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Complete Healthcare Compliance Manual 2024
Civil Monetary Penalties Law

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Fast Facts

Title of law: The Civil Monetary Penalties Law (CMPL), exclusion of certain individuals and entities from participation in Medicare and state health care programs

Categories:

- Fraud and abuse
- Medicare
- Medicaid

U.S. Code: 42 U.S.C. § 1320a-7a

Year enacted: 1981

Major amendments: Not applicable.

Enforcement agencies: U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG), Centers for Medicare & Medicaid Services (CMS)

Link to full text of law: https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXI-partA-sec1320a-7a.pdf

Applies to: Any person or entity that presents fraudulent Medicare or Medicaid claims to federal or state agencies; authorizes the secretary of the U.S. Department of Health & Human Services to impose civil monetary penalties, assessment, and Medicare and Medicaid program exclusion.

What Is the Civil Monetary Penalties Law?

The Civil Monetary Penalties Law (CMPL) authorizes the HHS to impose civil money penalties against any person or entity, including a laboratory, that presents fraudulent claims to a federal or state agency. The law also prohibits the following conduct:

- Offering something of value to a Medicare or other state or federal healthcare program beneficiary that the

person knows or should know is likely to influence the beneficiary to obtain items or services billed to a state or federal healthcare program.

- Employing or contracting with an individual or entity that the provider knows or should know is excluded from participation in a federal healthcare program.
- Billing for services requested by an unlicensed physician or an excluded provider.
- Knowing of an overpayment and failing to return and report it in a timely fashion.
- Billing for medically unnecessary services.[6]

History

The CMPL was enacted in 1981 in response to widespread fraud and abuse involving the Medicare and Medicaid programs. It was designed to not only punish healthcare providers who knowingly committed fraud and abuse through their healthcare claims, but also providers who were unaware of the fraud and abuse they were committing. This law encourages providers to verify the accuracy of the Medicare, Medicaid, and state health claim forms submitted by in-house staff and billing services.[7]

Related Laws

Federal Anti-Kickback Statute, 42 U.S.C. 1320a-7b(b)

The federal Anti-Kickback Statute is a criminal law that prohibits the knowing and willful payment of "renumeration" to induce or reward patient referrals or the generation of business involving any item or service payable by federal healthcare programs (e.g., drugs, supplies, or healthcare services for Medicare or Medicaid patients). Renumeration includes anything of value, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. Physicians are common targets for kickback schemes because they can be a source of referrals for fellow physicians or other healthcare providers and suppliers.[8]

Physician Self-Referral Law, 42 U.S.C. § 1395nn

The Physician Self-Referral Law, commonly referred to as the Stark Law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship. Financial relationships include both ownership/investment interest and compensation arrangements. The Stark Law is a strict liability statute, which means proof of specific intent to violate the law is not required.[9]

Exclusion Statute, 42 U.S.C. § 1320a-7

The HHS OIG excludes healthcare providers in all federal healthcare programs who are convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; (2) patient abuse or neglect; (3) felony convictions for other healthcare-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substance.[10]

False Claims Act, 31 U.S.C. §§ 3729-3733

The civil False Claims Act protects the government from being overcharged or sold faulty goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that a provider knows or should know are false or fraudulent. The fact that a claim results from a kickback or is made in violation of the Stark Law also may render it as being false or fraudulent, creating liability under the civil False Claims Act as well as the Anti-Kickback Statute, Stark Law, or CMPL.[11]