





Medicare Fraud & Abuse: Prevention, Detection, and Reporting





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Objectives

At the end of this presentation, you should be able to correctly:

- Identify one of the methods to PREVENT Medicare fraud and abuse
- Identify one of the methods the Federal Government uses to DETECT Medicare fraud and abuse
- Identify how you can REPORT Medicare fraud and abuse



















Question 1

Select True or False.

CMS requires an enrollment application fee for certain health care providers to prevent Medicare fraud and abuse.

- A. True
- B. False







Question 2

Select the false statement.

- A. Medicare Carriers, Fls, MACs, CERT Contractors, and Recovery Auditors all conduct claim review.
- B. Medicare Carriers, Fls, MACs, CERT Contractors, and Recovery Auditors all conduct extensive investigations.
- C. The OIG, the DOJ, and PSCs/ZPICs all conduct extensive investigations.







Question 3

Select the correct answer.

The OIG Provider Fraud Hotline is:

A. 1-800-CMS-TIPS

B. 1-800-HHS-TIPS

C. 1-800-OIG-TIPS

D. 1-800-DOJ-TIPS







Are you smarter than an OIG Fugitive?









Medicare Fraud and Abuse













Medicare Fraud and Abuse Is a Serious Problem



Most Medicare providers/contractors are honest

However, \$4 billion recovered in 1 year













How much did these providers plead guilty to?

Two owners of a home health care company that claimed to provide skilled nursing to Medicare beneficiaries pleaded guilty in connection with a \$____ Medicare fraud scheme. Each owner pleaded guilty to:

- 1 count of conspiracy to commit health care fraud,
- 1 count of conspiracy to pay kickbacks, and
- 16 counts of payment of kickbacks to Medicare beneficiary recruiters. Each owner faces a maximum sentence of 10 years in prison for the health care fraud conspiracy count, 5 years in prison for the kickback conspiracy count, and 5 years in prison for each kickback count.

What is the dollar amount of this Medicare fraud scheme?

- 1. 500,000
- 2. 2.6 million
- 3. 5.2 million
- 4. 110 million

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What is Fraud?

Making false statements or representations of material facts to

Obtain some benefit or payment For which no entitlement would otherwise exist

Includes obtaining something of value through Misrepresentations or Concealment of material facts









What is Abuse?

Abuse describes practices that:

- Result in unnecessary costs,
- Are not medically necessary,
- Are not professionally recognized standards, and
- Are not fairly priced.













A DMEPOS supplier was paid \$5,049 for a power wheelchair, Group 2 standard. The documentation did not support medical necessity according to the applicable National Coverage Determination (NCD) and Local Coverage Determination (LCD). Neither the diagnoses submitted nor the face-to-face evaluation received from the physician's office supported the inability to self-propel. No other valid rationale was offered as to why a power mobility device versus another mobility device was reasonable and necessary.





How much of the \$5,049 payment did Medicare recoup from this supplier?

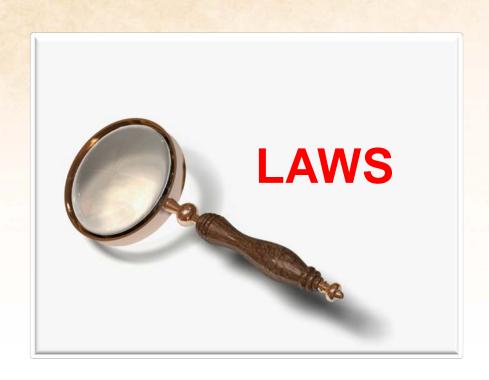


- 1. Nothing (\$0)
- 2. Half (\$2,524.50)
- 3. All (\$5,049)
- 4. Triple (\$15,147)



Medicare Fraud and Abuse













Some Major Medicare Fraud and Abuse Laws

False Claims Act

Anti-Kickback Statute

Physician Self-Referral Law

Criminal Health Care Fraud Statute

These laws apply to Medicare Parts A, B, C, D.









What is the False Claims Act (FCA)?

Protects the Federal Government from

- Overcharges or
- Sold substandard goods or services

Imposes civil liability on any person who knowingly

 Submits, or causes to be submitted a false or fraudulent claim









What is the Anti-Kickback Statute?

Prohibits knowingly and willfully

- Offering, paying, soliciting, or receiving remuneration
- To induce or reward referrals of items/ services reimbursable by a Federal health care program

Safe harbors exist









What is the Physician Self-Referral Law (Stark Law)?

Prohibits referring Medicare beneficiaries for

Certain designated health services

To an entity in which the physician (or an immediate family member) has

An ownership/investment interest, or

A compensation arrangement

Exceptions may apply









What is the Criminal Health Care Fraud Statute?

Prohibits knowingly and willfully executing, or attempting 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;
- In connection with the delivery of or payment for health care benefits, items or services.













True or False:

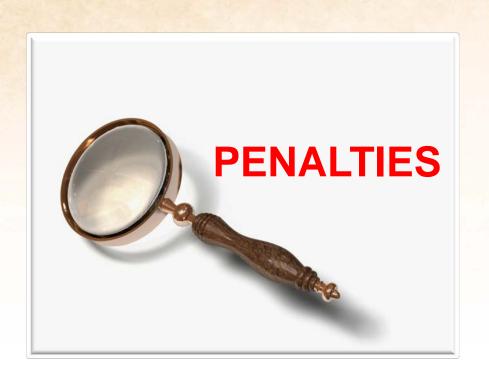
Both the Anti-Kickback Statute and the False Claims Act apply only to Medicare.

- 1. True
- 2. False



Medicare Fraud and Abuse













Types of Penalties

Civil Monetary Penalties (CMPs)

Criminal sanctions

Exclusion

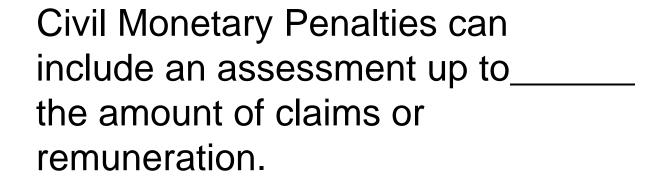














- 1. 2 times
- 2. 3 times
- 3. 4 times
- 4. 5 times



Civil Monetary Penalties (CMPs)

Up to \$10,000 to \$50,000 per violation Can also include an assessment of up to 3 times the amount

- Claimed for each item/service, or
- Of the remuneration offered, paid, solicited, or received









Criminal Prosecution and Penalties



Criminal convictions are also available when prosecuting health care fraud.

Federal sentencing guidelines







Mandatory Exclusions by HHS OIG

From participation in all Federal health care programs, health care providers and suppliers convicted of:

Medicare fraud,

Patient abuse or neglect,

Felonies for

- Other health care-related fraud, theft, or other financial misconduct, or
- Unlawful manufacture, distribution, prescription, or dispensing of controlled substances









Permissive Exclusions by HHS OIG

- Misdemeanor convictions related to:
 - Health care fraud
 - Controlled substances
- Conviction related to fraud in a non-health care program
- License revocation or suspension, or
- Obstruction of an investigation







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Excluded Individuals/Entities

Providers and contracting entities must check exclusion status before employment or contractual relationships

How?

- OIG List of Excluded Individuals/Entities (LEIE)
- General Services Administration (GSA) Excluded Parties Listing System (EPLS)









Medicare Fraud and Abuse













CMS is Working to Prevent Medicare Fraud and Abuse

Enhanced Medicare enrollment protections

- Fees
- Screening categories
- Revalidation

Automated prepayment claims edits

Predictive analytics technologies

Suspension of payments

Education









Providers' Role

Provide only medically necessary, high quality services

Properly document all services

Correctly bill and code for services

Check LEIE and EPLS

Comply













Which of the following statements is <u>false</u>?

- Medicare never allows routine foot care to be billed
- 2. CMS offers a product for Outpatient Rehabilitation Therapy Services Providers about documentation requirements
- 3. Medicare does not allow stamped signatures
- CMS offers a product to assist with E/M coding







True or False:

A physician must visit or evaluate Medicare beneficiaries prior to the initial certification or recertification of the need for in-home oxygen.

- 1. True
- 2. False



CMS Partners with State and Federal Law Enforcement Agencies



OIG

FBI

DOJ

MFCUs

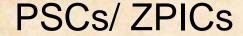








CMS Contracts with Other Entities



MEDICs

Medicare Carriers, Fls, MACs

MA Plans and PDPs

Recovery Audit Program Recovery

Auditors

CERT Contractors

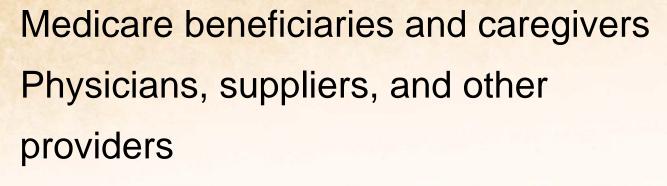








Other CMS Partners



Accreditation Organizations
Senior Medicare Patrol (SMP)













Which is **not** a CMS Partner to prevent and detect Fraud and Abuse?

- 1. MEDIC
- 2. OIG
- 3. SMP
- 4. CRIME

Half Time Team Results



Medicare Fraud and Abuse













The Role of Data

Target high-risk areas

- Services, geographic locations, and/or provider types
- Outlier providers that bill differently in a statistically significant way

Integrated Data Repository (IDR)









Claim-Reviewing Entities

Conduct prepayment and/or postpayment review:

Medicare Carriers, Fls, MACs, MA Plans and PDPs

CERT Contractors

Recovery Audit Program Recovery Auditors

PSCs/ZPICs/MEDICs







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Medical Review (MR) Program

Goal:

Reduce payment errors by identifying and addressing provider coverage and coding mistakes

Who?

Medicare Carriers, Fls, and MACs MA Plans and PDPs

How?

Pre and postpayment review













The acronym CERT in the Medicare Program stands for:

- Certified Education & Reporting Team
- 2. Comprehensive Error Rate Testing
- 3. Criminal Evasion Record Task
- 4. Criminal Emergency Response Team



Comprehensive Error Rate Testing (CERT) Program

Goal:

Identify high-risk areas, measure improper payments, and produce a national Medicare Fee-For-Service (FFS) error rate

Who?

CERT contractors

How?

- Randomly select statistically-valid sample of claims
- Conduct postpayment review
- Publish results annually









Recovery Audit Program



Goal:

Detect improper underpayments and overpayments

Who?

Recovery Auditors

How?

- Postpayment claims review
- May target reviews













Which of the following acronyms is an organization that investigates Medicare fraud?

- 1. APIC
- 2. FPIC
- 3. MPIC
- 4. ZPIC



Investigating Entities



PSCs/ZPICs/MEDICs

OIG

DOJ

HEAT









PSCs, ZPICs, MEDICs

Identify cases of suspected fraud and abuse

Refer cases of suspected fraud to OIG

Refer cases of suspected abuse to:

- Appropriate Medicare Contractor, and/or
- OIG

May take concurrent action









HHS OIG



Protects

Audits, investigates, inspects

Excludes and penalizes









Investigates fraud and abuse in Federal Government programs

Partners with the OIG through HEAT









Health Care Fraud Prevention and Enforcement Action Team (HEAT)

- Gathers Government resources to
 - Help prevent waste, fraud, and abuse in the Medicare and Medicaid Programs, and
 - Crack down on fraud perpetrators who abuse the system
- Reduces health care costs and improves the quality of care
- Highlights best practices by providers and public sector employees
- Builds upon existing partnerships between the DOJ and OIG
- Maintains the Stop Medicare Fraud website









Medicare Fraud and Abuse













Reporting Suspected Fraud and Abuse to the OIG

Accepts and reviews tips from all sources

OIG encourages you to provide contact information







Reporting to HHS OIG Hotline

http://oig.hhs.gov/fraud/report-fraud/report-fraud-form.asp

Phone: 1-800-HHS-TIPS (1-800-447-8477)

TTY: 1-800-377-4950

Fax: 1-800-223-8164

E-mail: HHSTips@oig.hhs.gov

Mail: Office of Inspector General

Department of Health and Human Services

Attn: Hotline

P.O. Box 23489

Washington, DC 20026









Other Ways to Report Fraud and Abuse

Medicare MA Plan or PDP complaints MEDIC 1-877-7SafeRx (1-877-772-3379)

Medicare FFS complaints
Carrier/FI or MAC

Beneficiaries Only (any complaints) 1-800-MEDICARE (1-800-633-4227) TTY 1-800-486-2048













True or False:

You can call the following for both Part C and D fraud issues:

1-877-7SafeRx

(1-877-772-3379)

- 1. True
- 2. False



OIG Provider Self-Disclosure Protocol (SDP)



Avoid costs and disruptions

OIG works cooperatively









CMS Self-Referral Disclosure Protocol (SRDP)



Actual or potential violations of Physician Self-Referral Law (Stark Law)

Not used to obtain a CMS determination

Submit with intent to resolve overpayment









Medicare Incentive Reward Program (IRP)



Encourages reporting of suspected fraud and abuse

Pays rewards: minimum recovery of \$100













True or False:

The Self-Referral Disclosure Protocol (SRDP) is sent to the OIG.

- 1. True
- 2. False







Which is <u>not</u> an acronym relevant to today's Medicare Fraud and Abuse presentation?

- 1. MLN
- 2. UPS
- 3. LEIE
- 4. SRDP

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Resources

Centers for Medicare & Medicaid Services (CMS) Home Page http://www.cms.gov

Civil Monetary Penalties (CMP) Law http://oig.hhs.gov/fraud/enforcement/cmp

CMS Self-Referral Disclosure Protocol (SRDP)

http://www.cms.gov/Medicare/Fraud-and-

Abuse/PhysicianSelfReferral/Self_Referral_Disclosure_Protocol.html

Department of Health & Human Services (HHS) http://www.hhs.gov

General Services Administration (GSA) Excluded Parties Listing System (EPLS) http://www.epls.gov







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Resources - Continued

Health Care Fraud Prevention and Enforcement Action Team (HEAT) http://www.stopmedicarefraud.gov/heattaskforce

HHS Office of Inspector General (OIG) http://oig.hhs.gov

Medicare Contact Information for Local Contractors
http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Medicare.gov http://www.medicare.gov

Medicare Learning Network® (MLN)
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html









Resources - Continued

Medicare Provider Enrollment:

http://www.cms.gov/Medicare/Provider-Enrollment-and Certification/MedicareProviderSupEnroll/index.html

MLN Provider Compliance Web Page:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network MLN/MLNProducts/ProviderCompliance.html

OIG Exclusions Program "The Effect of Exclusion From Participation in Federal Health Care Programs"

http://oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm http://oig.hhs.gov/fraud/exclusions.asp

OIG Fraud Prevention & Detection http://oig.hhs.gov/fraud

OIG Hotline

http://oig.hhs.gov/fraud/report-fraud









Resources - Continued

OIG List of Excluded Individuals/Entities (LEIE)

http://oig.hhs.gov/exclusions/exclusions_list.asp

OIG Provider Self-Disclosure Protocol

http://oig.hhs.gov/compliance/self-disclosure-info

OIG Safe Harbor Regulations

http://oig.hhs.gov/compliance/safe-harbor-regulations

Physician Self-Referral Law (Stark Law)

http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html

Senior Medicare Patrol (SMP)

http://smpresource.org

Stop Medicare Fraud:

http://www.stopmedicarefraud.gov









Summary of Today's Topics

Medicare fraud and abuse is a serious problem.

Multiple laws and penalties address Medicare fraud and abuse.

Multiple Federal agencies work together to detect fraud through:

- Data analysis
- Review of claims
- Investigations
- Other methods







Summary of Today's Topics: Your Role



Although CMS works to prevent fraud and abuse, your assistance is needed in prevention. Educate yourself and comply with all laws and regulations.

You should self-disclose any potential violations and report all suspected fraud.







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Post-Assessment

Question 1

Select the false statement.

- A. Medicare Carriers, Fls, MACs, CERT Contractors, and Recovery Auditors all conduct claim review.
- B. Medicare Carriers, Fls, MACs, CERT Contractors, and Recovery Auditors all conduct extensive investigations.
- C. The OIG, the DOJ, and PSCs/ZPICs all conduct extensive investigations.







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Post-Assessment

Question 2

Select the correct answer.

The OIG Provider Fraud Hotline is:

- A. 1-800-CMS-TIPS
- B. 1-800-HHS-TIPS
- C. 1-800-OIG-TIPS
- D. 1-800-DOJ-TIPS







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Post-Assessment

Question 3

Select True or False.

CMS requires an enrollment application fee for certain health care providers to prevent Medicare fraud and abuse.

- A. True
- B. False









Are you smarter than an OIG Fugitive?

...and the winner is!



Thanks for playing!

