Medicare Fraud & Abuse: Prevention, Detection, and Reporting

ICN 908103

Disclaimers

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Medicare Learning Network® (MLN)

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html on the CMS website.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services, and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html and click on the link called 'MLN Opinion Page' in the left-hand menu and follow the instructions.

Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.

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

Pre-Assessment

Pre-Assessment

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

Pre-Assessment

Question 2

Select the false statement.

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

Pre-Assessment

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?

OIG

MOST WANTED

FUGITIVES

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

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

Civil Monetary Penalties can include an assessment up to_______ the amount of claims or remuneration.

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

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 false?

1. 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
4. 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

PSCs/ ZPICs

MEDICs

Medicare Carriers, FIs, MACs

MA Plans and PDPs

Recovery Audit Program Recovery Auditors

CERT Contractors

Other CMS Partners

Medicare beneficiaries and caregivers

Physicians, suppliers, and other providers

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, FIs, MACs, MA Plans and PDPs
- CERT Contractors
- Recovery Audit Program Recovery Auditors
- PSCs/ZPICs/MEDICs

Medical Review (MR) Program

Goal:

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

Who?

Medicare Carriers, FIs, and MACs

MA Plans and PDPs

How?

Pre and postpayment review

The acronym CERT in the Medicare Program stands for:

1. 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

DOJ

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 not an acronym relevant to today's Medicare Fraud and Abuse presentation?

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

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

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.

Post-Assessment

Question 1

Select the false statement.

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

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

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!