufficient capital from other sources to fund its ongoing operations?

Physician Recruitment

A hospital will sometimes provide a physician with a recruitment incentive to induce the physician to relocate to the hospital’s geographic area, join its medical staff, and establish a practice that helps serve that community’s medical needs. Often, such recruitment efforts fill a legitimate “clinical gap” in a medically underserved area where it may be difficult to attract physicians in the absence of financial incentives. However, in some communities, especially ones with multiple hospitals, hospitals compete fiercely for patients. Some hospitals may offer illegal inducements to you, or to the established physician

More Information: Physician Investments

For more information on physician investments, refer to:

- OIG’s Special Fraud Alert on joint venture arrangements at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html> on the OIG website;
- OIG’s Special Advisory Bulletin on physician-owned entities at https://oig.hhs.gov/fraud/docs/alertsandbulletins/2013/POD_Special_Fraud_Alert.pdf on the OIG website;
- OIG’s Special Advisory Bulletin on contractual joint ventures at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/042303SABJointVentures.pdf> on the OIG website; and
- OIG’s “Supplemental Compliance Program Guidance for Hospitals” at <http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf> on the OIG website.

practice you join in the hospital's community, to gain referrals. This means that the competition for your loyalty can cross the line into an illegal arrangement with liability 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. **You should admit your patients to the hospital best suited to care for their particular medical conditions or to the hospital your patient selects based on his or her preference or insurance coverage.**

As noted, if a hospital or physician practice separately or jointly recruits you as a physician to the community, you may be offered a recruitment package. Unless you are a hospital employee, you may not negotiate for benefits in exchange for an implicit or explicit promise that you will 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.

More Information: Physician Relationships

For more information on physician relationships with:

- Fellow providers, refer to the OIG's "Compliance Program Guidance for Individual and Small Group Physician Practices" at <http://oig.hhs.gov/authorities/docs/physician.pdf> on the OIG website;
- Hospitals, refer to the OIG's "Supplemental Compliance Program Guidance for Hospitals" at <http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf> on the OIG website; and
- Nursing homes, refer to the OIG's "Supplemental Compliance Program Guidance for Nursing Facilities" at http://oig.hhs.gov/fraud/docs/complianceguidance/nhg_fr.pdf on the OIG website.

V. Physician Relationships With Vendors

Free Samples

Many drug and biologic companies provide physicians with free samples that the physicians may give to patients free of charge. It is legal to give these samples to your patients for free, but it is illegal to sell the samples. The Federal Government prosecutes physicians for billing Medicare for free samples. If you choose to accept samples, you will need reliable systems in place to safely store the samples and ensure that samples are not commingled with your commercial stock.

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 receive. Test the propriety of any proposed relationship by asking the following questions:

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

**More Information:
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 for their respective industries regarding relationships with health care professionals. For more information on the PhRMA code, visit <http://www.phrma.org/principles-guidelines/code-on-interactions-with-health-care-professionals> on the Internet. For more information on the AdvaMed code of ethics, visit <http://advamed.org/issues/code-of-ethics> on the Internet.

**More Information:
Industry Relationships**

For more information on distinguishing between legitimate and questionable industry relationships, refer to the OIG's "Compliance Program Guidance for Pharmaceutical Manufacturers" at <http://oig.hhs.gov/authorities/docs/03/050503FRCPGPharmac.pdf> on the OIG website.

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 or use a medical device or refer your patients for particular services or supplies, the proposed consulting arrangement likely is one you should avoid as it could violate fraud and abuse laws.**

Transparency in Physician-Industry Relationships

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

OPEN PAYMENTS Program

In 2014, the public will know what gifts and payments a physician receives from industry relationships. The Affordable Care Act requires drug, device, and biologic companies to publicly report nearly all gifts or payments they make to physicians beginning in 2013. The OPEN PAYMENTS program implements the Sunshine Rule which requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals. CMS will post payments or other transfers of value and ownership or investment interest reports on a public website no later than September 30, 2014, for the initial implementation year. For ongoing years, CMS will post the information on June 30 of each year.

CMS does not require physicians to register with or send any information to OPEN PAYMENTS. However, CMS encourages you to help ensure accurate information:

- Become familiar with the information OPEN PAYMENTS will report about physicians;
- Keep records and use the OPEN PAYMENTS Mobile for Physicians app to track payments and other transfers of value you received from applicable manufacturers and applicable Group Purchasing Organizations (GPOs) (visit <http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Apps-for-Tracking-Assistance.html> on the CMS website for instructions on downloading the app);
- Register with the OPEN PAYMENTS system and subscribe to the electronic mailing list for program updates;
- Review the information manufacturers and GPOs submit on your behalf; and
- Work with manufacturers and GPOs to settle data issues about your OPEN PAYMENTS profile.

CMS' commitment to data accuracy extends to closely monitoring this process to ensure integrity in the data posted. For more information, visit <http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program> on the CMS website.

Academic Institutions

Academic institutions also may impose various restrictions on the interactions their faculty members or affiliated physicians have with industry.

Conflict-of-Interest Disclosures

Many of the relationships discussed in this document are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you may have an obligation 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, and from the 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 someone. **You always can apply the “newspaper test” and ask yourself whether you would want the arrangement to appear on the front page of your local newspaper.**

More Information: FDA Bad Ad Program

Advertisements and other promotional materials for drugs, biologics, and medical devices 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, you should report them to the FDA by calling 877-RX-DDMAC (877-793-3622) or by emailing HHSTIPS@oig.hhs.gov.

For a brief video with more information and examples of situations to look for, visit <http://www.medscape.com/viewarticle/754890> or click the image below.



Continuing Medical Education

You are responsible for your Continuing Medical Education (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 in nature and sessions that constitute marketing by a drug or device manufacturer.** If speakers recommend use of a drug to treat conditions for which there is no FDA approval or use of a drug by children when the FDA has approved only adult use, you should independently seek out the empirical data that support 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 uses of drugs.

VI. Compliance Programs For Physicians

Establishing and following a compliance program will help physicians avoid fraudulent activities and ensure that they submit true and accurate claims. The following seven components provide a solid basis upon which a physician practice can create a voluntary 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; and
7. Enforce disciplinary standards through well-publicized guidelines.

More Information:

Compliance Programs for Physicians

For more information on compliance programs for physicians, visit the OIG's Compliance website at <https://oig.hhs.gov/compliance> on the OIG website.

Section 6401(a)(7) of the Affordable Care Act requires physicians who treat Medicare beneficiaries to establish a compliance program.

VII. Resources

Where to Go for Help

When considering whether or not to engage in a particular billing practice; enter into a particular business venture; or pursue an employment, consulting, or other personal services relationship, evaluate the arrangement for potential compliance problems. The following is a list of possible resources that can help you:

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 attorneys in your area 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 lawyers in your area.
- Your specialty society may have information on additional risk areas specific to your type of practice.

CMS

- Medicare Administrative Contractor (MAC) medical directors are a valuable source of information on Medicare coverage policies and appropriate billing practices. For contact information, visit <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map> on the CMS website.
- For more information on the Medicare Program and information on Medicare reimbursement and payment policies, refer to the “Basic Medicare Information for Providers and Suppliers” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Basic-Medicare-Information-for-Providers-and-Suppliers-Guide-ICN005933.pdf> on the CMS website.
- CMS issues advisory opinions to parties who seek advice on the Physician Self-Referral Law (Stark Law). For more information on how to request a CMS advisory opinion and links to previously published CMS advisory opinions, visit http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/advisory_opinions.html on the CMS website.

More Information: Medical Identity Theft

For more information on provider medical identity theft, refer to <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/Downloads/prevent-medID-theft-factsheet.pdf> on the CMS website or http://oig.hhs.gov/fraud/medical-id-theft/OIG_Medical_Identity_Theft_Brochure.pdf on the OIG website.



OIG

- For more information on OIG compliance recommendations and discussions of fraud and abuse risk areas, refer to OIG's Compliance Program Guidance documents available at <http://oig.hhs.gov/compliance/compliance-guidance> on the OIG website. For compliance education, visit <http://oig.hhs.gov/compliance/101> on the OIG website.
- OIG issues advisory opinions to parties who seek advice on the application of the Anti-Kickback Statute, CMP Law, and Exclusion Authorities. For more information on how to request an OIG advisory opinion and links to previously published OIG advisory opinions, visit <http://oig.hhs.gov/compliance/advisory-opinions> on the OIG website.

What to Do if You Think You Have a Problem

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

- Immediately cease filing the problematic bills;
- Seek knowledgeable legal counsel;
- Determine what money you collected in error from your patients and from the Federal health care programs and report and return overpayments;
- Undo the problematic investment by taking all necessary steps to free yourself from your involvement in the investment;
- Disentangle yourself from the suspicious relationship; and
- 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 physicians to voluntarily disclose self-discovered evidence of potential fraud. The protocol gives providers the opportunity to avoid the costs and disruptions associated with a Federal Government-directed investigation and civil or administrative litigation. For more information on the OIG Provider Self-Disclosure Protocol, visit <http://oig.hhs.gov/compliance/self-disclosure-info> on the OIG website.

CMS Self-Referral Disclosure Protocol (SRDP)

The Self-Referral Disclosure Protocol (SRDP) enables health care providers and suppliers to self-disclose actual or potential violations of the Physician Self-Referral Law (Stark Law). For more information, visit <http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral> on the CMS website.

What to Do if You Have Information About Fraud and Abuse Against Federal Health Care Programs

If you have information about fraud and abuse against Federal health care programs, use the OIG Fraud Hotline to report that information to the appropriate authorities. The Hotline allows the option of reporting anonymously. You may also contact your local MAC.

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Fax: 1-800-223-8164

Email: HHSTIPS@oig.hhs.gov

Online: <https://forms.oig.hhs.gov/hotlineoperations>

Mail: U.S. Department of Health & Human Services
Office of Inspector General
Attn: HOTLINE
P.O. Box 23489
Washington, DC 20026

You can also visit <http://www.stopmedicarefraud.gov> on the Internet.



Online Resources

For more information about the OIG and fraud, visit <https://oig.hhs.gov> or scan the Quick Response (QR) code on your right. For more information regarding preventing, detecting, and reporting Medicare fraud and abuse, refer to the resources listed in Table 1. Table 2 provides hyperlinks to applicable laws.



Table 1. Fraud and Abuse Resources

Resource	Website
CMS	http://www.cms.gov
“CMS Electronic Mailing Lists: Keeping Health Care Professionals Informed” fact sheet	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf
CMS Fraud and Abuse Products	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf
CMS Fraud Prevention Toolkit	http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force	http://www.stopmedicarefraud.gov/about/fraud/heattaskforce
“How CMS Is Fighting Fraud: Major Program Integrity Initiatives”	http://www.medscape.org/viewarticle/764791 NOTE: To access this program, you will need to create a free account.
“Medicaid Program Integrity: Safeguarding Your Medical Identity” Products	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf
Frequently Asked Questions (FAQ): Medicare Fraud and Abuse	https://questions.cms.gov/faq.php?id=5005&rtopic=1887
Medicare Learning Network® (MLN) Provider Compliance	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
OIG Email Updates	https://oig.hhs.gov/contact-us
“Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients”	http://www.medscape.org/viewarticle/764496 NOTE: To access this program, you will need to create a free account.

Table 2. Table of Applicable Laws

Statutory References	Website
Anti-Kickback Statute 42 United States Code (U.S.C.) Section 1320a-7b(b)	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXI-partA.pdf
Civil False Claims Act 31 U.S.C. Sections 3729-3733	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title31/pdf/USCODE-2012-title31-subtitleIII-chap37-subchapIII.pdf
Civil Monetary Penalties Law 42 U.S.C. Section 1320a-7a	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXI-partA-sec1320a-7a.pdf
Criminal False Claims Act 18 U.S.C. Section 287	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title18/pdf/USCODE-2012-title18-partI-chap15-sec287.pdf
Criminal Health Care Fraud 18 U.S.C. Section 1347	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title18/pdf/USCODE-2012-title18-partI-chap63-sec1347.pdf
Exclusion Statute 42 U.S.C. Section 1320a-7	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXI-partA-sec1320a-7.pdf
Physician Self-Referral Law (Stark Law) 42 U.S.C. Section 1395nn	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXVIII-partE-sec1395nn.pdf
Regulatory Safe Harbors 42 Code of Federal Regulations (CFR) Section 1001.952	http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol5/pdf/CFR-2013-title42-vol5-sec1001-952.pdf



This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official information health care professionals can trust. For additional information, visit the MLN's web page at <http://go.cms.gov/MLNGenInfo> on the CMS website.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to <http://go.cms.gov/MLNProducts> and in the left-hand menu click on the link called 'MLN Opinion Page' and follow the instructions. Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.

Check out CMS on:

