

Health Care Fraud Trends, Initiatives and Referrals



*Empowering Seniors
to Prevent
Healthcare Fraud*

**SMP National Conference
August 18, 2009**

Health Care Fraud Panelists

- ▶ Kim Brandt, Director, Program Integrity Group, CMS HQ
- ▶ Jean Stone, Director, New York Field Office, CMS
- ▶ Bernie Rodriguez, Special Agent, OIG Investigations, Miami, FL
- ▶ Amy Miller, IntegriGuard, Omaha, NE

Health Care Fraud Panel

**Kim Brandt, Director
Program Integrity Group
CMS HQ
Baltimore, MD**

Medicare Hot Scams

Parts A, B, C & D

08/18/09

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ALPHABET SOUP: CMS Parts A/B/C/D MDs, DME, HOSPICE, HOSPITAL, HHA, ID Theft, INFUSION



CMS – Centers for Medicare & Medicaid Services

CMS administers Medicare & Medicaid programs. July 1, 1966 – Title XVIII of Social Security Act established **Medicare**

National health insurance program for individuals who are:
Age 65 or older. SSA amendments of 1972: expanded benefits to:

Disabled under 65 (receiving SSA disability payments for \geq 24 mos.) or who have

End Stage Renal Disease (ESRD) who require maintenance dialysis or kidney transplant

Part A – Hospital Insurance (inpatient hospital, skilled nursing facility [SNF] & some home health & hospice services)

Part B – Supplemental Medical Insurance (outpatient hospital, lab & diagnostic tests; ambulance services, physician services, PT/OT/ST, Durable Medical Equipment [DME])

Part C – Medicare Advantage Program (Managed Care Orgs.)

Part D – Medicare Prescription Drug Coverage

Medicare Expenditures

According to 2007 Medicare Trustees report:

FY 2006 = **\$408 billion** for **43.2 million** beneficiaries

FY 2008 = **\$456.3 billion** for **44.6 million** beneficiaries



- Congressional Budget Office (CBO) projects expenditures to **double over the next 10 years.**
- Majority of Medicare spending (approximately **75%**): for Part A & B benefits (**fee-for-service** portion of program)
- As one of fastest growing sectors of federal budget, **challenge** is to **maintain & ensure integrity of nation's largest health insurance program.**



Part A – Hospital Fraud

- **Bill** for services **not rendered**
- **Double bill**
- **Misrepresent** patient diagnosis or **up-code DRG's**
 - Submit claim for “septicemia” dx, but medical record shows “urosepsis” (blood cultures negative) with lower DRG \$. RAC errors = >90% inpatient hospital.
- Pay **kickbacks** for physician referrals
- **Falsify** information in **costs reports**
- **Forge/alter** medical records, test results
- **Bill Excessive Units**
 - Submit 1 claim for 3 colonoscopies for same beneficiary on same day (overpayment = \$ value of 2nd/3rd colonoscopies)



Part A – Hospice Fraud

- **Forge/alter** medical records to obtain coverage
- **Misrepresent** patient diagnosis or condition (patient not “**terminally ill**” as defined in § 1879(g)(2) of SSA)
- **Transfer in & out** of hospice for non-palliative care
- **Underutilize** (Quality of Care)



Part A & B Ambulance Fraud

- Bill for services **not rendered**
- **Double bill** (Part A & Part B) or bill extra **mileage**
- **Misrepresent non-emergency** as emergency transport &/or emergency **air** transport
- Bill **non-medical** as **non-emergency** transport
- Pay **kickbacks** for referrals (hospital, dialysis center, SNF, physician)
- **Falsify** physician **orders &/or forge/alter** medical **records**

Part A & B – Home Health Fraud

- Admit patients **not homebound**
- **Coach** diabetic patients to **not self-inject &/or stop oral medication** – for patients able to self-inject &/or with willing caregivers
- **Bill daily/twice daily aide visits** (not reasonable & necessary)
- **Bill therapy** visits without physician **order**
- **Upcode** HIPPS codes
- Bill for **services not rendered**
- **Recruit patients** (pay kickbacks – incentives of cash & home health aides)





Part B - Physician Fraud

Bill for **services not rendered**

Up-code, fragment, **unbundle**

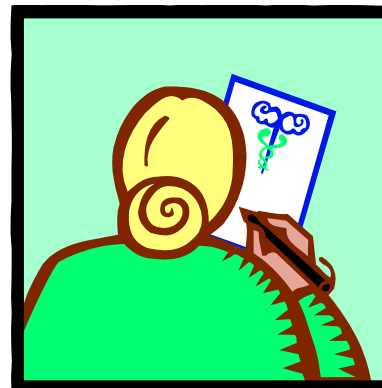
Bill for **medically unnecessary services**

Receive/pay **kickbacks**

- **Sign orders for unnecessary** lab & diagnostic tests (from **Independent Diagnostic and Testing Facilities [IDTFs]**), therapy, DME, HHA &/or Hospice care, prescription drugs
- Bill for services of unlicensed, unsupervised staff

Part B -Durable Medical Equipment (DME) Fraud

- Pay **kickbacks** for referrals
- Bill for equipment **not provided**
- **Up-code or Swap** – bill high end/substitute lesser equipment
- **Falsify** Certificates of Medical Necessity (**CMN's**) and physician **orders**
- **Forge**/alter medical records
- **Misrepresent** patient diagnosis or medical condition
- “Phantom” providers – **bill** with no inventory, bill after **closing** location
- **Hire** nominee owners



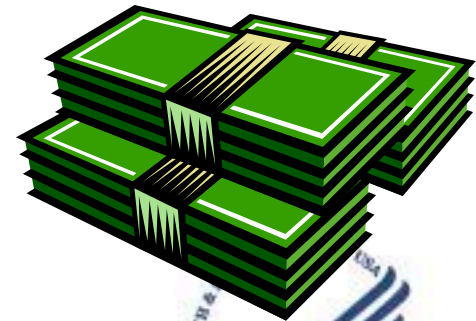
Part D - Pharmacy Fraud

- ◆ Pay **kickbacks** to physicians to prescribe unnecessary medications
- ◆ **Upcode** (bill name brand/give generic)
- ◆ **Buy back** drug after dispensing & **re-sell**
- ◆ Bill for **services not rendered** (pills not dispensed)
- ◆ **Buy prescriptions**
- ◆ **Recruit patients/pay kickbacks**
- ◆ **Divert drugs/buy black market**



Part A/B/C/D - Beneficiary Fraud

- **“Professional”** patients
- Solicit **kickbacks** to participate in fraud
 - receive unnecessary service (surgery/tests)
 - accept free transport, sign logs for services not received
- **Obtain physician orders** for unnecessary diagnostic tests, drugs, treatments
- **“Rent”** use of Medicare ID # (**“no show”** patient)
- **Re-sell drugs** back to pharmacy after dispensing
- **Recruit** friends for **“finder’s fee”**



CMS Efforts to Reduce Medicare Improper Payments

- **Data analysis** – target highest risk providers & services
- New/clarified **national/local policies** & Provider Education
- **Prepayment** claim review
 - New edits (automated review)
 - Medical record review (complex review)
- **Postpayment** claim & medical record review
- **Overpayment** recoupment
- **Enhanced Provider Enrollment** & more frequent, **unannounced site visits**
- **Revoke or Deactivate** Medicare billing privileges
- **Suspend** Medicare payments
- **Investigate** Fraud Complaints *from SMP & beneficiaries*



CMS Efforts to Reduce Medicare Fraud – All Tools to Reduce Medicare Error Rate, plus:

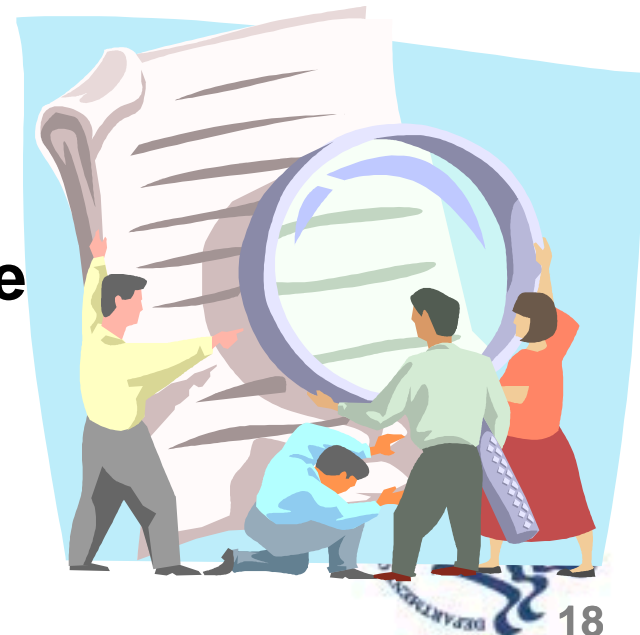
- **Field Offices (FOs)**: CMS established **FOs** in High Risk Areas (**Miami, Los Angeles & New York**)
- Medicare Program Safeguard Contractors (**PSCs**), Zone Program Integrity Contractors (**ZPICs**) & Medicare Part D Integrity Contractors (**MEDICs**)
 - perform **proactive data analysis** to ID vulnerabilities, investigate & **refer potential fraud** to law enforcement (**OIG**)
 - perform audits & evaluations
 - assist **law enforcement** (respond to Requests for Information, perform data analysis)
 - lead Medi-Medi initiative (combined Medicare-Medicaid data analysis to identify and investigate potential fraud and abuse)
- Partner with federal & state **law enforcement**
 - National & local health care fraud task forces
 - Strike Forces – H.E.A.T.
- Partner with AoA and SMP
- Conduct Demonstrations & Special Projects



Part B - CMS' 2-Year DME Demo

6/28/07: HHS announced **2-year demo** to reenroll suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) into Medicare. Goal of this project is to strengthen:

- CMS's ability to detect and prevent fraudulent activity
- Focus - DMEPOS suppliers in **SOUTH FLORIDA** – Miami-Dade; Broward; Palm Beach
SOUTHERN CALIFORNIA – Orange
Los Angeles; Riverside;
San Bernardino



Part B - CMS DME Demo

- ◆ 4,663 suppliers affected
 - 4,602 Site Inspections conducted
 - ▶ CA 2,915 / FL 1,687
 - **671 providers' Medicare billing privileges were revoked** for non-response to revalidation request
 - Of over 1,500 referrals received, **610** investigations also resulted in **revocation**
 - Of **1281** provider revocations (as of Feb 1), only 86 (6.7%) revoked suppliers are now active (after appeal)

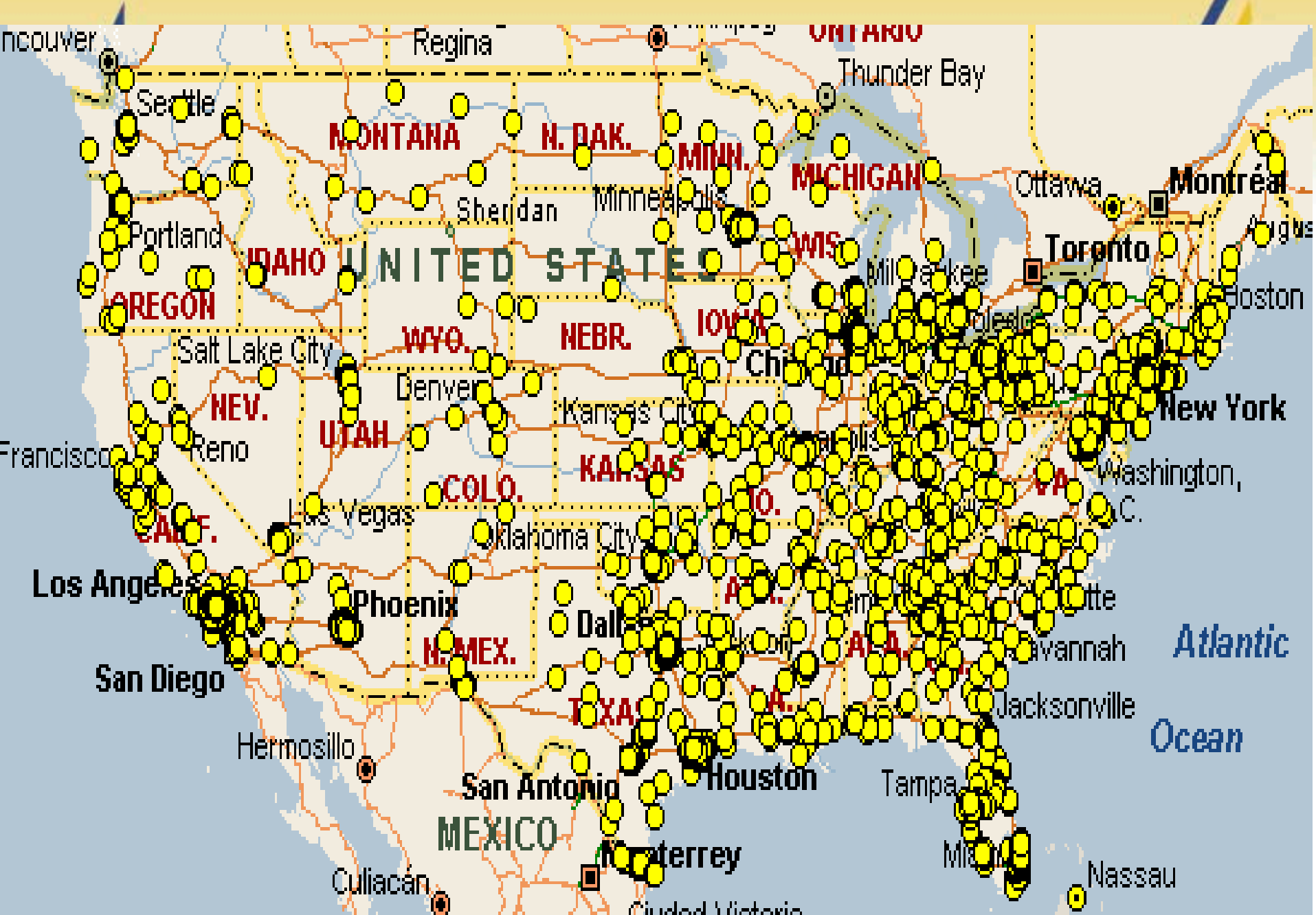
NSC HIGH RISK DME SUPPLIERS "T"

FLIT codes from 1-2-09 data



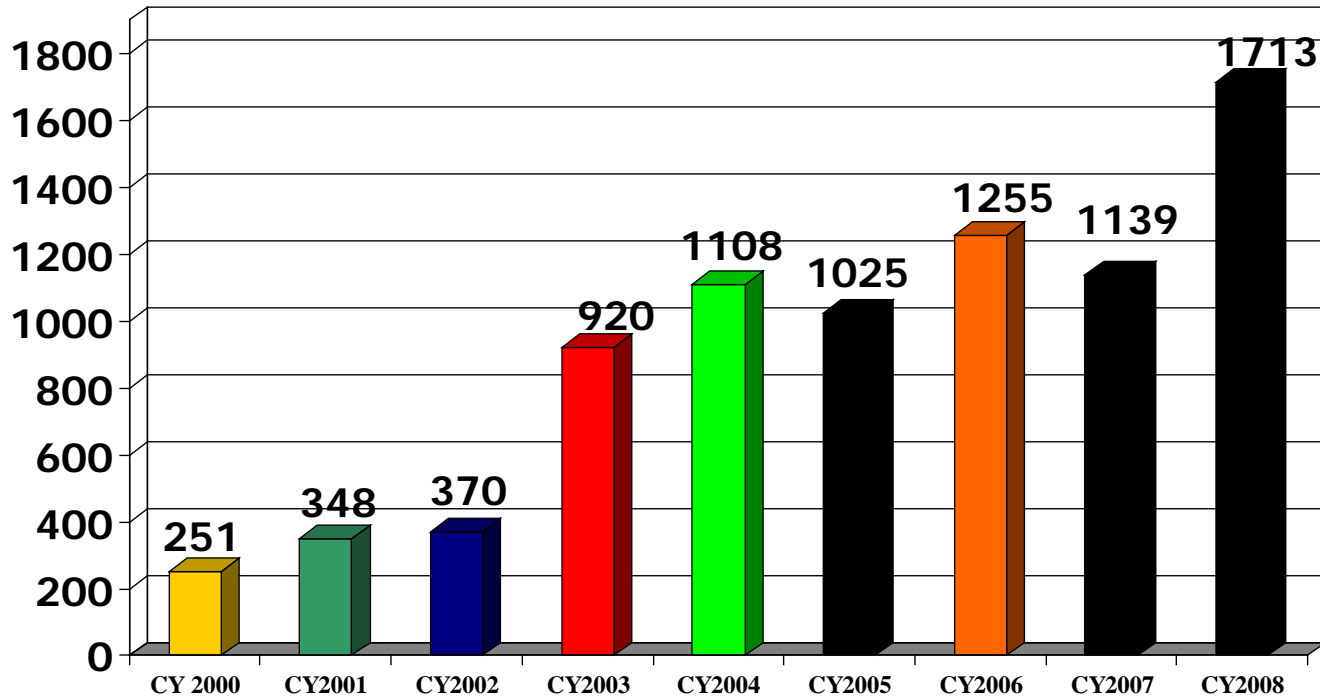
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NSC MEDIUM RISK DME SUPPLIERS "S"



NSC Supplier Audit and Compliance Unit

DME Revocations by Year



As of Jan 1, 2009

Part B - DME Stop Gap Plan – Background

- **Short-term plan to enhance DME fraud, waste and abuse detection and prevention activities in 7 states (CA, FL, IL, MI, NC, NY and TX) with home visits & calls to beneficiaries!!!**
- **High DMEPOS expenditures and growth rates and focus on highest billed items in each:**
 - **CPAP**
 - **Oxygen**
 - **Glucose Monitors/Diabetes Testing Strips**
 - **Power Mobility Devices**

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Part B - DME Stop Gap Plan – 4 Areas of Focus

CMS and its contractors (PDAC, NSC, DME PSCs and ZPICs) will identify the:

- (1) highest paid/highest risk **DMEPOS suppliers**
- (2) highest ordering **physicians**
- (3) highest billed/highest risk **DMEPOS equipment and supplies**, and
- (4) *highest utilizing **beneficiaries** for enhanced scrutiny.*

CMS' 4-pronged approach addresses all 4 of these DME high risk components

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Part B - DME Stop Gap Plan - High Risk Physicians

- **Conduct data analysis to identify the highest ordering and most vulnerable (elderly) docs & Identify their related DMEPOS suppliers, the equipment ordered and the beneficiaries for whom the equipment is ordered**
- **Interview physicians to validate their NPIs & identify NPIs which are invalid, belong to deceased physicians, or are stolen/compromised & take corrective action**



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Part B - DME Stop Gap Plan - Beneficiaries

- Conduct data analysis to ID high utilizing beneficiaries with no clinical relationship with ordering physician
- Conduct *home visits/phone interviews* (CA/FL/TX/NY/MI/IL/NC)
- Implement auto denial edits
- Develop tools to address problem of beneficiaries who are “*professional patients*” who actively participate in fraud scams & repeatedly sell their Medicare #s in exchange for kickbacks



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Part B - CMS Infusion Demo



- On August 20, 2007, HHS announced **2-year demo** to crack down on South Florida Infusion Provider fraud.

Physicians were manipulating the system:

- Paying patients \$100-\$400/infusion session
- One patient went to 7 different clinics for IVIG on same day. Medicare received claims for IVIG from 7 different clinics for same date
- Using vans & recruiters (“cappers”) to enlist patients, provide free pick-up & drop off
- Unlike traditional ID theft, because the patients themselves participated in fraud, they didn’t report it.

DOJ Strike Force – FL Infusion Fraud



At 8/20/07 Demo press conference, the US Attorney's Office Southern District of FL announced filing of 20 criminal cases against 42 defendants:

- (1) US vs. Frantz Achille, No. 06-20496-CR
- (2) US vs. Onelio Baez, et al., No. 05-20849-CR
- (3) US vs. Gregory Delatour, No. 06-20029-CR
- (4) US vs. Pedro Diaz, et al., No. 05-20869-CR
- (5) US vs. Luis Manuel Fernandez, et al., No. 06-20322-CR
- (6) US vs. Magda Lavin, No. 05-20814-CR
- (7) US vs. Thaiz Parra, et al., No. 06-60167-CR
- (8) US vs. Isaac Nosovsky, et al., No. 06-20178-CR
- (9) US vs. Rafael Walled, No. 06-20030-CR
- (10) US vs. Rosa Walled, No. 06-20031-CR

DOJ Strike Force – FL Infusion Fraud (continued)



▶ 20 Criminal Cases announced by DOJ on 8/20/07:

- (11) US vs. Cesar Romero, No. 06-20740-CR
- (12) US vs. Arnold Garcia, et al., No. 07-20057-CR
- (13) US vs. Luis G. Henriquez Delgado, No. 07-20180-CR
- (14) US vs. Jose Prieto, et al., No. 07-20177-CR
- (15) US vs. Leider Alexis Munoz, No. 07-20225-CR
- (16) US vs. Jorge Luis Mocega, et al., No. 07-20419-CR
- (17) US vs. Orestes Alvarez-Jacinto, MD, No. 07-20420-CR
- (18) US vs. Lester Miranda, et al., No. 07-20612-CR
- (19) US vs. Rupert Francis, No. 07-20631-CR
- (20) US vs. Rita Campos Ramirez, No 07-20633-CR (1)

Infusion Demonstration Results

October 2007 – January 2009

• Providers on Prepayment Review	283
• Providers with Payments Suspended	8
• Provider Numbers Deactivated (estimate)	296
• Provider Specialty and/or Service Code Edits	36
• Beneficiaries on Part A and/or Part B edits	46,797
• Providers on Part A and/or Part B edits	314
• Requests for Overpayments	\$164.3 million
• Referrals to Law Enforcement	25
• Immediate Advisements to the OIG	2

Savings: \$366.9 million

Return on Investment – FCSSO/MAC \$93 to \$1

Return on Investment – SGS/ZPIC \$130 to \$1

CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES



Spread of Florida Infusion Fraud

PR: Infusion fraud spread to 4 clinics in PR in 2006 – payments were suspended & several principals pled guilty or were convicted; new cases have sprung up

MI: In 2007, 4 clinics in Dearborn area were shut down & referred to LE.

GA: In 2007, 4 clinics were shut down & referred to LE; Recently, more than a dozen additional clinics have sprung up.

Managed Care & Private Insurers: In response to private insurer & managed care plan requests for info, CMS is partnering with FBI & OIG.

NHCAA sponsored a meeting 1/28/09 & established a workgroup to raise awareness & share information.

Part C - Eligibility

Medicare C = Medicare A + pay for B & D
- premium approx \$100/mo

Medicare D = Medicare A and/or B
- current av. FFS premium = \$35/month

Many FFS Medicare beneficiaries also purchase a Medi-gap policy
- current premium = +/- 200/month

Medicare FFS fraud migrated to MAOs

Fraudulent FFS clinics & physicians & suppliers are joining MAO networks and/or billing out-of-network

Performing/ordering physicians may be participating in fraud or their IDs may be stolen.

Beneficiaries are being recruited to join MAPs

**Fraudulent enrollment schemes online & by phone
(Demand for enrollment in areas where no marketing is taking place)**

Part C Fraud Spreading from Part B

- Recruit disabled and/or dual-eligible beneficiaries to enroll in MA plans
 - pay their premiums for them

- ***ID Theft:***

- Change beneficiary's address
 - Change beneficiary's telephone # to cell phone #

- ***Plans cannot contact real beneficiaries to verify enrollment***

Part C Fraud Spreading from Part B

**If there is a pattern of high or suspicious Part C billing for infusion therapy, or to report information related to this scheme, please contact the
MEDIC:**

North: SafeGuard Services (SGS)

South: Health Integrity (HI)

•877-7SAFERX (877-772-3379)*

Part C & D Fraud MEDIC Contact Info

North: SafeGuard Services (SGS)

Complaint line: **877-7SAFERX (877-772-3379)***

Fax: 717-975-4442

In writing: SGS MEDIC North
225 Grandview Avenue Mailstop F10
Camp Hill, PA 17011

South: Health Integrity (HI)

Complaint line: **877-7SAFERX (877-772-3379)***

Fax: 410-819-8698

In writing: Health Integrity Attention: MEDIC
9240 Centreville Road, Easton, MD 21601

*Note: **Both MEDICs** can be reached by the **same general number: 1-877-772-3379**

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CENTERS FOR MEDICARE & MEDICAID SERVICES



Contact Information

Email: Jean.Stone@[cms.hhs.gov](mailto:Jean.Stone@cms.hhs.gov)

Telephone: (212) 616-2541

USEFUL WEBSITE

www.cms.hhs.gov/medlearn

Notices, alerts, bulletins, on-line education

Health Care Fraud Panel

Bernie Rodriguez
Supervisory Special Agent
DHHS OIG
Office of Investigations
Miami Lakes, FL

A pair of glasses with a dark frame and clear lenses is positioned in the upper right corner of the slide. The background is a solid orange color. The glasses are slightly out of focus, with the left lens being more prominent than the right.

Coordinating Medicare Benefit Integrity

Presented by Amy Miller
August 18, 2009



Role of PSC/ZPIC and MEDIC BI Units

- Primary goals of the Program Safeguard Contractor, Zone Program Integrity Contractor and MEDIC Benefit Integrity (BI) unit
 - Identify cases of suspected fraud
 - Develop them thoroughly and in a timely manner
 - Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out, and that any mistaken payments are recouped





Primary Responsibilities of BI Units

- Investigation of healthcare fraud and abuse
- Data analysis to identify potential fraud and abuse
- Medical record reviews in support of BI activities
- Cost report audits
- Education related to BI activities
- Support of federal law enforcement in the investigation and prosecution of healthcare fraud cases





Coordination among SMP, PSC/ZPIC, MEDIC



- SMP refers potential investigations of fraud and abuse to PSC/ZPIC/MEDIC through the PSC/ZPIC/MEDIC Point of Contact (POC).
- PSC/ZPIC/MEDIC and SMP work together to identify, track, and report beneficiary complaints involving fraud and abuse.
- PSC/ZPIC/MEDIC is a resource for SMP to help define what is fraud and abuse and to help guide where additional assistance may be obtained.



What to Refer to PSC/ZPIC and MEDIC

- Incorrect reporting of diagnoses or procedures to maximize payments
- Billing for services not furnished and/or supplies not provided
 - Includes billing Medicare for appointments that patient failed to keep
- Billing that appears to be a deliberate application for duplicate payment for same services or supplies
 - Billing both Medicare and beneficiary for same service
 - Billing both Medicare and another insurer in an attempt to get paid twice





What to Refer to PSC/ZPIC and MEDIC (cont'd)

- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount
- Soliciting, offering, or receiving a kickback, bribe, or rebate
 - Paying for referral of patients in exchange for ordering of diagnostic tests and other services or medical equipment
 - Offering "free services"





What to Refer to PSC/ZPIC and MEDIC (cont'd)

- Unbundling or “exploding” charges
- Completing Certificates of Medical Necessity (CMN) for patients not personally and professionally known by the provider
- Participating in schemes involving collusion between a provider and a beneficiary, or between a supplier and a provider, and resulting in higher costs or charges to the Medicare program
- Billing based on “gang visits”
 - Physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients



What to Refer to PSC/ZPIC and MEDIC (cont'd)



- Misrepresentations
 - Dates and descriptions of services furnished
 - Identity of beneficiary or individual who furnished services
- Billing non-covered or non-chargeable services as covered items
- Using another person's Medicare card to obtain medical care



What Not to Refer to PSC/ZPIC, MEDIC (cont'd)

- Complaints or inquiries regarding Medicare coverage policy
- Excessive charges
- Complaints regarding the appeals process
- Complaints over status of a claim
- Requests for an appeal or reconsideration
- Complaints concerning providers or suppliers that are general in nature and are policy or program oriented
 - Exceptions: complaints meeting the criteria established above





What Not to Refer to PSC/ZPIC, MEDIC (cont'd)

- Complaints alleging malpractice or poor quality of care may or may not involve a fraudulent situation
 - To be reviewed and determined on a case-by-case basis
- Refer complaints alleging poor quality of care to
 - State Medicare/Medicaid survey
 - Certification agencies
 - QIO





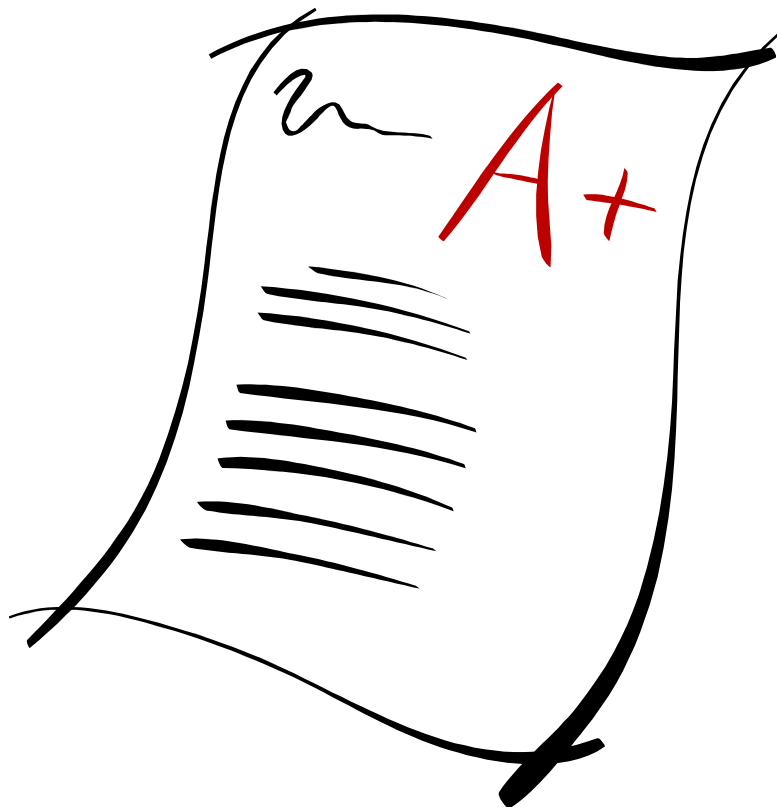
What to Include in a Referral

- At a minimum, a referral shall include the following information
 - An explanation of why the activity is considered to be fraudulent or abusive
 - Name and contact information of the individual who made the referral
 - Name and address of person/provider/supplier who is suspected of fraudulent or abusive activities
 - Beneficiary name
 - HIC number
 - Dates of service involved
 - Description of services involved
 - A description of the alleged activity
 - Services billed but not furnished





Examples





Questions



Thank you for your participation!