national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Fraud Prevention and Detection

7/26/2023

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NGS Medicare University
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

NGS PROVIDER EXPERIENCE
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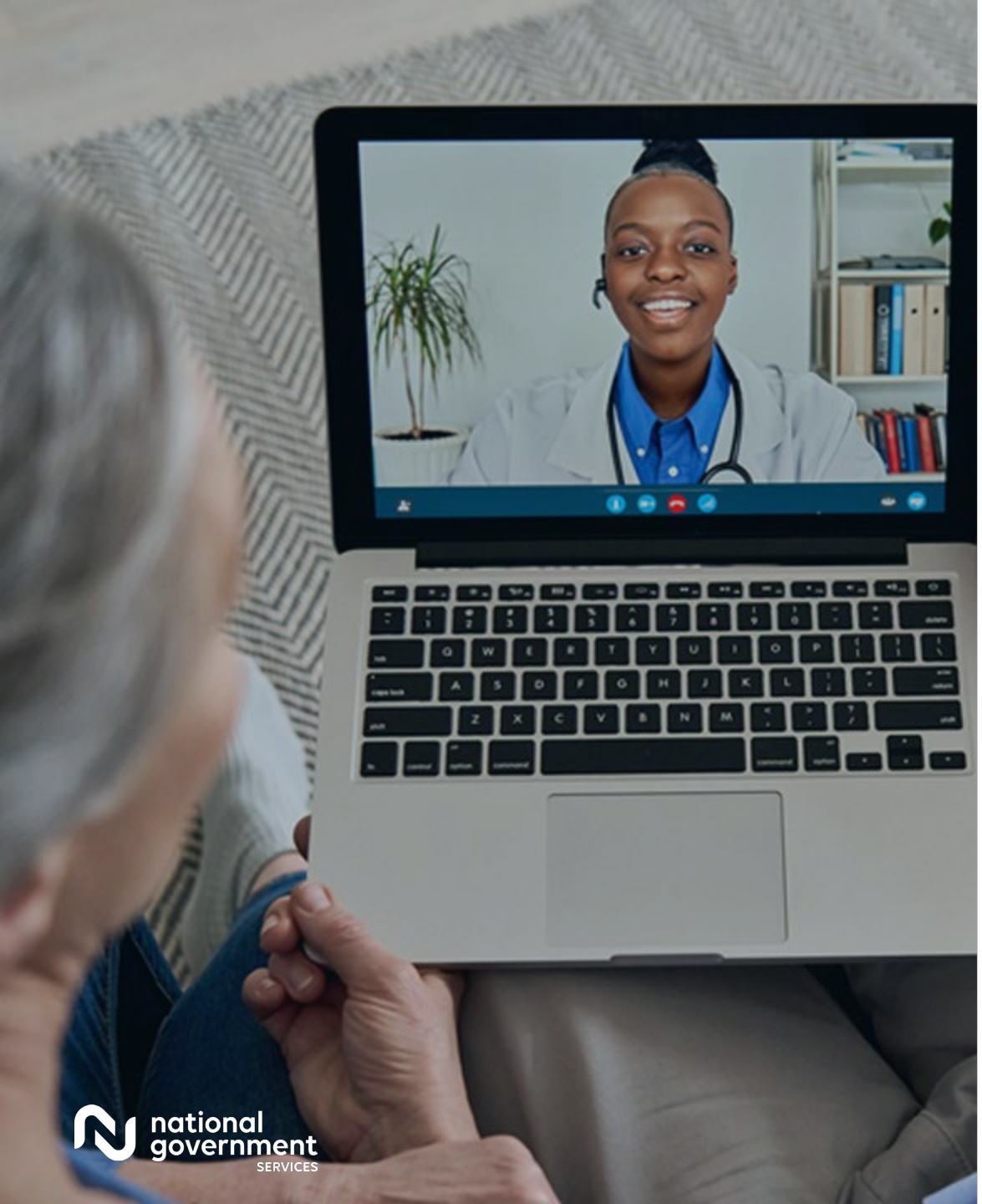

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Objective

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

Agenda

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

Fraud, Waste 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
- Altering claims/documentation to obtain a higher amount
- Paying for referrals
- Billing for appointments that did not occur

Waste

- Overuse of services/practices resulting in unwarranted costs to a health care benefit program
- Not considered a criminal act
  - Misuse of resources

Examples of Waste

- Overusing services that are not necessary
- Prescribing drugs or DME the patient does not need
- Performing procedures in the hospital when it can safely be performed in an office setting
- Excessive use of disposable items
  - Hypodermic needles/syringes
  - Diapers/under pads
  - Diabetic test strips

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

- parenteral and enteral nutrients, equipment, and supplies
- prosthetics, orthotics, prosthetic devices and supplies
- home health services
- outpatient prescription drugs
- inpatient and outpatient hospital 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

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 to either:
    - ✓ Defraud any healthcare benefit program
    - ✓ Obtain, under false pretenses, any of the money owned by, or under the control of, any health care benefit program

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
  - 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 acting 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

PA Guilty of $10M Medicare Fraud

- Worked as an independent contractor for a physician staffing and telemedicine company
- Genetic testing scheme
  - Signed fraudulent prescriptions for beneficiaries he never met
  - Falsified medical records
  - Falsely certified the tests were medically necessary
- Convicted of one count of health care fraud and six counts of making false statements relating to healthcare matters

$4.7M Health Care Fraud Scheme

- Owner/operator of outpatient behavioral services clinic
- Plead guilty to health care fraud and money laundering conspiracies
  - Obtained PII through community outreach programs and submitted more than 1,500 claims for services never provided
    - ✓ Some claimed he provided services that exceeded 24 hours in a single day
  - Used proceeds to pay kickbacks to co-conspirators, and to cover personal expenses
    - ✓ Personal travel, luxury items, timeshares and cash withdrawals
- Maximum penalty of 10 years in prison for healthcare fraud conspiracy
- Up to 20 years in prison for money laundering conspiracy

Nearly $15M DME Fraud Scheme

- NP working for a telemedicine company pleaded guilty to a conspiracy charge for his role in a DME scheme
  - Thousands of claims submitted for medically unnecessary DME supplies
  - Signed false medical records certifying he performed exams when he had no interaction with the beneficiaries
  - Telemedicine company provided unsigned orders for DME which he signed and returned in exchange for $15 per so-called “assessment” he performed
- Conspiracy charge carries a maximum term of five years in prison and a $250K fine

Nearly $38M Fraud Scheme

- A man and his co-conspirators submitted more than $134M in fraudulent claims for diagnostic lab testing, including urine drug testing and tests for respiratory illnesses during COVID-19 pandemic
  - Medically unnecessary, not ordered by medical personnel, not provided
- Obtained and misused confidential personal information to file claims
  - Received more than $38M in claims
- Pleaded guilty to conspiracy to commit healthcare fraud and money laundering
  - Sentenced to 15 years in prison followed by 3 years supervised release and ordered to pay $29,835,825.99 in restitution

$1M Prescription Drug Fraud Scheme

- Pharmacist in charge of a pharmacy billed Medicare for expensive compound drug creams never actually purchased or dispensed
  - Instead provided an inexpensive drug cream not covered by Medicare
  - Did not purchase appropriate quantity to bill all prescriptions billed to Medicare
- He and his co-conspirators received more than $1M in fraudulent Medicare proceeds
- Sentenced to two years in prison

Nearly $2M Fraudulent Billing

- Podiatrist previously suspended by Medicare for suspicious billing practices, billed Medicare under a false identity
- Created new business and convinced another doctor to enroll in Medicare and place her name on corporate/banking documents relating to him
- He submitted bills to Medicare reflecting services were rendered by the other doctor
- Sentenced to seven years in prison

Health Care Fraud Conviction/False Claims Act Allegations

- Vascular surgeon submitted claims for procedures he did not perform
- Prepared medical records to justify the billing
- Improperly used modifier 59 to “unbundle” services to increase payment
- Qui tam (whistleblower) filed action
  - As part of civil resolution, will receive up to $4,341,900 of monies recovered
- Sentenced to 80 months in prison and ordered to pay $19.5M in restitution to Medicare, Medicaid and BCBS of Michigan

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

Quiz Time

Question 1

- Performing procedures in the hospital when it can safely be performed in an office setting is an example of
  - A. Fraud
  - B. Waste
  - C. Abuse

Question 2

- 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

  A. Fraud

  B. Waste

  C. Abuse

Question 3

- A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than provided violates
  - A. Anti-kickback Statute
  - B. Criminal Healthcare Fraud Statute
  - C. Federal Civil False Claims Act

Question 4

- The UPIC stands for
  - A. United Protocol Integrity Corporation
  - B. Unified Program Integration Corporation
  - C. Unified Program Integrity Contractor

Question 5

- The Physician Self-Referral Law
  - A. Authorizes the imposition of civil monetary penalties for a variety of health care fraud violations
  - B. 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
  - C. 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

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
- USDHHS OIG – A Roadmap for New Physicians
- MLN® Booklet *Medicare Fraud & Abuse: Prevent, Detect, Report*

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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