Medicare Fraud & Abuse: Prevent, Detect, Report

Slide 1: Title

Medicare Fraud & Abuse: Prevent, Detect, Report

Slide 2: Introduction

The Medicare Fraud & Abuse: Prevent, Detect, Report course is brought to you by the Medicare Learning Network®.

Slide 3: Introduction cont.

Welcome to the Medicare Fraud & Abuse: Prevent, Detect, Report Course!

This course educates health care professionals about how to prevent, detect, and report Medicare fraud & abuse.

Although there is no precise measure of health care fraud, those who exploit Federal health care programs can cost taxpayers billions of dollars while putting beneficiaries' health and welfare at risk. The impact of these losses and risks magnifies as Medicare continues to serve a growing number of beneficiaries.

The Federal government aggressively cracks down on fraud & abuse, but it needs your help. All health care professionals must do their part to prevent fraud & abuse.

Please note: The information in this course focuses on the Medicare FFS Program (also known as Original Medicare). Many of the laws discussed apply to all Federal health care programs (including Medicaid and Medicare Parts C and D). See Job Aid C for information on fraud & abuse in Medicaid and Medicare Parts C & D.

Slide 4: Introduction cont.

Do Your Part, Get Informed!

Committing Fraud is Not Worth it

- Medicare Trust Fund recovered approximately $1.2 billion
- $232 million recovered in Medicaid Federal money transferred to the Treasury
- The Federal government convicted 497 defendants of health care fraud
- Department of Justice (DOJ) opened 1,139 new criminal health care fraud investigations
- DOJ opened 918 new civil health care fraud investigations

Slide 5: Introduction cont.

Consequences

- HHS OIG Criminal Actions:
  - FY 2016: 765
  - FY 2017: 766
  - FY 2018: 679
- HHS OIG Civil Actions:
  - FY 2016: 690
  - FY 2017: 818
  - FY 2018: 795
- 2,712 Exclusions

NOTE: All statistics cover FY 2018 unless otherwise noted.

Slide 6: Introduction cont.

After completing this course, you should correctly:
- Identify what Medicare considers fraud & abuse
- Identify Medicare fraud & abuse provisions and penalties
- Recognize Medicare fraud & abuse prevention methods
- Recognize entities that detect Medicare fraud & abuse
- Recognize how to report Medicare fraud & abuse

Slide 7: Introduction cont.

This course consists of five lessons:
- Lesson 1: Medicare Fraud & Abuse explains fraud & abuse basics
- Lesson 2: Medicare Fraud & Abuse Laws and Penalties outlines the laws and sanctions used to fight fraud & abuse
- Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors describes methods to prevent Medicare fraud & abuse
- Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies identifies the entities charged with detecting Medicare fraud & abuse
- Lesson 5: Report Suspected Medicare Fraud & Abuse describes how to report suspected Medicare fraud & abuse, how to self-disclose violations, and the rewards available for reporting fraud & abuse

Slide 8: Lesson 1: Medicare Fraud & Abuse

This lesson introduces the basic Medicare fraud & abuse concepts and what you must know to detect it within your organization. Fraud is a crime with serious consequences, including exclusion from Federal health care programs, fines, and prison. It should take about 10 minutes to complete this lesson.

In this lesson, you'll learn about:
- Medicare fraud
- Medicare abuse

This lesson includes Medicare fraud & abuse examples.

In 2018, the Federal government won or negotiated over $2.3 billion in health care fraud judgements and settlements.

Slide 9: Lesson 1: Medicare Fraud & Abuse cont.

After completing this lesson, you should correctly:

- Identify Medicare fraud basics
- Identify Medicare abuse basics
- Recognize Medicare fraud & abuse instances

Slide 10: Lesson 1: Medicare Fraud & Abuse cont.

A Serious Problem Requiring Your Attention

Health care fraud can cost taxpayers billions of dollars. The dollars lost to Medicare fraud & abuse increase the strain on the Medicare Trust Fund. The impact of these losses and risks magnifies as Medicare continues to serve a growing number of people.

Schemes and fraudulent billing practices not only cost taxpayers, they endanger the health and welfare of beneficiaries. For example, dozens of patients got medically unnecessary cardiac pacemakers implanted because of a cardiologist-involved scam. The doctor convinced his patients to get the pacemakers by telling them they would die, even though they had a non-fatal diagnosis. Thanks to anti-fraud efforts and education, law enforcement caught and prosecuted the doctor. He was sentenced to 42 months in prison and ordered to pay over $300,000 in fines and restitution.

Slide 11: Lesson 1: Medicare Fraud & Abuse cont.

To combat fraud & abuse, you must know how to protect your organization from potential abusive practices, civil liability, and possible criminal activity. You play a vital role in protecting the integrity of the Medicare Program.

Click video for more information.

Slide 12: Lesson 1: Medicare Fraud & Abuse cont.

What is Medicare Fraud?

- Knowingly submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain a Federal health care payment (in other words, fraud includes obtaining something of value through misrepresentation or concealment of material facts)

- Knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health services.

Slide 13: Lesson 1: Medicare Fraud & Abuse cont.

Examples of actions that may constitute Medicare fraud include:

- Knowingly billing services not given or supplies not provided, including billing Medicare appointments patients fail to keep
- Knowingly altering claim forms, medical records, or receipts to get a higher payment
- Paying for referrals of Federal health care program beneficiaries

To learn about real cases of Medicare fraud and its consequences, see the case studies in Job Aid A.

Slide 14: Lesson 1: Medicare Fraud & Abuse cont.

Fraud in Practice

Anyone can commit Medicare fraud, including people you know.

Medicare fraud extends beyond medical professionals. Corporations and organized crime networks commit Medicare fraud, unlawfully getting millions of Medicare Program dollars.

A major pharmaceutical manufacturer pled guilty to misbranding and paid $600 million to resolve criminal and civil liability from promoting a certain drug. Part of the settlement resolved allegations the company misled doctors about the drug's safety and success and instructed them to miscode claims to ensure Federal health care payments. The company also allegedly paid doctors kickbacks.

In another case, the government charged 73 defendants when investigators uncovered an organized crime ring's scheme that allegedly involved more than $163 million in fraudulent billings and identity theft impacting thousands of beneficiaries and doctors.

Slide 15: Lesson 1: Medicare Fraud & Abuse cont.

Fraud Examples

A hospital paid $8 million to settle allegations it knowingly kept patients hospitalized, beyond the time considered medically necessary, to increase its Medicare payments and maintain its classification as a long-term acute care facility.

A Durable Medical Equipment (DME) business owner served 70 months in prison and paid $1.9 million in restitution after pleading guilty to conspiracy to commit health care fraud and aggravated identity theft. The DME company owner created several different companies and submitted more than 1,500 false and fraudulent claims to Medicare for unnecessary medical equipment.

An oncologist and his wife paid $3.1 million to resolve allegations they jointly defrauded Medicare and other Federal health care programs by overbilling medications and services and billing medications and services not provided.

A court sentenced a home health provider to 168 months in prison for his role as one of the owners of a home health agency that submitted about $45 million in false claims to Medicare. Almost all his insulin claims billed twice-daily injections to purportedly homebound diabetic patients. The investigation revealed most patients were not homebound or insulin-dependent diabetics.

Slide 16: Lesson 1: Medicare Fraud & Abuse cont.

What is Medicare Abuse?

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice inconsistent with providing patients medically necessary services, meeting professionally recognized standards, and charging fair prices.

Both fraud & abuse can expose providers to criminal, civil, and administrative liabilities.

Slide 17: Lesson 1: Medicare Fraud & Abuse cont.

Examples of actions that may constitute Medicare abuse include:

- Billing unnecessary medical services
- Charging excessively for services or supplies
- Misusing claim codes, such as upcoding or unbundling codes

To learn about real Medicare abuse cases and its consequences, see the case studies in Job Aid B.

Slide 18: Lesson 1: Medicare Fraud & Abuse cont.

Program Integrity

Program Integrity includes a range of activities to target the various causes of improper payments beyond fraud & abuse.

- Mistakes result in errors: such as incorrect coding
- Inefficiencies result in waste: such as ordering excessive diagnostic tests

- Bending the rules results in abuse: such as improper billing practices (like upcoding)
- Intentional deceptions result in fraud: such as billing for services or supplies that were not provided

NOTE: The types of improper payments are examples for educational purposes. Providers who engage in these practices may be subject to administrative, civil, or criminal liability.

Slide 19: Lesson 1: Medicare Fraud & Abuse cont.

Lesson 1: Summary

- Fraud & abuse drain billions of dollars from the Medicare Program each year and put beneficiaries' health and welfare at risk by exposing them to unnecessary services, taking money away from care, and increasing costs.
- Fraud & abuse jeopardize quality health care and services and threaten the integrity of the Medicare Program by fostering the misconception that Medicare means easy money.
- Fraud & abuse cost you as a health care provider and taxpayer. Fraud & abuse result in waste and unintentionally financing criminal activities.
- Fraud includes, but is not limited to, knowingly submitting false statements or making misrepresentations of material facts to get a Federal health care payment for which no entitlement would otherwise exist.
- Abuse describes practices that, either directly or indirectly, result in unnecessary Medicare Program costs.

Slide 20: Lesson 1: Medicare Fraud & Abuse cont.

Review Question 1

If you knowingly submit a false statement of material fact to get a Medicare payment when no entitlement would otherwise exist for someone other than yourself, you did not commit Medicare fraud.

A. True
B. False

Correct Answer – B

Slide 21: Lesson 1: Medicare Fraud & Abuse cont.

Review Question 2

Medicare abuse describes practices that directly or indirectly result in unnecessary Medicare Program costs.

A. True
B. False

Correct Answer – A

Slide 22: Lesson 1: Medicare Fraud & Abuse cont.

Review Question 3

A physician regularly bills Medicare X-rays never provided to beneficiaries. This is considered Medicare _____.

A. Mistakes
B. Inefficiencies
C. Abuse
D. Fraud

Correct Answer – D

Slide 23: Lesson 1: Medicare Fraud & Abuse cont.

You've completed Lesson 1: Medicare Fraud & Abuse

Now that you've learned about Medicare fraud & abuse, let's look at relevant Medicare fraud & abuse laws. Lesson 2 explains provisions and penalties used to fight and punish fraud & abuse and preserve Medicare Program integrity.

Slide 24: Lesson 2: Medicare Fraud & Abuse Laws and Penalties

In this lesson, you'll learn about laws the Centers for Medicare & Medicaid Services (CMS) and its partners use to address fraud & abuse. Knowledge of fraud & abuse laws helps you partner in preventing these activities, which drains billions of dollars from the Medicare Program, endangers its integrity, drives up health care costs, and compromises beneficiary health care services. This lesson should take you about 35 minutes to complete.

In this lesson, you'll learn about:

- Federal laws governing fraud & abuse
- Penalties for fraud & abuse

Slide 25: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

After completing this lesson, you should correctly

- Identify these fraud & abuse Federal laws:
  - Federal Civil False Claims Act (FCA)

    - Anti-Kickback Statute (AKS)
    - Physician Self-Referral Law (Stark Law)
    - Criminal Health Care Fraud Statute
    - Exclusion Statute
    - Civil Monetary Penalties Law (CMPL)
  - Recognize civil and criminal fraud penalties

Use Job Aid F as a resource for the laws discussed in this lesson.

Slide 26: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Medicare Fraud & Abuse Laws

The FCA, AKS, Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statue, Social Security Act, which includes the Exclusion Statute, and CMPL, are the main laws that address Medicare fraud & abuse and specify the criminal, civil, and administrative penalties the government imposes on those committing fraud & abuse. Violations may result in:

- Medicare-paid claims recoupment
- Civil Monetary Penalties (CMPs)
- Exclusion from Federal health care programs participation
- Criminal and civil liability

These laws prohibit Medicare Part C and Part D and Medicaid fraud & abuse.

Let's take a closer look at Medicare fraud & abuse laws.

Slide 27: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

False Claims Act

The FCA (31 United States Code [U.S.C.] Sections 3729-3733) protects the Federal government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal government. The terms "knowing" and "knowingly" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim.

There is also a criminal FCA (18 U.S.C. Section 287) . Criminal penalties for submitting false claims may include prison, fines, or both.

Example: A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than provided.

Click video for more information about the FCA.

Slide 28: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Anti-Kickback Statue

The AKS (42 U.S.C. Section 1320a-7b(b))makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program. Remuneration includes anything of value such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultations.

Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participating in Federal health care programs.

Example: A provider gets cash or below-fair-market-value rent for medical office space in exchange for referrals.

The Code of Federal Regulations (CFR) at 42 CFR Section 1001.952 sets the safe harbor regulations and describes various payments and business practices that may satisfy regulatory requirements and may not violate AKS. Go to the Safe Harbor Regulations webpage for more information.

Click video for more information about the AKS.

Slide 29: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (Stark Law) (42 U.S.C. Section 1395nn) prohibits a physician from referring certain "designated health services“ (for example, clinical laboratory services, physical therapy, and home health services), payable by Medicare or Medicaid, to an entity where the physician (or an immediate family member) has an ownership/investment interest or has a compensation arrangement, unless an exception applies.

Penalties for physicians who violate the Stark Law include fines, repayment of claims, and potential exclusion from participation in Federal health care programs.

Example: A provider refers a patient for a designated health service to a clinic where the physician (or an immediate family member) has an investment interest.

Review the Code List for Certain Designated Health Services (DHS) webpage and request an advisory opinion if you have questions on specific scenarios.

Click video for more information about the Stark Law.

Slide 30: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie about the delivery of, or payment for, health care benefits, items, or services to either:

- Defraud any health care benefit program
- Get (by means of false or fraudulent pretenses, representations, or promises) the money or property owned by, or under the custody or control of, a health care benefit program

Example: Several doctors and medical clinics conspired to defraud the Medicare Program by submitting claims for medically unnecessary power wheelchairs.

Penalties for violating the Criminal Health Care Fraud Statute may include fines, prison, or both.

Now, let's review Medicare fraud & abuse penalties for violating the FCA, AKS, Stark Law, or the Criminal Fraud Statute.

Slide 31: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Medicare Fraud & Abuse Penalties

Beyond paying restitution to CMS for money acquired fraudulently, Medicare fraud & abuse penalties may include exclusions, CMPs, and sometimes criminal sanctions—including fines and prison—against health care providers and suppliers who violate the FCA, AKS, Physician Self- Referral Law (Stark Law), or Criminal Health Care Fraud Statute.

Now, let's look at Medicare Program exclusions and how they affect providers.

Slide 32: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion Statute

The Exclusion Statute (42 U.S.C. Section 1320a-7) requires the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) to exclude health care providers and suppliers convicted of certain offenses from participating in Federal health care programs. OIG may also impose permissive exclusions on several other grounds.

Visit the OIG Exclusions Program webpage for more information.

Click video for more information about the Exclusion Statute.

Slide 33: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion Statute: Referrals

Excluded providers may not participate in Federal health care programs for a designated period but may refer a patient to a non-excluded provider if the excluded provider does not furnish, order, or prescribe services for the referred patient. In this case, the non-excluded provider must treat the patient and independently bill Federal health care programs for items or services provided. Covered items or services from a non-excluded provider to a Federal health care program beneficiary are payable, even when an excluded provider referred the patient.

Slide 34: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Mandatory Exclusion

For certain offenses, the OIG must impose an exclusion. Mandatory exclusions stay in effect for a minimum of 5 years; however, aggravating factors may lead to an even longer or permanent exclusion. Providers and suppliers face mandatory exclusions if convicted of these offenses:

- Medicare or Medicaid fraud and criminal offenses related to the delivery of items or services under a Federal or State health care program
- Criminal offenses related to patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct connected to the delivery of a health care item or service
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances

Slide 35: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Permissive Exclusion

The OIG may impose exclusions for offenses not under a mandatory exclusion. Permissive exclusions vary in length.

The OIG may issue permissive exclusions for various actions.

For a complete list of permissive exclusions, review 42 U.S.C. Section 3120a-7.

Slide 36: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Permissive Exclusion Examples

- Misdemeanor health care fraud convictions other than Medicare or Medicaid fraud

- Misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances
- Revocation, suspension, or health care license surrender for reasons of professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard service
- Convictions for obstructing an investigation or audit
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

Slide 37: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

OIG List of Excluded Individuals/Entities

The OIG List of Excluded Individuals/Entities (LEIE) publicly lists individuals and entities currently excluded from participation in all Federal health care programs. Providers and contracting entities must check the program exclusion status of individuals and entities in the LEIE before entering employment or contractual relationships.

Health care providers that knowingly hire an excluded party are subject to potential FCA liability and CMPs. Medicare will not pay for services by an excluded party, with certain exceptions. Prior to hiring an individual, purchasing supplies, or contracting with an entity (and periodically thereafter), health care providers should use the OIG LEIE to check program exclusion status.

Slide 38: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Search the List of Excluded Individuals/Entities

The LEIE is accessible through a searchable online database. It identifies parties excluded from Medicare reimbursement. The list includes information about the provider's specialty, exclusion type, and exclusion date.

Access the LEIE on the OIG website.

Using the Exclusions Database: Click video for information on searching the LEIE.

Slide 39: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

General Services Administration’s System for Award Management

The General Services Administration (GSA) consolidated several Federal procurement systems into one new system—the System for Award Management (SAM). SAM incorporated the Excluded Parties List System (EPLS) and includes information on entities:

- Debarred or proposed for debarment

- Disqualified from certain types of Federal financial and non-financial assistance and benefits
- Disqualified from getting Federal contracts or certain subcontracts
- Excluded
- Suspended

OIG compliance guidance encourages health care providers to check the SAM prior to hiring an individual, purchasing durable medical equipment (DME), supplies, or contracting with an entity (and periodically thereafter). Read the GSA fact sheet How do I search for an exclusion? for detailed instructions.

Remember, health care providers should check the LEIE and the SAM before making employment and contract decisions. You cannot get Federal payment or compensation for services provided by individuals and organizations listed on the LEIE and the SAM.

Now, let's look closer at the exclusion payment denial.

Slide 40: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion: Denial of Payment

An OIG exclusion means Federal health care programs do not pay for items or services given, ordered, or prescribed by an excluded individual or entity. Federal health care programs also make no payment to the excluded individual, anyone who employs or contracts with the excluded individual, and a hospital or other provider where the excluded individual provides services.

The exclusion applies regardless of who submits the claims for payment and applies to all administrative and management services given by the excluded individual.

For example, Federal health care programs do not make payment if:

- A hospital employs an excluded nurse who provides items or services to Federal health care program beneficiaries, even if the nurse's services are not separately billed and are paid as part of a Medicare diagnosis-related group payment the hospital gets
- The excluded nurse violates their exclusion thereby causing the hospital to submit claims for items or services they provide

During an exclusion period, the excluded individual or entity may face additional penalties for submitting or causing the submission of claims to a Federal health care program. The excluded individual or entity is susceptible to CMP liability as well as reinstatement denial to the Federal health care programs, including Medicare. Exceptions to payment denial apply in specific situations.

Slide 41: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion: Denial of Payment Exceptions

If a beneficiary submits claims for items or services given, ordered, or prescribed by an excluded individual or entity in any capacity after the effective date of the exclusion:

- Medicare pays the first claim submitted by the beneficiary and immediately gives the beneficiary notice of the exclusion
- Medicare makes no payment for the beneficiary items or services given more than 15 days after the date of the notice or after the effective date of the exclusion, whichever is later

The same process applies when labs or DME suppliers submit item or service claims ordered or prescribed by an excluded individual or entity.

There are also exceptions for certain inpatient hospital, skilled nursing facility, home health, and emergency services detailed in the Medicare Program Integrity Manual. Chapter 4, Section 4.19.2.6.

Slide 42: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Exclusion: Reinstatement

Reinstating excluded entities and individuals is not automatic once the specified exclusion period ends. Those who want to participate in all Federal health care programs must apply for reinstatement and get authorized notice from the OIG they granted reinstatement. If the OIG denies reinstatement, the excluded party is eligible to re-apply after 1 year.

Now, let's look at CMPs.

Slide 43: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Civil Monetary Penalties

CMPs apply to a variety of health care fraud violations, and assessment of the CMP depends on the type of violation. The CMP authorizes penalties up to $100,000 (in 2018) per violation, and assessments of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received. Violations that justify CMPs include:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or is false and fraudulent
- Violating the AKS
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs

CMP Inflation Adjustment

Each year, the Federal government adjusts all CMPs for inflation. The adjusted amounts apply to civil penalties assessed after August 1, 2016, and violations after November 2, 2015. Refer to 45 CFR 102.3 for the yearly inflation adjustments.

Now, let's look at civil prosecutions and penalties.

Click video for an example of where CMPs applied in a kickback scheme.

Slide 44: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Civil Prosecutions and Penalties

Depending on the severity of the violation, a civil suit or settlement may include any combination of the following:

- A CMP for each item or service in non-compliance (or higher amounts where applicable by statute)
- Payment up to 3 times the amount claimed for each item or service instead of damages sustained by the Federal government
- Exclusion from all Federal health care programs for a specified period
- An OIG Corporate Integrity Agreement (CIA), which requires an individual or entity to carry out a compliance program (including, for example, hiring a compliance officer, developing written standards and policies, carrying out an employee training program, and conducting annual audits and reviews)

In addition to civil prosecutions and penalties, law enforcement may prosecute health care fraud and pursue criminal convictions. Under the Affordable Care Act, the U.S. Sentencing Commission may add offense levels for health care fraud crimes with more than $1 million in losses. It is also a crime to obstruct fraud investigations.

Stay updated on the latest enforcement actions on the OIG Criminal and Civil Enforcement webpage.

Slide 45: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Lesson 2: Summary

The FCA, AKS, Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statute, the Social Security Act which includes, the Exclusion Statute, and the CMPLs, are the main Federal laws that address Medicare fraud & abuse.

- FCA: The FCA imposes civil liability on a person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim.

- Anti-Kickback Statute: The AKS prohibits knowingly and willfully offering, paying, soliciting, or getting remuneration in exchange for Federal health care program business referrals.
- Physician Self-Referral Law (Stark Law): The Physician Self-Referral Law (Stark Law) prohibits physicians from referring Medicare beneficiaries for designated health services to an entity where the physician (or an immediate family member) has an ownership/investment interest or a compensation arrangement, unless an exception applies.
- Criminal Health Care Fraud Statute: The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie for delivering, or paying for, health care benefits, items, or services to defraud a health care benefit program, or to get (by means of false or fraudulent pretenses, representations, or promises) the money or property owned by, or under the custody or control of, a health care benefit program.

Slide 46: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

- Exclusion Statute: The Exclusion Statute prohibits the excluded individual or entity from participating in all Federal health care programs. The exclusion means no Federal health care program pays for items or services given, ordered, or prescribed by an excluded individual or entity.
- Civil Monetary Penalties (CMPs): CMPs apply to a variety of conduct violations and assessing the CMP amount depends on the violation. Penalties up to $100,000 (in 2018) per violation may apply. CMPs may also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount offered, paid, solicited, or got.

Providers and contracting entities must check for program exclusion status prior to entering employment or contractual relationships using the OIG LEIE. OIG recommends checking SAM as well.

Civil and criminal prosecutions can result in a variety of fines, exclusion, CIAs, and even prison in criminal cases.

Slide 47: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Review Question 1

The Federal fraud & abuse laws are the False Claims Act (FCA), the Anti-Kickback Statute, the Physician Self-Referral Law (Stark Law), Criminal Health Care Fraud Statute, Social Security Act, and the Civil Monetary Penalties Law (CMPL).

A. True
B. False

Correct Answer – A

Slide 48: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

Review Question 2

Which of the following is NOT a possible penalty for Medicare fraud or abuse?

A. Exclusion from participating in all Federal health care programs
B. Imprisonment in criminal cases
C. Civil Monetary Penalties (CMPs) up to $500,000 per violation

Correct Answer – C

Slide 49: Lesson 2: Medicare Fraud & Abuse Laws and Penalties cont.

You've completed Lesson 2: Medicare Fraud & Abuse Laws and Penalties.

Now that you've learned about Medicare fraud & abuse basic laws and penalties, let's look at preventing Medicare fraud & abuse.

Slide 50: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors

In this lesson, you'll learn how physician relationships with payers, other providers, and vendors can prevent Medicare fraud & abuse. It should take about 15 minutes to complete.

In this lesson, you'll learn about:

- How you can help prevent Medicare fraud & abuse
- How compliance with Medicare laws, regulations, and policies prevent fraud & abuse
- Continuing education available on Medicare laws, regulations, and polices about fraud & abuse prevention

Slide 51: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

After completing this lesson, you should correctly:

- Identify ways your relationships with payers, other providers, and vendors prevent fraud & abuse
- Identify ways to comply with Medicare laws, regulations, and policies to prevent fraud & abuse
- Identify continuing education available on Medicare laws, regulations, and policies

Slide 52: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Relationships with Payers, Other Providers, and Vendors

The U.S. health care system relies on third party payers to pay most medical bills on behalf of patients. These payers understand Federal fraud & abuse laws apply when the government covers items or services provided to Medicare and Medicaid beneficiaries. This lesson focuses on:

- Physician Relationships with Payers
- Physician Relationships with Other Providers
- Physician Relationships with Vendors
- Continuing Medical Education on Medicare laws, regulations, and policies

Slide 53: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

You Can Help Prevent Medicare Fraud & Abuse

As a health care provider, you play a vital role in the fight against Medicare fraud & abuse. Help prevent Medicare fraud & abuse by:

- Checking the List of Excluded Individuals/Entities (LEIE) and System for Award Management (SAM) before making hiring and contracting decisions
- Providing only medically necessary, high quality Medicare beneficiary services
- Accurately coding and billing Medicare services
- Maintaining accurate and complete Medicare beneficiary medical records
- Understanding and complying with the Anti-Kickback Statute and Physician Self-Referral Law (Stark Law) when making investments or doing business with vendors

Slide 54: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Fraud & abuse also exist in Medicare Part C, Part D, and Medicaid, especially involving "dual eligibles."

For more information, see Job Aid C and Job Aid D.

Now let's look at physicians' relationships with payers related to accurate coding, billing, documentation, investments, and physician recruitment.

Click video, which focuses on fraud in Medicare Part D.

Slide 55: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Accurate Coding and Billing

As a physician, payers trust you to provide medically necessary, cost-effective, quality care. When you submit claims for Medicare services, you certify you earned the payment and complied with billing requirements. If you knew, or should have known, you submitted a false claim, this is an illegal attempt to collect payment. Examples of improper claims include:

- Billing codes that reflect a more severe illness than existed or a more expensive treatment than provided
- Billing medically unnecessary services
- Billing services not provided
- Billing services performed by an improperly supervised or unqualified employee
- Billing services performed by an employee excluded from participation in Federal health care programs
- Billing services of such low quality they are virtually worthless
- Billing separately for services already included in a global fee, like billing an Evaluation and Management (E/M) service the day after surgery

Slide 56: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Documentation

Maintain accurate and complete records of the services you provide. Make sure your documentation supports your claims for payment. Good documentation practices help ensure your patients get appropriate care and allow other providers to rely on your records for patients' medical histories.

The Medicare Program may review beneficiaries' medical records. Good documentation helps address any challenges raised about the integrity of your claims. You may have heard the saying regarding malpractice litigation: "If you didn't document it, it's the same as if you didn't do it." The same can be said for Medicare billing.

Slide 57: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Medicare pays for many physician services using E/M codes. These codes identify the level of service and pay new patient codes at a higher level than established patients. Billing an established patient follow-up visit using a higher-level E/M code is upcoding.

Another example of E/M upcoding is misusing modifier -25, which allows additional payment for a significant, separately identifiable E/M service provided on the same day of a procedure or other service. Upcoding occurs when a provider uses modifier -25 to claim payment for a medically unnecessary E/M service, an E/M service not distinctly separate from the procedure provided, or an E/M service not above and beyond the care usually associated with the procedure.

Slide 58: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Investments in Health Care Business Ventures

Some physicians who invest in business ventures with outside parties (for instance, imaging centers, laboratories, equipment vendors, or physical therapy clinics) refer more patients for services provided by those parties than physicians who do not invest. These business relationships may improperly influence or distort physician decision-making and result in improper patient-steering to a therapy or service where a physician has a financial interest.

Excessive and medically unnecessary referrals waste Federal government resources and can expose Medicare beneficiaries to harmful, unnecessary services. Many of these investment relationships have legal risks under the AKS and Stark Law.

If a health care business invites you to invest and might be a place where you would refer your patient, investigate the relationship thoroughly before proceeding.

Slide 59: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Recruitment

Hospitals and other health systems may provide a physician-recruitment incentive to induce providers or practices to join their medical staff. Often, such recruitment efforts fill a legitimate "clinical gap" in a medically underserved area where attracting physicians may be difficult without financial incentives.

Some hospitals, however, may offer incentives which cross the line into an illegal arrangement with legal consequences for the provider and the hospital.

A hospital may pay a provider a fair market-value salary as an employee or pay them a fair market value for specific services they provide to the hospital as an independent contractor. The hospital may not offer money, free or below-market rent for a medical office, or engage in similar activities designed to influence referral decisions.

Now let's look at physician relationships with vendors related to transparency and conflict of interest.

Slide 60: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Physician Relationships with Vendors

Many drug and biologic companies provide free product samples to physicians. It is legal to give these samples to patients free of charge, but it is illegal to sell the samples. The Federal government prosecutes physicians for billing Medicare for free samples. Implement reliable systems to safely store free samples and ensure they remain separate from your commercial stock.

Some pharmaceutical and device companies use sham consulting agreements and other arrangements to buy physician loyalty.

If you have opportunities to work as a consultant for the drug or device industry, evaluate the link between the services you provide and the compensation you get. Test the appropriateness of any proposed relationship by asking yourself:

- Does the company really need your specific expertise or input?
- Does the company's monetary compensation represent a fair, appropriate, and commercially reasonable exchange for your services?
- Is it possible the company is paying for your loyalty, so you prescribe or use its products?

Slide 61: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Federal Open Payments Program

The Federal Open Payments Program is a national disclosure program that promotes health care transparency by making financial relationships between health care providers and drug and medical device companies available to the public. The Open Payments data includes payments and other transfers of value such as gifts, honoraria, consulting fees, research grants, travel reimbursements, and other payments drug or device companies provide to physicians and teaching hospitals. The data also includes ownership and investment interests held by physicians or their immediate family members in reporting entities.

Data from a given year must be reported by drug and device companies by March 31 of the following year. CMS posts Open Payments data on or by June 30 each year. The public data is accessible via the Open Payments Search Tool. CMS closely monitors this process to ensure reported data integrity.

Visit Open Payments for more information.

Slide 62: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Conflict-of-Interest Disclosures

Rules about disclosing and managing conflicts of interest come from a variety of sources, including grant funders, such as States, universities, and the National Institutes

of Health (NIH), and from the U.S. Food and Drug Administration (FDA) when you submit data to support marketing approval for new drugs, devices, or biologics.

If you are uncertain whether a conflict exists, ask yourself if you would want the arrangement to appear in the news.

Slide 63: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Education on Medicare Laws, Regulations, and Policies

The Medicare Learning Network® (MLN) offers a variety of health care training and educational materials explaining Medicare policy. The MLN delivers planned and coordinated provider education through various media, including MLN Matters® Articles, fact sheets and booklets, web-based training courses, videos, and podcasts. Visit the MLN for a list of educational products.

The MLN Provider Compliance webpage contains educational products informing Medicare Fee-For-Service (FFS) Providers how to avoid common Medicare Program billing errors and other improper activities.

The OIG Compliance webpage provides education, compliance guidance, advisory opinions, and training resources.

Medicare Administrative Contractor (MAC) Provider Outreach and Education (POE) Programs offer providers and suppliers education on the fundamentals of the Medicare Program.

Slide 64: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Lesson 3: Summary

You play a vital role in detecting fraud. Your actions can help protect the Medicare Trust Fund. Be sure to review:

- Your relationships with payers related to accurate coding, billing, and documentation
- Your relationships with other providers related to investments and recruitment
- Your relationships with vendors related to transparency and conflict of interest
- Training available related to Medicare laws, regulations, and policies

Slide 65: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Review Question 1

You can help prevent Medicare fraud & abuse by _____.

A. Providing only medically necessary, high quality services to Medicare beneficiaries
B. Properly documenting all services provided to Medicare beneficiaries
C. Correctly billing and coding services provided to Medicare beneficiaries
D. All of the above

Correct Answer – D

Slide 66: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

Review Question 2

The Medicare Learning Network provides a variety of _____ for health care professionals.

A. Coding Rules
B. Training and educational products
C. Regulations
D. Enrollment forms

Correct Answer – B

Slide 67: Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors cont.

You've completed Lesson 3: Physician Relationships with Payers, Other Providers, and Vendors

Now that you've learned how your relationships with payers, other providers, and vendors prevent fraud & abuse, let's look at Medicare anti-fraud partnerships and agencies.

Slide 68: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies

In this lesson, you'll learn about the entities and methods used to detect fraud & abuse. It should take about 15 minutes to complete this lesson.

In this lesson, you will learn about:

- Efforts by the Centers for Medicare & Medicaid Services (CMS) to detect fraud & abuse in the Medicare program
- Data analysis, the Fraud Prevention System (FPS), and the Integrated Data Repository (IDR)
- Entities that conduct pre-payment and/or post-payment claims review to detect Medicare fraud & abuse

- Entities that investigate suspected Medicare fraud & abuse

The return on investment from 2016-2018 was $4.00 for every $1.00 dollar spent on fighting health care fraud & abuse.

Slide 69: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

After completing this lesson, you should correctly:
- Recognize efforts by CMS to detect fraud & abuse in the Medicare program
- Recognize entities conducting pre-payment and/or post-payment claims review
- Recognize entities investigating suspected Medicare fraud & abuse

Slide 70: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Health Care Fraud Prevention Partnership

The Health Care Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership including 132 partners from the Federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations. Their goal is to identify and reduce fraud, waste, and abuse across the health care sector through collaboration, data and information sharing, and cross-payer research studies. The HFPP also performs sophisticated industry-wide analytics to detect and predict fraud schemes.

Slide 71: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

The Centers for Medicare & Medicaid Services

CMS is the Federal agency within the Department of Health and Human Services (HHS) that administers the Medicare and Medicaid programs.

CMS works with individuals, entities, and law enforcement agencies to prevent fraud & abuse including:
- Accreditation Organizations
- Medicare beneficiaries and caregivers
- Physicians, suppliers, and other health care providers
- Office of Inspector General (OIG)
- Federal Bureau of Investigation (FBI)
- Contractors

Let's review the contractors that assist with CMS efforts to prevent and detect fraud.

Slide 72: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Claim-Reviewing Entities

CMS authorizes several different contractors to conduct pre-payment and/or post-payment review of claims. These include:

- Comprehensive Error Rate Testing (CERT) Contractors
- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractors (UPICs)

If one of these entities contacts you, respond within the specified timeframe and with all requested documentation supporting the claim service(s) medical necessity. This ensures accurate payment of the claim(s) under review and prevents payment recoupment for claims correctly paid. Contact your MAC to find contact information for your review contractors.

Slide 73: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Comprehensive Error Rate Testing Program

The CERT Program produces a national Medicare Fee-For-Service (FFS) error rate. CERT randomly selects a statistically valid, random sample of Medicare FFS claims and reviews those claims' and related medical records' compliance with Medicare coverage, payment, coding, and billing rules.

To accurately measure the MACs' performance and gain insight into error causes, CMS calculates a national Medicare FFS paid claims error rate and an improper payment rate by claim type and publishes the results of these reviews annually.

Slide 74: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

For example, here are the improper payment rate and projected improper payment amounts by claim type for Fiscal Year (FY) 2018. If you see your provider type on this list, refer to Job Aid D for tips on avoiding fraud & abuse.

Service Type	Improper Payment Rate	Improper Payment Amount
Inpatient Hospitals	4.29%	$4.96B
Durable Medical Equipment	35.54%	$2.59B
Physician/Lab/Ambulance	10.68%	$10.47B
Non-Inpatient Hospital Facilities	8.07%	$13.60B
Overall	8.12%	$31.62B

Slide 75: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

CERT Program FFS Improper Payment Rate

The Medicare FFS Improper Payment Rate is a good indicator of how Medicare FFS claims errors impact the Medicare Trust Fund. CMS and MACs educate providers and suppliers on CERT-identified high-risk areas.

For more information, visit the CERT Documentation Contractor website. The CERT Outreach and Education Task Force provides consistent, accurate provider outreach and education to help reduce the improper payment rate.

Slide 76: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Medicare Administrative Contractors

CMS, MACs, and other claim review contractors identify suspected billing problems through error rates produced by the CERT Program, vulnerabilities identified through the Recovery Audit Program, analysis of claims data, and evaluation of other information (for example, complaints).

CMS, MACs, and other claim review contractors target Medical Review (MR) activities on problem areas based on the severity of the problem. The SMRC conducts nationwide MR as directed by CMS. This includes identifying underpayments and overpayments.

MR may occur before or after the MAC makes a payment on the claim. MACs may review one or multiple claims at the same time.

Some providers may go through probed reviews or placed on Progressive Corrective Action (PCA) plans depending on the extent of their billing errors.

Slide 77: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Medicare FFS Recovery Audit Program

Medicare FFS Recovery Audit Contractors (RACs) conduct post-payment claim reviews to detect improper underpayments and overpayments. RACs may target claim reviews by service. Each RAC website publishes its targeted services. Visit the Recovery Audit Program webpage for more information, including Medicare Parts A and B Recovery Auditors contact information.

Also review the Quarterly Provider Compliance Newsletter for common Medicare FFS Recovery Audit and CERT findings and tips for avoiding issues.

Slide 78: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Parts C and D Recovery Audit Program

CMS created the Parts C and D Recovery Audit Program to identify and correct past improper payments to Medicare providers. CMS also implemented procedures to help MACs prevent future improper payments. Communication about audit results and trends leads to continuous process improvement, more accurate payments, and helps plan sponsors correct issues in a timely manner.

CMS designated one Recovery Auditor to review payments for Medicare Part D. CMS will start the Recovery Audit Program for Medicare Part C payments in the future. Visit the Parts C and D Recovery Audit Program webpage for more information.

Now that you've learned about the entities that review claims, let's discuss entities that provide analytical support to CMS to detect fraud & abuse activities.

Slide 79: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Analytical Entities

Within CMS, the Center for Program Integrity (CPI) promotes Medicare integrity through audits, policy reviews, and identifying and monitoring program vulnerabilities. CPI oversees CMS' collaboration with key stakeholders on detecting, deterring, monitoring, and combating fraud & abuse issues.

In 2010, HHS and CMS launched the Fraud Prevention System (FPS), a state of-the-art predictive analytics technology that runs Medicare FFS claims predictive algorithms and other analytics prior to payment to detect potentially suspicious claims and patterns that may constitute fraud & abuse.

Slide 80: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Fraud Prevention System

The FPS uses sophisticated analytics to prevent and detect fraud & abuse in the Medicare FFS Program. It provides a comprehensive view of Medicare FFS provider and beneficiary activities to identify and analyze provider networks, billing patterns, beneficiary usage patterns, and patterns representing a high risk of fraudulent activity.

The FPS is fully integrated with the Medicare FFS claims processing system and uses other data sources, such as the Integrated Data Repository (IDR).

Slide 81: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Examples of these fraudulent activities:

- A home health agency in Florida billed services never provided. Due to the FPS, CMS placed the home health agency on pre-payment review and payment suspension, referred the agency to law enforcement, and ultimately revoked the agency's Medicare enrollment.
- In Texas, the FPS identified an ambulance company submitting claims for non-covered services and services not given. Medicare revoked the ambulance company's enrollment.
- The FPS identified an Arizona medical clinic with questionable billing practices, such as billing excessive units of service per beneficiary per visit. The physicians delivered repeated and unnecessary neuropathy treatments to beneficiaries. CMS revoked the medical clinic's Medicare enrollment.

Slide 82: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Integrated Data Repository

The IDR creates an integrated data environment from Medicare and Medicaid claims, beneficiaries, providers, Medicare Advantage (MA) plans, Part D Prescription Drug Events (PDEs), and other data.

The IDR provides greater information sharing, broader and easier access, enhanced data integration, increased security and privacy, and strengthened query and analytic capability by building a unified data repository for reporting and analytics.

Now let's review the entities that help CMS investigate fraud & abuse activities.

Slide 83: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Investigating Entities

The following entities review claims and more extensively investigate specific health care providers:

- Unified Program Integrity Contractors (UPICs)
- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Federal Bureau of Investigation (FBI)

These entities work with the claim reviewing entities and CMS to protect the Medicare Program against fraud & abuse.

Medicare Advantage (MA) plans also investigate Medicare Part C fraud & abuse. Prescription Drug Plans (PDPs) investigate Medicare Part D fraud & abuse. Medicare Drug Integrity Contractors (MEDICs) investigate Medicare Part C and Part D fraud & abuse.

Slide 84: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Unified Program Integrity Contractors

UPICs identify suspected fraud & abuse cases and refer them to the OIG. UPICs may also act to minimize potential losses to the Medicare Trust Fund and protect Medicare beneficiaries from potential adverse effects. Appropriate action varies from case to case. For example, when a provider's employee files a complaint, the UPIC immediately advises the OIG.

For more information, go to the Medicare Program Integrity Manual. Chapter 4.

Slide 85: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Office of Inspector General

The OIG protects the integrity of HHS programs, including Medicare, and the health and welfare of its beneficiaries. The OIG carries out its duties through a nationwide network of audits, investigations, inspections, and other related functions. The OIG can exclude individuals and entities who engaged in fraud or abuse from participation in all Federal

health care programs and impose Civil Monetary Penalties (CMPs) for certain Federal health care program misconduct.

Click video for a snapshot of the OIG's work.

Slide 86: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Department of Justice

The DOJ investigates and prosecutes fraud & abuse in Federal government programs. The DOJ's investigators partner with the OIG; the FBI; and other Federal, State, and local law enforcement offices through HEAT to investigate and prosecute Medicare fraud & abuse. DOJ attorneys, through the U.S. Attorney's Offices, handle the civil and criminal prosecutions.

Slide 87: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Health Care Fraud Prevention and Enforcement Action Team

The DOJ and HHS established HEAT to build and strengthen existing programs to combat Medicare fraud while investing new resources and technology to prevent fraud & abuse. HEAT investigators use new state-of-the-art technology to fight fraud with unprecedented speed and efficiency.

Slide 88: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Medicare Fraud Strike Force

The DOJ-HHS Medicare Fraud Strike Force also fights fraud. Each Medicare Fraud Strike Force team combines the FBI's investigative and analytical resources with HHS-OIG's Criminal Division's Fraud Section and the U.S. Attorney's Offices prosecutorial resources.

Strike Force Statistics since Inception:

- Cases Filed: 1,750
- Defendants Charged: 3,800
- Defendants Billed Medicare: $15 billion

Slide 89: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Lesson 4: Summary

- Medicare fraud & abuse data helps guide claims reviewers and investigators to high-risk fraud & abuse areas.
- MACs and UPICs conduct pre-payment claims reviews.
- MACs, the SMRC, UPICs, CERT Contractors, and RAC Auditors conduct post-payment claims reviews.
- UPICs, OIG, DOJ, and HEAT investigate Medicare fraud & abuse.

Slide 90: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Review Question 1

Which of the following entities conduct claims Medical Review (MR)?

A. Medicare Administrative Contractors (MACs)
B. Comprehensive Error Rate Testing (CERT) Contractors
C. Recovery Audit Program Recovery Auditors
D. All of the above

Correct Answer – D

Slide 91: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

Review Question 2

Which of the following entities investigate health care providers suspected of Medicare fraud & abuse?

A. Office of Inspector General (OIG)
B. Department of Justice (DOJ)
C. Unified Program Integrity Contractors (UPICs)
D. B and C
E. A, B, and C

Correct Answer – E

Slide 92: Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies cont.

You've completed Lesson 4: Medicare Anti-Fraud and Abuse Partnerships and Agencies

Now that you've learned about the basic concepts of Medicare fraud & abuse detection, let's look at how to report Medicare fraud & abuse.

Slide 93: Lesson 5: Report Suspected Medicare Fraud & Abuse

In this lesson, you'll learn about reporting fraud & abuse. It should take about 5 minutes to complete. In this lesson, you'll learn about:

- How you can report suspected Medicare fraud & abuse
- How you can self-disclose Medicare fraud & abuse
- The Medicare Incentive Reward Program (IRP)

Slide 94: Lesson 5: Report Suspected Medicare Fraud & Abuse

After completing this lesson, you should correctly:

- Recognize how to report suspected Medicare fraud & abuse
- Recognize how to self-disclose Medicare fraud & abuse

Slide 95: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

How to Report Suspected Medicare Fraud & Abuse: IOG

The Office of Inspector General (OIG) maintains a hotline and webpage that accepts and reviews tips from all sources, such as Medicare and Medicaid beneficiaries and providers. You can report suspected fraud & abuse anonymously by phone (OIG Hotline), email, fax, mail, and on the OIG website. The OIG collects no information that could trace the complaint to you; however, lack of contact information may prevent a comprehensive review of the complaint. OIG encourages you to provide contact information for follow-up.

Use Job Aid E to report fraud & abuse to the appropriate authorities.

Click video for a snapshot of the OIG's work.

Slide 96: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

How to Report Suspected Medicare Fraud & Abuse: MAC

For questions about Medicare billing procedures, billing errors, or questionable billing practices, contact your Medicare Administrative Contractor (MAC).

Slide 97: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

What to do if you Suspect you have Problematic Relationships or Inappropriate Billing Practices:

- Stop submitting problematic bills
- Seek legal counsel
- Determine money collected in error from patients and from Federal health care programs and report and return refunds
- Cease involvement in a problematic investment

- Get out of the problematic relationship(s)
- Consider self-disclosing the issues

Slide 98: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

How to Self-Disclose Medicare Fraud & Abuse to the OIG

Providers who wish to voluntarily disclose evidence of potential fraud, where it may trigger Civil Monetary Penalties (CMPs), may do so under the OIG Provider Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to minimize the costs and disruptions associated with a government-directed investigation and civil or administrative litigation.

The OIG works cooperatively with forthcoming, thorough, and transparent providers in their disclosures to resolve these matters. While the OIG does not speak for the Department of Justice (DOJ) or other agencies, the OIG consults with these agencies, as appropriate, regarding SDP issues resolution.

Visit the OIG Self-Disclosure Information webpage for more information or to complete your self-disclosure online.

Slide 99: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

How to Self-Disclose Actual or Potential Violations of the Physician Self-Referral Law (Stark Law)

For Physician Self-Referral Law (Stark Law) actual or potential violations, Centers for Medicare & Medicaid Services (CMS) Self-Referral Disclosure Protocol (SRDP) allows health care providers and suppliers to self-disclose them through a separate OIG process.

The physician cannot use the SRDP to get a CMS determination as to whether an actual or potential violation of the Physician Self-Referral Law (Stark Law) occurred. Providers and suppliers should submit their overpayment liability exposure to the SRDP to resolve the conduct they identify.

Under certain circumstances, CMS can reduce the amount due. However, fraud & abuse self-disclosure does not protect health care providers from sanctions and prosecutions.

Slide 100: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

Medicare Incentive Reward Program

CMS established the Medicare IRP to encourage reporting suspected fraud & abuse.

The IRP rewards information on Medicare fraud & abuse or other punishable activities. The information must lead to a minimum Medicare recovery of $100 from individuals and entities CMS determines committed fraud.

For more information, go to the Medicare Program Integrity Manual, Chapter 4, Section 4.9.

Slide 101: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

Lesson 5: Summary

You may report suspected Medicare fraud & abuse by phone, email, fax, mail, and on the OIG website.

You may self-disclose fraud & abuse to the OIG using the Provider SDP. You may self-disclose actual or potential violations of the Physician Self-Referral Law (Stark Law) to CMS using the Medicare SRDP.

The Medicare IRP provides rewards for Medicare fraud & abuse information or other punishable activities.

Slide 102: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

Review Question 1

You may report suspected fraud & abuse anonymously by phone, email, fax, mail, and on the Office of Inspector General (OIG) website.

A. True
B. False

Correct Answer – A

Slide 103: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

Review Question 2

Health care providers who self-disclose fraud & abuse violations are protected from sanctions and prosecutions.

A. True
B. False

Correct Answer – B

Slide 104: Lesson 5: Report Suspected Medicare Fraud & Abuse cont.

You've completed Lesson 5: Report Suspected Medicare Fraud & Abuse.

Next you will be presented with the Job Aids mentioned throughout the course. Then you will be given a brief 10 question Post-Test to assess your knowledge. The Post-Test should take about 10 minutes.

Successfully completing the course includes finishing all lessons and scoring 70 percent or higher on the Post-Test.

Slide 105: Job Aids

Job Aid A

Case Examples of Medicare Fraud

To learn about more real Medicare fraud & abuse cases and their consequences, visit the Office of Inspector General (OIG) Criminal and Civil Enforcement webpage.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier

Violation of the Anti-Kickback Statute: A Durable Medical Equipment supplier paid $30 million and entered a Corporate Integrity Agreement (CIA) to settle allegations they paid illegal kickbacks to induce spinal surgeons to use the company's products. A subsidiary of the DME supplier paid kickbacks to spinal surgeons through sham consulting agreements, sham royalty arrangements, sham research grants, travel, and entertainment.

Home Health Agency (HHA)

Violation of the Criminal Health Care Fraud Conspiracy Statute and the Anti-Kickback Statute: Nine defendants got a combined 16 years and 2 months in prison and paid more than $5.8 million in restitution for their roles in an HHA fraud scheme. The president of the HHA and co-conspirators allegedly offered and paid kickbacks and bribes to patient recruiters in return for referring beneficiaries to the HHA to serve as patients. Beneficiaries also got kickbacks for agreeing to serve as HHA patients. The HHA received $9.5 million in reimbursements from these false claims.

Hospital or Other Health Care Facilities

Violation of the Civil False Claims Act (FCA): A clinic paid $656,000 to resolve allegations it violated the FCA and overcharged Medicare. The clinic allegedly performed certain blood tests (lipid panel tests and a cholesterol test) without any intervening review to determine the medical necessity of the second test.

Violation of the Physician Self-Referral Law (Stark Law): A hospital executive director personally paid $64,000 for allegedly causing Medicare Claims submission in violation of the Physician Self-Referral Law (Stark Law). During the relevant time, the hospital

executive director also served as the hospital's compliance officer and the court found him personally liable for the hospital's alleged violations.

Exclusion Statute and Civil Monetary Penalties Law: A long-term care facility paid $170,000 for allegedly violating the Civil Monetary Penalties Law by employing an individual the facility knew or should have known was excluded from Federal health care programs participation.

Exclusion Statute and Civil Monetary Penalties Law: Two hospitals paid $243,819 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged the hospitals knew or should have known they employed five individuals excluded from Federal health care programs participation.

Pharmacist/Pharmacy

Exclusion Statute and Civil Monetary Penalties (CMP) Law: A national drugstore chain paid nearly $1 million to settle allegations it billed Federal health care programs for prescriptions filled by an excluded pharmacist. For nearly 4 years, two stores allegedly submitted Medicare and TRICARE claims for medications filled by a pharmacist listed on the Federal health care programs List of Excluded Individuals/Entities (LEIE). The $969,230 settlement represented a recovery of double damages for all claims paid by Medicare and TRICARE for prescriptions the pharmacist filled at the stores.

Physical Therapist

Fraudulent Billing and the CMP Law: A physical therapist paid $122,474 for allegedly violating the CMP Law when the therapist improperly billed Medicare for physical therapy services not properly supervised by a licensed physical therapist.

Physicians

Violation of the Anti-Kickback Statute: A doctor pled guilty and got a prison sentence for accepting cash kickbacks for beneficiary information used to submit Medicare and Medicaid DME claims.

Violation of the Physician Self-Referral Law (Stark Law): A physician paid the Federal government $203,000 to settle allegations he violated the physician self-referral prohibition in the Physician Self-Referral Law (Stark Law) by routinely referring Medicare beneficiaries to an oxygen supply company he owned.

Exclusion Statute: A physician paid $65,000 and got a Notice of Exclusion barring the physician's participation in all Federal health care programs for 3 years. The physician solicited and got consulting payments from a medical device manufacturer for using the manufacturer's orthopedic hip and knee products.

CMP Law: A doctor paid $650,000 for allegedly violating the CMP Law provisions applicable to kickbacks. The doctor allegedly solicited and got consulting payments from two medical device manufacturers for using their orthopedic hip and knee products.

Fraudulent Billing: A psychiatrist paid a $400,000 fine and was permanently excluded from Federal health care programs participation. The psychiatrist misrepresented his 15 minutes or less medication checks as 30- 60 minutes of patient face-to-face therapy sessions. The psychiatrist also misrepresented he provided therapy sessions when a non-licensed individual conducted the sessions.

Misuse of Provider and Prescription Numbers: A physician paid $50,000 in restitution to the Federal government. On his provider number application, the physician falsely indicated he ran his own practice when, in fact, a neurophysiologist owned and operated the practice and paid the physician's salary.

Liability Resolved Under OIG Provider Self-Disclosure Protocol: A neurosurgery practice paid $10,000 to resolve liability for employing an individual excluded from Federal health care programs participation.

Job Aid B

Case Examples of Medicare Abuse

To learn about more real Medicare fraud & abuse cases and their consequences, visit the Office of Inspector General (OIG) Criminal and Civil Enforcement webpage.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier

Medically Unnecessary Services: A DMEPOS supplier got a Group 2 standard power wheelchair $5,049 payment. The power wheelchair documentation did not support medical necessity according to the applicable National Coverage Determination (NCD) and Local Coverage Determination (LCD). Neither the diagnoses nor the face-to-face physician's evaluation supported the inability to self-propel. The DMEPOS supplier provided no other valid documentation why a power mobility device was reasonable and necessary. Medicare recouped the entire payment.

Medically Unnecessary Services: A DMEPOS supplier got $231 monthly payments for an oxygen concentrator and a portable gaseous unit. When asked for supporting documentation, the supplier provided an incomplete Certificate of Medical Necessity (CMN) dated 4 months after the claim's adjudication date. On the CMN, no responses appeared for the following inquiries: (1) the results of the oxygen saturation test, (2) whether the beneficiary was an inpatient during testing, and (3) the oxygen-flow rate. This record did not meet the LCD for oxygen and oxygen equipment medical necessity criteria. Medicare recouped the entire payment.

Hospital or Other Health Care Facilities

No Documentation: A provider received a $520 payment for a colonoscopy. After reviewers made several attempts to get the record, the provider sent a letter that stated, "Patient was not seen on this date of service." The Medicare Administrative Contractor (MAC) recouped the entire payment.

Insufficient Documentation: A hospital got an inpatient hospital stay $2,767 payment. After reviewers made multiple attempts to get the documentation, the hospital submitted an initial history and physical, and a brief discharge summary. Insufficient documentation did not support the services billed. The recouped the entire payment.

Medically Unnecessary Services: A provider got a $146 payment for outpatient diagnostic tests. Repeated requests for evidence showing the treating physician's intent to order the specific diagnostic tests did not support medical necessity. Medicare recouped the entire payment.

Medically Unnecessary Services: A hospital received a 1-day inpatient $4,699 hospital stay payment. The hospital admitted the beneficiary with abdominal pain and hospitalized the patient for less than 12 hours. The beneficiary failed to meet inpatient admission medical necessity criteria. The hospital, however, could have treated the beneficiary on an outpatient observation status. The MAC recouped the entire payment.

Incorrect Coding: A provider got a transthoracic echocardiography with contrast, with real time exercise stress test $741 payment. Documentation of the transthoracic echocardiography revealed the provider performed the diagnostic study without using contrast material. This coding error resulted in a $14 provider overpayment. Medicare recouped it.

Hospital or Other Health Care

Violation of the Civil False Claims Act (FCA): A clinic paid $656,000 to resolve allegations it violated the FCA and overcharged Medicare. The clinic allegedly performed certain blood tests (lipid panel tests and a cholesterol test) without any intervening review to determine the medical necessity of the second test.

Violation of the Physician Self-Referral Law (Stark Law): A hospital executive director personally paid $64,000 for allegedly causing Medicare Claims submission in violation of the Physician Self-Referral Law (Stark Law). During the relevant time, the hospital executive director also served as the hospital's compliance officer and the court found him personally liable for the hospital's alleged violations.

Exclusion Statute and Civil Monetary Penalties Law: A long-term care facility paid $170,000 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged the hospitals knew or should have known they employed five individuals excluded from Federal health care programs participation.

Physical Therapist

Insufficient Documentation: A MAC paid $136 for physical therapy visits. The physical therapy records included no order, ordering physician-signed plan of care, or treatment notes. The MAC recouped the entire payment.

Physician

No Documentation: A physician got a $183 hospital visit payment. After multiple attempts to get the record, the physician sent a letter that stated, "No record for time period found." The MAC recouped the entire payment.

Job Aid C

Fraud & Abuse in Medicare Part C and Part D, and Medicaid

Medicare Part C

Medicare Part C, or Medicare Advantage (MA), is a Medicare beneficiary health plan choice. MA is run by Medicare-approved private insurance companies. These companies arrange for, or directly provide, health care services to the beneficiaries who elect to enroll in an MA plan.

MA plans must cover all services Medicare covers except hospice care. MA plans provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Medicare Part D

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Insurance companies or other Medicare-approved companies provide prescription drug coverage to individuals who live in a plan's service area.

Fraud, Waste, and Abuse in Medicare Part C and Part D

Medicare Part C and Part D contractors and plans play a vital part in preventing, detecting, and reporting Medicare fraud & abuse. MA plans and PDPs must follow certain requirements and report suspected fraud & abuse. Part C and Part D contractors must have an effective compliance program that includes measures to prevent, detect, and correct Medicare non-compliance, fraud, and abuse. Contractors also must have effective fraud & abuse training.

Medicare Part C and Part D Indicators of Fraud & Abuse

The following details types of entities and the key indicators for each:

Beneficiary

- Does the prescription, medical record, or lab test look altered or possibly forged?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person getting the medical service/picking up the prescription the actual beneficiary (identity theft)?
- Is the beneficiary's prescription appropriate based on their other prescriptions?
- Does the beneficiary's medical history support the services requested?

Provider

- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Are the provider's prescriptions appropriate for the beneficiary's health condition (medically necessary)?
- Is the provider prescribing a higher quantity of medication than the medically necessary amount for the condition?
- Is the provider giving medically unnecessary beneficiary services?
- Is the provider's beneficiary diagnosis supported in the medical record?
- Does the provider bill the MA plan or PDP sponsor for services not provided?

Pharmacy

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are prescriptions altered (changing quantities or Dispense As Written [DAW])?
- Are proper provisions made if the pharmacist cannot fill the entire prescription (no additional dispensing fees for split prescriptions)?
- Are generic drugs provided when the prescription requires brand name drugs?
- Are Pharmacy Benefit Managers (PBM) getting bills for prescriptions not filled or picked up?
- Are drugs diverted? (Are drugs meant for nursing homes, hospices, and other entities sent elsewhere?)

Wholesaler

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immunodeficiency Syndrome (AIDS) clinics and then marking up the prices and sending the drugs to other smaller wholesalers or pharmacies?

Manufacturer

- Does the manufacturer promote off-label drug use?
- Does the manufacturer provide samples, knowing the entity bills them to a Federal health care program?

MA Plan/PDP Sponsor

- Does the sponsor have an easily accessible employee and beneficiary plan to report potential fraud, abuse, or other misconduct?
- Does the sponsor provide Medicare Part C and Part D fraud & abuse fliers, letters, and Explanations of Benefits (EOBs) beneficiary education?
- Does the sponsor accept anonymous and confidential reports? (MA plans and PDPs cannot retaliate against those who report potential misconduct.)
- Does the sponsor promptly respond to and correct potential or actual fraud & abuse? (The MA or PDP compliance officer must engage in this process to ensure appropriate documentation and fraud & abuse investigations tracking, including the investigations and corrective actions.)
- Does the sponsor offer beneficiary cash inducements to join the plan?
- Does the sponsor lead the beneficiary to believe the cost of benefits is one price, only for the beneficiary to find out the actual cost exceeds that price?
- Does the sponsor use unlicensed agents?
- Does the sponsor encourage/support inappropriate risk adjustment submissions?

Medicaid

Medicaid is a joint Federal and State health care program that helps some people with low incomes and limited resources with medical costs. Medicaid programs vary from state to state. The term “dual eligibles" refers to individuals entitled to, or enrolled in, Medicare Part A or Part B, and eligible for Medicaid. Federal and the respective state fraud & abuse laws apply to the Medicaid Program and protect Medicaid beneficiaries and dual eligibles.

Go to the Medicaid Program Integrity Education webpage for toolkits and resources.

Medicaid Indicators of Fraud & Abuse

There Are Many Types of Medicaid Fraud describes various fraud indicators using provider and beneficiary examples.

Report Suspected Fraud & Abuse

MA plans and PDPs cannot retaliate against those who report potential misconduct. To report suspected fraud & abuse to the Office of Inspector General (OIG), use the contact information below:

Forms.OIG.HHS.gov/HotlineOperations/index.aspx
Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY: 1-800-377-4950

Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Mail: U.S. Department of Health and Human Services
Attn: OIG Hotline Operations P.O. Box 23489 Washington, DC 20026

Additionally, Medicaid beneficiaries and providers may contact their Medicaid State Agency: the National Association of Medicaid Fraud Control Units (NAMFCU) lists State Medicaid Fraud Control Units.

Medicare beneficiaries may call 1-877-7SafeRx (1-877-772-3379) or 1-800-MEDICARE (1-800-633-4227) for Medicare Managed Care or Prescription Drug Plan options.

Job Aid D

Tips for Avoiding Medicare Fraud & Abuse

To help you prevent Medicare fraud & abuse, these tips on vulnerabilities appear according to provider type. For additional guidance on compliance, visit the OIG Compliance webpage. For additional guidance on recognizing fraud & abuse, visit the CMS Fraud Prevention Toolkit webpage.

All Provider Types Vulnerabilities

- All Services
  - Tips

    The Office of Inspector General (OIG) "spotlights" certain services vulnerable to fraud & abuse and all recent material added to the website, including the latest reports, advisory opinions, enforcement actions, and other OIG news, in one easy-to-access spot.

  - Resources

    OIG Eye on Oversight
    OIG What's New

- Computed Tomography (CT) Scans
  - Tips

    Check the order from the ordering practitioner to make sure it is signed and keep a copy. Document a performed CT scan in your medical record.

    Keep a copy of the CT scan radiologist report or interpreting physician.

    If you get a documentation request from a claim review contractor, submit:
    - The order
    - The ordering practitioner's progress notes

        - The medical record entry
        - The interpreting physician's CT scan report

    - Resources
      Medicare Imaging Services Coverage

- Evaluation and Management (E/M) Services
    - Tips

      Ensure you bill the correct service code level provided.

      Correctly use the appropriate pulmonary diagnostic, therapeutic, or monitoring procedures modifier on the same date of an E/M service.

      Follow payment guidelines for E/M services provided during the global surgery period. Correctly bill for services provided to patients in swing beds.

    - Resources

      Evaluation and Management Services Guide

      Global Surgery

      Swing Bed Services

- Signature Requirements
    - Tips

      Ensure the ordering practitioner authenticates services ordered or provided and adequately documented.

      Ensure handwritten or electronic (stamped signatures are only allowed for limited exceptions) signatures.

      Ensure legible signatures.

    - Resources

      Complying with Medicare Signature Requirements

      Complying with Documentation Requirements for Laboratory Services

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Vulnerabilities

- Diabetes Supplies
  - Tips

    Ensure the physician signs and dates the glucose testing supplies order describing the dispensed items.

    Ensure the medical record contains the beneficiary's test log results or other documentation (such as, diagnosis and treatment regimen) supporting frequency.

    Ensure documentation reflects the reason the beneficiary is testing above policy limits.

    Ensure you document the beneficiary's diagnosis.

    Medicare policy states the supply allowance for supplies used with a therapeutic CGM system encompasses all items necessary for the use of the device and includes, but is not limited to: CGM sensor, CGM transmitter, home BGM, related BGM supplies (test strips, lancets, lancing device, calibration solutions) and batteries. Supplies or accessories billed separately will be denied as unbundling.

  - Resources

    Provider Compliance Tips for Diabetic Test Strips

    Provider Compliance Tips for Glucose Monitors

    Recovery Auditor Finding: Blood Glucose Monitor Device Bundling

- Parenteral Nutrition
  - Tips

    Document the reason enteral nutrition is needed.

    Document the reason the parenteral nutrition is needed.

    Verify the physician wrote a detailed enteral nutrition and pump order, signed and dated by the treating physician, and available upon request.

  - Resources

    Provider Compliance Tips for Parenteral Nutrition

- Infusion Pumps, Accessories, and Drugs
  - Tips

Ensure billing staff know the billing infusion pumps, accessories, and drugs requirements.

- Resources

  MLN Matters Special Edition Article SE1609, Medicare Policy Clarified for Prolonged Drug and Biological Infusions Started Incident to a Physician's Service Using an External Pump

- Nebulizers and Related Drugs
  - Tips

    Medicare requires that claims for nebulizer machines and related drugs be reasonable and necessary. Local Coverage Determinations issued by Medicare contractors that process Durable Medical Equipment (DME) and supply claims, include utilization guidelines and documentation requirements.

  - Resources

    Provider Compliance Tips for Nebulizers and Related Drugs

- Oxygen Therapy Supplies
  - Tips

    Ensure physician visit or evaluation documentation before the initial or recertification date. Ensure the original blood, gas, or saturation test results documentation.

    Ensure documentation indicates beneficiary oxygen needs and home uses.

    Ensure documentation shows continued equipment need or use.

    For portable oxygen, ensure documentation demonstrates the beneficiary is mobile within the home.

  - Resources

    Provider Compliance Tips for Ordering Oxygen Supplies and Equipment

- Positive Airway Pressure (PAP) Devices
  - Tips

Ensure documentation exists of the treating physician's initial face-to-face clinical evaluation conducted before the sleep study to assess Obstructive Sleep Apnea (OSA).

Ensure Medicare-covered sleep study documentation supporting PAP device medical necessity.

Ensure the treating physician signs and dates the order describing the dispensed items.

Ensure the treating physician's face-to-face re-evaluation documentation within the proper time frame.

- Resources

Provider Compliance Tips for Positive Airway Pressure (PAP) Devices and Accessories Including Continuous Positive Airway Pressure (CPAP)

- Power Mobility Devices (PMDs)
  - Tips

Ensure you correctly document PMDs and medical necessity.

  - Resources

Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements

Inclusion of Power Mobility Device Codes in the Prior Authorization Program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items

Inpatient and Outpatient Provider Vulnerabilities

- Cardiac Pacemakers
  - Tips

For dual-chamber pacemakers, ensure documentation supports the medical need for a dual-chamber pacemaker rather than a single-chamber pacemaker.

Ensure beneficiaries identified for dual-chamber pacemakers do not have a clear contraindication, such as chronic atrial fibrillation.

- Resources

  Medicare Billing for Cardiac Device Credits

- Hospice Care
  - Tips

    Ensure all Medicare coverage requirements are met, including plan-of-care guidelines.

    Bill hospice patient services appropriately.

  - Resources

    Provider Compliance Tips for Hospital Based Hospice

    Hospice Payment System

- Inpatient Hospital Services
  - Tips

    Ensure inpatient admissions are medically necessary, reasonable, and appropriate for the beneficiary's diagnosis and condition at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the medical care and must get services of such intensity that they can be given safely and effectively only on an inpatient basis.

    Ensure the claim diagnosis codes are correct by waiting to assign diagnosis codes until you have the complete medical record.

    Appropriately bill pre-admission diagnostic testing services.

  - Resources

    Comprehensive Error Rate Testing (Cert): Observation And Inpatient Hospital Care

    Recovery Auditor Finding – A Reminder: Durable Medical Equipment (DME) Suppliers Billing For DME For Beneficiaries In A Medicare Inpatient Stay

    Guidance for Medicare Administrative Contractors (MACs) Processing Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIO) Two-Midnight (2MN) Short Stay Review (SSR) Determinations

- Inpatient Rehabilitation Services
  - Tips

    Ensure properly documented and coded services.

    Ensure appropriate, complete, and legible.

  - Resources

    Provider Compliance Tips for Inpatient Rehabilitation Facility (IRF) – Inpatient

    Rehabilitation Hospitals and Inpatient Rehabilitation Units

- Laboratory Services
  - Tips

    Ensure the treating physician orders all diagnostic X-ray tests, diagnostic lab tests, and other diagnostic tests.

    In progress notes, clearly indicate all ordered tests.

  - Resources

    Complying with Documentation Requirement for Laboratory Services

- Outpatient Rehabilitation Therapy Services
  - Tips

    Ensure the plan of care is completed.

    Ensure appropriate, present, complete, legible, and dated signatures. Ensure documented modality times.

    Ensure completed plan of care certifications and recertifications.

  - Resources

    Therapy Services

- Outpatient Services
  - Tips

    Include the appropriate billing for multiple diagnostic services on the same day modifier.

Ensure you bill the correct services or procedures code.

Ensure you bill the correct number of units.

Ensure you properly document all services and procedures.

- Resources

Provider Compliance Tips For Ordering Hospital Outpatient Services

- Skilled Nursing Facilities (SNF)
  - Tips

Ensure your services meet quality of care requirements.

Provide adequate discharge planning.

  - Resources

SNF Billing Reference

Provider Compliance Tips For Ordering Hospital Outpatient Services

Physician Vulnerabilities

- All Physician Services
  - Tips

Ensure Federal law compliance that combat fraud & abuse.

Ensure you provide beneficiaries appropriate quality medical care.

Ensure you can identify "red flags" that could lead to potential law enforcement liability and administrative actions.

  - Resources

Medicare Fraud & Abuse: Prevent, Detect, Report

- Chiropractic
  - Tips

Ensure you properly code and bill maintenance therapy.

Ensure you properly and correctly document services.

- Resources

  Chiropractic Services

  Medicare Documentation Job Aid for Doctors of Chiropractic

- Correct Coding
  - Tips

    Ensure you correctly code the Place of Service (POS)

    Ensure you do not upcode services (services billed at a higher reimbursement level than the beneficiary service provided).

  - Resources

    Proper Coding for Specimen Validity Testing Billed in Combination with Drug Testing

- Open Payments
  - Tips

    Voluntarily track payments and value transfers made to you by pharmaceutical and medical device manufacturers, and be aware these value/payments and ownerships investment interests in pharmaceutical, medical device, or group purchasing organizations transfers held by you or your immediate family are reported to the Centers for Medicare & Medicaid Services (CMS) and published on a publicly searchable website.

    Voluntarily register with CMS to get industry-submitted notifications and information.

    Voluntarily review attributed data for accuracy before public posting and dispute potentially inaccurate data.

  - Resources

    OPEN PAYMENTS Physicians and Teaching Hospitals Webpage

- Podiatry
  - Tips

    Ensure you do not bill routine foot care, unless an exception applies.

Job Aid E

How to Report Fraud & Abuse

Medicare Beneficiary

For any complaints:
Centers for Medicare & Medicaid Services (CMS) Hotline:
1-800-MEDICARE (1-800-633-4227) or TTY 1-800-486-2048

OR

For Medicare Managed Care or Prescription Drugs:
1-877-7SafeRx (1-877-772-3379) or 1-800-MEDICARE (1-800-633-4227)

Office of Inspector General (OIG) Hotline
Phone: 1-800-HHS-TIPS (1-800-447-8477)
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
TTY: 1-800-377-4950
Web: Forms.oig.hhs.gov/HotlineOperations/index.aspx

Mail: U.S. Department of Health and Human Services
Attn: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

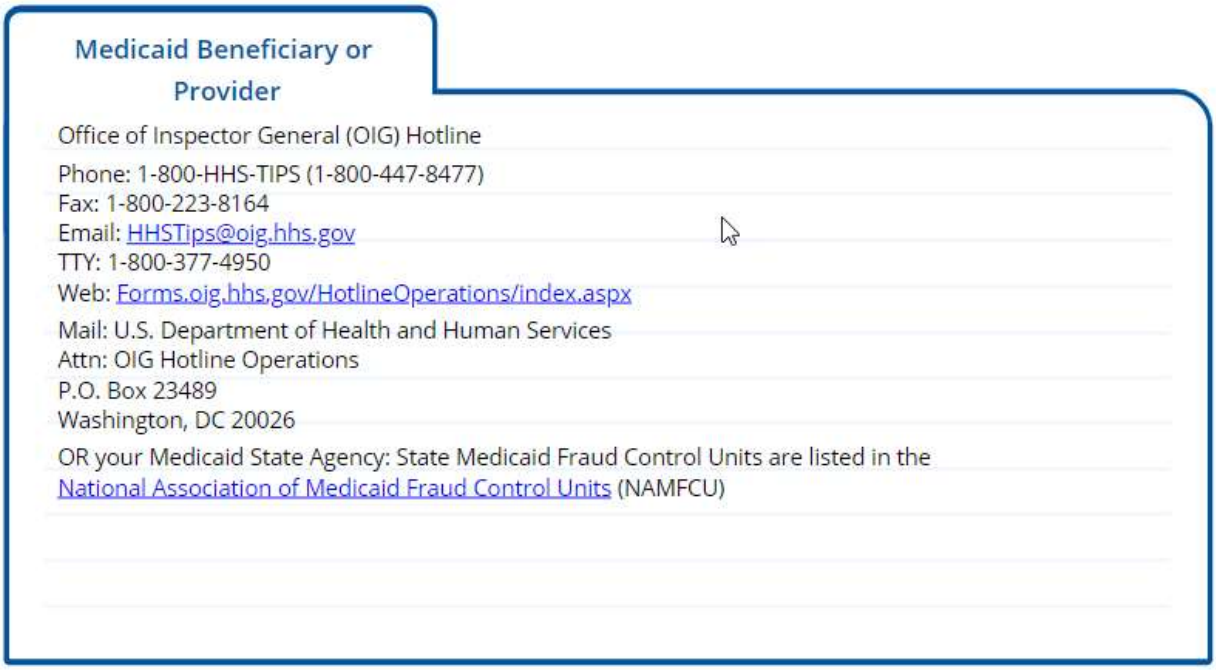
For Medicare Part C (Managed Care) or Part D (Prescription Drug Plans) complaints:
1-877-7SafeRx (1-877-772-3379)

Medicare Provider

Office of Inspector General (OIG) Hotline

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY: 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Web: Forms.oig.hhs.gov/HotlineOperations/index.aspx
Mail: U.S. Department of Health and Human Services
Attn: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

OR your Medicare Administrative Contractor (MAC)



Job Aid F

Medicare Fraud & Abuse: Prevent, Detect, Report Booklet

Learn fraud and abuse definitions, laws, how to report suspected fraud, and physician business relationships that may raise concerns.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

Test Questions (10 questions Post-Test)

MULTIPLE CHOICE

1. The Federal laws that address fraud & abuse include _____.

   a. False Claims Act (FCA)
   b. Anti-Kickback Statute
   c. Physician Self-Referral Law (Stark Law)
   d. Civil Monetary Penalties Law (CMPL)
   e. All of the above

2. Health care providers can prevent fraud & abuse in the Medicare Program by _____.

   a. Not selling free samples from vendors
   b. Carefully reviewing business ventures to avoid violating the Anti-Kickback Statute
   c. Reviewing training and educational materials on Medicare policy on the Medicare Learning Network ® (MLN)
   d. All of the above

3. A chiropractor, in an intentional attempt to falsely get Medicare Program money, billed medically unnecessary services and falsified the beneficiary's Medicare claim diagnosis. Depending on the facts and circumstances, she most likely committed _____.

   a. A violation of the Anti-Kickback Statute
   b. A violation of the Physician Self-Referral Law (Stark Law)
   c. Medicare fraud or abuse because she knowingly submitted false Medicare Program claims

4. You may report suspected fraud & abuse anonymously to the Office of Inspector General (OIG) via _____.

   a. Phone or fax
   b. Email or mail
   c. OIG website
   d. All of the above

5. You can help prevent Medicare fraud & abuse by _____.

   a. Checking the Office of Inspector General List of Excluded Individuals/Entities (LEIE) before entering employment or contractual relationships with individuals or entities.

b. Providing Medicare beneficiaries only medically necessary, high-quality services
c. Properly documenting all Medicare beneficiary services provided
d. All of the above

6. Possible Medicare fraud & abuse penalties include _____.

a. Imprisonment in criminal cases
b. Civil Monetary Penalties (CMPs) up to $100,000 (in 2018) per violation and assessments of up to 3 times the amount claimed for the item, service, or remuneration offered, paid, solicited, or received
c. Exclusion from participation in all Federal health care programs
d. A, B, and C
e. A and C

7. Select the true statement.

a. Medicare Administrative Contractors (MACs), Comprehensive Error Rate Testing (CERT) Contractors, and the Office of Inspector General (OIG) review only claims and do not investigate health care providers suspected of Medicare fraud & abuse.
b. MACs, CERT Contractors, and the OIG investigate only health care providers suspected of Medicare fraud & abuse and do not review claims.
c. MACs, CERT Contractors, and Recovery Audit Program Recovery Auditors review only claims and generally do not investigate health care providers suspected of Medicare fraud & abuse.
d. MACs, CERT Contractors, and Recovery Audit Program Recovery Auditors investigate only health care providers suspected of Medicare fraud & abuse and do not review claims.

TRUE/FALSE

8. You can help prevent Medicare fraud & abuse by properly and thoroughly documenting all services provided to Medicare beneficiaries.

9. Medicare abuse includes any practice inconsistent with the goals of providing patients with all requested services, meeting professionally recognized standards, and charging fair prices.

10. Health care providers use the Self-Referral Disclosure Protocol (SRDP) to report all suspected fraud & abuse.