

Medical Billing Fraud & Abuse Prevention Guide

A Plain-Language Resource for Healthcare Billing Teams

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This guide explains — in simple, everyday language — what medical billing fraud and abuse are, how to spot them, and what your team must do to prevent them. No legal jargon. No confusing terms. Just clear, practical guidance.

1. What Is Medical Billing Fraud?

Medical billing fraud happens when someone **intentionally** bills for something that is false or did not happen. This is not a mistake — it is done on purpose to get money that is not owed.

Common Examples of Fraud:

- **Billing for services never provided:** Charging insurance for a visit, test, or procedure that never actually happened.
- **Upcoding:** Billing for a more expensive service than what was actually done. For example, billing for a 45-minute visit when the patient was only seen for 10 minutes.
- **Unbundling:** Breaking one procedure into multiple separate bills to charge more — when those services should be billed together at a lower rate.
- **Duplicate billing:** Sending the same bill more than once for the same service.
- **Billing for a different provider:** Submitting a claim under a doctor's name when a less-qualified person actually performed the service.
- **Phantom patients:** Creating fake patient records to submit claims for people who do not exist.

Key point: Fraud always involves intent. If someone knowingly submits a false claim, that is fraud — even if no money has been paid out yet.

2. What Is Medical Billing Abuse?

Abuse is different from fraud. Abuse happens when billing practices are **improper or wasteful** but not always done on purpose. Think of it as doing something wrong without realizing it — but it still costs the system money it should not have paid.

Common Examples of Abuse:

- Ordering too many tests that are not medically necessary
- Billing for a higher level of service just to get more money, without proper documentation
- Not following correct coding guidelines, leading to overpayments
- Scheduling unnecessary follow-up visits
- Using outdated billing codes that no longer apply

Fraud vs. Abuse — Quick Comparison

Fraud	Abuse
Done on purpose	May be a mistake
Knowingly false claims	Improper or wasteful practices
Criminal charges possible	Usually results in repayment + fines
Example: Billing for fake visits	Example: Over-ordering lab tests

3. Laws You Must Know

Several federal laws protect against billing fraud and abuse. You do not need to memorize every word, but you do need to understand what they mean for your daily work.

False Claims Act (FCA)

This is the most important anti-fraud law. It says you cannot submit a false claim to the government (like Medicare or Medicaid). Penalties can reach \$27,000+ per false claim, plus three times the amount wrongly paid. Whistleblowers (people who report fraud) are protected and may receive a portion of recovered funds.

Anti-Kickback Statute (AKS)

It is illegal to pay or receive anything of value in exchange for patient referrals or for ordering services paid by Medicare or Medicaid. This includes cash, gifts, meals, or other benefits. Violations are a felony.

Stark Law (Physician Self-Referral Law)

Doctors cannot refer patients to a facility where the doctor (or their family) has a financial interest — unless a specific exception applies. This law is strict: even if there was no bad intent, a violation still counts.

HIPAA (Health Insurance Portability and Accountability Act)

HIPAA protects patient privacy and sets rules for how health information is handled. Billing fraud that involves misusing patient data can trigger HIPAA violations on top of fraud charges.

Civil Monetary Penalties Law (CMPL)

The government can fine providers for submitting incorrect claims, employing excluded individuals, or giving patients incentives to use certain services.

4. Red Flags — What to Watch For

Your team should always be on the lookout for warning signs. If you see any of the following, report it immediately to your compliance officer.

Billing-Related Red Flags:

- Claims submitted for dates when the provider was not working
- Services billed for deceased patients
- Same service billed multiple times for one patient on the same day
- Codes that do not match the patient's diagnosis
- Unusually high billing volume from one provider compared to peers

Documentation-Related Red Flags:

- Medical records that look altered or backdated
- Identical notes copy-pasted across different patient visits
- Missing signatures or unsigned orders
- Records that do not match what was actually billed

Behavior-Related Red Flags:

- A provider who discourages questions about billing
- Pressure to hit billing targets regardless of actual services
- Staff submitting claims without proper review
- Requests to split or delay claims without clear reason

5. Prevention Steps for Your Team

The best way to avoid fraud and abuse is to build strong habits and follow clear processes every day. Here is what your team should be doing:

Step 1: Train Regularly

Every billing team member should complete compliance training at least once a year. New hires should be trained before they touch any claim.

Step 2: Verify Before You Bill

Always confirm that services were actually provided and properly documented before submitting a claim. Never bill based on what was planned — only what was done.

Step 3: Use the Right Codes

Follow current CPT, ICD-10, and HCPCS coding guidelines. When unsure, ask a certified coder. Do not guess.

Step 4: Check OIG Exclusions

Before hiring anyone or contracting with any vendor, check the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE). Billing for services by excluded individuals is a serious violation.

Step 5: Conduct Internal Audits

Review a sample of claims every month to catch errors before they become problems. Look for patterns, not just one-time mistakes.

Step 6: Document Everything

Good documentation is your best protection. If it is not written down, it did not happen. Every service must have clear, complete supporting records.

Step 7: Report Concerns Safely

Your organization must have a way for staff to report concerns without fear of retaliation. Use the hotline or anonymous reporting tool if something seems wrong.

Step 8: Respond to Overpayments Quickly

If you discover that you were paid too much, you must report and return the money within 60 days. Keeping overpayments can itself become a violation.

6. Consequences of Fraud & Abuse

The penalties for medical billing fraud are serious. They affect not just the organization, but individual employees too.

Type of Penalty	What It Means
Civil Fines	Up to \$27,000+ per false claim plus 3x the amount improperly paid
Criminal Charges	Fraud can lead to prison time for individuals involved
Exclusion	Providers can be banned from Medicare and Medicaid permanently
Loss of License	State medical or billing licenses can be revoked
Reputation Damage	News of fraud becomes public and destroys patient trust
Corporate Integrity Agreements	Organizations may be placed under years of government monitoring

Remember: Even if you did not commit the fraud yourself, you can still face penalties if you knew about it and did nothing. Always speak up.

7. How to Report Suspected Fraud

If you suspect fraud or abuse — whether by a coworker, a vendor, or even a manager — you have both the right and the responsibility to report it.

Method	Contact / Details
Internal Compliance Hotline	Contact your organization's compliance department
OIG Hotline	1-800-HHS-TIPS (1-800-447-8477)
CMS Fraud Tip Line	1-800-MEDICARE (1-800-633-4227)
Online OIG Complaint	oig.hhs.gov/fraud/report-fraud
State Medicaid Fraud Control	Contact your state's attorney general office

You are protected. Federal and state laws protect people who report fraud in good faith. You cannot be fired, demoted, or harassed for reporting suspected fraud. This protection is called whistleblower protection.

8. Quick Reference Checklist

Use this checklist every time you submit a claim or review billing records:

■ Was the service actually provided and documented?
■ Does the billing code match the documentation exactly?
■ Is the diagnosis code appropriate for the service billed?
■ Has the provider been checked against the OIG exclusion list?
■ Are there any duplicate claims for this patient on this date?
■ Did a qualified provider perform and sign off on the service?
■ Have all known overpayments been reported and returned?
■ Were any unusual patterns flagged during the internal audit?
■ Has the patient's identity been verified?
■ Is all documentation complete and free of copied/pasted notes?

Questions? Contact your Compliance Officer. This guide is reviewed annually and updated to reflect the latest regulations. Keep a copy at your workstation.