PeakHealth

Provider Network - Fraud, Waste and Abuse

1 Healthcare Fraud Enforcement and Other Standards

What is Fraud, Waste, & Abuse | Your Role in the Fight Against Fraud, Waste, & Abuse

Healthcare Fraud Enforcement and Other Standards

Why do I need this training?

Each year, billions of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). This training will help you detect, correct, and prevent FWA in order to protect Medicare beneficiaries, the Medicare Program, and the Medicare Trust Fund. As a contracted First-Tier, Downstream, or Related Entity (FDR) with Peak Health, including providers and delegated entities, you are an essential part of the solution.

As a Medicare Advantage and Part D Sponsor, Peak Health is required to ensure that applicable FDR personnel complete FWA training within 90 days of contracting or network participation and annually thereafter, consistent with CMS compliance-program requirements at 42 CFR §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi).

What is Fraud, Waste, & Abuse?

Fraud is:

- Knowingly and willingly submitting, or causing to be submitted, false claims or making misrepresentations of federal healthcare payment when no entitlement would otherwise exist.
- Knowingly and willingly soliciting, getting, offering, or pay remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by federal health programs.
- Making prohibited referrals for certain designated health services.

> Fraud requires *intent* to get payment and *knowledge* the actions are wrong.

What is Fraud, Waste, & Abuse?

Criminal Healthcare Fraud Statute:

- Makes it a criminal offense to knowingly and willfully execute a scheme to defraud a healthcare benefit program.
- Healthcare fraud is punishable by imprisonment of up to 10 years. It is also subject to criminal fines of up to $250,000.
- The statute (18 United States Code (USC) 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for healthcare benefits or services to either:
  - Defraud any healthcare benefit program.
  - Obtain by means of false or fraudulent pretenses, representations, or promises, money or property owned or controlled by any healthcare benefit program.
- A conviction under the Health Care Fraud Statute does not require proof the violator knew the law or had specific intent to violate it.

What is Fraud, Waste, & Abuse?

Waste and Abuse:

- Waste* includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not caused by criminally negligent actions but rather by the misuse of resources.
- Abuse* includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly misrepresented facts to obtain payment.

Waste and Abuse do not require the same *intent* and *knowledge* that actions are wrong as is required for Fraud.

- *As defined in Chapter 21 of the Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual

What is Fraud, Waste, & Abuse?

Below are examples of Fraud, Waste, & Abuse. Review them and think of where you may see those scenarios in your daily work.

Fraud	Waste	Abuse
• Knowingly and willfully billing for services of higher complexity than services provided to a member or document in their medical records. • Knowingly and willfully billing for services or supplies not provided, including falsifying records. • Knowingly and willfully ordering medically unnecessary items or services. • Remuneration to induce referrals paid for by Federal health care programs. • Billing Medicare for appointments members did not keep.	• Conducting excessive office visits or writing excessive prescriptions. • Prescribing more medications than necessary for treating a specific condition. • Ordering excessive lab tests.	• Billing unnecessary medical services. • Charging excessively for services or supplies. • Unintentional use of and/or misusing codes on a claim, like upcoding or unbundling codes.

Fraud, Waste, & Abuse: Key Laws to Know

Federal Civil False Claims Act (FCA):

- FCA makes a person liable to pay damages to the government if they knowingly:
- Conspire to violate the FCA
- Carry out the acts to get government property through misrepresentation
- Conceal or improperly avoid or decrease an obligation to pay the government
- Make or use a false record or statement supporting a false claim
- Present a false claim for payment or approval

The Criminal FCA can enforce criminal penalties on individuals or entities that include fines, imprisonment, or both.

Click on the "FCA Whistleblower Facts" button to learn more.

Penalties for violating the Civil FCA include up to three times the government's damages, plus civil monetary penalties per claim, as adjusted annually under Federal law.

Federal Civil False Claims Act (FCA)

Whistleblowers who file a qui tam action under the FCA may receive between 15% and 30% of the funds recovered.



Fraud, Waste, & Abuse: Key Laws to Know

Criminal Health Care Fraud Statute:

Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice:

- to defraud any health care benefit program; or
- to 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"

Conviction under this statute does not require proof the violator knew the law or had specific intent to violate the law.

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000
- Imprisonment for up to 20 years
- If the violations result in death, they may be imprisoned for life

Fraud, Waste, & Abuse: Key Laws to Know

Anti-Kickback Statute (AKS):

- AKS makes it a crime to knowingly and willfully offer, pay, solicit, or get any remuneration directly or indirectly to induce or reward patient referrals or business generation involving any item or service payable by a federal health care program. When a provider offers, pays, solicits, or gets unlawful remuneration, they violate AKS.
- The safe harbor regulations describe various payment and business practices that are not treated as AKS offenses if they meet certain regulatory requirements. Individuals and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their business

Violations are punishable by: A fine of up to $250,000; Imprisonment of up to 5 years, or both.

*AKS can be found at 42 USC § 1320a-7b(b)

Fraud, Waste, & Abuse: Key Laws to Know

Physician Self-Referral Law (Stark Law):

- The Stark Law prohibits a physician from referring a patient to get designated health services from a provider with whom a physician or a physician's immediate family member has a financial relationship, unless an exception applies.
- The designated health services are: Clinical lab services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and other imaging services; radiation therapy services and supplies; DME and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and supplies; home health services; outpatient prescription drugs; and, inpatient and outpatient hospital services.
- CMS will not pay claims tainted by an arrangement that does not comply with the Stark Law.

Penalties for Stark Law violations may include denial of payment, required refunds, and civil monetary penalties. CMP amounts are set by federal regulation and are adjusted annually.

*The Stark Law can be found at 42 USC § 1395nn

Fraud, Waste, & Abuse: Key Laws to Know

Civil Monetary Penalties Law (CMPL):

- CMPL authorizes The Department of Health and Human Services' Officer of Inspector General (OIG) to seek Civil Monetary Penalties (CMP) and sometimes exclusions for a variety of healthcare fraud violations.
- Violations that could result in a CMP include, but are not limited to: arranging for an excluded individual's or entity's services or items; failing to grant OIG timely records access; filing a claim you know or should know is for an item or service that wasn't provided as claimed or is false or fraudulent; filing a claim you know or should know is for an item or service for which CMS will not pay for; violating AKS; Violating the Medicare assignment provisions; violating the Medicare physician agreement; providing false or misleading information expected to influence a discharge decision; making false statements or misrepresentations on applications or contracts to participate in federal healthcare programs.

CMPs can be: Approx. $25,000–$125,000 per violation, plus up to 3 times the amount claimed or remuneration involved.

*The Stark Law can be found at 42 USC § 1395nn

Fraud, Waste, & Abuse: Key Laws to Know

Exclusion Statute:

Requires the OIG to exclude individuals and entities from participating in all federal healthcare programs when certain grounds apply, including convictions for the following offenses:

- Medicare or Medicaid fraud, as well as other offenses related to providing Medicare or Medicaid items or services
- Patient abuse or neglect
- Felony convictions for other health care related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescribing, or dispensing controlled substances

*The Exclusion Statute can be found at 42 USC 1320a-7

Fraud, Waste, & Abuse: Key Laws to Know

Health Insurance Portability & Accountability Act (HIPAA):

- HIPAA created greater access to health care insurance, strengthened health care data privacy protection, and promoted health care industry standardization and efficiency.
- HIPAA safeguards deter unauthorized access to protected health care information. As someone with access to protected healthcare information, you must comply with HIPAA.
- You will learn more about HIPAA and other privacy requirements and practices here at Peak in another module.

HIPAA Damages and Penalties: May result in CMPs and in some cases, criminal penalties may apply

*HIPAA can be found at 42 U.S.C. 1320d–2.

2 Healthcare Fraud Enforcement and Other Standards

Your Role in the Fight Against Fraud, Waste, & Abuse

Healthcare Fraud Enforcement and Other Standards

Your Role in the Fight Against Fraud, Waste, & Abuse:

Peak Health is a Part C and Part D Plan Sponsor, or CMS Contractor.

You play an important role in preventing, detecting, and reporting potential FWA concerns, as well as Medicare noncompliance.

- You must comply with all applicable statutory, regulatory , and other Medicare Part C and Part D requirements, including adopting and following Peak Health's Compliance Programming.
- You have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations you may know.
- You have a duty to follow Peak Health's commitment to standards of conduct and ethical rules of behavior.

Healthcare Fraud Enforcement and Other Standards

Your Role in the Fight Against Fraud, Waste, & Abuse:

You help prevent Fraud, Waste, & Abuse when you:

- Look for suspicious activity
- Conduct yourself ethically
- Ensure accurate and timely data and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance
- Verify all information you get

Healthcare Fraud Enforcement and Other Standards

Stay informed about Policies and Procedures:

- You play an important role in preventing, detecting, and reporting potential FWA concerns, as well as Medicare noncompliance.
- You must comply with all applicable statutory, regulatory, and other Medicare Part C and Part D requirements.
- You have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations you may know.
- You have a duty to follow Peak's commitment to standards of conduct and ethical rules of behavior.

Healthcare Fraud Enforcement and Other Standards

Report Fraud, Waste, & Abuse:

All instances of FWA must be reported, as outlined in Peak's Procedure for Reporting Instances of FWA.

Report any potential FWA concerns you have by:

Report Compliance Issues 1.844.860.9049 or https://peakhealth.ethicspoint.com

Contacting Medicare directly at:

1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048; or

https://www.medicare.gov/my/medicare-complaint

Reporting Fraud, Waste and Abuse

Reporting Fraud, Waste, & Abuse Outside of Peak:

- If warranted, Plan Sponsors, Providers, and FDRs must report potentially fraudulent conduct to government authorities, like the OIG, Department of Justice (DOJ), or CMS.
- Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol, which provides the opportunity to avoid costs and disruptions of government-directed investigation and civil or administrative litigation.

MA and Part C Plans can Report FWA to:

Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx

CMS Hotline at 1-800-MEDICARE

Potential Fraud, Waste, & Abuse Indicators

Potential Fraud, Waste, & Abuse Indicators:

Possible forged prescription, medical record, or laboratory testing;

- Numerous identical prescriptions for a single beneficiary, possibly from different doctors;
- Instances of identity theft; billing for services not provided or not medically necessary;
- Prescriptions missing a provider's active and valid National Provider Identifier;
- Diagnosis for a member that is not supported in the medical record.

3 Medicare Fraud & Abuse: Prevent, Detect, Report

Medicare Fraud & Abuse| Laws & Penalties | Medicare Anti-Fraud and Abuse Partnerships & Agencies | Reporting Suspected Medicare Fraud & Abuse |

Medicare Fraud & Abuse

Do your part – get informed!

Committing Medicare fraud is not worth the effort.

- Medicare Trust Fund has recovered $7.13 billion in expected recoveries and receivables (FY2024)
- Over $4 billion recovered in investigative receivables during the most recent semiannual period of FY 2024
- The federal government completed 1,548 criminal and civil enforcement actions in FY2024 (combined total)
- DOJ/OIG investigations contributed to these FY2024 outcomes (criminal + civil enforcement actions)
- OIG excluded 3,234 individuals and entities from Federal health care programs in FY2024

And the consequences add up. From FY2024, OIG had:

- 1,548 criminal and civil enforcement actions (combined)
- 3,234 exclusion

Medicare Fraud & Abuse

A Serious Problem Requiring Your Attention

- Healthcare fraud can cost taxpayers billions of dollars. The money lost to Medicare fraud and abuse increases the strain on the Medicare Trust Fund. The impact of those losses and risks magnifies as Medicare continues to serve a growing number of people.
- Schemes and fraudulent billing practices not only cost taxpayers, they endanger health and welfare of beneficiaries, such as Peak's members. For example, in 2025, a group of healthcare professionals — including a laboratory owner, marketing company owner, and a physician — were sentenced for a scheme that billed Medicare and Medicaid for medically unnecessary genetic tests. They submitted over $129 million in false claims and received more than $35 million in payments. The doctor involved was sentenced to prison and ordered to pay $495,000 in restitution.
- To combat fraud &abuse, you must know how to protect Peak and Peak's members from potential abusive practices, civil liability, and possible criminal activity. You play a vital role in protecting the integrity of the Medicare Program.

Medicare Fraud & Abuse

What is Medicare Fraud?

- Knowingly submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain a federal healthcare payment. Fraud includes obtaining something of value through misrepresentation or concealment of material facts.
- Knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by federal healthcare programs.
- Making prohibited referrals for certain designated health services.

Examples of Medicare Fraud: Knowingly billing CMS for service not provided; Knowingly altering claims forms to get higher payment; Paying for referrals of MA beneficiaries

Medicare Fraud & Abuse Examples

Anyone can commit Medicare fraud, including people you know, and it extends beyond medical professionals. Corporations and organized crime networks commit Medicare fraud, unlawfully getting millions of Medicare Program dollars.

Example 1	Example 2	Example 3
A major pharmaceutical manufacturer pled guilty to misbranding a paid $600 million to resolve criminal and civil liability from promoting a certain drug. Part of the settlement resolved allegations the company misled doctors about the drug's safety and success and instructed them to miscode claims to ensure Medicare payments. The company also allegedly paid doctors' kickbacks.	The government charged 73 defendants when investigators uncovered an organized crime ring's scheme that allegedly involved more than 163 million in fraudulent billings and identity theft impacting thousands of Medicare beneficiaries and doctors.	A hospital system paid $8 million to settle allegations it knowingly kept patients hospitalized, beyond the time considered medically necessary, to increase Medicare payments and maintain its classification as a long-term acute care facility

Medicare Fraud & Abuse

What is Medicare Abuse?

- Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice inconsistent with providing patients medically necessary services, meeting professionally recognized standards, and charging fair prices.
- Both Medicare fraud &abuse can expose providers and health plans, such as Peak Health, to criminal, civil, and administrative liabilities.

Examples of Medicare Abuse: Approving Prior Authorization for unnecessary medical services; Approving upcoded or unbundled codes claims

Medicare Fraud & Abuse

Program Integrity:

Program Integrity includes a wide range of activities Peak can target in order to reduce various causes of improper payments beyond Medicare fraud and abuse.

Mistakes	Inefficiencies	Bending the Rules	Intentional Deceptions
Result in errors such as incorrect coding or incorrect Medicare beneficiary information.	Result in waste such as ordering excessive diagnostic tests	Results in abuse such as improper billing practices (e.g., upcoding)	Result in fraud such as billing for services or supplies that were not provided.

NOTE: The types of improper payments are examples for educational purposes. Plans that engage in these practices may be subject to administrative, civil, or criminal liability.

Medicare Fraud & Abuse: Laws & Penalties

Medicare Fraud & Abuse Laws:

As mentioned in Section 1 of this module, the FCA, AKS, Stark Law, Criminal Health Care Fraud Statute, the Exclusion Statute, and CMPL, are the main laws that address Medicare fraud and abuse. Those laws also specify the criminal, civil, and administrative penalties the government imposes on those committing fraud and abuse.

Violations of those laws within the Medicare Program may result in:

- Medicare-paid claims recoupment
- Civil Monetary Penalties (CMPs)
- Exclusion from participating in federal health care programs
- Civil and criminal liability, including fines and imprisonment

These laws prohibit Medicare Part C and Part D fraud and abuse.

Medicare Fraud & Abuse: Laws & Penalties

Civil Monetary Penalties (CMPs):

Depending on the violation type, CMPs can exceed $1,000,000—e.g., information blocking carries up to $1,000,000 per violation (2023 rule)—and CMPL penalties for other fraud/abuse violations include lower per-violation maximums plus assessments up to 3× the amount claimed or remuneration.

Violations that justify CMPs include:

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

Each year the federal government adjusts all CMPs for inflation. Refer to 45 CFR 102.3 for yearly inflation adjustments.

Medicare Fraud & Abuse: Laws & Penalties

Civil Prosecutions and Penalties:

Civil Monetary Penalties (CMPs), which vary by violation type and are adjusted annually under federal law and include any of the following:

- ACMP for each item or service in non-compliance
- Payment up to 3 times the amount claimed for each item or service instead of damages sustained by the federal government.
- Exclusion from all federal healthcare programs for a specific period of time.
- An OIG Corporate Integrity Agreement (CIA), which requires an individual or entity to carry out a compliance program (including, for example, hiring a compliance officer, developing written standards and policies, carrying out an employee training program, and conducting annual audits and reviews).

In addition to civil prosecutions and penalties, law enforcement may prosecute healthcare fraud and pursue criminal convictions. Under the Affordable Care Act, the U.S. Sentencing Commission may add offense levels for healthcare fraud crimes with more than $1 million in losses. It is also a crime to obstruct fraud investigations.

Medicare Anti-Fraud and Abuse Partnerships & Agencies

Healthcare Fraud Prevention Partnership (HFPP):

- HFPP is a voluntary, public-private partnership including over 132 agencies from the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations.
- HFPP is a voluntary public-private partnership of more than 200 partners, including federal and state agencies, law enforcement, private health insurance plans, employer organizations, and anti-fraud associations.
- Their goal is to identify and reduce fraud, waste, and abuse across the healthcare sector through collaboration, data and information sharing, and cross-payer research studies.
- The HFPP also performs sophisticated industry-wide analytics to detect and prevent fraud schemes



Medicare Anti-Fraud and Abuse Partnerships & Agencies

The Centers for Medicare & Medicaid Services (CMS):

CMS is the federal agency within the Department of Health and Human Services that administers the Medicare program, as well as Medicaid. Individuals, entities, and law enforcement agencies CMS works with to prevent Medicare fraud &abuse include:

- Accreditation Organizations
- Medicare beneficiaries and caregivers
- Physicians, suppliers, and other healthcare providers
- OIG
- Federal Bureau of Investigation (FBI)
- Contractors

Medicare Fraud & Abuse: Laws & Penalties

CMS Contractors to Help Prevent Medicare Fraud & Abuse:

CMS engages a large number of contractors to support their efforts in preventing and identifying Medicare fraud and abuse. Here is an exemplary listing of some of those contractors:

- Comprehensive Error Rate Testing (CERT): randomly selects a random sample of Medicare Fee-For-Service (FFS) claims for review.
- Recovery Audit Contractors: conduct post-payment reviews of claims.
- Medicare Administrative Contractors (MACs): identify suspected billing problems.
- Medicare FFS Recovery Audit Contractors (RACs): conduct post-payment claims reviews.
- Parts C and D Recovery Audits: identify and correct past improper payments.
- Center for Program Integrity (CPI): promotes Medicare integrity through audits, reviews, and monitoring

If any of these entities contacts you, immediately contact Peak's Compliance Department who will work to respond within the specified timeframe with all requested documentation.

Medicare Fraud & Abuse: Laws & Penalties

Investigating Entities:

The following entities review claims and more extensively investigate healthcare fraud:

- Unified Program Integrity Contractors (UPICs)
- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Medicare Fraud Strike Force (formerly part of HEAT): joint CMS-OIG-DOJ teams that investigate and prosecute major healthcare fraud scheme
- Federal Bureau of Investigations (FBI)

Reporting Suspected Medicare Fraud & Abuse

Reporting Suspected Medicare Fraud & Abuse:

In addition to Peak's Fraud, Waste, and Abuse Policy & Procedures, which outlines how to report instances of FWA, the OIG also maintains a hotline and webpage that accepts and reviews tips regarding suspected Medicare fraud and abuse. You can report suspected fraud &abuse anonymously by phone, fax, mail, and on the OIG website. The OIG collects no information that could trace the complaint to you; however, lack of contact information may prevent a comprehensive review of the complaint.

File a Complaint Online: https://tips.oig.hhs.gov/

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

Mail: U.S. Department of Health and Human Services

Office of Inspector General

ATTN: OIG HOTLINE OPERATIONS

P.O. Box 23489 Washington, DC 20026

Visit https://oig.hhs.gov/fraud/ for more information

Reporting Suspected Medicare Fraud & Abuse

Report Fraud, Waste, & Abuse:

All instances of FWA must be reported, as outlined in Peak's Procedure for Reporting Instances of FWA.

Report any potential FWA concerns you have by:

Report Compliance Issues 1.844.860.9049 or https://peakhealth.ethicspoint.com

Contacting Medicare directly at:

1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048; or

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Reporting Suspected Medicare Fraud & Abuse

Report Fraud, Waste, & Abuse:

If warranted, Plan Sponsors and FDRs must report potentially fraudulent conduct to government authorities, like the OIG, Department of Justice (DOJ), or CMS.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol, which provides the opportunity to avoid costs and disruptions of government-directed investigation and civil or administrative litigation.

Plan Sponsors and FDRs must report substantiated potential fraud to CMS or the appropriate Medicare program integrity contractor, consistent with CMS reporting rules.

MA and Part C Plans can Report FWA to: Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx; CMS Hotline at 1-800-MEDICARE

Reporting Suspected Medicare Fraud & Abuse

Medicare Incentive Reward Program (IRP):

- CMS established the Medicare IRP to encourage reporting of suspected fraud &abuse.
- The IRP rewards information on Medicare fraud &abuse or other punishable activities. The information must lead to a minimum Medicare recovery of $100 from individuals and entities CMS determines committed fraud.
- For more information, go to the Medicare Program Integrity Manual, Chapter 4, Section 4.15 Incentive Reward Program.

Thank you!

You've completed Provider Network - Fraud, Waste and Abuse.