Chapter 14 Contents

Introduction – Medicare Fraud and Abuse

The Medicare program provides reimbursement for health care services for millions of beneficiaries and provides payment to tens of thousands of providers and suppliers of services. Numerous public and private organizations are involved in the program's administration. Within a program of such complexity and magnitude, the opportunities for fraud, abuse, and waste are considerable. The quality control effort to eliminate fraud, abuse, and waste is necessarily a cooperative effort involving the beneficiaries, contractors, Quality Improvement Organizations, state Medicaid agencies, and federal agencies such as the Centers for Medicare & Medicaid Services (CMS), the Office of the Inspector General (OIG) and the Department of Health and Human Services (DHHS). Most suppliers and supplier organizations are also interested in fraud and abuse control to protect their industry's image with the public and Congress.

1. Unified Program Integrity Contractor (UPIC)

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 4, §4.2

Unified Program Integrity Contractors (UPICs) are responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims) and coordination of Medicare-Medicaid data matches (Medi-Medi). UPICs are divided into five zones across the country, one of which covers the states that encompass Jurisdiction B.

The functions and activities of the UPICs allow Medicare Administrative Contractors (MACs) to place greater focus on claims processing and customer service, while the UPICs concentrate on benefit integrity issues. UPICs are responsible for identifying cases of suspected fraud and making referrals of all such cases to the OIG, regardless of dollar thresholds or subject matter.

UPICs use a variety of tools including data analysis, fraud complaints, and referrals. They also develop innovative tools and techniques to identify potential Medicare fraud and abuse. These approaches are used in building and referring cases to law enforcement involving those who are suspected of perpetrating Medicare fraud.

CoventBridge Group is the UPIC which services DME MAC Jurisdiction B.

UPIC Responsibilities

The UPICs have the responsibility to:

- Investigate allegations of fraud made by beneficiaries, providers, suppliers, CMS, OIG, and other sources, including proactive data analysis results and pre and post pay medical review for benefit integrity.
- Explore all available sources of fraud leads in its zone.
- Refer investigations to the Office of Inspector General/Office of Investigations (OIG/OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions.
- Support law enforcement in requests for information, including but not limited to data and data analysis, cost report data, and medical review.
- Recommend administrative actions to CMS, such as suspending Medicare payment, identifying and recouping overpayments, pursuing civil monetary penalties, and recommending program exclusions.
- Prevent fraud by identifying program vulnerabilities to CMS.
- Work cooperatively with law enforcement and other partners, including CMS, affiliated contractors (MACs), Harkin Grantees, providers, suppliers, and other UPICs to fight fraud and abuse
- Initiate and maintain networking, education, and outreach activities to ensure effective interaction and exchange of information with internal components as well as outside groups, suppliers, providers, and beneficiaries.

2. Defining Fraud and Abuse

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 4, §4.2.1

Fraud is intentional deception or misrepresentation that an individual makes, knowing it to be false and that it could result in some unauthorized benefit to them.

Abuse describes incidents or practices of providers, physicians, or suppliers of services and equipment which, although not usually fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices may, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, or payment for services which fail to meet professionally recognized standards of care or which are medically unnecessary.

Defining a Complaint of Fraud and Abuse

A complaint is a statement, oral or written, alleging that a provider, supplier, or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which they are not entitled under current Medicare law, regulations, and/or program policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for Medicare-covered items and services.

Examples of complaints include:

- Allegations that items or services are not received;
- Allegations that the services received are inconsistent with the services billed (as indicated on the Medicare Summary Notice);
- Allegations that a supplier has billed both the beneficiary and Medicare for the same item or service;
- Allegations regarding the waiver of coinsurance or deductibles;
- Allegations that a supplier has misrepresented itself as having an affiliation with an agency or department of state, local, or federal government, whether expressed or implied; and/or
- Beneficiary inquiries concerning payment for an item or service, which in his or her opinion, may far exceed a reasonable payment for the service which they received, (i.e., the supplier or physician has "upcoded" to receive a higher payment).

The following are not fraud and abuse complaints:

- Complaints (or inquiries) regarding Medicare coverage policy;
- Complaints (or inquiries) regarding the status of claims;
- Requests for claims appeal or complaints regarding the appeals process; and/or
- Complaints concerning suppliers (other than those complaints meeting the criteria established) which are general in nature and are policy or program oriented.

Fraud

The most frequent type of fraud arises from a false statement or misrepresentation which is material to entitlement or payment under the Medicare program. The violator may be a supplier of durable medical equipment, a beneficiary, or some other person or business entity (e.g., a prescribing physician).

Fraud in the Medicare program takes such forms as, but is not limited to:

- Billing for services or supplies that were not provided;
- Supplier claim forms which have been altered to obtain a higher payment amount (i.e., falsifying a beneficiary's address to a DME MAC jurisdiction with higher fee schedule amounts; or using a beneficiary's home address when in fact the beneficiary is in a nursing home);
- Supplier's deliberate application for duplicate payment (i.e., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice);
- Soliciting, offering, receiving, or giving a kickback, bribe, or rebate, in exchange for referring a patient or arranging for referral of a patient;
- Physician signing of Certificates of Medical Necessity (CMNs) for patients not personally and professionally known to the physician;

- False representation with respect to the nature of services rendered, amounts charged for services rendered, identity of the person receiving the services, dates of services, etc.;
- Claims for non-covered services billed as covered services;
- Claims involving collusion between a provider and a beneficiary or between a supplier and a provider resulting in unwarranted or higher costs or charges to the Medicare program;
- Use of another person's Medicare card in obtaining medical services;
- Repeated violations of the participation agreement or the assignment agreement;
- Unbundled or fragmented charges (e.g., billing for parts of an ostomy bag);
- Falsification of CMNs (e.g., misrepresenting the diagnosis for the patient to justify the services or equipment furnished, indicating a patient cannot swallow—when in fact he or she can—to justify enteral nutrition);
- Falsification of qualifying tests (e.g., exercising a patient before oximetry or ABG testing).

Abuse

The type of abuse to which Medicare is most vulnerable is over-utilization of medical and healthcare services.

Abuse takes such forms as, but is not limited to:

- Breaches of assignment agreements which result in beneficiaries being billed for disallowed amounts on the basis that such charges exceeded the reasonable charge criteria (unless Advance Beneficiary Notice applies);
- Claims for services not medically necessary or not medically necessary to the extent rendered (e.g., an electric hospital bed is supplied where a manual bed would be medically sufficient);
- Routine waiver of coinsurance and/or deductibles;
- Excessive charges for services or supplies;
- Improper billing practices which include:
    - Supplier failure to file non-assigned claims,
    - Supplier billing Medicare at a higher and different fee schedule rate than they would for a non-Medicare patient,
    - Submission of bills to Medicare instead of third-party payers which are primary insurers for Medicare beneficiaries, and/or
    - Unbundled or fragmented charges;
- Supplier violations of Medicare participation agreements or supplier standards (see Chapter 2 of this manual for a list of the supplier standards).

Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud.

Other Illegal Activities

Other illegal activities include (but are not limited to):

- A supplier completing the sections of a Certificate of Medical Necessity (CMN) which must be completed by a physician.
- A supplier misrepresenting itself as having an affiliation with any agency or department of state, local, or federal government, whether expressed or implied.

Bribes, Kickbacks, and Rebates

Under federal law, Section 1877 (b) and 1909 (b) of the Social Security Act [42 USC 1395 nn (b) and 42 USC 1396h (b)], it is a felony for anyone to knowingly and willfully offer, pay, solicit, or receive any payment in return for referring an individual to another person for the furnishing, or arranging for the furnishing, of any item or service that may be paid for by the Medicare or Medicaid program. Individuals convicted under these felony provisions may be fined up to $25,000 or imprisoned up to five years, or both.

Anyone who accepts or solicits any payment for referring patients to any practitioner, durable medical equipment supplier, home health agency, laboratory, or any other health provider or facility which furnishes items or services that may be paid for by Medicare or Medicaid may be subject to prosecution.

The criminal statute applies regardless of whether the payment for referral is made directly or indirectly, overtly or covertly, in cash or in kind.

The following are examples of potential violations of federal law if the services are covered under the Medicare or Medicaid programs:

- Physicians who are offered percentages of Medicare payment either acting in the capacity of a consultant, attending physician, etc., if they refer patients needing DMEPOS services to specific DMEPOS suppliers.
- Skilled Nursing Facilities or Nursing Homes who are offered at no charge Durable Medical Equipment (DME), formula for non-Medicare-eligible beneficiaries (i.e., Medicaid-eligible beneficiaries), or computers and/or billing services, or a rebate on the 20 percent coinsurance as an inducement to refer patients needing Parenteral or Enteral Nutrition (PEN) to a specific PEN supplier.
- Hospital social workers or discharge planners who receive payment from DME suppliers for referring hospital patients who will need home medical equipment once they are discharged from the hospital.

In the examples listed above, the unlawful activity is not the referral but the solicitation, receipt, offering, or giving of payment or free items/services. A referral of a patient that does not involve a solicitation or offer, or result in the receipt of a gift of any payment or free items would not be considered a violation of the statute. Furthermore, these examples are not all-inclusive of the types of kickback arrangements that are violations of the law.

3. Procedures for Handling Fraud and Abuse Situations

You may contact the appropriate UPIC using the contact information found at the end of this chapter. You may also call the OIG at their fraud hotline at 1-800-HHS-TIPS. Please be specific about the potential fraud you suspect. You may remain anonymous if you prefer.

Documentation

Unsubstantiated allegations from suppliers will be accepted and recorded in Benefit Integrity Unit files; however, investigative action will not be initiated until some verification of the allegation is received. This not only will preserve limited investigative resources, but will protect innocent suppliers from false or vindictive allegations by unfriendly competitors.

Penalties

Providers and suppliers may be subject to up to a $25,000 fine and a five-year imprisonment term, or both per violation, under the applicable federal law and suspended from the Medicare program. Civil penalties include $2,000 fines plus double damages per violation and exclusion. Administrative remedies for abuse include revocation of assignment privileges, withholding of payments, recovery of overpayments, educational contacts and/or warnings, as well as exclusion from the Medicare program.

Keep in mind that the suspects in Medicare fraud and abuse are seldom beneficiaries. Most often the suspects are suppliers or physicians. Many times the beneficiaries are witnesses in suspected fraud and abuse cases.

4. Protect Yourself from Fraud

What you can do as a Medicare supplier to protect yourself from fraud:

- **Be informed:**
  It is important to understand Medicare eligibility criteria, coverage guidelines, billing, and cost report requirements. Seek clarification from your DME MAC as necessary and attend training opportunities by CMS and Medicare contractors.

- **Be an educator:**
  Keep beneficiaries properly informed and educated about the care or supplies you are providing, and ensure the physician is actively involved in the planning and delivery of your service to the beneficiary. Many recent OIG hotline reports by beneficiaries relate to billing and service issues. You can prevent inappropriate referrals from beneficiaries if you have informed beneficiaries and family members of Medicare rules and policy. Always provide complete and accurate information to beneficiaries according to your participation agreement.

- **Be in compliance:**
  If your agency does not have a compliance program in place, development of one should be considered. The OIG has developed a number of model compliance programs for providers and suppliers to use as guidance in developing individual agency programs. These programs, along with other pertinent information can be found on the OIG website at http://oig.hhs.gov, or by contacting the OIG directly.

- **Be a responsible employer:**
  Every supplier should be aware of and use the OIG's Sanction List. This list identifies Medicare providers who have been restricted from participation in government programs. For your protection, the list should be checked prior to hiring new employees to ensure the government has not sanctioned the prospective employee. The OIG Sanction List can be accessed via the OIG website at address http://oig.hhs.gov.

- **Be a Medicare Anti-Fraud Team member:**
  You may contact the appropriate UPICs using the contact information found at the end of this chapter. You may also call the OIG at their fraud hotline at 1.800.HHS.TIPS. Please be specific about the potential fraud you suspect. You may remain anonymous.

5. UPIC Contact Information

You may contact the appropriate UPIC using the information below:

CoventBridge Group

Unified Program Integrity Contractor, Midwestern Jurisdiction

Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin

Note: The Midwestern Jurisdiction includes other states outside of Jurisdiction B not listed above.

Website: https://coventbridge.com/midwest-upic/