Fraud and Abuse in the Medicare Program

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Learning Objectives

- Define what fraud is and identify examples of fraud.
- Identify proactive measures to mitigate risk to your business or organization.
- Demonstrate the significance of compliance programs.
- Demonstrate how to report suspected fraud or abuse.
- Identify safeguard activities used to protect the Medicare program.

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Overview of Medicare Program

- Established by Title 18 of the Social Security Act and began in 1966.
- Title 42, U.S. Code of Federal Regulations
  - Sections 400-499 and 1000-2004
- Funded by taxes and premiums from beneficiaries
- Oversight
  - U.S. Department of Health and Human Services
    - Centers for Medicare and Medicaid Services
    - Office of the Inspector General

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Overview of Medicare Program

- Program is divided into four parts:
  - Part A: hospitals and facility charges
  - Part B: professional services (e.g., physicians, labs, ambulance, DME)
  - Part C: managed care, HMOs (Medicare Advantage Plans)
  - Part D: prescription drugs
- Who Is Eligible for Medicare Benefits?
  - Individuals age 65 or older
  - Individuals with certain disabilities (regardless of age)

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What Does Medicare Pay For?

- General: Covers services and items that are considered to be medically reasonable and necessary for the treatment or diagnosis of a patient's condition.
- There are policies issued by CMS and its contractors that dictate coverage and billing requirements for certain services and items.
  - Not all services and items have specific coverage criteria associated with them.
  - Policies may be developed for specific services and items when:
    - There is a statutory requirement.
    - There is a need to ensure that payment is made only for those that are medically reasonable and necessary.
  - Types of Policies:
    - Provider specific (e.g., professional qualifications, limits to body systems, etc.).
    - Service/item specific (e.g., utilization limits, medical condition/diagnosis).

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Definitions of Fraud and Abuse

- **Fraud:**
  - Knowingly and willfully executing or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain by means of false of fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody of, any healthcare benefit program.
- **Abuse:**
  - May result, directly or indirectly, in unnecessary costs to the Medicare program, or improper payment for services or items that fail to meet professionally recognized standards of care or are medically unnecessary. It involves payment for services or items when there is no legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

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Fraud vs. Errors

Fraud	Errors
➢ Billing for services or items not furnished. ➢ False information on medical records, claims, applications, cost reports, etc. ➢ Offering, soliciting, or accepting bribes, kickbacks, rebates, or discounts in return for the order or referral of services or items.	➢ Billing for services or items not furnished. ➢ Incorrect information on medical records, claims, applications, cost reports, etc.

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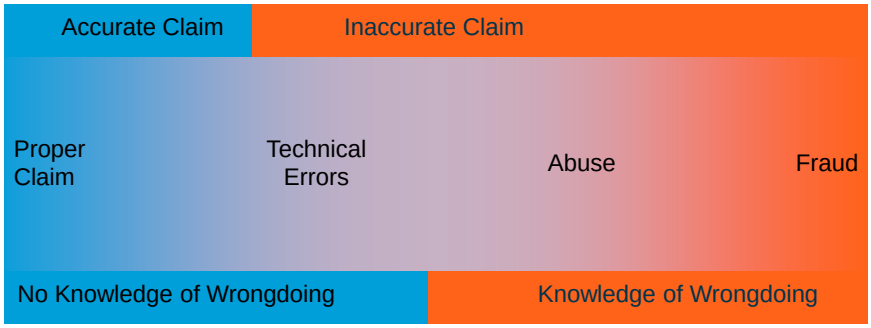
The Claims Continuum



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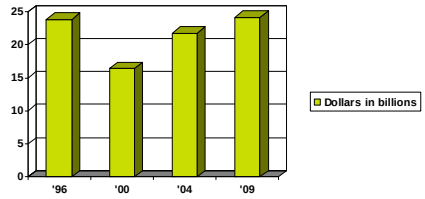
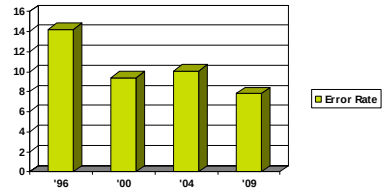
Payment Error Rate





- 1996
  - $23.8 billion
  - 14.2%
- 2000
  - $16.4 billion
  - 9.4%
- 2004
  - $21.7 billion
  - 10.1%
- 2009*
  - $24.1 billion
  - 7.8%
- Lowest in 2008
  - $10.4 billion
  - 3.6%

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Examples of Fraud

- Billing for services/items not furnished
  - Stolen Health Insurance Claim Numbers (HICN) used to bill for fictitious claims.
  - Clinical laboratory bills for tests in addition to those ordered and rendered.
- Misrepresenting services
  - "Free" exercise and/or social activities billed as covered physical therapy or mental health services.
  - TENS treatments billed as complex neurologic tests.
  - Vitamin injections billed as infusion therapy.

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Examples of Fraud

- Falsifying records
  - Doctor completes Certified Medical Necessity (CMN) for patients never seen or treated. Durable Medical Equipment (DME) supplier then bills for items that are not needed or are not furnished.
  - Fictitious test results are created to falsely document the need for therapy.
- Billing for more extensive services/items
  - High-level Evaluation and Management (E/M) services are routinely billed for all visits, although many do not meet the requirements.
  - Hospital reports bacterial pneumonia vs. viral pneumonia for all patient admissions for pneumonia.

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Examples of Errors

- Incorrect date of service billed
- Claims submitted or processed with incorrect HICN
  - Spouse
  - Other person
- Claims billed or processed with incorrect codes
  - CPT, HCPCS, DRG, Revenue
  - Patient diagnosis
  - Service or item billed
  - Number or quantity billed

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Examples of Misunderstandings

- Patient does not recognize provider listed on Medicare Summary Notice (MSN)
  - Diagnostic tests
  - Anesthesia
- Billing address vs. practice address
  - Provider's address listed on MSN is the provider's billing address; patients do not recognize address.
- Services or items furnished by office or clinic personnel
  - Claims for these services/items are typically billed as services by a physician (who employs the office/clinic personnel).

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Risk Mitigation: Resources

- Regulations
  - Social Security Act; Title 18
  - Code of Federal Regulations; Title 42; Sections 400-429, 430-499, 1000-2004
  - Federal Register
- Coverage, policies, reimbursement, documentation, claim filing, coding
  - CMS Web site
  - OIG Web site
  - Medicare contractor Web sites
  - Seminars (CMS, contractors, private)
  - Consultants, healthcare attorneys
  - Contractor customer service

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Risk Mitigation: Resources

- Centers for Medicare &Medicaid Services
  www.cms.gov
- Office of Inspector General
  www.oig.hhs.gov
- U.S. Code of Federal Regulations
  www.ecfr.gpoaccess.gov
- Social Security Act
  www.ssa.gov
- Federal Register
  www.gpoaccess.gov/fr
- First Coast Service Options
  http://medicare.fcso.com
- Palmetto GBA
  http://palmettogba.com
- CIGNA
  http://www.cignagovernmentservices.com
- National Government Services
  http://www.ngsmedicare.com

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Risk Mitigation: Guidelines and Procedures

- Standard operating procedures for adherence to guidelines
  - Coding guidelines (e.g., CPT, HCPCS, Revenue, DRG, ICD-9-CM)
  - National and Local Coverage Determinations
  - Coverage requirements
  - Claim filing requirements
  - Reimbursement guidelines
- Documentation requirements and record retention
  - Supports services/items billed/reported
  - Controlled and accessible
- Assessment of processes and application of rules
  - Evaluate performance against criteria (e.g., periodic review, audits)

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Risk Mitigation: Business Practices

- Maintaining confidentiality of your ID
  - Security of documents and claims
  - Billing staff understands needs for confidentiality
- Reassignment of benefits
  - Area of risk --- unauthorized use
  - Access to information, records, and claims
  - Periodic review of billing and records
  - Notification to Medicare of any changes (e.g., moving, leaving group)
- Business relationships/contractual arrangements
  - Anti-kickback statutes
  - Stark Amendments (self-referrals)
  - Safe Harbor provisions
  - Advisory opinions
  - Referrals to and from other providers
- Employment
  - Screening (history, debarment/exclusions list)
  - Authorization and access to information
  - Training and development

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Risk Mitigation: Billing Services and Consultants

- Selection of billing service/consultant
  - Past reputation
  - Electronic claim filing compatible with Medicare?
  - Edits prior to submission?
- Contract of work
  - Payment set at a single rate vs. based on volume
  - Retention and security of records
  - Access to information
- Monitoring of services and performance
  Should be performed periodically
  - May be performed independently or by consultant

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Risk Mitigation: Patient Protections

- Beneficiary impostors
  - Verify identity of patients.
- Confidentiality of HICNs and medical records
  - Maintain security of records and IDs.
  - Shred or destroy records if appropriate.
- Certificates of Medical Necessity
  - Need for services, equipment, or supplies should be dictated by patient's physician.
  - CMN should be completed by patient's physician only if a need exists.
- Educational and informational materials
  - Assist patients in understanding their benefits.
  - Disseminate among patients to keep them informed.

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Compliance Programs

- Model compliance programs issued by HHS Office of the Inspector General.
  - www.oig.hhs.gov
- Not required – VOLUNTARY.
- Use of one does not preclude you from review, investigation, or prosecution.
- Healthcare attorneys and consultants can assist in establishing a plan.

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Compliance Programs

Elements

- Implement written policies, procedures, and standards of conduct.
- Designate compliance officer or committee.
- Conduct effective training and education.
- Develop formal lines of communication.
- Enforce standards through well-publicized disciplinary guidelines.
- Conduct internal monitoring and auditing.
- Respond promptly to detected offenses and develop corrective actions.

Objectives

- Prevent, identify, and correct inappropriate activities.
- Establish a culture in which all staff are active participants.
- May reduce exposure to liabilities and penalties.
- May be applied to all aspects of the organization or to areas of higher risk.

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How to Report Suspected Fraud or Abuse

- Suspected fraud or abuse should be reported to the Medicare contractor who processed the claims.
- At minimum, reports of suspected fraud or abuse should include the following information:
  - Name and address of person/provider who is suspected of fraudulent or abusive activities
  - Dates of service involved
  - Description of services involved
  - A description of the alleged activity (e.g., services billed but not furnished)
  - An explanation of why the activity is considered to be fraudulent or abusive

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Where to Report Suspected Fraud

Parts A and B

First Coast Service Options
PO Box 45087
Jacksonville FL 32232
Part A – FL:
(888) 664-4112
Part B – FL & USVI:
(866) 454-9007
Part A – PR:
(877) 908-8433
Part B – PR:
(877) 715-1921
Part A – USVI:
(888) 664-4112

DMEPOS

CIGNA Government Services
PO Box 20010
Nashville TN 37202
(866) 270-4909

Home Health / Hospice

Florida:
Palmetto GBA
Provider Contact Center
Mail Code: AG-620
PO Box 100238
Columbia SC 29209
(866) 801-5301

Puerto Rico & US Virgin Islands:
National Government Services
PO Box 7191
Indianapolis, IN 46207
(866) 590-6728

Office of Inspector General Fraud Hotline
(800) HHS-TIPS

Zone 7 Program Integrity Contractor Hotline
(866) 417-2078

Medicare Customer Service (Medicare Beneficiaries)
(800) MEDICARE

Senior Medicare Patrol (Medicare Beneficiaries)
(866) 357-6677

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Voluntary Refunds vs. Self-Disclosure

Voluntary Refund	Self-Disclosure
• Used to report overpayments where fraud or abuse is not an issue	• Used to report overpayments in which fraud or abuse is suspected or when there is an appearance of fraud or abuse
• Reported to Medicare	• Reported to HHS Office of the Inspector General
• Specify claims and methodology used to identify overpayment	• Protocol must be followed
• Subject to further action	• No appeal rights
• Appeal rights	• May lessen penalties and/or mitigate prosecution

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Medicare Integrity Program

- Established by the Health Insurance Portability and Accountability Act of 1996
  - Dedicated resources for program integrity activities.
  - Authority for CMS to contract with private entities solely for program integrity activities.
    - Program Safeguard Contractors (PSC)
      - »Part A and/or Part B
      - »DMEPOS
      - »Home Health and Hospice
- CMS strategy
  - Prevention
  - Detection
  - Close coordination
  - Fair and firm enforcement

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Zone Program Integrity Contractors

- Medicare Modernization Act of 2003:
  - Medicare Administrative Contractors (MAC) created to streamline and regionalize Medicare claims processing.
  - Centers for Medicare and Medicaid Services (CMS) establishes Zone Program Integrity Contractors (ZPIC) to align Medicare program integrity activities with MAC claims processing jurisdictions.
    - Replaces previous Program Safeguard Contractors
    - May eventually include Part C and Part D (MEDICs)
- September 30, 2008:
  - CMS awards Zone 7 ZPIC to SafeGuard Services LLC.
- February 2009:
  - SafeGuard Services begins operations as Zone 7 ZPIC.

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Zone 7 ZPIC

- Areas of responsibility:
  - Florida
  - Puerto Rico
  - U.S. Virgin Islands
- Claim types involved:
  - Part A
  - Part B
  - Durable Medical Equipment, Prosthetics, and Orthotics
  - Home Health and Hospice
- Primary activities:
  - Complaint processing and resolution
  - Data analysis to identify potential fraud and abuse
  - Investigation of healthcare fraud and abuse
    - Desk and field investigations
    - Medical record reviews
    - Cost report audits
  - Development of cases for referral to law enforcement
  - Education related to benefit integrity
  - Ongoing support of CMS and law enforcement efforts
  - Medicare-Medicaid data matching for Florida

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Program Integrity Activities

- Identification of inappropriate activities
  - Allegations (must be reviewed and validated)
  - Data analysis (identify trends and patterns, support program integrity functions)
  - Medical review
  - Government and industry sources
- A decision is made on the appropriate course of action:
  - Nothing
  - Education
  - Pre- or post-payment review
  - Overpayment recovery
  - Investigations
  - Criminal and/or civil prosecution
  - Civil monetary penalties
  - Impose sanctions

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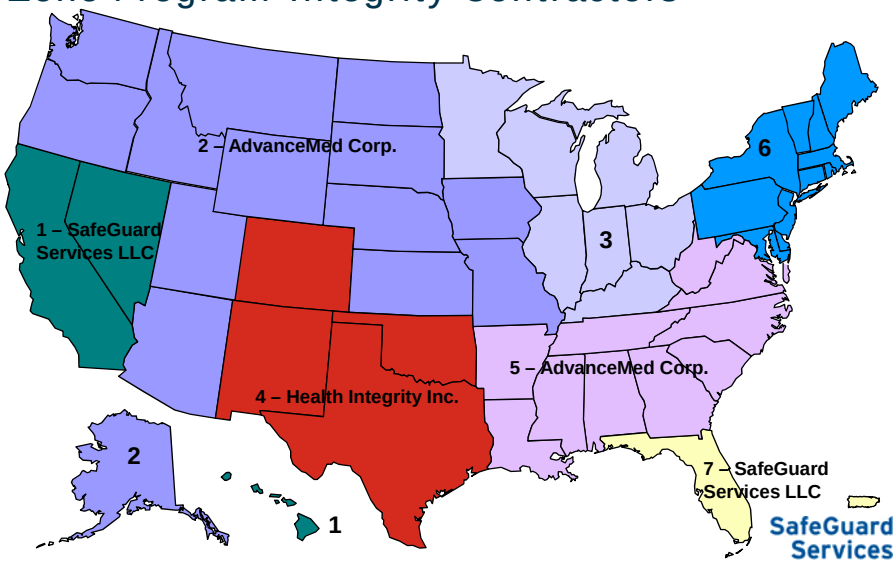
Zone Program Integrity Contractors



*Other territories of Zone 1 include American Samoa, Northern Marianas Islands and Guam

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Federal Law Enforcement

- Federal agencies involved
  - DHHS Office of the Inspector General
  - US Department of Justice
    - United States Attorney's Office
    - Federal Bureau of Investigations
  - Medicaid Fraud Control Unit/State Attorney's Office
- Investigation and prosecution of health care fraud
- Imposition of sanctions and penalties

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Federal Law Enforcement Actions

In Fiscal Year 2010:

- 1,116 criminal health care fraud investigations opened involving 2,095 potential defendants.
- Criminal charges filed in 488 cases involving 931 defendants.
- 942 civil health care fraud investigations opened.
- 726 defendants convicted for health care fraud related crimes.
- 3,340 individuals and entities excluded from participating in federal health care programs.
- Approximately $2.5 billion in judgments and settlements won or negotiated, and additional administrative impositions attained in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of more than $2.86 billion during this period as a result of these efforts.

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Affordable Care Act

- Improves and expands consumer protections, strengthens Medicare, and reduces health care costs.
- New tools to improve and enhance efforts to prevent, detect, and take strong enforcement actions against fraud in Medicare, Medicaid, and Children's Health Insurance Program.
- Increased Federal sentencing guidelines by 20-50% for crimes involving more than $1 million.
- Obstruction of fraud investigation is now a federal offense.
- Enhanced oversight of providers/suppliers:
  - Licensure and background checks.
  - Withhold payments if a credible allegation of fraud is made.
  - Provisions will focus on high-risk providers.
  - Exclusion from participation if enrollment application is falsified.
- Increased resources.
- Enhanced data and information sharing among agencies.
- Stronger civil and monetary penalties.

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Questions???

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