



VGM BULLETIN:

“Fraud & Abuse in HME...”

Introduction

Since 1987, VGM has provided compliance suggestions and tips, offered OIG-approved corporate compliance plan templates, and information on how to report fraudulent/abusive HME suppliers.

All homecare organizations should now be aware that the OIG has identified high-risk priority compliance areas that they perceive are Federal health program vulnerabilities.

We have prepared an updated summary to assist homecare providers in identifying and focusing their compliance efforts.

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This paper was authored by Mark J. Higley, Vice President – Development. The information reported should not be construed as legal advice, nor utilized to resolve legal problems.

The federal government's focus on fighting health care fraud and abuse is well known. The Office of Inspector General (OIG) has increased its enforcement efforts with the help of additional funds authorized by the Health Insurance Portability and Accountability Act (HIPAA).

CMS' Medicare Integrity Program (MIP) engages *Program Safeguard Contractors (PSC)*, which are responsible for combating and preventing Medicare fraud and abuse.

TO REPORT SUSPECTED HME FRAUD & ABUSE

Contact the applicable PSC:

TriCenturion performs all Medicare Program Integrity functions for DME Regions A and B. Contact information: 7909 Parklane Rd., Suite 190, Columbia, SC 29223. Telephone: (803) 264-7700

TrustSolutions, LLC (TrustSolutions) is the PSC for DME Region C. For issues relating specific to potential Durable Medical Equipment fraud and abuse contact: TrustSolutions, LLC, P.O. Box 50218, Indianapolis, IN 46250, via facsimile to (317) 863-3755, Telephone: (317) 863-3736

Electronic Data Systems (EDS) and its subcontractor, IntegriGuard, LLC, is the PSC for DME Region D. Contact information: IntegriGuard, LLC, Region D DME PSC, 2301 N 117 Avenue Suite 200, Omaha NE 68164, via facsimile to (402) 498-2306. Telephone (402) 498-2319

In addition, the **Office of the Inspector General** maintains a hotline, which offers a confidential means for reporting vital information. The Hotline can be contacted:

By Phone: 1-800-HHS-TIPS (1-800-447-8477)

By Fax: 1-800-223-2164

By E-Mail: HHSTips@oig.hhs.gov

By Mail: Office of the Inspector General, HHS TIPS Hotline, P.O. Box 23489, Washington, DC 20026

If you are attempting to report specific information proving Medicare fraud, please provide as much identifying information as possible regarding your concern. Such information should include subject's name, address and phone number etc. Details regarding the allegation should include the basics of “who, what, when, where, why, and how”. When a PSC contractor is investigating potentially fraudulent behavior by a supplier, it will be the supplier’s responsibility to prove the authenticity/validity of the claim(s) under investigation. The PSC may require the supplier to prove the authenticity/validity of the signature on the Certificate of Medical Necessity (CMN) or order, or any other questionable portion of the claim(s) under investigation.

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program or to obtain, by means of false pretenses or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

Examples of Fraud:

- Billing for services not rendered
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Using an incorrect or inappropriate provider number in order to be paid (e.g., using a deceased provider’s number)
- Signing blank records or certification forms that are used by another entity to obtain Medicare payment
- Selling or sharing patients’ Medicare numbers, so false claims can be filed
- Offering incentives to Medicare patients that are not offered to non-Medicare patients (e.g., routinely waiving or discounting the Medicare deductible and/or coinsurance amounts)
- Falsifying information on applications, medical records, billing statements, and/or cost reports, or on any statement filed with the government
- Misrepresenting as medically necessary, noncovered services by using inappropriate procedure or diagnosis codes

Abuse may, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, or payment for services, which fail to meet professionally recognized standards of care, or 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 the facts to obtain payment.

Examples of Abuse:

- Using procedure or revenue codes that describe more extensive services than those actually performed

- Collecting more than the 20% coinsurance or the deductible on claims filed to Medicare; providers may, of course, bill patients for services not covered (e.g., service exclusions)
- Routinely submitting duplicate claims
- Billing for services grossly in excess of those needed by patients
- Incorrectly apportioning costs on cost reports for Part A providers
- Charging more than the actual purchase price of a service, item, or drug

Although many types of inappropriate practices may be considered abusive, they may evolve into fraud. Beneficiaries are advised to report any instances of fraudulent or abusive practices to the DME MAC

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

Audits

The PSC Benefit Integrity (BI) Unit routinely conducts audits of the billing practices of suppliers. These audits may be the result of inquiries from beneficiaries, providers, or an internal inquiry from the DME MAC's customer service, provider relations, or medical review units. Audits may also result from statistical analyses that indicate that a supplier's billing pattern is aberrant. Suppliers may be asked to forward documentation to support the services that were billed. Suppliers may also be asked to provide financial records pertaining to their business to verify that they are properly collecting co-payments. The request for documentation or records will be in writing.

Note: Suppliers should read the entire letter, because contact information is provided for any questions that suppliers may have. In some instances, onsite audits may be conducted at the supplier's place of business. If requested information is not received, the service or equipment will be considered as not documented and a refund will be requested. Therefore, it is vitally important that suppliers keep accurate records. During the course of the audit, the BI Unit may also contact the prescribing physician and the beneficiary in order to verify that the services were received as billed and that the medical necessity requirements are met. When the BI Unit performs an audit, the following items must be available for review:

- Certificate of Medical Necessity (CMN)
- Physician's orders
- Signed and dated delivery slip
- Signed and dated pickup slip, when equipment has been returned
- Completed description of equipment supplied, including the appropriate serial numbers
- Signed authorization for Medicare payment

- Billing and financial records

Suppliers should also:

- Document all contacts with the patient, or authorized representative, and maintain the contact report in the file.
- Identify all rented equipment with the supplier's name and telephone number.
- Give explicit instructions on how and when to return the equipment, and advise the patient and/or representative that the supplier is to be contacted if the patient deceases, moves, and/or is admitted to a nursing home or hospital, or the equipment is no longer needed.
- Retain and have available Medicare beneficiary records for seven (7) years.

Suppliers who fail to permit examination of records may be terminated from participation in the Medicare program.

Background and Civil Monetary Penalties

In 1981, Congress added Section 1128A (42 U.S.C. 1320a-7a) to the Social Security Act to authorize the Secretary of the Department of Health and Human Services (HHS) to impose civil money penalties (CMPs). Since the enactment of the first CMP authority in 1981, Congress has increased both the number and types of circumstances under which CMPs may be imposed. Most of the specific statutory provisions authorizing CMPs also permit the Secretary to impose an assessment in addition to the CMP. An assessment is an additional monetary payment in lieu of damages sustained by the government because of the improper claim.

Also, for many statutory violations, the Secretary may exclude the individual or entity violating the statute from participating in Medicare and other federal healthcare programs for specified periods of time. In October 1994, the Secretary realigned the responsibility for enforcing these CMP authorities between CMS and the Office of Inspector General (OIG). CMS was delegated the responsibility for implementing CMPs that involve program compliance. The OIG was delegated the responsibility for implementing CMPs that involve threats to the integrity of the Medicare or Medicaid programs; i.e., those which involve fraud or false representations.

On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, referred to as HIPAA) was enacted. This law provides for higher maximum CMPs (\$10,000 per false item or service on a claim or instance of noncompliance, instead of \$2,000 per item or service), and higher assessments (three times the amount claimed, instead of twice the amount) for some of the violations. Other less severe administrative remedies may precede the more punitive sanctions affecting participation in the Medicare program. In order to avoid any sanctions being levied against them, suppliers should ensure that the Medicare program rules and regulations are appropriately followed.

The False Claims Act & Supplier Responsibilities

The False Claims Act has proven to be one of the most effective tools in fighting Medicare and Medicaid fraud and other types of fraud perpetrated against the federal government. The qui tam provisions, which allow whistleblowers to file False Claims Act lawsuits against companies and individuals that defraud the government, have been key to the law's success. Since the False Claims Act was amended, the government has recovered more than \$3.5 billion as a result of qui tam lawsuits.

Seventeen states -- Arkansas, California, Delaware, Florida, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Montana, Nevada, New Hampshire, New Mexico, Tennessee, Texas and Virginia -- as well as the District of Columbia have their own versions of the False Claims Act. In those places, whistleblowers can recover money against defendants who commit fraud against state and local governments.

The False Claims Act stipulates that whistleblowers be rewarded with a percentage of the money that the government recovers as a result of their qui tam lawsuits. This provision helps encourage people to assist the government in stopping Medicare and other kinds of fraud despite the effect whistleblowing might have on their jobs and personal lives.

Under the False Claims Act the government may recover up to three times the amount of money it lost as a result of the defendant's fraud. The whistleblower's (or "relator's") share is calculated based upon the amount the government recovers, not the actual losses.

A number of factors determine how much money a relator will receive if the government is able to recover money from the defendant. If the government joins the case, the relator is entitled to at least 15 percent but not more than 25 percent of what the government recovers. If the government declines to join the case and the relator proceeds against the defendant anyway, the relator is entitled to at least 25 percent but not more than 30 percent of the money the government recovers.

Supplier Responsibilities

The PSC BI Unit realizes that most suppliers operate reputable businesses and are only interested in serving their customers in an honest and straightforward manner. This is why all suppliers are treated fairly when there is a suspicion of fraud or abuse.

Suppliers have a number of responsibilities as participants in the Medicare program:

- Suppliers must maintain proper documentation and provide it to the DMERCs, HHS/OIG, or any other federal law enforcement agency upon request. The documentation must be complete, accurate, and legible. Suppliers should keep original copies, not facsimiles or photocopies. Suppliers must also make sure the documents bear no alterations, such as white-out.

- Suppliers must read the supplier manual and any Medicare bulletins, including updates to policies and procedures. Suppliers are responsible for understanding the information contained in these documents.
- Suppliers must report individuals or companies who they suspect are committing Medicare fraud to the BI Unit.

For more information on fraud and abuse, suppliers should refer to Chapter 4 (Benefit Integrity) of Pub. 100-8, Medicare Program Integrity Manual www.cms.hhs.gov/manuals/downloads/pim83c04.pdf

VGM members who would like to review an OIG-approved corporate compliance template should contact Mark Higley, Vice President – Development, at 800.642.6065, or mark.higley@vgm.com.