Health Care Fraud and Program Integrity: An Overview for Providers

Presentation

Objectives

- Recognize at least two types of Medicaid fraud, waste, or abuse
- Identify two laws against Medicaid fraud and abuse
- Recall two steps that may be taken to prevent fraud, waste, and abuse
- Recognize two Medicaid anti-fraud measures taken by the government
- Recall where to report Medicaid fraud, waste, or abuse

Medicaid

The Medicaid program:

- Covers medical expenses for more than 70 million beneficiaries each year through 56 State and territory-administered programs
- Cost $547.7 billion in 2015
- Made improper payments of $29.12 billion in 2015

Improper Payments

- Divert resources away from necessary care
- May subject health care professionals to recoupment
- If the result of fraud or abuse, may also incur criminal penalties and other sanctions

Waste Defined

- Waste can be defined as overutilization, underutilization, or misuse of resources
- Waste typically is not an intentional act

Abuse Defined

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in:

- Unnecessary cost to the Medicaid program, or
- Payment for services that are:
  - Not medically necessary, or
  - Fail to meet professionally recognized health care standards

It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Fraud Defined

Fraud is:

- An intentional deception or misrepresentation
- Made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person

It includes any act that constitutes fraud under applicable Federal or State law.

Types of Fraud, Waste, and Abuse

Common types of health care fraud, waste, and abuse include:

- Medical identity theft
- Billing for unnecessary items or services
- Billing for items or services not provided
- Upcoding
- Unbundling
- Items or services not covered
- Kickbacks
- Beneficiary fraud

Medical Identity Theft

Medical identity theft involves:

- The appropriation or misuse of a patient's or provider's unique medical identifying information
- The use of identifying information
- Obtaining or billing public or private payers for medical goods or services that were not necessary, not authorized, or not delivered

Medical Identity Theft—Pharmacist

A pharmacist in Nebraska:

- Forged the names and credentials of providers and filed claims with the names of children of his customers
- For six years, billed for inhalers intended for cystic fibrosis patients; billed for drugs never dispensed, for patients who did not have the disease
- Was ordered to pay more than $14.4 million in restitution
- Was convicted on 18 counts of false claims and identification (ID) theft in September 2015 and sentenced to 110 months in prison

Medical Identity Theft—Durable Medical Equipment Company Owner

The owner of a Texas durable medical equipment (DME) company:

- Used recruiters to get beneficiary Medicare and Medicaid identities
- Submitted more than $11 million in fraudulent claims for power wheelchairs and other DME
- Admitted in court that 85 percent of their Medicare and Medicaid billings were false and fraudulent
- Was sentenced to 12 years in prison, and ordered to pay more than $6 million in restitution

Medical Identity Theft—Stolen Medicare Numbers

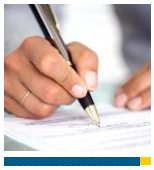
The ringleader of a Louisiana health care fraud scheme:

- Used recruiters to get Medicare identities
- Submitted fraudulent claims for unwanted or unneeded DME and orthotics
- Billed Medicare for more than $3.2 million
- Convicted in April 2016 on 18 counts of fraud, conspiracy, and paying kickbacks

Medical Identity Theft—Prevention

- Manage enrollment information with payers
- Monitor billing and compliance processes
- Control unique medical identifiers and prescription pads
- Educate and train staff
- Engage patients about the risks of medical identity theft

Authorization and Medical Necessity



Medicaid covers items and services:

- Authorized by the State Medicaid program
- Determined to be medically necessary

A health care professional's signature on a claim certifies the item or service is medically necessary and supported by documentation.

Unnecessary Services—Oncology and Hematology

A Michigan hematologist-oncologist:

- Gave patients false cancer diagnoses and subsequently provided unnecessary aggressive and invasive treatments to 553 patients
- Billed Medicare and private insurers approximately $34 million for these services
- Was found guilty of 13 counts of health care fraud, sentenced to 45 years in prison, and ordered to forfeit $17.6 million in restitution

Unnecessary Services—Physician

A Texas physician:

- Wrote unnecessary prescriptions for painkillers from 2010 to 2011
- Required office visits and diagnostic tests that were not medically necessary
- Caused Medicare and Medicaid to pay more than $865,000 for the cost of the prescriptions, office visits, and tests
- Pleaded guilty to conspiracy to commit health care fraud. He was sentenced to 4 years in Federal prison and was ordered to pay restitution

Services Not Provided—Personal Care

An Illinois personal care attendant:

- Signed false time records for care and forged the beneficiary's signature
- Billed a Medicaid waiver program for these services
- Received a 2-year sentence of probation with 4 months home confinement and was ordered to pay $6,660.75 in restitution

Services Not Provided—Behavioral Health Services Provider

A Nevada provider:

- Did not provide claimed substance abuse services to patients
- Submitted false documentation to his employer for Medicaid claims
- Pleaded guilty to failure to adequately document services, received a suspended 364-day sentence, had to perform 80 hours of community service, and was ordered to repay Nevada Medicaid $4,726

Services Not Provided—Family Practitioner

A North Carolina physician:

- "Added and padded" Medicare and Medicaid reimbursements
- Billed Medicare and Medicaid more than $450,000 for services not delivered
- Was sentenced to 18 months in prison, 1 year of supervised release, and was ordered to repay more than $210,000 to Medicare and Medicaid

Services Not Provided—Nursing Home

A Georgia nursing home owner:

- Received $32.9 million from Medicare and Medicaid
- Provided a near-starvation diet to residents and maintained unsanitary conditions
- Was sentenced to 20 years in prison

Items Not Provided—DME and Prescriptions

A Florida pharmacy provider:

- Billed Medicare and Medicaid for prescriptions never provided to patients and unnecessary enteral feeding supplies

A Nebraska DME provider:

- Billed Medicaid for nebulizer supplies never delivered

Falsifying Patient Records—DME Sales Reps

A Utah power wheelchair provider:

- Threatened sales representatives with disciplinary action and termination if they did not meet sales quotas
- Caused sales representatives to use computer software to modify paper medical records to justify medical necessity of power wheelchairs

The former owner/president was sentenced to 5 years in Federal prison, ordered to pay $4 million in restitution, and forfeited $776,001 he personally gained from the scheme. Three other sales representatives were also convicted.

Upcoding—Drugs, DME, and Home Visits

- A Florida physician ordered and administered less expensive drugs not approved by the U.S. Food and Drug Administration (FDA) and charged for FDA-approved drugs
- A Louisiana provider charged for more expensive back and knee braces than those that were provided
- An Illinois doctor upcoded home visits to the most extensive evaluations

Unbundling

Unbundling involves billing procedures separately rather than in a group. Examples include:

- Double billing and unbundling professional services included in the global code
- Billing separately for evaluation and management services on the same day as a related procedure
- Billing separately for each test in a comprehensive metabolic panel

Noncovered Services—Mammograms and Chemotherapy

A Maryland hospital and one of its oncologists:

- Allegedly falsified diagnoses to get Medicare and other Federal health care programs to pay for diagnostic mammograms
- Was ordered to pay $400,000 to settle allegations

Kickbacks Defined

A kickback is:

- Soliciting, offering, paying, or receiving remuneration (in kind or in cash) to induce or in return for:
  - Patient referrals, or
  - Generation of business involving any goods or services for which payment may be made under a Federal health care program

Kickbacks—DME Incentives

A Pennsylvania DME company:

- Promised DME suppliers free call center services if they exclusively supplied their sleep apnea masks to Medicare, Medicaid, and TRICARE beneficiaries
- Must pay $34.8 million to resolve the allegations

Kickbacks—Surgical Equipment Incentives

An American subsidiary of a Japanese multinational company:

- Offered improper incentives to buy surgical equipment
- Paid $306 million to settle allegations; New York Medicaid received $7.7 million of that settlement
- Entered into a mandatory corporate integrity agreement with the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG)

Kickbacks—Pharmacy

A home delivery pharmacy service in North Carolina:

- Gave gift cards and routinely waived copayments to promote referrals or enrollments of Medicare and Medicaid patients to receive their services
- Agreed to pay a settlement of $5 million for violation of the Anti-Kickback Statute

Knowledge Check

Common types of Medicaid provider fraud include:

A. Billing for unnecessary items or services
B. Billing for items or services not provided
C. Upcoding
D. All of the above

Beneficiary Fraud

Common forms of beneficiary fraud include:

- Eligibility fraud
- Card sharing
- Doctor shopping
- Drug diversion

Kickbacks— Drug Diversion

A Michigan pharmacy owner:

- Paid kickbacks to physicians to write prescriptions not medically necessary
- Dispensed controlled substances as kickbacks to patients and recruiters
- Billed Medicaid for prescriptions never filled
- Was found guilty of health care fraud and other offenses and was sentenced to 17 years in prison

Laws Against Health Care Fraud

- Health Care Fraud Statute
- False Claims Act
- Anti-Kickback Statute
- Patient Access and Medicare Protection Act
- Exclusion provisions of the Social Security Act
- Civil Monetary Penalties Law

Health Care Fraud Statute

The Health Care Fraud Statute:

- Prohibits knowingly and willfully executing a scheme to defraud a health care benefit program
- Punishes violations with up to 10 years in prison and up to $250,000 in fines
- Does not require proof of specific intent to violate the statute

False Claims Act

- Prohibits knowingly presenting a false or fraudulent claim to the government for payment
- Does not require proof that there was specific intent to violate the Act
- Punishes violations with:
  - Civil penalties of up to $11,000 per claim
  - Treble damages
  - Exclusion

False Claims Criminal Provisions

Persons who knowingly make a false claim may be criminally prosecuted.

Punishment may include:

- Fines up to $250,000
- Up to 5 years in prison

Referral Fees or Kickbacks Prohibited

The Anti-Kickback Statute prohibits giving or receiving anything of value in exchange for referrals that will lead to payment under a Federal health care program.

Criminal consequences include:

- Up to 5 years in prison
- Fines of up to $25,000

Kickbacks— Civil and Administrative Consequences

The civil and administrative consequences of kickback violations may include:

- Civil penalties up to $50,000 per violation
- Payment of three times the amount of remuneration
- Exclusion from Federal health care programs

Patient Access and Medicare Protection Act

The consequences of misappropriating a Medicare or Medicaid beneficiary's or health care provider's ID include:

- Up to 10 years in prison
- Up to a $500,000 fine for individuals
- Up to a $1,000,000 fine for corporations

Exclusion Provisions—Authority

Individuals and entities can be excluded from participation in Federal health care programs for reasons that include:

- Conviction of certain criminal offenses
- Loss of license due to professional competence or lack of financial integrity
- Participation in prohibited conduct

Exclusion Provisions—Effect

- Federal health care programs should not be billed for items or services furnished, ordered, or prescribed by an excluded individual or entity
- Payments for such items or services are considered overpayments that must be returned within 60 days of the date they are identified
- Failure to return these overpayments may lead to liability under the False Claims Act and the Civil Monetary Penalties Law

Screening For Exclusion

- Screen potential employees and contractors prior to hiring or contracting, and monthly
- Use the List of Excluded Individuals/Entities (LEIE) database https://exclusions.oig.hhs.gov/ or, System for Award Management Exclusions Extract https://www.sam.gov/
- Report any exclusion information discovered to the State immediately

Civil Monetary Penalties Law

The Civil Monetary Penalties Law gives HHS-OIG authority to impose civil penalties for certain prohibited acts, including but not limited to:

- Violations of the Anti-Kickback Statute and the exclusion provisions
- False claims
- False statements on applications or contracts for a Federal health care program

Knowledge Check

True or False?

Federal laws against health care fraud include:

- The Health Care Fraud Statute
- The False Claims Act
- The Anti-Kickback Statute

Prevention

Health care professionals can help prevent fraud, waste, and abuse by:

- Knowing the regulations and laws
- Screening potential and existing employees and contractors for exclusions
- Staying aware of current fraud schemes and educating employees
- Implementing a compliance program

Prevention—Compliance Program

HHS-OIG recommends a compliance program include:

1. Written standards and procedures
2. A compliance officer or contact(s) to monitor compliance
3. Training and education on standards and procedures
4. Open lines of communication
5. Well-publicized disciplinary standards
6. Internal monitoring and auditing
7. Prompt response to detected violations

Knowledge Check

True or False?

Steps health care professionals may take to prevent fraud, waste, and abuse include:

- Implementing written standards and procedures
- Conducting training and education on standards and procedures
- Developing open lines of communication
- Conducting internal monitoring and auditing

Recoveries and Prosecutions

In fiscal year 2015:

- The Federal government recovered more than $2.4 billion in health care fraud cases
- 613 defendants were convicted of health care fraud related crimes
  - 4,112 exclusions
- State Medicaid Fraud Control Units (MFCUs) reported:
  - 1,553 criminal convictions
  - 795 civil settlements and judgments
  - Recovered $744 million for the Medicaid program

Identification of Improper Medicaid Payments

- Payment Error Rate Measurement program
- Audit Medicaid Integrity Contractors
- Medicaid Recovery Audit Contractors

Anti-Fraud Efforts

Anti-fraud efforts undertaken or overseen by the Centers for Medicare & Medicaid Services' (CMS') Center for Program Integrity include:

- Tracking medical identity theft
- Offering identity theft remediation
- Using predictive modeling
- Screening providers at enrollment
- Suspending payments upon a credible allegation of fraud
- Terminating providers from Federal and State health care programs for cause

Screening Providers

Medicaid rules require screening providers for:

- Current licensure
- Exclusion
- Termination for cause

If a provider has previously been excluded, terminated, or suspended from Federal and State health care programs, the provider may also be subject to:

- A criminal background check
- Fingerprinting

Suspension of Payments

States are required to suspend Medicaid payments to providers when there is:

- A credible allegation of fraud
- A pending investigation

Reciprocal Termination

States must terminate a provider from Medicaid if the provider has been terminated for cause by:

- Another State's Medicaid program
- Another State's Children's Health Insurance Program (CHIP), or
- Medicare

For cause means for reasons of:

- Fraud
- Integrity
- Quality

Knowledge Check

Anti-fraud measures taken by the government include:

A. Tracking medical identity theft and screening providers at enrollment

B. Tracking medical identity theft and suspending payments upon a credible allegation of fraud

C. Screening providers at enrollment and issuing Medicaid ID cards that show any violations

D. Both a and b

How to Report Fraud, Waste, or Abuse

Health care professionals should report suspect provider practices to:

- Their SMA
- Their Medicaid Fraud Control Unit (MFCU)
  - Contact information for SMAs and MFCUs is posted to https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/report_fraud_and_suspected_fraud.html on the CMS website
- HHS-OIG
  - 1-800-HHS-TIPS
  - https://forms.oig.hhs.gov/hotlineoperations/

Knowledge Check

True or False?

A health care professional can report suspected Medicaid fraud, waste, or abuse to:

- Their SMA
- Their MFCU
- HHS-OIG

Correcting Fraud, Waste, and Abuse

Actions to correct fraud, waste, and abuse include:

- Education letters and warnings
- Discipline, from suspension to termination
- Training
- Revising policies or procedures
- Adopting new edits

Conclusion

By following program rules, taking reasonable preventive measures, and recognizing and reporting suspected fraud, waste, and abuse, health care professionals:

- Protect their practices
- Protect beneficiaries from harm
- Help preserve the solvency of the Medicaid program

Questions

Please direct questions or requests to:
MedicaidProviderEducation@cms.hhs.gov

To see the electronic version of this presentation and the other products included in the "Fraud, Waste, and Abuse" Toolkit posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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