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Fraud Prevention and Detection

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Gail Toussaint
- Lori Langevin
  - Provider Outreach and 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

The Civil Monetary Penalties Law

- Authorizes the imposition of civil monetary penalties for a variety of health care fraud violations
  - 42 U.S.C. Section 1320a-7a
- 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

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 Law

- What is the Physician Self-Referral Law?
  - 42 U.S.C. § 1395nn
  - Commonly referred to as the "Stark Law"
  - Prohibits physicians from making referrals for certain "designated health services" to an entity where they (or an immediate family member) have a financial relationship, unless an exception applies

Designated Health Services

- clinical laboratory services
- physical therapy, occupational therapy, and outpatient speech-language pathology services
- radiology and certain other imaging services
- radiation therapy services and supplies
- DME and supplies
- parenteral and enteral nutrients, equipment, and supplies
- prosthetics, orthotics, prosthetic devices and supplies
- home health services
- outpatient prescription drugs
- inpatient and outpatient hospital services

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

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

- 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
  - Claim 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

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

Telemedicine Fraud Scheme

- Nurse practitioner found guilty of health care fraud, aggravated identity theft, and other counts in telemedicine fraud scheme
  - Signed unnecessary orders for orthotic braces for patients never examined/spoken to
    - Including a knee brace for an amputee
    - Back brace for a recently deceased patient
  - Facilitated orders for more than 3,000 orthotic braces that generated more than $3M in fraudulent/excessive charges

Fraudulent Billing Practices

- Owner of counseling service faces charges for filing false claims
  - Billed insurances for services not provided
  - Billed approximately $151,000 in fraudulent claims
  - Previously charged with defrauding MassHealth $500,000, using funds for international travel, Disney trips, Red Sox games and more

Eye Care Practice and its Owners Pay $192K for Employing "Excluded" Individual

- The Eye Group is located in Windham, CT
  - Its owners, have entered into a civil settlement agreement with the federal and state governments to resolve allegations that they improperly employed an individual who was excluded from all federal healthcare programs
- To resolve their liability, they will pay $192,699
- The Eye Group employed the excluded individual as its practice administrator between February 2010 and May 2021
  - Previously convicted in the District of Jersey of health care fraud

Misuse of a Passport, False Citizenship and False Social Security Number

- A Providence, RI man is facing deportation
  - Convicted and sentenced in federal court for falsely representing his citizenship and Social Security number, misusing a passport, and for health care fraud
- He pled guilty on 12/1/2021
- In 2008 and 2010, he applied for and received a passport using the personal identifying information of a person living in Puerto Rico
  - Using the same personal information and that person's Social Security number he applied for and received a Rhode Island driver's license and identification card
  - Supplemental Nutrition Assistance Program benefits totaling $7,342.64
  - RI Medicaid Program RIte Care benefits totaling $39,023.61

Urology Practice Agrees to Pay $100,000 to Resolve Allegations that it Violated the False Claims Act

- A urology practice in Brockton, MA entered into an agreement with a Massachusetts hospital which obligated the urology practice to administer a "Prostate Cancer Center of Excellence" at said hospital
- The hospital never created a Prostate Cancer Center of Excellence and the urology practice never provided a physician to serve as the director of a Prostate Cancer Program
  - April 2011 through December 2017, the hospital paid the urology practice allegedly pursuant to the agreement and they referred patients to the hospital
- The United States contends that this course of conduct constitutes an unlawful financial relationship between the urology practice, a party referred health services and the hospital, the entity that billed Medicare for those services
  - Through this violation of the law, the urology practice caused the submission of false claims to Medicare

Newton Physician Resolves Allegations of Improper Prescribing Practices Concerning Controlled Substances

- A Newton, MA geriatric medicine physician paid $100,000 for prescribing controlled substances outside the usual course of professional practice
  - A violation of the Controlled Substances Act
- Violated the False Claims Act by submitting inflated claims to Medicare and the Massachusetts Medicaid program
- Doctor irresponsibly prescribed dangerous drugs to Massachusetts residents without abiding by critical requirements
- In 2019 and 2020, he issued 51 prescriptions for Schedule II, IV or V controlled substances without first reviewing the patients' prescription histories

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

OIG Compliance Guidelines

- Seven basic components/elements
  - Conduct internal monitoring and auditing periodically
  - 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
- OIG Work Plan

Compliance Resources

- CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 4 – Program Integrity
- CMS MLN® Educational Tool - *Medicare Provider Compliance Tips*
- Medicare Fee for Service Compliance Programs
- CMS' Fraud Prevention Toolkit

Compliance Resources

- MLN® Booklet *Medicare Fraud & Abuse: Prevent, Detect, Report*

Thank You!

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

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