MEDICARE FRAUD & ABUSE

On any given day if you log onto the Office of the Inspector General (OIG) website you will see on the home page enforcement actions such as "Fort Meyers Doctor Agrees to Pay More than $1.7M to Resolve Allegations of Fraud" or "Eight Dallas-Area Pharmacy Owners and Marketers Charged in 9M Kickback Scheme." Since it was established in 1976, the OIG has been leading the way in our nation's fight against fraud and abuse in Medicare and Medicaid.

Fraud and abuse schemes have run rampant forcing government agencies to aggressively audit and recoup federal dollars that have been paid out inappropriately. In the OIG's semi-annual report to Congress for September 2018, the agency boasted $2.9B in investigative recoveries which included 764 criminal actions and 813 civil actions. In 2017, $3.7M was recovered which was the third year in a row that the agency recovered over $3B.

What is Medicare fraud?

Medicare fraud includes but is not limited to:

- Knowingly receiving or paying remuneration for referrals for services reimbursed by Federal Healthcare programs
- Knowingly billing for services not provided
- Knowingly billing for appointments that were not kept.

What is Medicare abuse?

Medicare abuse refers to practices that are not consistent with the professional recognized standards for providing medical services and can include the following:

- Billing for unnecessary services
- Over-charging for services and supplies
- Upcoding to a higher priced service when not warranted

Both fraud and abuse can result in civil and criminal fines and penalties as well as exclusion from any future government program participation. Ultimately the difference between the two is the person's intent. Fraud is intentional deception where abuse is "bending the rules." Unfortunately, both have the same effect - inappropriately consuming the resources of the Medicare Trust Fund.

The False Claims Act

The False Claims Act, also know as the Lincoln Law, is the government's primary remedy to combat fraud. The success of the False Claims Act is largely due to the increase in qui tam or whistleblower lawsuits. This provision of the FCA allows individuals that are not affiliated with the government to file actions and claim fraud against the government. There is incentive to the whistleblower to the tune of 25-30% of the recovery. In 2017, $392M was paid out to individual whistleblowers. One of the government's largest recoveries was a whistleblower settlement of $465M with Mylan Inc. for it's classification of the EpiPen as a generic drug, which caused federal programs to overpay for the drug.

The Fraud Fight

In the fight against Healthcare Program fraud, the government agencies must partner with numerous contractors. They could be called the Alphabet Soup of Investigation.

(RAC) Recovery Audit Contractor is an aggressive program to reduce improper payments by detecting and collecting overpayments. Audits are conducted by third-party contractors that are paid on a contingency basis for overpayments they find

(CERT) Comprehensive Error Rate Testing Contractors review the Medicare Fee-For-Service payment rate to determine improper payments. Each year CERT evaluates random samples of claims to determine if they were paid properly under the Medicare coding and billing rules

(MACS) Medicare Administrative Contractors process claims and enroll providers and suppliers. They also perform audits and reviews of medical records and claims.

(MEDIC) Medicare Drug Integrity Contractors monitor fraud and abuse in the Medicare Parts C and D programs

(ZPIC) Program Integrity Contractors investigate fraud and abuse for durable medical goods, supplies, home health and hospice.

Who is vulnerable?

Any person or organization with a National Provider Identification (NPI) number can be audited. An NPI is the number issued to a healthcare provider by CMS and enables them to submit claims for reimbursement under Medicare or Medicaid. Providers could include physicians, nurses, hospitals, clinics, nursing homes, social service organizations, hospice organization, pharmacies, laboratories, and durable medical goods providers.

If fraud or abuse is suspected, CMS can suspend payments until patient records are reviewed. Even though no overpayment or questionable practices can be found, a provider can incur hundreds of thousands of dollars defending themselves against the allegations. Many providers believe incorrectly that outsourcing billing to a third party will eliminate the exposure. Providers are liable for the mistakes of third party billing companies. Along with exposures created by the False Claims Act, providers also my have exposures to other fraud and abuse laws such as Anti-Kickback Statue and the Physician Referral Law, also know as the Stark Law. The Anti-Kickback Statute prohibits a person or entity from paying another person or entity as an inducement for services reimbursed by a Federal program. The Stark Law prohibits a physician from making referrals for health services payable by Medicare to an entity with which the physician or an immediate family member has ownership or investment interest.

What steps can a provider take to minimize the effect of a potential government audit? The first step would be prevention by "audit proofing" and operating in accordance with all rules and regulations regarding reimbursement. This includes avoiding coding errors and making certain that services provided are consistent with the diagnosis. Training and periodic self-audits are also necessary. Along with prevention, there are insurance products available. These policies will reimburse defense costs and fines and penalties associated with billing error proceedings brought by government agencies, contractors working on their behalf and qui tam plaintiffs. Coverage can also be found for other fraud and abuse laws such as Stark – Physician referral, HIPAA – patient privacy, and EMTALA – Emergency Medical Treatment and Active Labor.

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