Fraud and abuse pose major risks for the Medicaid program. “Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.” “Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.”[1]

Providers who engage in fraud and abuse are subject to sanctions under a number of Federal and State laws. Sanctions under Federal law, for example, can take the form of administrative,[2] civil,[3] and criminal[4] penalties. These penalties range from monetary fines and damages to prison time and exclusion from the Federal health care programs, including Medicaid. By becoming familiar with common types of fraud and abuse, providers will be in a better position to ensure they are not involved in such conduct. Providers will also be better equipped to identify and report others who may be engaged in fraud and abuse. This fact sheet provides a brief overview of some common types of Medicaid fraud and abuse involving providers. This list is not intended to be exhaustive. Although the examples involve violation of Federal laws, many States have similar laws against fraud and abuse.

- **Medical Identity Theft**

Medical identity theft involves the misuse of a person’s medical identity to wrongfully obtain health care goods, services, or funds. More specifically, medical identity theft has been defined as “the appropriation or misuse of a patient’s or [provider’s] unique medical identifying information to obtain or bill public or private pay[o]rs for fraudulent medical goods or services.”[5] Stolen physician identifiers can be used to fill fraudulent prescriptions, refer patients for unnecessary additional services or supplies, or bill for services that were never provided. Beneficiary medical identifiers can be used to support fraudulent billings for services or items not provided. Providers should take steps to protect their identifying information and that of their patients from unauthorized use. Health care professionals may obtain more information on medical identity theft by reviewing a booklet on understanding provider identity theft that is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Med-ID-Theft-Booklet-ICN908264.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Med-ID-Theft-Booklet-ICN908264.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.
• **Billing for Unnecessary Services or Items**

Under 42 C.F.R. § 440.230(d), States may “place appropriate limits on a service based on such criteria as medical necessity….”[6] For Medicaid, each State defines medical necessity. Providers are responsible for ensuring that authorized services meet the definition of medical necessity in the States in which they practice. Intentional billing of unnecessary services or items can lead to the serious consequences mentioned earlier.

• **Billing for Services or Items Not Furnished**

To be covered by Medicaid, the billed service or supply must in fact be furnished. Furnishing different services or supplies is no justification for billing services or supplies not furnished. Some providers bill Medicaid for a covered service or item but do not deliver the service or item. These providers may create false records in an attempt to justify the bills. For example, a physician might sign charts and submit bills for examinations and tests that never took place. Providers should only bill for the medically necessary or otherwise authorized services or items actually furnished to beneficiaries, and should ensure that proper documentation is in place. Health care professionals should exercise appropriate caution in evaluating offers of payment in exchange for reviewing medical records written by others.[7]

• **Upcoding**

Upcoding is a term that is not defined in the regulations but is generally understood as billing for services at a level of complexity that is higher than the service actually provided or documented in the file.[8] For example, a supplier of durable medical equipment might bill for motorized scooters while supplying less expensive manual wheelchairs. As another example, a physician might bill simple office visits at the higher rate for complex visits. These practices are illegal. Providers should only bill for the level of services or items actually furnished.

• **Unbundling**

“Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.”[9] The way this form of fraud works is that the reimbursement for the individual codes billed separately is higher than the reimbursement for the single comprehensive code that should be used. For example, a laboratory might receive an order for a panel of tests on a patient. Instead of bundling the tests and billing for them together, the laboratory might attempt to increase its income by billing for each test separately. This is like ordering a value meal at a fast food restaurant and then being charged separately a higher individual price for each item. Providers should be familiar with applicable Medicaid rules on which services need to be bundled or billed together.
• **Kickbacks**

Kickbacks can be defined as offering, soliciting, paying, or receiving remuneration (in kind or in cash) to induce or in return for referral of individuals for the furnishing or arranging of any item or service for which payment may be made under Federal health care programs.[10, 11] Rewarding sources of new business may be acceptable in some industries but not when Federal health care programs and beneficiaries are involved. Kickbacks in health care can lead to overutilization, increased program costs, corruption of medical decision-making, patient steering, and unfair competition. For example, it would be illegal for a physician to accept payments for referring patients to a medical imaging facility.

To see specific examples of provider prosecutions and settlements resulting from these types of fraud, visit [https://oig.hhs.gov/fraud/enforcement/criminal/](https://oig.hhs.gov/fraud/enforcement/criminal/) on the Department of Health and Human Services, Office of Inspector General website.

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References

1 Definitions, 42 C.F.R. § 455.2. Retrieved January 31, 2014, from http://www.ecfr.gov/cgi-bin/text-idx?&idno=42&region=DIV1&mode=boolean;c=ecfr;cc=ecfr;sid=a6795a857e624da9bd3ae4123ae9dfe7;ql1=screen;rgn1=Section;op2=and;rgn2=Section;op3=and;rgn3=Section;rgn=div5&view=text;node=42%3A4.0.1.13%2342:4.0.1.13.0.132.2


6 42 C.F.R. § 440.230 (d). Retrieved January 31, 2014, from http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=a1a0fde3f92f59b18d89744d276d1a5&ty=HTML&h=L&n=42y4.0.1.1.9&r=PART/42:4.0.1.1.9.2.112.5


