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Understanding Medicare Fraud and Abuse

4/22/2025

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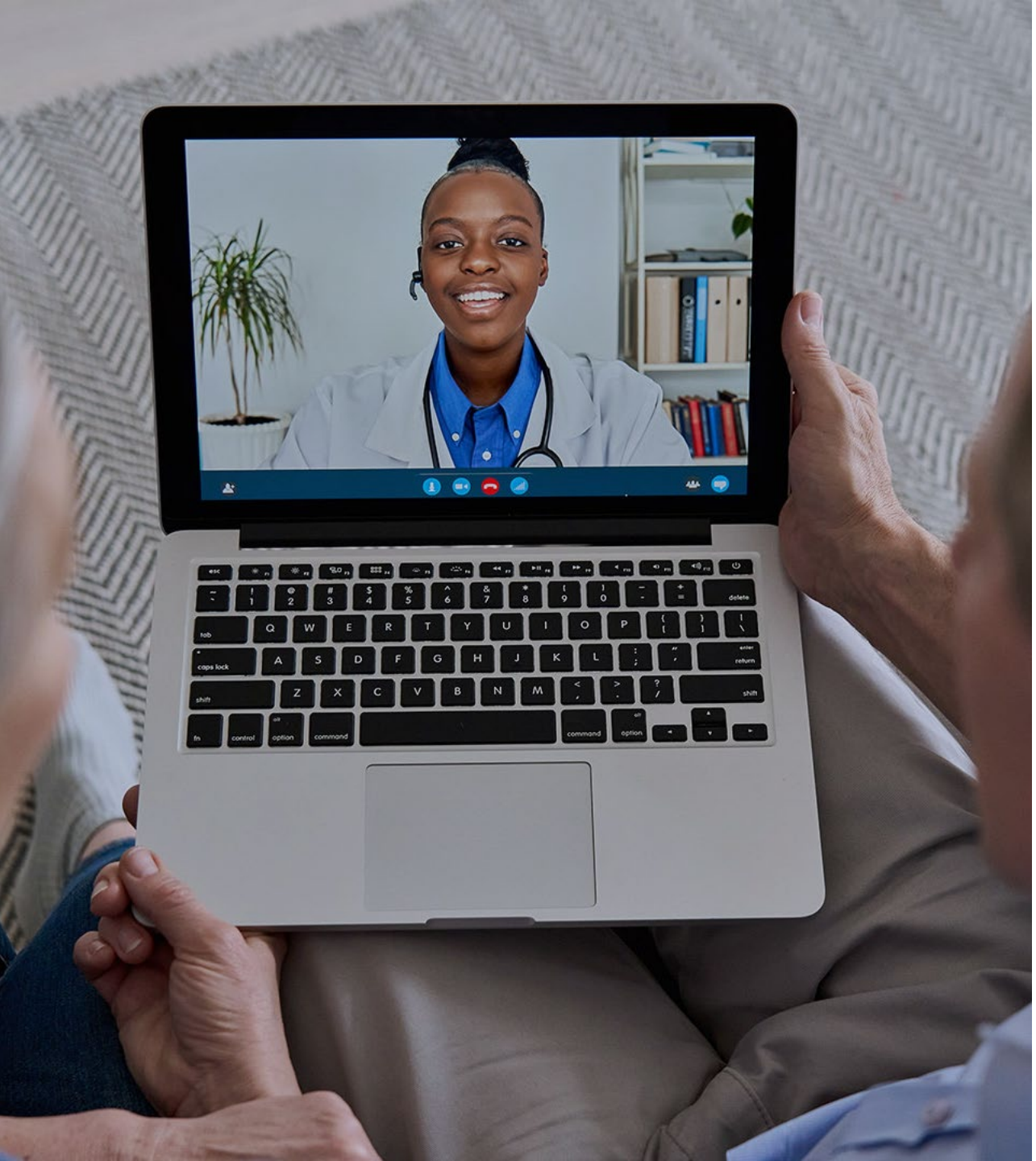

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Objective

Learn about fraud and abuse affecting providers and your Medicare patients to increase your awareness of integrity issues and prevent potential fraudulent and abusive practices against the Medicare Program.

Today's Presenters

- Provider Outreach and Education Consultants
  - Michael Dorris
  - Jean Roberts, RN, BSN, CPC

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Agenda

- Fraud and Abuse
- Laws and Mandates
- Unified Program Integrity Contractors
- Case Development and Referrals
- Health Care Fraud Case Examples
- Unacceptable Billing Practices and Protecting Your Facility
- Compliance Resources

Fraud and Abuse

Fraud

- The intentional deception or misrepresentation which an individual makes, knowing it to be false and that may result in some unauthorized benefit to themselves or some other person
- Elements of fraud
  - Knowingly false statement
  - Receives payment or benefit
  - Intent to defraud Medicare

Examples of Fraud

- Billing for a service not provided
- Billing at a level of complexity higher than provided
- Ordering unnecessary services
- Paying for referrals
- Billing for appointments that did not occur

Abuse

- Actions that are inconsistent with accept, sound medical, business or fiscal practices
  - Directly or indirect results in unnecessary costs to the program through improper payments
- CMS standards
  - Were the services medically necessary?
  - Did they exceed professionally recognized standards?
  - Were they provided at a fair price?

Examples of Abuse

- Billing for services that were not necessary
- Excessive charges for services
- Misusing codes
  - Upcoding/unbundling
- Abuse can expose providers to criminal and civil liability

Laws and Mandates

Federal Civil False Claims Act

- What is False Claims Act?
  - 31 United States Code (USC), Sections 3729–3733
- Protects federal government from being overcharged or sold substandard goods or services

Anti-Kickback Statute

- What is Anti-Kickback Statute?
  - 42 USC, Section 1320a–7b(b)
- Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any compensation directly or indirectly to induce or reward referrals of items or services reimbursable by a federal health care program

Physician Self-Referral Laws

- What is Physician Self-Referral Laws?
  - 42 USC Section 1395nn
- Commonly referred to as the “Stark Law”
- Commonly used exceptions
  - Personal services, bona fide employment relationships, physician recruitment and physicians practicing in rural areas and locations designated as HPSAs

Exclusion Statute

- What is Exclusion Statute?
  - 42 USC Section 1320a–7
- Excluded from participation if convicted of following types of criminal offenses
  - Medicare fraud
  - patient abuse or neglect
  - felony offense related to health care fraud or
  - felony offense related to controlled substances

Criminal Health Care Fraud Statute

- What is Criminal Health Care Fraud Statute?
  - 18 USC, Section 1347
  - Prohibits knowingly and willfully executing, or attempting to execute, a scheme in connection with delivery of or payment for health care benefits, items or services

Civil Monetary Penalties Law

- What is Civil Monetary Penalties Law?
  - 42 U.S.C. Section 1320a-7a
- Authorizes imposition of civil monetary penalties for a variety of health care fraud violations
- May include an assessment of up to three times the amount claimed for each item or service or up to three times the amount of payment offered, paid, solicited or received

Civil Monetary Penalty Inflation Adjustment

What is Civil Monetary Penalty Inflation Adjustment?

- 45 CFR Section 102.3
- To view yearly inflation adjustment

- Adjusted annually by the Federal Government

Penalties and Sanctions

- Providers of health care and services found to have been billing for services not provided, not covered or in excess of recognized standards of care are subject to a variety of sanctions including
  - Administrative overpayment recoveries
  - Expanded prepayment review
  - Payment suspension
  - Civil monetary penalties
  - Criminal and civil prosecutions and penalties
  - Administrative sanctions
  - Exclusion from the Medicare and Medicaid Programs

Fraud and Abuse Mandates

- Many organizations work together to fight Medicare fraud and abuse
- New laws and other recently passed antifraud legislation also help to further strengthen the efforts of reducing fraud and abuse in Medicare
- CMS has undertaken an aggressive role to combat Medicare/Medicaid fraud and abuse

Unified Program Integrity Contractor

UPIC

- Mission
  - To help address fraud, waste and abuse by performing Medicare data analysis and comprehensive problem identification and research
  - UPICs are primarily responsible for investigation and prevention of healthcare fraud for Parts A and B of the Medicare program

Role of UPIC

- Prevent and detect fraud through collaboration with other CMS contractors
- Develop leads and investigations for allegations of healthcare fraud and abuse
- Perform data analysis to identify fraud and abuse
- Initiate medical record reviews in support of program integrity
- Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid

Role of UPIC

- Identify improper payments that are to be recouped by MACs
- Support both state and federal law enforcement in investigations and prosecution of health care fraud cases
- Recommend revocation of billing privileges when appropriate
- Impose sanctions (exclusion from the Medicare Program) and civil monetary penalties

Role of MAC

- MAC's role
  - Claim processing, including paying providers/suppliers
  - Provide outreach and education
  - Recouping monies lost to the Medicare Trust Fund
    - UPICs identify these situations and refer them to the MACs for recoupment
  - Medical review not for benefit integrity purposes

Role of MAC

- MAC's role
  - Complaint screening
  - MAC will refer to the UPIC if fraud is suspected
  - Claims appeals of UPIC decisions
  - Claim payment determination and claims pricing
  - Auditing provider cost reports

UPIC Process

- Perform data analysis
- Request medical records and documentation
- Conduct interviews
- Conduct onsite visits
- Identify need for a prepayment or auto-denial edit and refer these edits to the MAC for installation
- Withhold payments
- Refer cases to law enforcement

UPIC Northeastern
Safeguard Services – Jurisdiction K

- UPIC Northeastern
- Safeguard Services
- States in UPIC Northeastern
  - Connecticut, Delaware, D.C., Maine, Maryland, Massachusetts, New Jersey, New York, New Hampshire, Pennsylvania, Rhode Island and Vermont

UPIC Southeastern
Safeguard Services – Jurisdiction 6

- UPIC Southeastern
- Safeguard Services
- States in UPIC Southeastern
  - Alabama, Florida, Georgia, North Carolina, South Carolina, Tennessee, Virginia, West Virginia, Puerto Rico and US Virgin Islands

UPIC Midwestern
CoventBridge Group – Jurisdiction 6

- UPIC Midwestern
- CoventBridge Group
- States in UPIC Midwestern
  - Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin

UPIC Western
Qlarant LLC – Jurisdiction 6

- UPIC Western
- Qlarant LLC
- States in UPIC Western
  - Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa and Northern Marianas Islands

Problematic Relations

- If you think you are in a problematic relationship or have been following billing practices you now realize were wrong
  - Stop filing problematic bills
  - Seek legal counsel
  - Determine money collected in error
  - Take necessary steps to free yourself from involvement
  - Take necessary steps to free yourself from suspicious relationship
  - Consider using OIG/CMS self-disclosure protocols

Voluntary Self Disclosures

- Report overpayments within 60 days after they have been identified
  - Date of identification and an explanation should accompany overpayment
  - If not, claims in question will be considered under the False Claims Act
- Acceptance of voluntary refunds from providers does not limit government action as appropriate to pursue criminal, civil or administrative remedies

Self-Disclosure Protocols

- OIG Provider Self-Disclosure Protocol
- CMS Self-Referral Disclosure Protocol

Reporting Fraud and Abuse

- Phone: 800-HHS-TIPS (800-447-8477)/TTY: 800-377-4950
- Fax: 800-223-8164
- Email
  - HHSTIPS@oig.hhs.gov
- Online
  - Office of Inspector General
- Mail
  - U.S. Department of Health and Human Services
    Office of Inspector General
    Attn: OIG Hotline Operations
    P.O. Box 23489
    Washington, DC 20026

Case Development and Referrals

Case Development

- Many cases are initiated as complaints or proactive projects
- Complaints are either developed into investigations or closed
- Investigations could end in administrative actions and closed or referred to law enforcement as cases
- Although an investigation is closed, follow up will occur
- Large percentage of complaints end with a resolution other than referral to law enforcement

Case Referral to Law Enforcement

- When investigator has substantiated potential for fraud, the case is referred to the OIG
- Fraud cases are considered for criminal prosecution and/or civil remedy
- Many cases are resolved with civil monetary penalty settlements with the OIG or False Claims Act settlements with DOJ
- Cases are prosecuted by DOJ but occasionally the DOJ will work with the state Attorney General

Administrative Sanctions

- Overpayment recovery and provider education including
  - Rationale for claim denial or reduction
  - Any published education regarding policy
  - Approximate overpayment
- Revocation of assignment privileges
- Referral to state licensing boards
- Civil money penalties – up to $10,000 for each claim
- Suspension of payment – claims review and money paid go into an escrow account
- Any administrative actions on cases accepted by law enforcement are coordinated with CMS

Health Care Fraud Case Examples

Health Care Fraud Cases

- Illinois skilled therapy provider pays settlement
- California owner of two hospices sentenced
- New York hospital settles health care fraud claims
- Lab accused of stealing millions from Medicare in COVID-19 test kit scheme

Unacceptable Billing Practices and Protecting Your Facility

Unacceptable Billing Practices

- Fragmenting (unbundling) procedure codes to obtain additional reimbursement
- Indicating “Signature on File” on claim when no patient signature authorization forms are maintained in provider’s office
- Submitting charges to Medicare for services advertised as “free exam”

Unacceptable Billing Practices

- Billing for items/services before they were delivered/performed
- Billing for noncovered services under a covered procedure code
- “Ping-ponging”
  - Example – providers of different specialties sharing same patients for services that are not reasonable and necessary

Improper Waivers

- Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in
  - False claims
  - Violations of anti-kickback statute
  - Excessive utilization of items and services paid for by Medicare

Protecting Your Facility

- Protect your provider identification number(s)
- Assign procedure codes yourself
- Document all services rendered
- Use caution when signing certificates of medical necessity
- Minimize risk from your employees
- Develop wise business relationships
- Use billing services wisely
- Keep up with Medicare
- Communicate with your patients
- Respond to Medicare's inquiries

OIG Compliance Guidelines

- Seven basic components/elements
  - Conduct internal monitoring and auditing through performance of periodic audits
  - Implement compliance and practice standards through development of written standards and procedures
  - Designate a compliance officer or contact(s) to monitor and enforce practice standards
  - Conduct appropriate training and education on practice standards and procedures
  - Respond appropriately to detected violations through investigation of allegations and the disclosure of incidents to appropriate government agencies
  - Develop open lines of communication
  - Enforce disciplinary standards through well-publicized guidelines

OIG Compliance Program

- Providers OIG Compliance Program for Individual and Small Group Physician Practices
  - *Federal Register*/Vol.65, No.194, pages 59434–59452

Qualified Medicare Beneficiary

- Medicare providers **cannot** bill QMB beneficiaries for Medicare cost-sharing
- This includes Medicare deductibles, coinsurance, and copayments
- In some cases, a beneficiary may owe a small Medicaid copayment
- Medicare and Medicaid payments (if any) are considered payment in full
- Providers are subject to sanctions if they bill a QMB above total Medicare and Medicaid payments, even when Medicaid pays nothing

Compliance Resources

Compliance Resources

- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 4 – Program Integrity
- The Medicare Learning Network® Provider Compliance page
- CMS MLN 4649244: Medicare Fraud & Abuse: Prevent, Detect, Report
- NGS Medicare Compliance Fraud & Abuse
- Senior Medicare Patrol – Preventing Medicare Fraud
- CMS webpage: Reporting Fraud
- CMS MLN web-based Training Course "Medicare Fraud & Abuse: Prevent, Detect, Report"
- OIG Fraud & Abuse Laws

Questions?

Thank you!

We'd like to hear from you!

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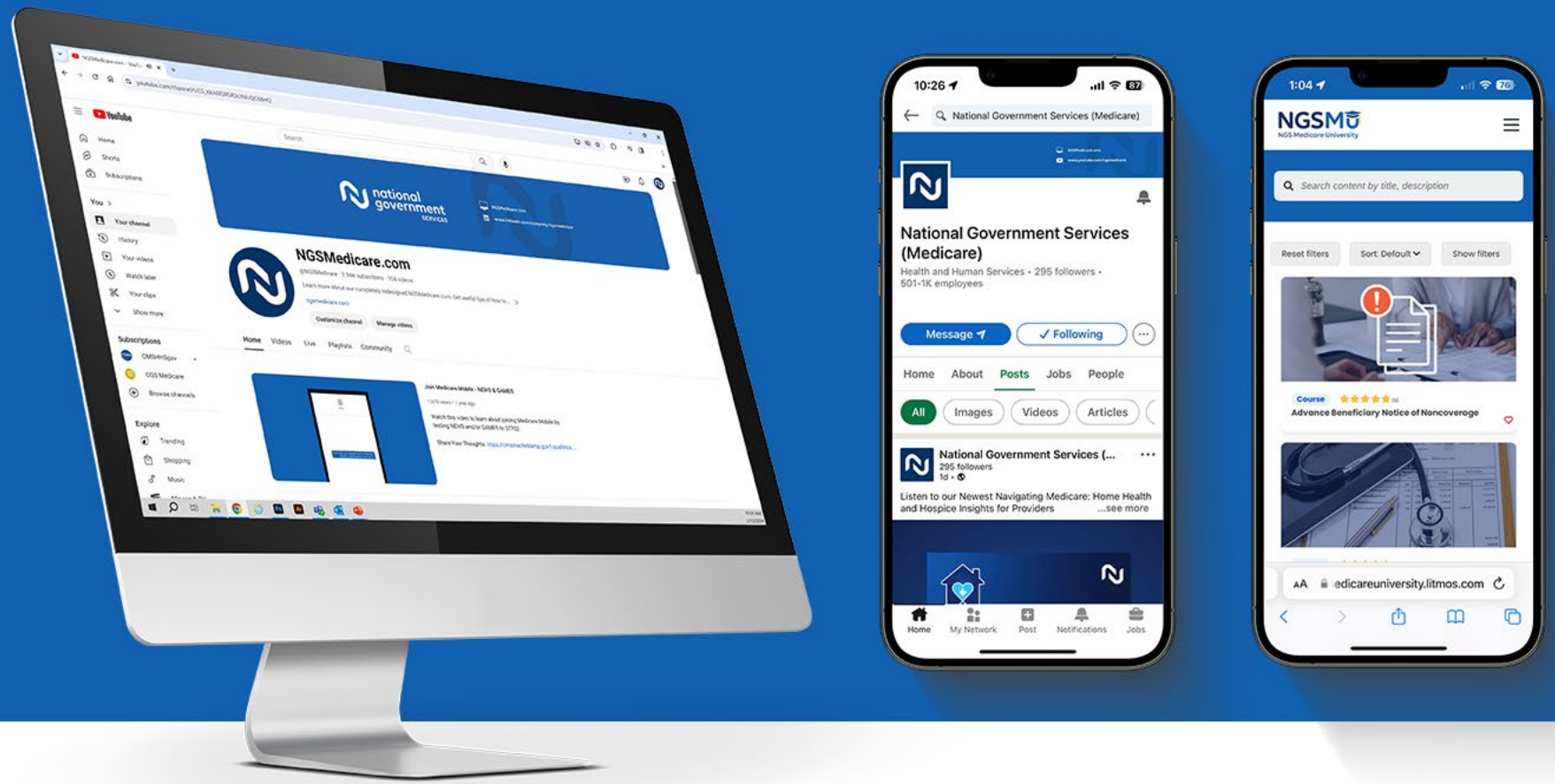

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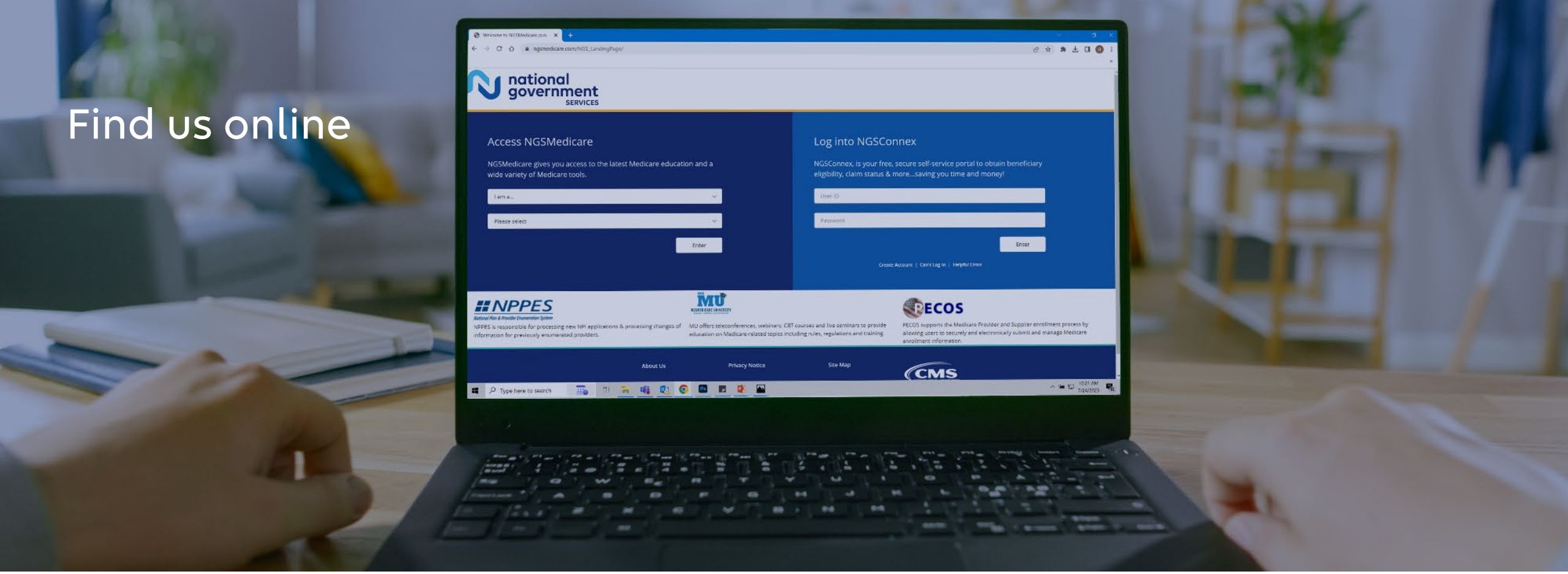

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Web portal for claim information

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