Fraud, Waste, and Abuse
WBT Course
(Annual Review Required)

The Medicare Fraud and Abuse Web-Based Training Course is brought to you by the Centers for Medicare & Medicaid Services' Medicare Learning Network.

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Welcome to the Medicare Fraud and Abuse Web-Based Training (WBT) Course.

An estimated 10 percent of Medicare costs are wrongly spent on incidences of fraud and abuse. Medicare and the Federal government are aggressively dealing with these issues and ask for help from all health care providers and suppliers in identifying, reporting and preventing inappropriate activities.

The Centers for Medicare & Medicaid Services (CMS) emphasizes early detection and prevention of fraud and abuse. Together with CMS, providers can help identify and prevent fraud and abuse.

The first step for providers to protect themselves against Medicare fraud and abuse is to understand the legal definitions of these two terms and be able to identify fraudulent and abusive practices.

The information found in this course is helpful for physicians, medical administrators, billing staff and other health care professionals involved in providing and billing for services to people with Medicare. This course provides information that will increase your awareness of Medicare fraud and abuse, assist you in educating your staff about correct billing practices, and help you file claims properly.

CMS created this web-based training to:

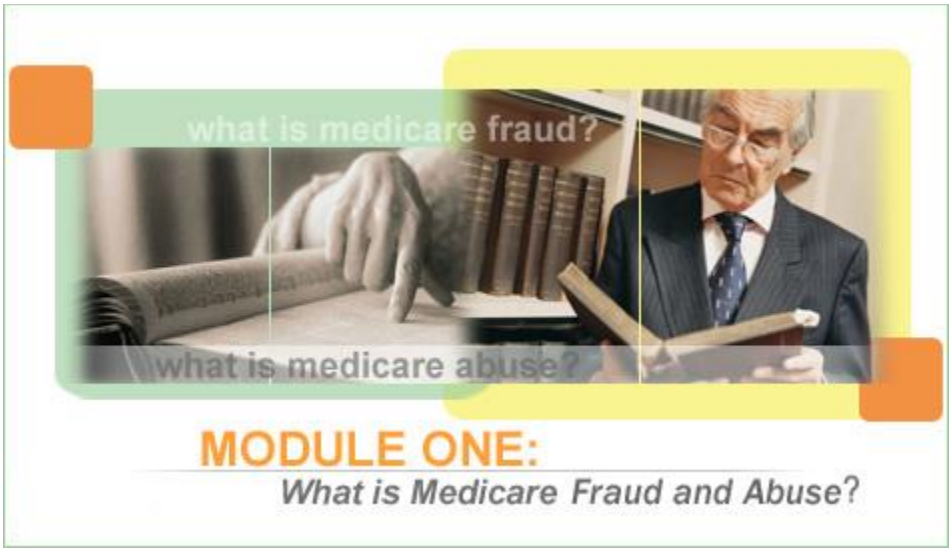
- Enhance providers' understanding of what constitutes Medicare fraud and abuse.
- Help providers understand their role in the effort to prevent fraud and abuse.
- Explain the possible penalties when fraud or abuse is committed.
- Provide guidance on protective measures providers can implement to avoid fraud and abuse in several key areas of their organizations.

The information is divided into the following modules:

- **Module 1** defines fraud and abuse and provides examples of each to better educate the health care community.
- **Module 2** explains the various actions that can be taken against health care providers found to be defrauding or abusing the Medicare Program and its beneficiaries.
- **Module 3** describes how fraud is investigated and situations where providers may encounter payment denials or suspensions.
- **Module 4** discusses additional programs and laws put in place to protect Medicare from fraud and abuse.

This Web-Based Training (WBT) course contains information about the Medicare Trust Fund and how it is protected from Medicare fraud and abuse. This WBT is divided into four modules which cover Medicare fraud and abuse on many levels, such as defining fraud and abuse,

describing the prevention of fraud and abuse, and discussing the administrative and legal responses to fraud and abuse.



This module provides a detailed explanation about Medicare fraud and abuse and discusses the differences between fraud and abuse. To better understand these differences, examples have been provided of different cases where health care fraud and abuse are identified under different types of circumstances. As some cases are unintentional, a provider must first understand the differences, then know what to look for within their organization to ensure fraud and abuse is not evident, and train their staff in order to avoid harsh penalties.

Resources

The following resources are available for additional information about Medicare fraud and abuse:

Chapter 6, "Protecting the Medicare Trust Fund" from the Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals, can be downloaded at http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf on the CMS website. This publication can be printed or can be ordered in hard copy from the CMS website. To order a hard copy of this publication please visit the MLN Products web page http://www.cms.hhs.gov/MLNProducts on the CMS website. Click on "MLN Product Ordering Page" from the Related Links Inside CMS section and follow the ordering procedures.

Please refer to CMS' Medicare Fraud and Abuse fact sheet which can be downloaded at http://www.cms.hhs.gov/MLNProducts/downloads/Fraud and Abuse.pdf on the CMS website.

- **Module 1: What is Medicare Fraud and Abuse?**
  Upon completion of this Module you should be able to correctly:
  - Identify Medicare fraud
  - Recognize instances of Medicare fraud

Learning Objectives

- Identify Medicare abuse
- Recognize instances of Medicare abuse

Billions of dollars are billed to the Medicare Program each year, making it vulnerable to fraud and abuse. While most providers are honest and make every effort to adhere to Medicare Program guidelines, there are instances of dishonesty. First, it is important to understand the differences between Medicare fraud and Medicare abuse and then to look for these instances within your organization.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) included a provision that established the Medicare Integrity Program (MIP). The goal of the Medicare Integrity Program is to pay it right - pay the right amount, to the right provider or supplier, for the right service, to the right beneficiary.

To further this goal, the Centers for Medicare & Medicaid Services (CMS) staff and Medicare Contractors work within a wide range of Medicare Program areas to improve payment accuracy. These programs include cost report auditing, the Medicare Secondary Payment (MSP) provisions, Medical Review (MR), the Recovery Audit Contractors (RACs) efforts, and anti-fraud activities to improve payment accuracy.

Most billing errors that providers make are not attempts to knowingly, willfully, or intentionally commit fraud. 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 an appropriate plan of correction.

In rare situations, if 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 cost report auditing, fraud investigation, data analysis, and medical review (MR) to detect potential payment errors. The results of data analysis indicate 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".

To best reduce payment errors, and best protect and strengthen the Medicare Trust Fund, CMS follows four parallel strategies:

- Preventing fraud through effective enrollment and through education of physicians, providers, suppliers, and beneficiaries.
- Early detection through Medical Review (MR) and data analysis.
- Close coordination with partners, including Program Safeguard Contractors (PSCs), Zone Program Integrity Contractors (ZPICs), Affiliated Contractors (ACs), Medicare

Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and law enforcement agencies.
- Applying fair and firm enforcement policies.

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

- Centers for Medicare & Medicaid Services;
- 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 (HHS), the Federal Bureau of Investigation (FBI), the Department of Justice (DOJ) , and State Medicaid Fraud Control Units (MFCUs).

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 individual.

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 individual in a position to file a claim for Medicare benefits or cause a claim to be filed for Medicare benefits.

Fraud schemes range from those perpetrated by individuals acting alone to broad-based activities by institutions or groups of individuals. Sometimes these activities employ 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 the public or private sector exclusively. Rather, most are simultaneously defrauding several private and public sector victims, including Medicare.

Health care fraud is defined in Title 18, United States Code (U.S.C.) § 1347, as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

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.

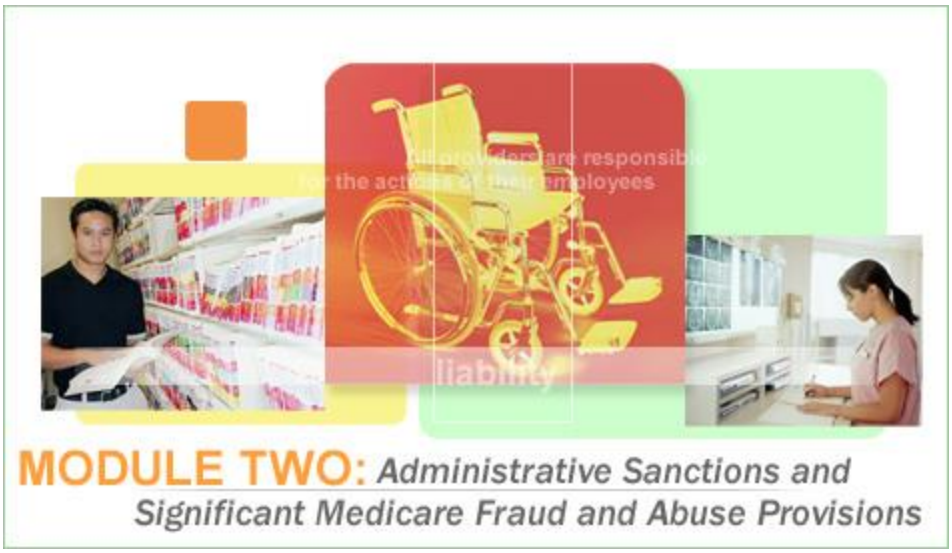
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Unbundling or “exploding” charges.
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider or supplier.

- Billing based on "gang visits" such as a physician visiting a nursing home and billing 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.
- Using another individual's Medicare Health Insurance card to obtain medical care.
- Billing or causing to be billed to the Medicare Program by an excluded provider for the furnishing of items or services after exclusion.

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 of admission or treatment 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.
- Allocation of costs to related organizations that have been determined to be improper.

Abuse describes practices that either directly or indirectly result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.



This module provides a detailed explanation of the potential actions and administrative sanctions which may be applied by CMS and other appropriate bodies, in response to fraudulent and/or abusive behavior.

Possible administrative sanctions that may be taken if CMS determines the existence of inappropriate and/or fraudulent behavior include:

- Denial or revocation of Medicare billing privileges.
- Suspension of provider payments.
- Application of Civil Monetary Penalties (CMPs).

This module also covers the following significant Medicare fraud and abuse provisions:

- False Statements and Kickbacks, Bribes, and Rebates;
- Anti-Kickback Statute; and
- Physician Self-Referral ("Stark") Statute.

Module 2: Administrative Sanctions and Significant Medicare Fraud and Abuse Provisions
Upon completion of this Module you should be able to correctly:

Learning Objectives

- Recognize types of administrative sanctions applied by CMS
- Identify denial or revocation of Medicare billing privileges
- Recognize the application of Civil Monetary Penalties
- Recognize a number of Medicare Fraud and Abuse Provisions

CMS has the authority to deny or revoke Medicare billing privileges if there is evidence of false or misleading information on the application, the applicant or enrolled provider or supplier does not meet or continue to meet program requirements such as licensing, or an owner or practitioner is convicted of a felony.

If changes have occurred to information on original applications for Medicare enrollment, individual providers or organizations must notify the applicable Medicare Contractor or State agency. Examples of such changes may include an 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.

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. 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. Appeal rights are available for the processed claims. However, during the period of suspension, Medicare withholds the actual payment(s) for the claims. The withheld payment(s) may be used to reduce or eliminate any overpayments identified by Medicare, and then to reduce any other obligation to Medicare or the U.S. Department of Health & Human Services (HHS).

There are no appeal rights to the decision to suspend payments. 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.

Title XI, Section 1128A of the Social Security Act authorizes the imposition of Civil Monetary Penalties when Medicare or the Office of Inspector General (OIG) determines that an individual or entity has violated Medicare rules and regulations. CMS maintains responsibility for implementing CMPs that involve program compliance, whereas the OIG maintains responsibility for implementing CMPs that involve threats to the integrity of the Medicare Program (such as fraud or false representation).

The following are some examples of violations for which CMPs and additional assessments may be imposed (and in some instances exclusion from the Medicare Program may apply):

- Violation of the Medicare assignment provisions.
- Violation of the Medicare physician, provider, 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 Durable Medical Equipment (DME) supplies without charge after rental payments may no longer be made.
- Hospital unbundling of outpatient surgery costs.
- Hospital/responsible physician "dumping" of patients based upon their inability to pay or lack of resources.
- Improper remuneration, such as kickbacks.
- False or fraudulent claims for items or services including incorrect coding or medically unnecessary services.
- Claims presented by an excluded provider.

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.

False Statements and Kickbacks, Bribes, and Rebates

Under 42 U.S.C. §1320a-7b(a), if an individual or entity is determined to have engaged in any of the following activities, he or she shall be guilty of a felony and upon conviction shall be fined a maximum of $25,000 per violation or imprisoned for up to five years per violation, or both:

- Purposefully involved in supplying false information on an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment.
- Knows about, but does not disclose, any event affecting the right to receive a benefit.
- Knowingly submitting a claim for physician services that were not rendered by a physician.
- Supplies items or services and asks for, offers, or receives a kickback, bribe, or rebate.

Anti-Kickback Statute

The Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b), prohibits offering, soliciting, paying, or receiving remuneration for referrals for services that are paid in whole or in part by the Medicare Program. In addition, the statute prohibits offering, soliciting, paying, or receiving remuneration in return for purchasing, leasing, ordering, arranging for, or recommending the purchase, lease, or order of any goods, facility, item, or service for which payment may be made in whole or part by the Medicare Program.

An arrangement will be deemed to not violate the Anti-Kickback Statute if it fully complies with the terms of a safe harbor issued by the OIG. Arrangements that do not fit within a safe harbor and thus do not qualify for automatic protection may or may not violate the Anti-Kickback Statute, depending on their facts.

Physician Self-Referral ("Stark") Statute

The Stark Statute, 42 U.S.C. §1395nn, prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Exceptions to the prohibition on self referrals can be found in the Code of Federal Regulations (CFR) at 42 CFR 411.355-357. To access the Code of Federal Regulations, visit http://www.gpoaccess.gov/cfr/index.html on the Web.

Designated health services in which self-referral is prohibited include the following:

- Clinical laboratory services;
- Physical therapy services;
- Occupational therapy services;
- Speech-language pathology services;
- Radiology and certain other imaging services such as magnetic resonance imaging and ultrasound;
- Radiation therapy services and supplies;
- DME and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services and supplies;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

visit http://www.gpoaccess.gov/cfr/index.html on the Web.

Examples of Civil Monetary Penalties (CMPs) Based on False and Fraudulent Claims

The following examples describe CMPs that were assessed based on false and fraudulent claims:

- November 2008 - After it self-disclosed conduct to the OIG, a city in Illinois, agreed to pay $6.9 million for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that the city submitted claims to Medicare for ambulance services that were not medically necessary, billed at the wrong level of service, and submitted claims without the patient's or other appropriate person's signature as required by CMS regulations.

- June 2008 - After it self-disclosed conduct to the OIG, three Arkansas health care providers, agreed to pay $1,142,973 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that the respondents billed Medicare for medically unnecessary hospital services.

- November 2007 - After it self-disclosed conduct to the OIG, a Texas home care company agreed to pay $54,115 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that certain employees of the company altered information on Certificates of Medical Necessity (CMNs) that were used to support claims to the Medicare Program by adding information that a patient's physician had failed to provide or adding physician signatures to unsigned CMNs.

Examples of Civil Monetary Penalties Based on Kickback and Physician Self-Referrals

The following examples describes CMPs that were assessed based on kickback and physician self-referrals:

- August 2008 - After it self-disclosed conduct to the OIG, a Wyoming hospital agreed to pay $635,000 for allegedly violating the Civil Monetary Penalties Law provisions applicable to kickbacks. The OIG alleged that the hospital paid prohibited remuneration to physicians in the form of free rent, equipment and furnishings, leases at less-than-fair-market value, reimbursement for medical-director services in excess of fair-market value, and reimbursement in excess of the requirements of an income-guarantee agreement.

- November 2008 – A Minnesota hospital agreed to pay $350,000 for allegedly violating the Civil Monetary Penalties Law provisions applicable to physician self-referrals. The OIG alleged that the hospital made physician salary guarantee payments to three orthopedic specialists without entering into written physician recruitment agreements with the recruited physicians.

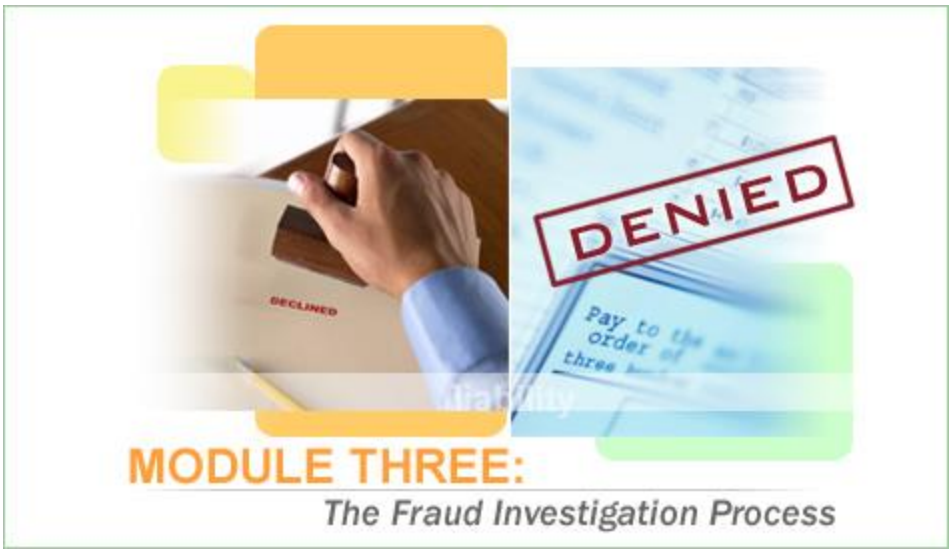
The following items describe criminal actions based on false and fraudulent claims:

- December 2008 - A Miami physician and nurse were sentenced to 30 years and seven years in prison, respectively, and ordered to pay $8,289,286 in restitution in connection with their roles in an $11 million HIV infusion fraud scheme. Evidence established that HIV positive Medicare patients were brought to the clinic for the purpose of receiving cash payments in exchange for allowing the clinic to bill for unnecessary treatments. The patients were paid cash kickbacks of approximately $150 per visit. After patients had been paid, they agreed to allow the physician to prescribe unnecessary infusion treatments. The clinic then billed Medicare for approximately $11 million for the unnecessary services during that five-month period. For those claims, Medicare paid more than $8 million to the clinic.

- December 2008 - A registered nurse was sentenced in federal court to 18 months in prison and to pay $600,000 in restitution for making false statements in connection with a health care fraud matter. The nurse operated a business that provided consulting services to skilled nursing facilities (SNFs) in Alabama and other states. From approximately January 2002 until approximately December 2006, she intentionally created documents which she knew were false and would mislead Medicare's fiscal intermediaries into believing that physicians working with her consulting business were performing a larger portion of the Utilization Review (UR) services despite her knowledge that the physicians did not do so. The nurse knew that the SNFs would use these false statements to submit cost reports to Medicare fiscal intermediaries containing false information regarding the UR services.

- A Texas man was sentenced to 70 months imprisonment and ordered to pay $3,217,579 in restitution for his role in a scheme to defraud Medicare involving motorized wheelchairs. The man owned and operated a durable medical equipment supply company

which would bill Medicare for motorized wheelchairs, often called K0011 wheelchairs, but would routinely provide Medicare beneficiaries with a less expensive item know as a scooter. In 2002-2003, the reimbursement rate for a motorized wheelchair was approximately $4,200, while the less expensive scooters that were actually delivered were reimbursed at approximately $1,600. During the time period of the fraudulent scheme, the company was paid more than $1.4 million by Medicare, primarily for motorized wheelchairs and related accessories. In addition the man had participated in similar fraudulent schemes with two other local wheelchair supply companies by assisting others in establishing those businesses and sharing in the fraudulent proceeds they generated. In total, the companies with which he was affiliated received more than $3 million in payments from Medicare for fraudulent motorized wheelchair claims.



This module describes how fraud committed against the Medicare Program is investigated and prosecuted under provisions of the United States Code. The fraud investigation process is a cooperative effort between Medicare providers and a number of governmental organizations. Criminal prosecutions and penalties, and/or civil prosecutions and penalties may be applied when willful and intentional acts of wrongdoing are discovered. Denial of payments and exclusion from the Medicare Program are penalties which may be applied based on fraudulent practices.

Module 3: The Fraud Investigation Process

Upon completion of this Module you should be able to correctly:

Learning Objectives

- Recognize the purpose of the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- Identify potential elements of criminal prosecutions and penalties and civil prosecutions and penalties
- Differentiate between mandatory and permissive exclusions

Fraud committed against the Medicare Program may be prosecuted under various provisions of United States Code and could result in the imposition of restitution, fines, and possibly imprisonment. In addition, there is also a range of administrative sanctions, including Civil Monetary Penalties (CMPs), 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 providers fairly when making decisions that will affect them or their organizations.

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

- Centers for Medicare & Medicaid Services;
- Medicare beneficiaries;
- Medicare Contractors;
- Physicians, suppliers, and other providers;
- Quality Improvement Organizations (QIOs); and
- Federal and State law enforcement agencies such as the Office of Inspector General (OIG) of the Department of Health & Human Services (HHS), the Federal Bureau of Investigation (FBI), the Department of Justice (DOJ) and State Medicaid Fraud Control Units (MFCUs).

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. Additionally, the high monetary amount billed to the Medicare Program makes it vulnerable to individuals who may inappropriately administer medical and health care 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 medically reasonable and necessary high quality services.

Beneficiaries, physicians, suppliers, and other providers can and should report instances of suspected or potential fraud to Medicare. CMS and other agencies have a responsibility to perform the following tasks:

- 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 CMPs or other administrative sanctions (e.g., exclusion from participation in the program).

Investigation and prosecution of health care 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.

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.

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 typically include restitution and significant fines. In some states, providers and health care organizations may also lose their licenses. Convictions may also result in exclusion from Medicare participation for a specified length of time.

The Federal government uses civil prosecutions against offenses that are committed with the actual knowledge of the falseness of the claim, with reckless disregard, or with deliberate ignorance of the truth or the falseness of the claim. Another major civil remedy available to the Federal government is the Civil Monetary Penalties Law, which has the same standard of proof as the Civil False Claims Act.

The Inspector General has the exclusive authority to settle any issues or case, without the consent of the Administrative Law Judge (ALJ). Depending on the severity of the issue or case, the civil suit or settlement may include the following:

- Civil Monetary Penalty (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).
- 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.
- Imposition of a "Corporate Integrity Agreement" with the Federal government, whereby 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 Office of Inspector General (OIG) has the authority to exclude (sanction) providers or suppliers who have engaged in certain forms of program abuse and quality of care issues. The term "exclusion" means that, for a designated period, Medicare, Medicaid, and other Federal health care programs will not pay the provider for services performed or for services ordered by the excluded party.

In addition, under Title XI, Section 1128A [42 U.S.C 1320a-7a] of the Social Security Act, many of the penalties imposed under this section may be imposed in conjunction with 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 Department of Health and Human Services (HHS).

Title XI, Section 1128 [42 U.S.C 1320a-7] of the Social Security Act also describes the mandatory and permissive exclusions discussed in the following sections

Mandatory Exclusions

Mandatory exclusions are imposed for a minimum period of five years, although aggravating factors may result in imposition of a lengthier exclusion.

Exclusions are mandated for individuals and entities who:

- Have been convicted of any type of program-related violation;
- Have been convicted of an offense related to patient abuse or neglect;
- Have felony convictions related to other health care programs; or
- Have felony convictions related to certain types of controlled substance offenses.

Permissive Exclusions

The OIG may impose permissive exclusions on individuals and entities who have misdemeanor convictions that are related to:

- Health care fraud;
- Obstruction of an investigation; and
- Certain types of controlled substance offenses.

These permissive exclusions typically have a benchmark period duration of three years, although aggravating or mitigating factors may result in imposition of lengthier or shorter exclusions.

Other permissive exclusions are based on determinations made by other agencies such as licensing boards, Federal or State health care programs, and/or recommendations from payer agencies. The period of exclusion in most of these actions varies and is subject to the discretion of the OIG.

Payment Denials Due to Exclusion

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

or referral of an excluded individual or entity. An excluded party that submits claims for items or services furnished during the exclusion period is subject to Civil Monetary Penalty (CMP) liability under Title XI, Section 1128A(a)(1)(D) of the Social Security Act, in addition to denial of reinstatement to the Medicare Program.

Denial of Payment to a Supplier

Medicare will not pay for any items or services that an excluded party furnishes, orders, or prescribes. This payment prohibition applies to the excluded party and anyone who employs or contracts with the excluded party. 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 Place 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 exclusion

Denial of Payments 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 exclusion:

- Medicare may pay for the first claim submitted by the beneficiary and will immediately give the beneficiary notice of the exclusion.
- Medicare will not pay the beneficiary for items or services furnished more than 15 days after the date of the notice to the beneficiary or after the effective date of the exclusion, whichever is later.
- Medicare may pay for certain emergency items or services furnished by an excluded party under the medical direction, or on the request of an excluded party during the period of exclusion. The claim for emergency services must be accompanied by a sworn statement of the individual furnishing the items or services specifying the nature of the emergency and the reason that items or services were not furnished by an eligible party.
- Medicare will not pay claims for emergency items or services if items or services were provided by an excluded party, who, through employment or contractual arrangement, routinely provides emergency health care items or services.

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 for items furnished to a beneficiary who was admitted to a hospital or SNF before the effective date of the exclusion.
- Home health services or items furnished under a plan of treatment established before the effective date of the exclusion.

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

Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)

The OIG List of Excluded Individuals/Entities identifies individuals and entities that are excluded from Medicare reimbursement. The list includes the provider's specialty, type of sanction, notice date, and the end of the sanction period.

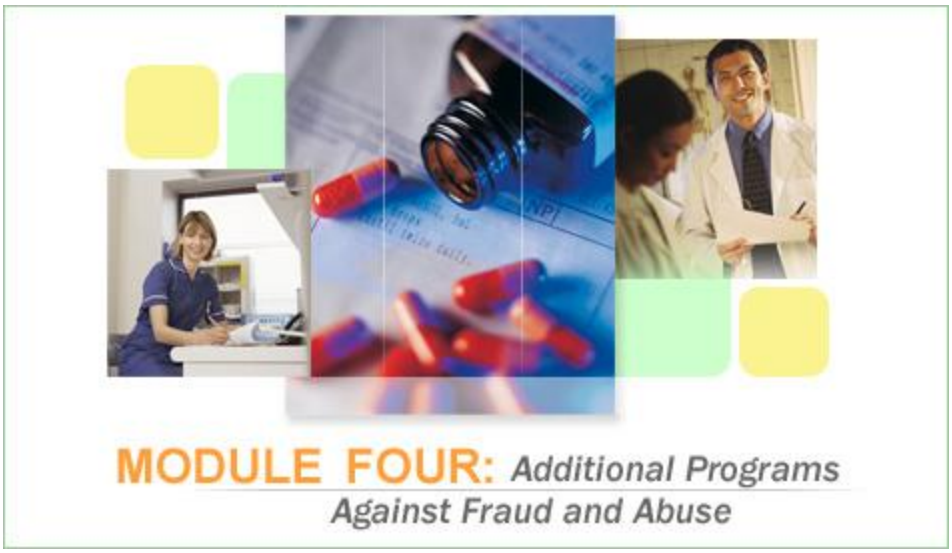
General Services Administration (GSA) Excluded Parties Listing System (EPLS)

In addition to the OIG LEIE exclusions database, the EPLS website, maintained by GSA, contains exclusion actions taken by various Federal agencies. The EPLS website assists Medicare and Medicaid Contractors in verifying the eligibility of health care providers or entities seeking to participate in the Medicare and Medicaid Programs. The GSA debarment, exclusion, and suspension lists for all Federal agencies are available at http://www.epls.gov on the Web.

CMS encourages individuals and entities to research the information on this website before:

- Adding a provider to a physician group or medical staff;
- Purchasing supplies; or
- Considering involvement in a medical facility or other entity that may seek payment from Medicare.

You have now completed Module 3: The Fraud Investigation Process.



There are a number of programs and tools which State and Federal authorities can use in their efforts to discover and prevent fraud and abuse. Medical Review (MR) identifies and addresses billing errors through data analysis. The Probe Review is a review process which validates claims errors through examination of claims. The Medicare Incentive Reward Program (IRP) encourages the reporting of fraud by offering a financial incentive for notifying authorities about illegal activities. National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) are issued to encourage providers and suppliers to code claims correctly.

Module 4: Additional Programs Against Fraud and Abuse

Upon completion of this Module you should be able to correctly:

Learning Objectives

- Recognize the goal of the Medical Review Program
- Identify the three basic components of data analysis
- Identify the Medicare Incentive Reward Program
- Identify the purpose of National Coverage Determinations and Local Coverage Determinations

The goal of the MR Program is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. To achieve the goal of the MR Program, contractors proactively identify potential billing errors concerning coverage and coding made by providers through analysis of data such as profiling of providers, services, and/or beneficiary utilization and evaluation of other information such as complaints, enrollment, and/or cost report data.

Submission of medical records is required when requested for prepayment reviews, postpayment reviews, and probe reviews. A review of the medical records confirms that the services furnished are reflected on the claim, coded correctly, and covered by Medicare. If medical records are requested, they must be submitted within the specified timeframe or the claim will be denied. In

some instances, claim attachments, such as Certificates of Medical Necessity and patient history files, will be reviewed.

The MR process includes reviewing claims appropriately submitted to Medicare Contractors to identify atypical billing patterns or particular kinds of problems such as errors in billing a specific type of service.

The focus of the MR Program is to reduce the error rate through medical review and provider notification and feedback, whereas, medical review for Benefit Integrity (BI) purposes focuses on addressing potential fraud, waste, and abuse.

Importance is placed on ensuring that MR activities are targeted at identified problem areas that place the Medicare Trust Fund at the greatest risk. Once corrective actions are imposed, the corrective action must be appropriate for the severity of the problem through Progressive Corrective Actions.

Providers with identified problems submitting correct claims may be subject to three types of corrective actions:

- **Education** about appropriate billing procedures.
- **Prepayment review** occurs before payment of the claim can be authorized.
- **Postpayment review** occurs when a Contractor makes a coverage or coding determination after the claim has been paid.

The probe review is used to validate claims errors. Providers are notified when probe reviews are conducted and asked to provide medical documentation for the claim(s) in question. Once the results of the probe review are determined, providers are notified of those results.

Probe reviews can either:

- Examine 20 - 40 claims per provider for provider-specific problems.
- Examine approximately 100 claims from multiple providers for widespread, larger problems such as a spike in billing for a specific procedure

When a probe review verifies that an error exists, the following occurs:

- The severity of the problem is classified as minor, moderate, or significant which is determined by the provider-specific error rate -- which is the number of claims paid in error, dollar amounts improperly paid, and past billing history.
- Overpayments are collected if the probe was conducted on a postpayment basis.
- A determination is made as to what steps need to be taken to correct the problem.

Providers can provide medical record documentation that assists the MR process by ensuring that:

- Documentation is provided, when requested, for every service selected for MR.

- Documentation demonstrates that the patient's condition warrants the type and amount of services furnished.
- Documentation is legible.
- Each service is coded and billed correctly.

Providers can assist in the MR process by:

- Becoming familiar with coverage requirements.
- Ensuring that office staff and billing vendors are familiar with claim filing rules.
- Comparing records and billed claims.
- Creating a patient educational awareness campaign that explains Medicare coverage limitations and medical necessity requirements.
- Performing mock record audits to ensure that documentation reflects requirements outlined in Medicare coverage policies.

Data analysis is an integrated, on-going component of MR and BI activities and involves collecting and analyzing data.

The three basic components of data analysis are:

- Collecting data;
- Identifying potential errors; and
- Ongoing monitoring and modification of data analysis components.

Initially, historical data and referral data are collected. The **historical data** encompasses review experience, denial data, provider billing problems, provider cost report data, provider statistical and reimbursement data, billing data, Common Working File (CWF) data, and data from other Federal sources such as Quality Improvement Organizations (QIOs), Medicare Contractors including the Comprehensive Error Rate Testing (CERT) contractor, and Medicaid. The **referral data** comes from both internal and external sources such as provider audits, the Program Safeguard Contractor (PSC), beneficiary complaints, and other complaints.

After the collection of data, the information is used to identify provider billing practices and services that pose the greatest financial risk to the Medicare Program. Ongoing monitoring and modification of data analysis program components are also instituted as a part of the data analysis process.

Overpayments are Medicare funds a provider or beneficiary has received in excess of the amount due and payable under the Medicare statutes and regulations. Once it has been determined that 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 mistake is made by CMS.

Providers are responsible for making voluntary refunds to Medicare when overpayments are identified. Additionally, providers are responsible for timely repayment when Medicare notifies

them of an overpayment. If a timely repayment is not made after proper notice, interest will accrue on the outstanding balance at an annual rate specified by law. Finally, penalties may be imposed on overpaid monies, depending on the circumstances involved in the case. These overpayments often require the refund of coinsurance payments made by or on behalf of beneficiaries.

In an effort to identify improper Medicare payments and fight fraud, waste, and abuse in the Medicare program, CMS has implemented the Recovery Audit Contractor (RAC) program designed to guard the Medicare Trust Fund. The goal of the RACs is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. Improper payments may be overpayments or underpayments.

Implementing a compliance program can assist in establishing an environment that promotes prevention, detection, and resolution of conduct that does not conform to legal, ethical, or program requirements. Although compliance programs are strictly voluntary, adopting one may be beneficial to providers, suppliers, and other health care entities.

The adoption and implementation of a compliance program significantly reduces the risk of fraud, abuse, and waste in the health care setting while providing quality services and care to patients.

The Office of Inspector General has identified seven fundamental elements of an effective compliance program:

1. Implementing written policies, procedures, and standards of conduct;
2. Designating a compliance officer and compliance committee;
3. Conducting effective training and education;
4. Developing and maintaining effective lines of communication;
5. Enforcing standards through well-publicized disciplinary guidelines;
6. Conducting internal monitoring and auditing; and
7. Responding promptly to detected offenses and developing a corrective action plan.

Section 203(b)(1) of HIPAA (Public Law 104-191) established the Medicare IRP to encourage others to report information on individuals and entities that are engaged in or have engaged in illegal acts or omissions, or who have otherwise engaged in sanctionable fraud and abuse against the Medicare Program.

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 PSC or Zone Program Integrity Contractor (ZPIC) BI units to OIG, made pursuant to the criteria set forth in Chapter 4, Section 4.19, of the Medicare Program Integrity Manual are considered sanctionable for the purpose of the Medicare IRP.

Additional information regarding the Medicare IRP is available in the Medicare Program Integrity Manual, Section 4.9, at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS website. Search for publication #100-08.

PSC and ZPIC BI Units Responsibility

The PSC and ZPIC BI units 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 PSC and ZPIC BI unit have documented allegations including, but not limited to, when a provider, beneficiary, supplier, or other subject has done any of the following:

- Intentionally engaged in improper billing.
- Submitted improper claims with actual knowledge of their falsity.
- 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 percent 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.

To ask questions about fraud and abuse or to report suspected fraudulent or abusive activities, providers are encouraged to contact their Medicare Contractor or to call HHS/OIG directly at 1-800-HHS-TIPS (1-800-447-8477). TTY/TDD users should call 1-800-377-4950.

There are two types of coverage policies that assist providers and suppliers in coding correctly and billing Medicare only for items and services that are covered.

The two policies are:

- National Coverage Determinations (NCDs); and
- Local Coverage Determinations (LCDs).

NCDs set forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare Contractors are required to follow NCDs. Prior to an NCD taking effect, CMS must first issue a Manual Transmittal, ruling, or Federal Register Notice. If an NCD and an LCD exist concurrently regarding the same coverage policy, the NCD takes precedence.

Requesting an NCD is a formal process outlined in the September 26, 2003, Federal Register Notice and in several subsequent guidance documents. Those wishing to request an NCD (e.g., industry, beneficiaries, or others who may be unfamiliar with the process) are encouraged to contact CMS informally prior to the formal request to learn more about the process. Informal and formal requests may be submitted through the

http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=6 websiteor e-mailed to cms_caginquiries@cms.hhs.gov.

Formal requests for NCDs may also be submitted to:

Centers for Medicare & Medicaid Services
Director, Coverage and Analysis Group
7500 Security Boulevard
Baltimore, MD 21244

When formal requests are accepted and posted, the public may submit evidence or other comments relevant to the request at http://www.cms.hhs.gov/center/coverage.asp on the CMS website for a period of 30 days in accordance with §522(b) of the Benefits Improvement and Protection Act of 2000.

Drafts of proposed decisions are posted at http://www.cms.hhs.gov/center/coverage.asp on the CMS website, at which time the public may comment for a period of 30 days. Comments are reviewed and a final decision memorandum, which includes a summary and responses to public comments, is issued no later than 60 days after the conclusion of the comment period.

In the absence of a specific NCD, local Medicare Contractors may issue LCDs, which replaced Local Medical Review Policies (LMRPs) in 2003. The difference between LMRPs and LCDs is that LCDs consist only of "reasonable and necessary" information, while LMRPs could also contain category or statutory provisions.

LCDs are coverage decisions made at the discretion of the Medicare Contractor to provide guidance to the public and the medical community within a specified geographic area. LCDs outline coverage criteria, define medical necessity, provide codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity, and provide references upon which a policy is based. CMS reviews LCDs to ensure that they do not conflict with NCDs. Providers and suppliers may submit requests for new or revised LCDs to Medicare Contractors.

The LCD development process is open to the public and includes:

- Developing a draft;
- Making the draft available to the public; and
- Soliciting comments about the draft from the public, which can be electronically submitted on your Medicare Contractor's website.

NCDs and LCDs that may prevent access to items and services or have resulted in claim denials can be challenged by aggrieved parties (Medicare beneficiaries or the estate of Medicare beneficiaries) who:

- Are entitled to benefits under Part A, are enrolled in Part B, or both, including beneficiaries who are enrolled in fee-for-service Medicare, a Medicare + Choice plan, or in another Medicare managed plan.
- Are in need of coverage for items or services that are denied based upon an applicable LCD or NCD, regardless of whether the items or services were received.
- Have obtained documentation of the need for the items or services from his or her treating physician.

If a claim is denied by a Contractor based on an NCD or LCD, the beneficiary is notified about the denial and the reasons for the denial on the Medicare Summary Notice. Information about NCDs is available in the National Coverage Determinations Manual (Publication #100-03) at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS website.

You have now completed Module 4: Additional Programs Against Fraud and Abuse.