

Primer on Medicare/Medicaid Fraud and Abuse - Part II

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Like kickbacks and rebates, discussed in Part I of this Primer, the basis for enforcement action in the area of false claims in federal and state healthcare programs is also a federal statute. It says:

“Whoever--

1. knowingly and willfully makes or causes to be made any false statement or a representation of a material fact in any application for any benefit or payment under this subchapter,
2. at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,
3. having knowledge of the occurrence of any event affecting
 - a) his initial or continued right to any payment or
 - b) the initial or continued right to any such benefit or payment of any other individual on whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent to fraudulently secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or
 - c) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willingly converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, shall
 - (1) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) or items or services for which payment is or may be made under this subchapter, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years, or both, or
 - (2) in the failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more

than \$10,000 or imprisoned for not more than one year, or both.”

The gist of this statute is that false statements on cost reports or claims submitted for payment may result in enforcement action.

In 1976, the U.S. Congress established the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services. The purpose of the OIG is to identify and eliminate fraud, abuse, and waste in federal and state healthcare programs and to promote efficiency and economy in departmental operations. The OIG reaches these goals through a nationwide program of audits, investigations, and inspections.

The jurisdiction of the OIG includes the Medicare and Medicaid Programs and other state and federal health care programs, including Medicaid waiver programs. To help reduce fraud and abuse in these programs, the OIG actively investigates attempts to fraudulently obtain money from these programs and, when appropriate, issues Special Fraud Alerts, Guidance, and Bulletins that identify segments of the health care industry that are especially vulnerable to abuse.

The Centers for Medicare and Medicaid Services (CMS), staff of the OIG and other regulators are absolutely convinced that fraud and abuse is rampant in the health care industry. Representatives of these agencies are determined to ferret out and correct violations.

Now is the time to sharpen the ability to recognize and correct violations internally before enforcers identify them and force compliance.