Health Care Financing Administration

THE MEDICARE INTEGRITY PROGRAM

PAY IT RIGHT!

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HIGHLIGHTS

WHAT IS MEDICARE'S INTEGRITY PROGRAM?

Medicare's Integrity Program was established by Congress in 1996 to help reduce payment errors and protect and strengthen the Medicare Trust Funds. Health Care Financing Administration staff and contractors work in a wide range of Medicare program areas such as cost report auditing, medical review, anti-fraud activities and the Medicare Secondary Payer program to improve payment accuracy.

WORKING WITH PARTNERS; GETTING RESULTS.

In 1996, the Inspector General's office estimated that 14 percent of Medicare payments were made improperly. Since then that error rate has been cut roughly in half. The credit for such improvement in payment accuracy goes to all the stakeholders and partners in the system who have worked to improve it.

Our partners include providers, beneficiaries, contractors, other federal agencies such as the Department of Health and Human Services' Office of Inspector General and the U.S. Department of Justice, State agencies, Congress and the Administration. We will continue to work with these partners because there is more to be done.

WHAT MEDICARE'S INTEGRITY PROGRAM DOES NOT DO.

We want you to know about the program and understand how it works. We want to dispel several misconceptions. For example:

- Many people do not know how the program is funded and think that we must generate funds by finding payment errors. Actually the program uses money appropriated by Congress. Overpayments recovered, fines and penalties go to the Medicare Trust Fund.
- Some people think we penalize providers who make "honest mistakes," and that we report providers who have made errors to law enforcement agencies, thus undermining the public's confidence in the health care community. In actuality, we very seldom have to refer providers to law enforcement agencies. Most payment problems are handled administratively. *For more information on provider rights, see page 5.*

PURPOSE OF THIS PAMPHLET

The purpose of this pamphlet is to give physicians, providers and suppliers information on the Medicare Integrity Program—what it is all about, how it works, and how it might affect you.

PROGRAM INTEGRITY GOALS

The goal of program integrity is to "pay it right"— pay the right amount, to the right provider, for the right service, to the right beneficiary. Our emphasis is on making accurate payments when claims are first submitted because increased accuracy and efficiency benefit everyone involved in the system. We are committed to working collaboratively with our Medicare partners—providers, beneficiaries, contractors, and other Federal and State agencies—to protect and strengthen the Medicare Trust Funds.

In 1996, the Inspector General's office estimated that 14 percent of Medicare payments were made improperly. Since then, we have made real progress in reducing the error rate to 7.97 percent in 1999. The credit goes to all the stakeholders and partners in the system who have worked diligently to raise Medicare program integrity to the top of their agendas: physicians, providers, suppliers, law enforcement officials, Medicare beneficiaries, Medicare contractors, Congress, and the Administration. Though substantial progress remains to be made, those results demonstrate the possibilities for improvement if we all remain committed to our program integrity goals.

THE MEDICARE INTEGRITY PROGRAM

The Medicare Integrity Program (MIP) was created by Congress as part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

In HIPAA, Congress provided a stable source of funding for program integrity efforts by the Medicare program. In 1999, $560 million was provided to support a wide range of efforts by the Medicare program, including cost report audits, medical review, anti-fraud activities, and the Medicare Secondary Payer program. HCFA's total MIP budget, although seemingly large in the absence of any context, is actually less than one percent of the total amount of paid claims for fiscal year 1999 ($170.1 billion).

LAW ENFORCEMENT

At the same time it created MIP, Congress also provided more funds for law enforcement agencies, including the U.S. Department of Health and Human Services' Office of Inspector General (OIG), and the U.S. Department of Justice (DOJ), for investigation and prosecution of health care fraud—not only for the Medicare program, but also for State Medicaid agencies and even private insurers. In 1999, these law enforcement agencies received $203 million for these activities.

The Health Care Financing Administration (HCFA) does not direct the activities or resources of law enforcement agencies. It refers suspected fraud to the OIG for investigation, and provides technical assistance to law enforcement (in obtaining Medicare data, or in understanding Medicare program requirements, for example) as cases are developed and pursued. Law enforcement agencies are an important partner with HCFA in protecting the integrity of the program, but they are independent agencies.

FUNDING

The MIP represents a breakthrough in how the program can support and sustain its integrity efforts. Prior to MIP, no special funds were set aside for this purpose, and it was difficult to plan integrity work when program appropriations could vary from year to year. Recognizing how such efforts pay for themselves many times over, by preventing and recouping financial losses, Congress and the Administration worked in a bipartisan effort to ensure that Medicare could undertake these critical activities.

It is a common misconception that HCFA receives its funding only by generating "returns" through overpayment recoveries. This is not true. In creating MIP, Congress and the Administration expressly rejected this approach, and instead set out in advance the amount available each year to fund program integrity activities. Overpayments recovered are returned to the Medicare Trust Fund.

KEY HCFA ACTIVITIES UNDER MIP

The central activities of HCFA in the Medicare Integrity Program are:

- cost report audits;
- medical review;
- anti-fraud activities; and
- Medicare secondary payer activities.

Taken together, these activities utilize the vast majority of MIP funds. They are all carried out by contractors that HCFA carefully selects for these purposes. Generally, these contractors are the same ones that HCFA employs to process claims, although we're now beginning to try different ways of contracting out this business. MIP funds are also used to support special provider enrollment initiatives, education and outreach, and software to automatically review claims for errors.

COST REPORT AUDITS

Thirty two percent of MIP funds in 1999 were used for cost report audits. Cost reports are prepared by hospitals, nursing homes, home health agencies, and other providers who are or have been paid on a cost reimbursement basis. They provide detailed accounting of what costs have been incurred, what costs the provider is charging to the Medicare program, and how such costs are accounted for by the provider. Auditors review all or

part of the cost report, sometimes requesting additional or supporting documentation, to assess whether costs have been properly allocated and charged to the Medicare program.

Providers may be selected for cost report audits based on several factors and selection for an audit does not necessarily indicate a suspicion of wrongdoing. Random cost report audits are sometimes conducted. Some reviews are required by law (for example, of End Stage Renal Disease Facilities). More typically, however, providers are selected for cost report audits on the basis of prior cost report concerns or atypical allocations and costs reported. A provider may also be selected for review because auditors are focusing on a particular kind of problem in a specific section of the cost report for which they reported activity (e.g., related party transactions).

CLAIM AND MEDICAL REVIEW

Thirty three percent of MIP funds in 1999 were used for medical review. Most of the medical review we conduct, however, does not require us to ask for or look at individual patients' medical records. Often, medical review is conducted by simply examining the claim itself and the information that has been submitted for payment. If we need more information, we examine attachments to the claims (certificates of medical necessity, for example) and patient history files. In a small percentage of cases, we ask for and look at actual medical records, to confirm that the services were rendered to the patient as reflected on the claim, that the coding of the service is correct, and that the service was covered by Medicare. Medicare pays more than 95 percent of the claims submitted to the program without obtaining medical records.

The vast majority of the improper payments Medicare makes are for services that appear correct on the claim form but are determined to be medically unnecessary after reviewers analyze the underlying clinical record. According to Medicare's 1997 Chief Financial Officer's audit, paying for medically unnecessary care was the most common mistake Medicare made. However, reviewing medical records to make a claim payment determination is costly and burdensome for both the Medicare program and the provider, supplier or physician. For this reason, the Medicare program is always seeking ways to make this process easier and more efficient; for example, by adapting electronic technologies for submission of certain information.

Providers may be selected for medical review based on several factors. Random reviews are sometimes conducted, primarily as a way to assess where problems are occurring through out the system, but also as a general programmatic control. More typically, however, providers are selected for medical review on the basis of prior problems or atypical billing patterns. They may also be selected for review because contractors are focusing on a particular kind of problem (e.g., errors in billing a type of service) for which they are submitting claims.

We try to do most medical review on a prepayment, rather than a postpayment, basis. This ensures that we make an appropriate payment in the first place (prepayment), rather than paying incorrectly and then "chasing" after overpayments (postpayment). Providers

who have been identified as having problems submitting correct claims in the past may be placed on "prepayment review," in which a percentage of their claims are subjected to medical review before payment can be authorized. Once providers have reestablished a practice of billing correctly, they are removed from prepayment review.

Postpayment review can be done as a claim by claim review, or by using statistically valid random samples. The advantage of sampling is that an underpayment or overpayment (if one exists) can be estimated without requesting all records on all claims from a provider. This balances our desire to reduce administrative burden and costs for both the Medicare program and the provider with our responsibility to compensate the trust fund for damages from past errors. We have established minimum sampling requirements to ensure that samples are drawn appropriately and an acceptable level of precision is obtained. Among the safeguards we have established for sampling is the balancing, or "netting out" of overpayments with underpayments; inclusion of claims denied as well as claims paid in the universe from which the sample is drawn; use of the lowest estimate of the overpayment; and a requirement for contractors to consult with statistical experts in developing the sampling method. Providers undergoing review also have the right to appeal not only the individual determinations of the claims in the sample, but also the sampling method.

YOUR RIGHTS AS A PROVIDER

Being selected for a cost report audit or medical review does not necessarily mean that the Medicare program thinks you have done anything wrong. Auditors and reviewers will review your cost reports and claims with open and neutral minds. While contractors are focusing attention on you because of unexpected billing patterns, for example, there may be appropriate and good explanations for those patterns. Only by reviewing information actually on the cost report, claim, and perhaps reviewing supporting information can contractors reach conclusions about whether there is a problem.

You have the right, during any review, to be treated respectfully, courteously and fairly, and to have your questions answered in a timely manner. You also have a right to appeal determinations which you disagree, so long as such appeals are filed in accordance with regulations governing that process.

ANTI-FRAUD ACTIVITIES

In 1999, 16 percent of MIP funds were spent on contractor anti-fraud units. These units, which exist in both fiscal intermediaries (processing Part A, or institutional, bills from hospitals, home health agencies, nursing homes and others) and carriers (processing Part B, or noninstitutional bills, from physicians, suppliers and others). The units respond to beneficiary complaints of fraud, develop cases for referral to law enforcement, support law enforcement in their efforts, and conduct data analysis to identify suspicious billing or service delivery patterns that could be indicative of fraud.

The overwhelming percentage of providers, suppliers and physicians who provide services to Medicare beneficiaries are honest, careful and conscientious. However, there are some who enter the program solely intending to run a scam. Some are drawn into illegal activity by others. There are those who consistently cheat the program by padding lots of bills "a little at a time." Some desire to participate in the program and receive payments, but "deliberately ignore" or "recklessly disregard" problems in their operations that lead to Medicare overpayments.

Providers, suppliers, and physicians sometimes express concern that, with all the attention being paid to anti-fraud activities in health care by the government, two problems will result. First, they fear providers who are making "honest mistakes" will be assumed to be fraudulent and penalized. Second, they are concerned that by publicizing the problem and involving beneficiaries and others in identifying and reporting fraud, we are undermining the public's confidence in the health care community.

We recognize honest mistakes can and do happen. In fact, most overpayments that Medicare contractors find, or that providers find and report themselves, are handled administratively. **The Medicare program does not routinely refer providers to law enforcement agencies for investigation, except where there is indication of fraud.** Law enforcement agencies then evaluate the referral to determine if it merits further investigation. If the Medicare program has reliable evidence of fraud, it can suspend payments to the provider in question while an analysis is undertaken to determine the extent of the overpayment, so that the trust fund is protected from further losses. But most overpayment situations do not merit such actions. We do not seek to penalize honest mistakes; but we do seek to recover overpayments when they have been made, regardless of the reason the overpayment occurred. No matter the reason for the overpayment, these are funds collected solely for providing health care to the elderly and disabled and the overpayments must be recovered.

We also encourage beneficiaries, and others (including health care professionals) to report suspicions of fraud. By law, individuals who report such allegations are eligible for rewards of up to $1,000 if their allegations are sustained after further review. Often such complaints are resolved by communication and education, or by collecting an overpayment, without referral to law enforcement. In fact, we encourage beneficiaries to first contact their physician, provider or supplier if they have questions about their bills, since this simple step can often resolve their questions. While recognizing that fraud is a serious threat to the Medicare program which we want to address effectively, we also know and emphasize that most questions can be resolved through simple communication with a health care provider, and most errors are honest ones. In addition, beneficiaries sometimes misunderstand their notices or question services that are proper and correct. Just as you might review your credit card bill carefully to check for errors, we believe that it is appropriate for Medicare beneficiaries to do the same when reviewing their notices.

MEDICARE SECONDARY PAYER

In 1999, 19 percent of MIP spending went to Medicare Secondary Payer (MSP) activities. By law, when Medicare beneficiaries have certain private insurance, other insurers should pay first. The MSP program collects information on the proper order of payers, and makes sure that Medicare makes primary payment only for those claims where it has primary responsibility to pay for health care services to Medicare beneficiaries. When mistaken Medicare primary payments are identified, recovery actions from other insurers are undertaken.

OTHER IMPORTANT ACTIVITIES

Beyond these core program integrity activities funded through the MIP budget, the Health Care Financing Administration undertakes a number of other programs which assist in preventing improper payments or are related to our program integrity activities. They include:

PHYSICIAN, PROVIDER, SUPPLIER EDUCATION.

Medicare spends more than $50 million a year on provider education activities. These funds are used to provide information to physicians, providers and suppliers on Medicare program rules, how to comply, how to avoid common mistakes, and how to get claims processed expeditiously. Increasingly, we are taking advantage of new technology—satellite broadcasts and Internet-based computer training, for example—to reach out, make contact with, and listen to our providers.

PROVIDER ENROLLMENT.

The process of obtaining a Medicare billing number is an important program safeguard, ensuring that only qualified, legitimate providers, physicians and suppliers enter the program. In the near future, we will be issuing a revised form for enrollment which simplifies processing while maintaining program protections. We will also issue a regulation which specifies how application information will be used to make enrollment decisions.

CONTRACTOR EVALUATION AND OVERSIGHT.

Since the activities discussed in this pamphlet are all undertaken by contractors, it is critical that we have a robust operation for management and oversight. We are devoting more resources and attention to this critical function, have consolidated responsibility for these oversight activities under a senior official who is also a physician, and have stepped up our on-site reviews of contractors.

PRIVACY PROTECTIONS.

HCFA has established a Beneficiary Confidentiality Board, to assess programs and activities which affect the privacy of beneficiaries and other stakeholders in the system. The protection of medical records and sensitive patient information is a key focus of this Board.

PAYMENT ERROR PREVENTION PROGRAM.

HCFA has also launched a new initiative through Peer Review Organizations (PROs). These organizations have longstanding relationships with hospitals on quality improvement projects, and under the new initiative they will work in a similar fashion with hospitals to improve payment accuracy. The PROs' efforts will be customized to address specific payment error problems within the State, and like other Medicare integrity efforts will use education and prevention as a key approach to problem solving.

MANAGED CARE.

HCFA is also paying attention to program integrity issues in managed care, and has developed an approach to addressing integrity issues in those settings through requirements on Medicare+ Choice plans and new monitoring approaches.

MEDICAID FRAUD AND ABUSE NATIONAL INITIATIVE.

HCFA also formed the Medicaid Fraud and Abuse National Initiative to combat fraud and abuse within the Medicaid program. The Initiative is based on a Federal partnership with the State Medicaid Agencies. At the State level there are two basic components charged with controlling fraud and abuse; specifically, the State Attorney General's office and the State Medicaid Agency. Also, most States have in place a Surveillance and Utilization Review System (SURS) unit which is responsible for analyzing post-payment data from the Medicaid Management Information System and preparing data profiles on suspected fraudulent patterns. The SURS unit is required to refer suspected fraud for investigation and possible prosecution. HCFA works closely with States to continually devise and provide methods to more effectively combat fraud and abuse in the 50 plus Medicaid programs.

COMMON QUESTIONS AND ANSWERS

CAN I BE PUNISHED WITH JAIL OR FINES FOR MAKING INNOCENT MISTAKES?

Providers are not subject to civil or criminal penalties for innocent errors, mistakes or even negligence. The Government's primary enforcement tool, the civil False Claims Act (FCA), covers only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard of the truth or falsity of the claim, or deliberate ignorance of the truth or falsity of the claim. The FCA simply does not cover mistakes, errors or negligence. The other major civil remedy available to the Federal Government, the Civil

Monetary Penalties Law, has exactly the same standard of proof. We are mindful of the difference between innocent errors and negligence (erroneous claims) on the one hand, and reckless or intentional conduct (fraudulent claims) on the other.

When billing errors, honest mistakes or negligence result in erroneous claims, the provider will be asked to return the funds erroneously claimed, but without penalties. In other words, erroneous claims result only in the return of funds claimed in error. Nevertheless, inadvertent billing errors are a significant drain on the program and all parties need to work cooperatively to reduce them.

CAN YOU EXPLAIN WHAT LOCAL MEDICAL REVIEW POLICY IS, AND HOW IT WORKS?

Local medical review policy is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. Local policies outline how contractors will review claims to ensure that they meet Medicare coverage requirements. HCFA requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with input from medical professionals (through advisory committees), and consistent with scientific evidence and clinical practice. They are developed by contractor medical directors.

The use of local medical review policy helps avoid situations in which claims are paid or denied without a full understanding of the basis for payment and denial. Providers can also request decisions at the national level on the appropriate conditions and indications for payment for a given service, procedure, or technology.

WHY CAN'T MEDICARE IMPLEMENT A "ONE-STRIKE" POLICY, SO THAT FIRST TIME ERRORS ARE DEALT WITH THROUGH EDUCATION?

In fact, most errors are addressed administratively when they are first encountered, by collecting the overpayments identified in the specific cases or claims and engaging in education. However, when the information suggests that the error has resulted in significant losses to the Medicare program, additional corrective action should be taken (for example, conducting a postpayment review to determine the amount of overpayments made). We are all accountable to the program, its beneficiaries, and the public to correct errors as we find them.

As an example, suppose that a computer program has caused a provider to submit claims in error for a period of time, and this is discovered through a contractor's review of a single claim. In light of the nature of the error, it would be appropriate not only to collect the overpayment on the one claim which brought the problem to light, but also to conduct a postpayment review or a statistical sample to establish an accurate overpayment amount reflective of a total cost to Medicare of the computer glitch. On the other hand, if the problem seemed to be isolated and minimal, that additional step would not be necessary. Contractors are directed to use progressive corrective action commensurate with the nature of the error and its impact on the program.

I'VE HEARD ABOUT SOMETHING CALLED CONSENT SETTLEMENTS. CAN YOU TALK ABOUT WHAT THESE ARE AND WHAT IT MEANS WHEN A PROVIDER SIGNS A CONSENT SETTLEMENT?

Consent settlements are opportunities for providers to "settle" their overpayment obligations with HCFA without going through a full fledged statistically valid random sample, which often requires more production of records and administrative costs for the provider. As a settlement, both HCFA and the provider agree to use the results of a more limited review to determine the overpayment amount. A consent settlement does not include any settlement of fraud issues, which is solely within the province of the DOJ.

I'M LOOKING AT MY OPERATIONS TO MAKE SURE I'M BILLING CORRECTLY. SOMETIMES I FIND THAT MEDICARE HAS OVERPAID ME. WHAT DO I DO?

Certainly you should repay any overpayments. Often these can be handled administratively by contacting your intermediary or carrier. They may be able to offset against future payments or can deposit a check you provide them. If you believe fraud has been involved, you should alert the U.S. Department of Health and Human Services' Office of Inspector General. In order to learn about the OIG's Self Disclosure Protocol, please see the descriptive federal register publication at the following website: **www.hhs.gov/oig/oig reg/selfdisclosure.pdf.**

WHAT ARE THE BENEFITS OF IMPLEMENTING A COMPLIANCE PROGRAM?

Providers that implement a compliance program have taken a significant step toward assuring that they are not submitting false or inaccurate claims to Government and private payers. Compliance programs make good business sense since they may help a provider fulfill its fundamental mission of providing quality services as well as assisting in identifying weaknesses in internal systems and management.

DO THE VARIOUS COMPLIANCE PROGRAM GUIDANCES ISSUED BY THE OIG REPRESENT THE ULTIMATE COMPLIANCE PROGRAMS FOR SPECIFIC INDUSTRIES?

The Compliance Guidelines represent the OIG's suggestions for how an applicable provider can best establish internal controls and monitoring to correct and prevent fraudulent activities. By no means should the contents of the Guidances be viewed as an exclusive discussion of the advisable elements of a compliance program. There is no single "best" Compliance Program Guidance plan, given the diversity of providers within the health care industry. However, elements of the guidance plans can be used by all providers, regardless of size, location or corporate structure, to establish an effective compliance program. We recognize that some providers may not be able to adopt certain elements to the same comprehensive degree that others with more extensive resources may achieve.

HOW DOES HCFA MAKE SURE PROVIDERS, PHYSICIANS AND SUPPLIERS HAVE INPUT INTO MEDICARE RULES AND PROGRAM DECISIONS?

HCFA uses a variety of mechanisms to receive feedback from its partners. At the local level, contractors use contractor advisory committees, and interact often with local providers, physicians and suppliers on a wide range of matters. Contact your carrier or intermediary for information on how to become involved with an advisory committee.

HCFA regional offices meet regularly with state associations and partners, and participate in conferences. HCFA has formally convened advisory committees, such as the Practicing Physicians Advisory Council, to provide input and advice, and to react to HCFA policy and program decisions. Furthermore, proposed rules are issued in the Federal Register and the public has the opportunity to provide comments or suggestions to HCFA.

I HEARD THAT MIP CONTRACTORS GET BONUSES FOR DOLLARS COLLECTED. ISN'T THIS ANOTHER FORM OF BOUNTIES?

The MIP has a stable source of funding under HIPAA. It is not funded out of "savings" or monies recovered through program integrity efforts. All recovered monies are returned to the Medicare Trust Funds. Contractors do not receive bonuses for dollars they recover, nor are they paid on a bounty system.

WHAT IS A PAYMENT SUSPENSION? WHEN IS ONE IMPOSED AND FOR HOW LONG?

Payment suspension occurs when a contractor withholds an approved payment before the contractor has determined the full amount of the provider's overpayment. Payment may be suspended when the contractor has reliable information that an overpayment exists, the payment may not be correct, or fraud or willful misrepresentation exists. Payment may also be suspended when a provider fails to submit required documentation. The contractor must obtain prior approval from HCFA Regional Office before it can suspend payment.

Payment may be suspended for 180 days. In rare instances, a contractor may obtain approval from a Regional Office to suspend payment for an additional 180 days.

I UNDERSTAND HCFA IS USING DIFFERENT CONTRACTORS TO DO PROGRAM INTEGRITY ACTIVITIES. WHAT IS THIS ALL ABOUT?

HCFA is using its MIP authority to create new types of contractors. One kind is called Program Safeguard Contractors (PSCs). A PSC can take on some, all, or any sub-set of the work associated with the following payment safeguard functions: medical review, cost report audit, data analysis, provider education and fraud detection and prevention. In other words, PSCs are new contracting entities that will perform program safeguard activities in the Medicare program.

I WOULD LIKE TO LEARN MORE ABOUT THE EFFORTS OF LAW ENFORCEMENT IN FIGHTING FRAUD IN HEALTH CARE. WHERE CAN I GO TO GET MORE INFORMATION?

Information about the OIG can be found on its web site **www.hhs.gov/progorg/oig/.** Information about the DOJ can be found on its web site **www.usdoj.gov.** Information about the FBI can be found on its web site **www.fbi.gov**.

WHERE CAN I GO WITH QUESTIONS, OR TO GET MORE INFORMATION?

We are always interested in your thoughts on our efforts to strengthen and protect the Medicare program. Write us with any thoughts at the address on this pamphlet. You can also see much more information on our activities at the HCFA web site

(**http://www.hcfa.gov**). A list of regional offices and contractors is also available at that site.

We hope to hear from you....
Write to us at the address on the back cover if you have questions or comments.

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