Part 4
Protecting Medicare from Fraud and Abuse

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), also known as the Kassebaum-Kennedy legislation, includes a provision establishing the "Medicare Integrity Program". The primary principle of Medicare Program Integrity (PI) is to pay claims correctly. To meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. For their part, providers must make sure they comply with the coverage and payment policies established by Congress and the Medicare Program.

The Centers for Medicare & Medicaid Services (CMS) follow four parallel strategies in meeting this goal:

- Preventing fraud through effective enrollment and through education of physicians, providers, suppliers, and beneficiaries;
- Early detection (e.g., through medical review and data analysis);
- Close coordination with partners, including contractors and law enforcement agencies; and
- Fair and firm enforcement policies.

Most provider billing errors are not an attempt to knowingly, willfully, or intentionally commit fraud. For example, some errors are the result of provider misunderstanding or a failure to pay adequate attention to Medicare policy. However, other errors are a result of calculated plans to knowingly commit fraud for unjustified payment. When errors are identified, Medicare will take action commensurate with the error made. The agencies responsible for protecting Medicare will evaluate the circumstances surrounding the error and proceed with the appropriate plan of correction.

In rare situations where a provider has repeatedly submitted claims in error or has demonstrated gross disregard for Medicare conditions of participation, coverage, and payment policy, Medicare will seek legal action against the individual and/or organization. Medicare utilizes both medical review (MR) and fraud investigation data analysis to detect potential payment errors. The results identified by data analysis determine whether a situation is an error (pursued by the MR unit), potentially fraudulent (pursued by fraud investigators), or neither. Investigations may also be initiated by reports of improper activities reported by individuals, also referred to as "whistle blowers".

This section identifies the coordinated activities and explains the differences in the purpose, functions, and requirements of MR and fraud investigations in assuring correct initial Medicare payment. This background information will help the provider to identify and establish procedures to correctly code and submit claims for covered services that were rendered to eligible beneficiaries.

WHAT IS MEDICAL REVIEW (MR)?

All Medicare contractors are required to ensure that reimbursement is made only for those services that are reasonable and necessary. For medically necessary services, the contractor is also responsible for ensuring that services are rendered in the most cost-effective manner (i.e., consideration is given to the location of service and the complexity and level of care provided).

For Medicare to ensure that payment is made only for reasonable and necessary services, each Medicare contractor is required to perform extensive data analysis on the frequency a service is allowed. The focus is on how providers or suppliers and their services are trended and what Medicare does through the MR process when coverage and utilization problems are identified, resulting in various plans of action to correct the problem.

BENEFITS TO MEDICARE PROVIDERS AND SUPPLIERS

MR initiatives are designed to apply national payment criteria, to define Medicare coverage of medical care through the development of medical policy, and to ensure that Local Medical Review Policies (LMRPs) and review guidelines are consistent with accepted medical practice standards. The MR process provides the following benefits:

- **Decreased denials** - Knowledge of appropriate claims guidelines can result in a reduction in filing errors and an increase in more timely payments.
- **Improvement in the way Medicare reviews cases** - Development of LMRPs provide guidelines for the decision-making process.
- **Reduced claim reviews** - Because providers and suppliers have a better understanding of when and what Medicare needs to support a service as it relates to claim documentation, the claim filing process is smoother and faster.
- **Predictability in claim decisions** - Because local contractor policies are made available to all eligible providers and suppliers through contractor publications and websites, there is less “guess work” on behalf of the provider or supplier when furnishing information to support medical necessity.
- **Emphasis on education** - Medicare offers educational opportunities through comprehensive articles and contractor-sponsored educational training events.
- **Increased program integrity** - The Medicare Integrity Program helps to ensure that Medicare claims are correctly paid.

PROGRESSIVE CORRECTIVE ACTION (PCA)

MR PCA is a concept designed by CMS for Medicare contractors to use when deploying resources and tools to conduct MRs. PCA ensures that MR activities are targeted at identified problem areas and that imposed corrective actions are appropriate for the severity of the infraction of Medicare rules and regulations. The following four types of corrective actions can result from MR evaluations:

- Education;
- Policy development;
- Prepayment review; and
- Postpayment review.

HOW PCA WORKS

The decision to conduct MR is driven by data analysis. Data analysis is the first step in PCA for determining unusual or unexpected billing patterns that might suggest improper billing or payment. The data analysis may be general surveillance, or may be specific in response to complaints or reports from various agencies.

The second step in PCA is validating the hypothesis of the data analysis. Before assigning significant resources to examine claims identified as potential problems, probe reviews are conducted. A probe review generally does not exceed 20-40 claims per provider for provider-specific problems, and does not exceed 100 claims distributed among the identified provider community for general, widespread problems. All providers subject to a probe review are notified in writing that a probe review is being conducted, and are also notified in writing of the results of the review. Providers are asked to provide any and all medical documentation applicable to the claims in question.

WHAT PCA ACCOMPLISHES

The probe review step in PCA results in classification of a detected problem, if applicable. There are three classification levels of problems:

- Minor;
- Moderate; or
- Major.

The classification level of a detected problem is determined according to the:

- Provider-specific error rate (number of claims paid in error);
- Dollar amounts improperly paid; and
- Past billing history.

If a minor problem is detected, the Medicare contractor will:

- Educate the provider on appropriate billing procedures;
- Collect the money on claims paid in error; and
- Conduct further analysis at a later date to ensure that the problem was corrected.

If a moderate problem is detected, the contractor will:

- Educate the provider on appropriate billing procedures;
- Collect the money on the claims paid in error; and
- Initiate some level of prepayment MR until the provider demonstrates that they have corrected their billing procedures.

If a major problem is detected, the contractor will:

- Educate the provider on appropriate billing procedures;
- Collect the money on the claims paid in error; and
- Initiate a high level of prepayment medical review and/or a statistically valid random sample (SVRS), payment suspension, and/or referral to the contractor's Benefit Integrity Department (as appropriate).

WHAT TYPES OF CORRECTIVE ACTION ARE AVAILABLE?

There are various types of corrective actions that can be taken in the event a problem is discovered during the PCA process. Actions will be taken according to the classification of the problem, as appropriate. Possible actions that could be taken include:

- Development of provider education and feedback;
- Development of local policy;
- Performance of prepayment review;
- Performance of postpayment review; or
- Performance of proactive measures related to MR records requests.

PROVIDER EDUCATION AND FEEDBACK

Along with the planned MR activities, provider or supplier feedback and education developed according to the review findings are an essential part of the PCA process. When individual reviews are conducted, focused provider education is carried out through direct contact between the Medicare contractor and the provider via telephone, letter, and/or face-to-face contact. The overall goal of providing feedback and focused provider education is to ensure development of proper billing practices. This will ensure that claims will be submitted and paid correctly because the provider understands what to expect when a claim is submitted to Medicare.

LOCAL POLICY DEVELOPMENT

The MR process is conducted in accordance with both national and local policies that are the foundation of the review process. The primary authority for all coverage provisions and subsequent policies is the Social Security Act. Contractors use Medicare policies in the form of regulations, national coverage decisions (NCDs), coverage provisions in interpretive manuals, and LMRPs to apply the provisions of the Social Security Act.

NATIONAL COVERAGE DECISIONS (NCDS)

NCDs are developed by CMS to describe the circumstances for Medicare coverage for a specific medical service procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered) under §1862(a)(1) of the Social Security Act or its applicable provisions. These policies are usually issued as a CMS program instruction. Once published in a CMS program instruction, an NCD is binding on all Medicare contractors and providers or suppliers. NCDs made under §1862(a)(1) of the Social Security Act are also binding on Administrative Law Judges (ALJs) during the claim appeal process. For additional information on ALJ review, please refer to Part V, How to Request a Part B ALJ Hearing.

List of Current NCDs
Current NCDs are available at http://www.cms.hhs.gov/ncd/ncdindexlist.asp on the Web.

Within 30 calendar days after an NCD is issued by CMS, contractors will either publish the NCD on their contractor website or link to the NCD posted on the CMS website from their contractor website. In addition, the NCD will be included, as soon as possible, within a provider bulletin.

NCDs should not be confused with coverage provisions in interpretive manuals, which are discussed in the following section.

COVERAGE PROVISIONS IN INTERPRETIVE MANUALS

Coverage provisions in interpretive manuals are coverage instructions published by CMS that are not considered NCDs [see Part 4, National Coverage Decisions (NCDS)]. These instructions are used to further define when services may be covered or not covered under Medicare. Once published, the coverage provision in an interpretive manual is binding on all Medicare contractors and providers.

Within 30 calendar days of the new provision being issued by CMS, contractors will either publish the coverage provision on their contractor website or link to the coverage provision posted on the CMS website from their contractor website. In addition, the coverage provision will be included, as soon as possible, within a provider bulletin.

LOCAL MEDICAL REVIEW POLICY (LMRP)

An LMRP is a formal statement developed through a specifically-defined process that:

- Defines the service;
- Provides information about when the service is considered reasonable and necessary;

- Outlines any coverage criteria and/or specific documentation requirements;
- Provides specific coding and/or modifier information; and
- Provides references upon which the policy is based.

Generally, an LMRP is an administrative and educational tool used to assist providers and suppliers in submitting correct claims for payment, and to guide medical reviewers. LMRPs specify under what clinical circumstances a service is covered (including under what clinical circumstances it is considered to be reasonable and necessary) and correctly coded. LMRPs outline how contractors will review claims to ensure that they meet Medicare coverage and coding requirements. The contractor may adopt LMRPs that have been developed individually or collaboratively with other contractors. The contractor shall ensure that all LMRPs are consistent with all statutes, rulings, regulations, and national coverage, payment, and coding policies.

LMRP Format Standards
The standardized format required for all new LMRPs may be found within Exhibit 6 of the *Medicare Program Integrity Manual* which is available at http://www.cms.hhs.gov/manuals/108_pim/pim83exhibits.pdf on the Web.

Access to LMRPs
Copies of Draft and Final versions of LMRPs are available within the Medicare Coverage Database located at http://www.cms.hhs.gov/mcd on the Web.

Once developed and implemented, LMRPs provide the decision-making criteria for claim review and payment decisions. A major part of the process that defines an LMRP includes a review by a Carrier Advisory Committee (CAC) comprised of medical professionals within both the Medicare Program and the medical community. This review process also allows for other medical professionals throughout the state to comment on proposed policies prior to finalization, thus assuring an objective review of the policy. If a contractor develops an LMRP, its LMRP applies only within the geographic area that contractor services. While another contractor may come to a similar LMRP decision, CMS does not require that contractor to adopt an LMRP of the first contractor.

According to CMS requirements, all LMRPs are published and distributed to providers through local Medicare contractor news bulletins, publications, and the CMS website. Because the contractor provides this information to practitioners and facilities, it is understood that providers and their employees will be responsible for reading and knowing the information. These publications should be kept and used as ongoing references and instructional guides when billing Medicare. In some cases, if the contractor can determine that the provider knew, or should have known, the proper way to bill or utilize proper coding techniques, etc., the improper billing may be determined to be a willful or fraudulent act.

PREPAYMENT REVIEW

Prepayment review consists of MR of a claim prior to payment. This type of review may require submission of medical records and includes automated, routine, and complex activities. Prepayment review may affect any provider.

AUTOMATED PREPAYMENT REVIEW

When prepayment review is automated, decisions are made at the system level using available electronic information, without the intervention of contractor personnel. Automated editing allows the contractor to review information submitted on the claim regarding particular procedure codes. This may consist of the following:

- Diagnosis to procedure code;
- Frequency to time;
- Place of Service (POS) to procedure code; and/or
- Specialty to procedure code.

ROUTINE PREPAYMENT REVIEW

Routine prepayment review requires the intervention of specially trained MR staff. An intervention can occur at any point in the review process. For example, a claim may be suspended for routine review because an MR determination cannot be automated. Routine review requires hands-on review of the claim and/or any attachment submitted by the provider (other than medical records) and/or claims history file and/or internal MR guidelines.

COMPLEX PREPAYMENT REVIEW

Complex review goes beyond the routine review process to include the evaluation of medical records or other documentation that requires professional medical expertise. This may include ambulance trip reports for the purpose of preventing or identifying payments of non-covered or incorrectly coded services, as well as other types of medical documentation. This type of review involves the evaluation of medical records and may only be performed by a clinician reviewer (e.g., a nurse, a physician, or other qualified clinician).

Prepayment Edits

Prepayment edits are designed by contractor staff and put in place to prevent payment for non-covered and/or incorrectly coded services. These edits are also used to select targeted claims for review prior to payment. MR edit development is the creation of logic (i.e., the edit) that is used during claim processing prior to payment that validates and/or compares data element values on the claim.

Service-Specific Edits

Service-specific edits select claims containing specific services for review. They may compare two or more data element values present on the same claim (e.g., diagnosis to procedure code), or they may compare one or more data element values on a claim with data from the beneficiary's history file (e.g., procedure code compared to history file to determine frequency in the past 12 months).

Provider-Specific Edits

Provider-specific edits select claims from specific providers that are flagged for review. These providers are singled out due to unusual practice patterns, knowledge of service area abuses, and/or utilization complaints received from beneficiaries or others. These edits can suspend all claims from a particular provider or supplier, or place focus on selected services, POSs, etc.

Provider-Specific Review

A provider-specific review may include certain procedures or all claims from a particular provider. This review requires submission of documentation and results in either an educational intervention by the contractor or further corrective actions. Providers are notified that documentation submission is required. If a provider is placed on prepayment review, the procedure codes are contingent upon the scope of the problem identified.

POSTPAYMENT REVIEW

Postpayment review involves MR of a claim after payment has been made. This type of review includes:

- A probe review of an individual provider;
- A widespread probe; and
- An SVRS.

This type of review always requires the submission of medical documentation for review.

INDIVIDUAL PROVIDER PROBE REVIEW

When an individual provider is identified on a prepayment or postpayment basis as being statistically different from peers, a probe review is conducted. A small number of claims (approximately 20-40) are identified and a letter is sent to the provider requesting medical documentation to support those claims. Once

the documentation is received, it is reviewed to determine if the claims were documented as having been performed, coded correctly, reasonable and necessary, and a covered Medicare benefit. The provider will be notified, in writing, of the review results. The next steps in the process are dependent upon the results of the review and may include no action, collection of money paid in error, physician education, referral to prepayment flag, or an SVRS.

WIDESPREAD PROBE REVIEW

If a widespread problem is identified, approximately 100 claims are reviewed. An example of such a problem would be an overall spike in billing for a procedure or diagnosis code. A few claims (approximately 5-10) will be requested from several individual providers who have been billing the code in question. The results of this review will determine if:

- Widespread provider education is appropriate;
- Collection of money paid in error is needed;
- A policy needs to be developed;
- An existing policy needs to be revised; or
- System prepayment edits or audits need to be implemented.

STATISTICALLY VALID RANDOM SAMPLE (SVRS)

An SVRS is an in-depth audit of a provider's utilization, coding, and documentation practices. It is used after problems with a provider's utilization pattern have been validated through a probe review. This type of review will result in one or more of the following actions:

- Provider education;
- An overpayment request (possibly projected to the provider's community); or
- A prepayment MR.

If continued non-compliance is demonstrated despite documented educational interventions, a referral may be made to the Benefit Integrity Department for investigation and possible suspension.

PROACTIVE MEASURES RELATED TO MR RECORDS REQUESTS

The purpose of MR is to assist the medical community in the reimbursement of covered medical care with a minimum of inconvenience and dollar expenditure. The following are some measures that providers can take to help avoid any negative impact associated with the MR process:

- Review and read all contractor publications, including LMRPs, and become knowledgeable about the coverage requirements;
- Ensure that office staff and billing vendors are familiar with claim filing rules associated with any LMRP that affects a provider setting or specialty;
- Check records against claims billed;
- Create an educational awareness campaign for Medicare patients that helps them understand any specific coverage limitations or medical necessity requirements for those services provided;
- Work with claim submission vendors to incorporate LMRP edits; and
- Perform mock record audits to ensure that documentation reflects the requirements outlined in the LMRP.

SUBMITTING DOCUMENTATION FOR MR REVIEW

To perform an effective MR of services rendered by a provider, it may be necessary for the provider to furnish specific documentation upon request by the contractor. The following points about submitting documentation should be kept in mind:

- Every service billed must be documented since there must be clear evidence in the patient's record that the service, procedure, or supply was actually performed or supplied;
- The medical necessity for choosing the procedure, service, or medical supply must be substantiated;

- Every service must be coded correctly. Diagnoses must be coded to the highest level of specificity, and procedure codes must be current;
- The documentation must clearly indicate who performed the procedure or supplied the equipment;
- Although it may be dictated and transcribed, legible documentation is required. Existing documentation may not be embellished (e.g., adding what was omitted in the initial documentation), however, additional documentation that supports a claim may be submitted; and
- Voluntary disclosure of information by the provider is encouraged. When an error is discovered, any overpayments should be returned to Medicare.

Occasionally, documentation is requested through the contractor's Additional Development Request (ADR) letter. The contractor may also request documentation either during a data-driven review, or when the provider contests a denial determination, by requesting a review of the claim. Examples of documentation needed for MR of provider services could include, but are not limited to:

- Office records including progress notes, a current history and physical, and a treatment plan;
- Documentation of the identity and professional status of the clinician;
- Laboratory and radiology reports;
- A comprehensive problem list;
- A current list of prescribed medications;
- Progress notes for each visit that demonstrates the patient's response to prescribed treatment;
- Documentation supporting the time spent with the patient when using time-based codes;
- Any required referrals or prescriptions (for many non-physician services/supplies); or
- Any required Certificates of Medical Necessity (CMNs).

Additional MR Process Information

The *Medicare Program Integrity Manual* contains additional information regarding the MR process, including how LMRPs are developed. It may be accessed at http://www.cms.hhs.gov/manuals/108_pim/pim83toc.asp on the Web.

WHAT HAPPENS IF THE FRAUD INVESTIGATION PROCESS GOES WRONG?

Physicians, suppliers, and other providers have a legal obligation to conform to the requirements of the Medicare Program. While most individuals or organizations are honest and make every effort to adhere to the guidelines set forth in the Medicare Program, some may be dishonest. Further, the high monetary amount billed to the Medicare Program makes it vulnerable to individuals who may inappropriately administer medical and healthcare services or bill for services never rendered. CMS must take strong action to combat fraud and protect the Medicare Trust Fund. The goal is to make sure Medicare only does business with legitimate providers who will furnish Medicare beneficiaries with needed high quality services.

The effort to prevent and detect fraud is a cooperative one that involves:

- CMS;
- Medicare beneficiaries;
- Medicare contractors;
- Physicians, suppliers, and other providers;
- Quality Improvement Organizations (QIOs); and
- State and Federal law enforcement agencies such as the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS), the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ).

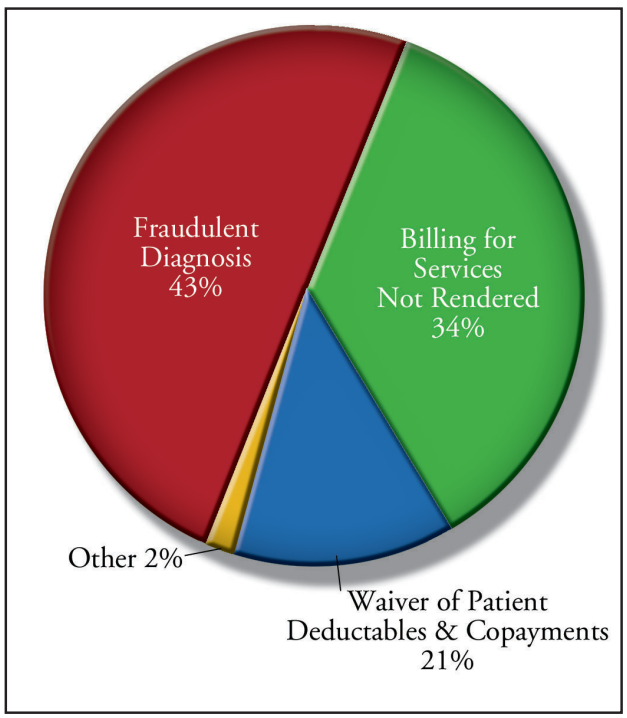
A primary role of each of these individuals/agencies is to:

- Identify cases of suspected fraud;
- Investigate suspected fraud cases thoroughly and in a timely manner; and
- Take immediate action to ensure that Medicare Trust Fund dollars are not inappropriately paid out and that any payments made in error are recouped.

Suspension and denial of payments and the recoupment of overpayments are only some of the possible actions. When appropriate, cases are referred to the OIG Office of Investigations Field Office for consideration of criminal actions, and initiation of civil monetary penalties or administrative sanction.

The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare Program. Figure 4-1 shows a numerical breakdown of the most common fraudulent activities by violators. The violator may be a provider, beneficiary, physician or other practitioner, supplier of durable medical equipment (DME), an employee of a physician or practitioner, or some other person or business entity including a billing service or a contractor employee.

Figure 4-1. Breakdown of Common Fraudulent Activities.



Fraud committed against the program may be prosecuted under various provisions of U.S. Code and could result in the imposition of restitution, fines, and possibly imprisonment. In addition, there is also a range of administrative sanctions (i.e., exclusion from participation in the program) and civil monetary penalties that may be imposed when facts and circumstances warrant such action.

Individuals or organizations identified as engaging in potentially inappropriate activities are not subject to automatic prosecution. Stewards of the Medicare Program (i.e., the Federal Government, its agencies, and its contractors) are required to be prudent and treat physicians, suppliers, and other providers fairly when making decisions that will affect them or their organizations.

Investigation and prosecution of healthcare fraud are reserved for willful and intentional acts of wrongdoing, substantiated through documented inappropriate billing patterns. To address other inappropriate activities or payments, “safeguard” measures, rather than punitive measures, may be taken.

WHAT CONSTITUTES FRAUD

Fraud occurs when an individual intentionally deceives or misrepresents the truth, knowing that it could result in some unauthorized benefit to himself or herself, or some other person. The violator may be a physician or other practitioner, a hospital or other institutional provider, a clinical laboratory or other supplier, an employee of any provider, a billing service, a beneficiary, a Medicare contractor employee, or any person in a position to file a claim for Medicare benefits.
Fraud schemes range from those perpetrated by individuals acting alone to broad-based activities by institutions or groups of individuals, sometimes employing sophisticated telemarketing and other promotional techniques

to lure consumers into serving as the unwitting tools in the schemes. Seldom do perpetrators target only one insurer or either the public or private sector exclusively. Rather, most are simultaneously defrauding several private and public sector victims, such as Medicare.

According to a 1993 survey by the Health Insurance Association of America of private insurers' healthcare fraud investigations, overall healthcare fraud activity could be broken down as follows:

EXAMPLES OF FRAUD

Fraud may take such forms as:

- Incorrect reporting of diagnoses or procedures to maximize payments;
- Billing for services not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;
- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies, billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice;
- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount;
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment);
- Unbundling or “exploding” charges;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider or supplier;
- Billing based on “gang visits” (e.g., a physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients);
- Misrepresentations of dates and descriptions of services furnished or the identity of the beneficiary or the individual who furnished the services;
- Billing non-covered or non-chargeable services as covered items; and
- Using another person's Medicare card to obtain medical care.

Examples of cost report fraud may include:

- Incorrectly apportioning costs on cost reports;
- Including costs of non-covered services, supplies, or equipment in allowable costs;
- Arrangements by providers or suppliers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the program through various devices (commissions, fee splitting) to siphon off or conceal illegal profits;
- Billing Medicare for costs not incurred, or costs that were attributable to non-program activities, other enterprises, or personal expenses;
- Claiming bad debts without first genuinely attempting to collect payment;
- Amounts paid to owners or administrators that have been determined to be excessive in prior cost report settlements;
- Days that have been improperly reported and would result in an overpayment if not adjusted;
- Program data where provider or supplier program amounts cannot be supported; and
- Allocation of costs to related organizations that have been determined to be improper.

WHAT CONSTITUTES ABUSE

Abuse describes practices that either directly or indirectly result in unnecessary costs to the Medicare Program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence that the subject was knowingly and willfully conducting an abusive practice.

EXAMPLES OF ABUSE

The following are examples of abuse:

- Charging in excess for services or supplies;
- Providing medically unnecessary services;
- Providing services that do not meet professionally recognized standards;
- Billing Medicare based on a higher Fee Schedule than is used for patients not on Medicare;
- Submitting bills to Medicare that are the responsibility of other insurers under the Medicare Secondary Payer (MSP) regulations;
- Violating the participating physician/supplier agreement with Medicare or Medicaid;
- Breaches of the assignment agreement; or
- Violating the Maximum Allowable Actual Charge Limits or the limitation amount.

FRAUD AND ABUSE CASE EXAMPLES

The following are some actions the Federal Government took in actual cases involving Medicare providers or suppliers:

- In Illinois, a former owner of an ambulance service was sentenced to 27 months imprisonment and ordered to pay $600,000 in restitution for healthcare fraud. The man submitted claims for transports that were medically unnecessary. In addition, ambulance run records were altered to add services that were not provided to patients.

- In Florida, a man in control of several DME corporations was sentenced to 84 months in prison and ordered to pay $14.4 million in restitution for his role in schemes to defraud Medicare and Medicaid. In addition, the court ordered a $14.8 million order of forfeiture against him. The man previously pled guilty on behalf of six DME corporations that were set up to launder money. Despite a temporary restraining order, the man and his co-conspirators continued to fraudulently bill Medicare and launder the proceeds of the fraud through offshore bank accounts.

- In addition, a co-conspirator was sentenced to one year and one day in prison and ordered to pay $474,000 in restitution for conspiracy and submitting false claims. The sales representative received commissions from the sale of motorized wheelchairs, alternating pressure mattresses, and related items. Another sales representative was ordered to pay $485,000 in restitution for conspiracy and submitting false claims to Medicare and Medicaid. The man received and distributed commission payments for other sales representatives working under his direction.

- A New York couple who owned a DME company was sentenced based on their guilty pleas. The husband was sentenced to 15 months incarceration and ordered to pay $210,000 in restitution for healthcare fraud. His wife was sentenced to six months in a halfway house and six months home detention for paying kickbacks to doctors. Although the owners and their staff provided Medicare and Medicaid beneficiaries with inexpensive soft back braces, they actually billed Medicare for expensive, firm body jackets. The wife provided the funding that was used to pay kickbacks to doctors for their referrals and prescriptions.

- In Massachusetts, a physician was ordered to pay a $5,000 fine for conspiring to receive kickbacks from a pharmaceutical company. The physician conspired with a sales representative from the company to receive free samples of the prostate cancer drug, Lupron Depot, in return for his decision to switch his patients from another drug to Lupron. The physician, who received 30 free samples, not only switched patients to the drug, but also billed Medicare for the free samples.

- A Pennsylvania podiatrist was sentenced to 12 months and one day of imprisonment and ordered to pay $409,000 in fines and restitution. The podiatrist previously pled guilty to false statements relating to healthcare matters. During a 6-year

period, the podiatrist billed Medicare for more than 20,000 nail avulsion surgical procedures when in fact the number was significantly lower.

- A New York physician was sentenced to six months imprisonment and ordered to pay $250,000 in restitution for healthcare fraud. The owner of a clinic billed Medicare using the physician's Medicare provider number. In return for the use of his provider number, the owner of the clinic paid the physician $2,500 a month and let him utilize office space and billing staff at the clinic. As a result, the owner received payments from Medicare for physical therapy services he was not qualified or legally allowed to perform and for services that were not provided.

- In New York, an individual practitioner was ordered to pay a $30,000 fine for violating the anti-kickback statute. The doctor received kickback payments from a medical supply company, an MRI center, and a laboratory.

- In Missouri, six co-defendants were sentenced for conspiring to defraud the U.S. through a system of kickbacks for patient referrals and the filing of false claims that resulted in overpayments from Medicare and Medicaid. The individuals sentenced included a licensed medical doctor, a registered nurse, a billing service owner, an employee who provided medical billing services, and two owners of several residential care facilities and Home Health Agencies (HHAs). The six were ordered to pay respective restitution amounts totaling $526,000 and four were sentenced to prison. One central aspect of the scheme involved the owners' referral of patients from their residential facilities to doctors in exchange for them to certify the patients as homebound and eligible for their home health services. This arrangement allowed the doctors to bill Medicare and Medicaid for patient visits and the HHAs to bill Medicare and Medicaid for providing home health services.

MEDICARE INCENTIVE REWARD PROGRAM (IRP)

Section 203(b)(1) of HIPAA (Public Law 104-191), established the Medicare IRP to encourage individuals to report information on individuals and entities that are engaged in or have engaged in acts or omissions that constitute grounds for the imposition of a sanction under Sections 1128, 1128A, or 1128B of the Social Security Act, or who have otherwise engaged in sanctionable fraud and abuse against the Medicare Program under Title XVIII of the Social Security Act.

The Medicare IRP pays an incentive reward to individuals who provide information on Medicare fraud and abuse or other sanctionable activities. The Medicare Program will make a monetary reward for information that leads to a minimum recovery of $100 of Medicare funds from individuals and entities determined by CMS to have committed sanctionable offenses. Only referrals from fiscal intermediaries (FIs) and carriers to OIG, made pursuant to the criteria set forth in Chapter 3, Section 10, of the *Medicare Program Integrity Manual* are considered sanctionable for the purpose of the Medicare IRP.

Obtaining Medicare IRP Information
Additional information regarding the Medicare IRP is available at http://www.cms.gov/manuals/108_pim/pim83c02.pdf on the Web.

Report or Ask Questions about Fraud and Abuse
To ask questions about fraud and abuse or to report suspected fraudulent or abusive activities, providers are encouraged to contact their Medicare contractor or call the national DHHS/OIG Hot Line directly at 1-800-HHS-TIPS.

Specific criteria inform Medicare contractors that they have a duty to identify cases of suspected fraud and to make referrals of all such cases to OIG, regardless of dollar thresholds or subject

matter. Matters should be referred when the contractor has a reasonable basis to suspect that the provider:

- Intentionally engaged in improper billing;
- Submitted improper claims with actual knowledge of their falsity; or
- Submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity.

In cases where providers' employees submit complaints, such cases should be forwarded to OIG immediately. The amount of the reward will not exceed 10% of the overpayment recovered in the case, or $1,000, whichever is less. Collected fines and penalties are not included as part of the recovered money for purposes of calculating the reward amount.

PREPAYMENT AND POSTPAYMENT REVIEW

Medicare contractors have a responsibility to ensure that claim payments are made appropriately. One way to do this is to review claims and medical records on either a prepayment or postpayment basis. Medicare may ask the physician and/or supplier to submit documentation for a detailed review of targeted claims. After the review, payment may be allowed, denied, or reduced.

If fraud is suspected or continued non-compliance with Medicare requirements is demonstrated, despite documented educational interventions, a referral to the Benefit Integrity Department of the Medicare contractor may be made for investigation and possible payment suspension.

OVERPAYMENTS

Overpayments are Medicare funds a provider or beneficiary has received in excess of amounts due and payable under the Medicare statute and regulations. Once it has been determined an overpayment has been made, the amount of the overpayment is a debt owed to the Federal Government. Federal law strictly requires CMS to seek recovery of overpayments, regardless of how an overpayment is identified or caused, including when an overpayment is CMS' mistake.

Medicare strives to ensure payment accuracy; however, mistakes occasionally occur. Providers are responsible for making voluntary refunds to Medicare when they identify an overpayment. Additionally, providers are also responsible for timely repayment when Medicare notifies them of an overpayment. If a timely repayment is not made after proper notice, interest will accrue at an annual rate specified by law on the outstanding balance. Finally, penalties may be imposed on overpaid monies, depending on the circumstances involved in the case. Part B overpayments must be returned to the local Medicare carrier; physicians, suppliers, and other providers must not keep incorrect payments. These overpayments may often require the refund of copayments made by or on behalf of beneficiaries.

Providers who may have questions related to a Medicare overpayment and/or other Medicare debt collection should call the local Medicare contractor's toll-free customer service number for assistance.

ADMINISTRATIVE SANCTIONS

If CMS determines the existence of inappropriate and/or fraudulent behavior on the part of a contractor, various administrative sanctions could be taken to address the issue. Possible sanctions that could be taken include:

- Denial or revocation of an application for a provider number;
- Suspension of payments to a provider; or
- Application of civil monetary penalties.

DENIAL OR REVOCATION OF PROVIDER NUMBER APPLICATION

CMS has the authority to deny or revoke an individual's or organization's application for a Medicare provider number if there is evidence of impropriety (e.g., previous convictions, false information on the application) or if the provider

does not meet State/Federal licensure or certification requirements.

If changes have occurred to information on original applications for Medicare provider numbers, individual providers or organizations must notify the applicable Medicare contractor or state agency. Examples of such changes may include address change, change of ownership, change in the name of the business, or change in the Tax Identification Number (TIN). Failure to notify Medicare of changes may result in revocation of provider billing privileges, thereby preventing payments from Medicare.

Additional Provider Enrollment Information
Additional information regarding application for provider numbers, adding/deleting group members, or changes to addresses is available at http://www.cms.hhs.gov/providers/enrollment/forms on the Web.

SUSPENSION OF PROVIDER PAYMENTS

CMS has the authority to suspend payment to a provider if fraud is suspected or if an overpayment exists. This action may be necessary to protect the Medicare Program against financial loss. Payment suspensions may last up to 180 days and, in certain cases, an additional 180-day payment suspension may be imposed, or the payment suspension may be imposed for an indefinite period.

Claims submitted by a provider during a payment suspension will continue to be processed, and the provider will continue to be notified of claim determinations. In addition, appeal rights are available for the processed claims. However, Medicare withholds the actual payment(s) for the claims. The withheld payment(s) may be used to offset or recoup overpaid funds identified by Medicare.

There are no appeal rights to the decision to suspend payments. However, providers may submit written rebuttals addressing why a payment suspension should not be imposed. A payment suspension may be lifted once the overpaid funds are recovered or if sufficient information is in the provider's rebuttal statement to demonstrate that the payment suspension is not necessary.

CIVIL MONETARY PENALTIES

Section 1128A(a) of the Social Security Act authorizes the imposition of Civil Monetary Penalties (CMPs) when it is determined that a person or entity has violated Medicare rules and regulations. The following are some examples of violations for which CMPs and additional assessments may be imposed (and in some instances exclusion from the program may apply):

- Violation of the Medicare assignment provisions;
- Violation of the Medicare physician or supplier agreement;
- False or misleading information expected to influence a discharge decision;
- Violation of assignment requirement for certain diagnostic clinical laboratory tests;
- Violation of requirement of assignment for nurse-anesthetist services;
- Supplier refusal to supply rental DME supplies without charge after rental payments may no longer be made;
- Physician billing for assistants at cataract surgery without prior approval of the Quality Improvement Organization (QIO);
- Hospital unbundling of outpatient surgery costs; or
- Hospital/responsible physician “dumping” of patients based upon their inability to pay or lack of resources.

Typically, penalties involve assessments of significant damages such as CMPs up to $10,000 per violation and exclusion from the Medicare Program for a minimum of five years.

INVESTIGATIONS

In cases of substantiated allegations of fraud or suspected inappropriate activities, Medicare contractors and/or Federal law enforcement may investigate individuals and providers or suppliers for subsequent prosecution.

CRIMINAL PROSECUTIONS AND PENALTIES

Because it is a Federal crime to defraud the Federal Government or any of its programs, individuals who commit fraud may be imprisoned, fined, or both. Criminal convictions usually include restitution and significant fines. In some states, providers and healthcare organizations may also lose their licenses. Convictions may also result in exclusion from Medicare participation for a specific length of time.

CIVIL PROSECUTIONS AND PENALTIES

The U.S. Attorney's Office may file a civil suit or decide that the interest of the Medicare Program is best served by settling a case. In these situations, the amount of damages plus additional money may be paid to the Federal Government in the form of penalties and fines. Depending on the severity of the case, the civil suit or settlement may include the following:

- CMP to the Federal Government for no more than $10,000 for each item or service in non-compliance (or higher amounts where applicable by statute);
- Penalty assessment payment to the Federal Government for up to three times the amount claimed for each item or service in lieu of damages sustained by the Federal Government;
- Exclusion from Medicare or any other Federally funded program for a specified number of years; or
- Imposition of a “Corporate Integrity Agreement” with the Federal Government. In these instances, the individual or entity is required to accomplish specific goals (e.g., educational plan, corrective action plan, reorganization) and is also subject to periodic audits by the Federal Government.

EXCLUSION AUTHORITY

The OIG has the authority to exclude (sanction) providers or suppliers who have been convicted of health care-related offenses. Even when the U.S. Attorney's Office declines to prosecute a case, the OIG may act to exclude the providers from the Medicare Program. The term exclusion means that, for a designated period, Medicare, Medicaid, and other Government programs will not pay the provider for services performed or for services ordered by the excluded party.

In addition, under Section 1128A(a) of the Social Security Act, many of the penalties imposed under this section may also cause exclusion from the Medicare Program. The authority to exclude providers and suppliers under this statute is delegated to CMS or the OIG, depending on which agency was delegated authority for the specific violation from the Secretary of the SSA.

Refer to Section 1128, 42 U.S.C. 1320a-7 of the Social Security Act for the mandatory and permissive exclusions discussed in the following sections.

Mandatory Exclusions

A mandatory exclusion exists if there is a conviction of fraud. Examples of mandatory exclusions can be found in the Social Security Act.

Permissive Exclusions

A permissive exclusion exists when there is no conviction of fraud; however, certain conditions and requirements have been met. Examples of permissive exclusions can be found within the Social Security Act.

Exclusion Information
A complete list of exclusions and other information related to exclusions is available at http://www.oig.hhs.gov/fraud/exclusions.html on the Web.

PAYMENT DENIALS DUE TO EXCLUSION

Medicare will not pay an excluded individual, or an entity that has accepted assignment. Medicare will also not pay a beneficiary who submits claims for items and services furnished on or after the effective date of a sanction. In addition, Medicare will not pay for services/items furnished on the order or referral of an excluded individual or entity.

DENIAL OF PAYMENT TO A SUPPLIER

Medicare will not pay for any items or service that an excluded party furnishes, orders, or prescribes. This payment prohibition applies to the excluded person and anyone who employs or contracts with the excluded person. The provider is ultimately responsible for establishing that the items and services billed were not furnished, ordered, or prescribed by an excluded individual.

DENIAL OF PAYMENT TO A PROVIDER OF SERVICE (POS)

A POS that is wholly owned by an excluded party will not be paid by Medicare for services performed or items received (including services performed under contract) by an excluded party on or after the effective date of the sanction.

DENIAL OF PAYMENT TO BENEFICIARIES

If a beneficiary submits claims for items or services furnished by an excluded party or by a supplier that is wholly owned by an excluded party on or after the effective date of the sanction:

- Medicare may pay for the first claim submitted by the beneficiary, and will immediately give the beneficiary notice of the sanction.
- Medicare will not pay the beneficiary for items or services furnished more than 15 days after the date of the notice to the beneficiary.

EXCEPTIONS TO PAYMENT DENIALS

Payment is available for services or items provided up to 30 days after the effective date of the sanction for:

- Inpatient hospital services or post-hospital Skilled Nursing Facility (SNF) services or items furnished to a beneficiary who was admitted to a hospital or SNF before the effective date of the sanction; or
- Home health services or items furnished under a plan of treatment established before the effective date of the sanction.

The Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) permits payment for an emergency item or service furnished by an excluded individual or entity.

REINSTATEMENT

At the conclusion of the designated period of sanction, an individual and/or entity may be eligible for reinstatement to the Medicare Program and may apply to OIG for reinstatement.

OIG LIST OF EXCLUDED INDIVIDUALS/ENTITIES (LEIE)

The OIG's sanctioned LEIE identifies individuals and entities that are excluded from Medicare reimbursement. In addition, the list includes the provider's specialty, notice date, and the end of the sanction period. The OIG LEIE also identifies individuals and entities that have been reinstated to the Medicare Program.

Accessing the LEIE
The OIG-sanctioned LEIE is available at http://www.oig.hhs.gov/ on the Web. Once at this address, click on “Exclusions Database”.

GOVERNMENT SERVICES ADMINISTRATION (GSA) EXCLUDED PARTIES LISTS SYSTEM (EPLS)

The GSA was established by the Federal Property and Administrative Services Act. Its role is to examine ways to improve the administrative services of the Federal Government. The GSA website contains debarment actions taken by various Federal agencies, in addition to those of the OIG LEIE exclusions database.

GSA EPLS Lists
The GSA debarment, exclusion, and suspension lists for all Federal Agencies are available at http://epls.arnet.gov on the Web.

The EPLS website assists Medicare and Medicaid contractors in verifying the eligibility of healthcare providers or suppliers and/or entities seeking to participate in the Medicare and Medicaid programs. CMS encourages individuals and entities to research the information on this website before adding a provider or supplier to a physician group or medical staff, purchasing or considering involvement in a medical facility or other entity that may seek payment from Medicare.

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