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# NGSMedicare University Virtual Conference

## Medicare 2021
## A Journey to a Healthier Future and Partnership

# Fraud Prevention and Detection

5/12/2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

# Today's Presenters

- Gail O'Leary
- Lori Langevin
  - Provider Outreach & Education Consultants

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# Objectives

- Increase awareness of integrity issues and prevention of potential fraudulent and abusive practices against the Medicare Program

# Agenda

- Fraud and Abuse
- Laws and Mandates
- Unified Program Integrity Contractor (UPIC)
- Case Development and Referrals
- Fraud Case Examples
- Unacceptable Billing Practices and Protecting Your Practice
- References

# Fraud and Abuse

# Fraud

- The intentional deception or misrepresentation which an individual makes, knowing it to be false, and that it could result in some unauthorized benefit to themselves or some other person
- Elements of fraud
  - Knowingly false statement
  - Causes a 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

- Definition of abuse
  - Actions that are inconsistent with accepted, sound medical, business or fiscal practices
  - Directly or indirectly 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 the False Claims Act?
  - 31 United States Code (USC), Sections 3729–3733
- Protects the federal government from being overcharged or sold substandard goods or services

# Anti-Kickback Statute

- What is the 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 the 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 the Exclusion Statute?
  - 42 USC Section 1320a–7
- Excluded from participation if convicted of the 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 the Criminal Health Care Fraud Statute?
  - 18 USC, Section 1347
  - Prohibits knowingly and willfully executing, or attempting to execute, a scheme in connection with the delivery of or payment for health care benefits, items or services

# The Civil Monetary Penalties Law

- Authorizes the 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

- Adjusted annually by the Federal Government
- 45 CFR Section 102.3
  - To view the yearly inflation adjustment

# 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 fraud and abuse in the Medicare Program
- 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)

# UPIC

- Mission
  - To help address fraud, waste and abuse by performing Medicare data analysis and comprehensive problem identification and research to identify potentially fraudulent Medicare providers and coordination of benefit integrity activities among MACs in the region, and dissemination of relevant benefit integrity information to the respective MACs

# UPIC Northeastern
# Safeguard Services, LLC – Jurisdiction K

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

# UPIC Midwestern
# CoventBridge Group – Jurisdiction 6

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

# UPIC Process

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

# Role of UPIC

- Investigate instances of suspected fraud, waste and abuse
- Develop investigations early, and in a timely manner
- Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid
- Identify any improper payments that are to be recouped by MACs

# Role of MAC

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

# What To Do

- If you think you are in a problematic relationship or have been following billing practices you now realize were wrong
  - Stop filing the 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 the suspicious relationship
  - Consider using OIG/CMS self-disclosure protocols

# Voluntary Self Disclosures

- Report overpayments within 60 days after they have been identified
  - The date of identification and an explanation should accompany the overpayment
  - If not, the claims in question will be considered under the False Claims Act
- The acceptance of voluntary refunds from providers does not limit the government from taking 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

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# 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
- A large percentage of complaints end with a resolution other than referral to law enforcement

# Case Referral to Law Enforcement

- When the investigator has substantiated the 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 the DOJ
- Cases are prosecuted by the DOJ but occasionally the DOJ will work with the state Attorney General

# Administrative Sanctions

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

# Fraud Case Examples

# Vascular Surgeon Fraudulently Billing Medicare For Medically Unnecessary Procedures

- U.S. Attorney's Office, Southern District of NY; released 3/8/2021
  - Doctor agrees to pay $800,000
  - Admits misconduct
  - Receives four-year ban from participating in federal healthcare programs
- The allegations of fraud in civil complaint were brought to attention of federal law enforcement by whistleblower who filed a lawsuit under the False Claims Act

# Doctor Admits Role in Genetic Testing Kickback and Bribery Schemes

- U.S. Attorney's Office, District of NJ; released on 3/5/2021
  - A doctor participated in conspiracies to receive bribes and kickbacks in exchange for ordering genetic tests
    - He pleaded guilty to conspiring to violate the Anti-Kickback Statute
  - Cash kickbacks ranged from $500 to over $8,000
  - Medicare paid $350,374 for genetic tests
  - Each charge is punishable by a maximum of five years in prison and a fine of $250,000, or twice the gross gain or loss, whichever is greater

# Two Women Plead Guilty in Multi-Million Dollar Medicare Fraud Scheme

- U.S. Attorney's Office, District of MA; released 2/24/2021
  - FL woman pleaded guilty to receiving kickbacks in connection with a federal health care program and another other CA woman pleaded guilty to violating the HIPAA statute
  - Sold Medicare patients' personal and medical data to a DME company
  - Worked with foreign call centers to contact Medicare patients asking if they were interested in medical equipment - collecting demographic and insurance information
    - They received more than $1.4 million from DME company for the patient data
    - DME company submitted more than $109 million in false and fraudulent claims

# Two Women Indicted on Charges From $100 million Home Health Care Fraud and Money Laundering Scheme

- U.S. Attorney's Office, District of MA; released on 2/1/2021
  - Two women indicted on conspiracy to commit health care fraud; health care fraud–aiding and abetting; and conspiracy to pay and receive kickbacks
  - One also indicted on money laundering conspiracy and seven counts of money laundering; the other also indicted on making false statements and making a false statement in a health care matter
  - From 1/2013 to 1/2017, the women, one part owner/operator of a homecare service and the other working as a LPN, defrauded MassHealth and Medicare of at least $100 million in health care fraud and paying kickbacks to induce referrals
  - The part owner of the homecare service allegedly laundered gains

# Unacceptable Billing Practices and Protecting Your Practice

# 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 the provider’s office
- Submitting charges to Medicare for services advertised as a “free exam”
- 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 the 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 the anti-kickback statute
  - Excessive utilization of items and services paid for by Medicare

# Protecting Your Practice

- 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

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# OIG Compliance Guidelines

- Seven basic components/elements
  - Conduct internal monitoring and auditing through the performance of periodic audits
  - Implement compliance and practice standards through the 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 the 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

# Compliance References

- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 4 – Program Integrity
- The Medicare Learning Network® Provider Compliance page

# Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?


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