Recognizing and Preventing Medicare and Medicaid Fraud & Abuse

Mental Health Facility
East Tennessee

Training Objectives

- Define terms and concepts
- Review laws
- Increase awareness
- Identify MHF compliance strategies
- Describe reporting procedures

Definitions

Medicare

Created in 1965 by Congress under Title XVIII of the Social Security Act.

Pays some health care costs of patients who are eligible, usually those age 65 and over or those with certain disabilities.

Definitions

Medicaid

Created under Title XIX of the Social Security Act and jointly funded by federal and state governments.

Pays some health care costs for eligible patients who are unable to pay.

Tennessee's Medicaid program is **TennCare**.

Definitions

Fraud

Making a false statement or misrepresentation with the intent to deceive and receive an unauthorized benefit, either personally or for someone else.

In everyday terms, fraud means someone lies or leaves out important information on purpose in order to receive something valuable.

Definitions

To be considered fraud by Medicare or Medicaid, an action must pass three tests:

- ***Knowledge***
- ***Willingness***
- ***Intention***

Definitions

Abuse

Taking advantage of a system or item of value for personal gain.

May be similar to fraud, but does not result from knowing, willful, and intentional acts.

In everyday terms, abuse is like discovering your ATM sometimes gives you a $20 bill instead of a $10 bill, but you do not tell the bank.

Definitions

Medicare Abuse

includes unsound medical or business practices that directly or indirectly create unnecessary costs to the program.

For example: an employee is clumsy and spills patients' drugs everyday, and Medicare is charged for the original and extra drugs.

Definitions

Intent

Knowingly and willfully acting in a manner that violates the law, such as

- filing a false claim
- knowing a false claim was filed and not reporting it
- ignoring fraud or abuse by someone else
- ignoring laws and rules, even when you know they exist

Definitions

Misrepresentation

Intentional or negligent words or actions that mislead others, causing them to act in a way they would not have acted otherwise.

For example, making up symptoms so a doctor will prescribe drugs a patient does not really need.

Laws & Administration

- Federal
  - Administered by Centers for Medicare & Medicaid Services (CMS)
  - False Claims Act (31 U.S.C.A. §3729-3733)
  - Anti-Kickback Statute (42 U.S.C.A. §1320a-1327b)
  - Mail Fraud (18 U.S.C.A. §1341)

False Claims Act

The False Claims Act imposes liability on anyone who knowingly submits, or causes another to submit, a false or fraudulent claim to the United States. The term "knowingly" includes actions taken with actual intent taken in reckless disregard or in deliberate ignorance of the truth.

Anyone who knowingly submits false claims to the government under the False Claims Act is liable for damages up to three times the amount of any erroneous payments plus mandatory penalties between $5000-10,000 for each false claim submitted.

In everyday terms, this means someone files a claim that he or she knows is wrong.

Any provider who files a claim he or she knows is wrong can be made to repay three times the amount that Medicare or Medicaid paid, plus penalties of anywhere from $5000 to $10,000 for each false claim.

False Claims Act

The False Claims Act allows a private individual or "whistleblower" with knowledge of fraud (either in the past or the present) against the federal government, to sue on behalf of the government. This could include the recovery of civil penalties as well as triple damages. In general, the Act covers any fraud involving any federally funded contract or program with the exception of tax fraud.

In everyday terms, this means anyone who knows about Medicare or Medicaid fraud – now or in the past – can "blow the whistle" by reporting it. The whistleblower can file a lawsuit against the provider committing fraud. If the whistleblower's lawsuit is a success, the whistleblower can receive a reward in the form of penalties and fines the provider is required to pay.

Anti-Kickback Statute

The Anti-Kickback Statute provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce or reward the referral of business reimbursable under any of the Federal health care programs (ex. Medicare and Medicaid).

The statute also prohibits remuneration for ordering, arranging for, or recommending the purchase or order of any item for which payment may be made – in whole or in part – under a federal health care program.

Kickbacks include such things as free items or services, grants, travel, entertainment, gifts, free consultants, and continuing education.

For example, it would be a kickback if a wheelchair company gives a doctor a new car so the doctor will send his patients to that company to buy a wheelchair.

Mail Fraud

Mail Fraud occurs whenever the U. S. Postal Service is used to commit a criminal act.

In everyday terms, if you send something illegal through the U. S. mail, you commit mail fraud. For Medicare and Medicaid purposes, mail fraud usually occurs when claims are filed, payments are made, or incorrect documents are intentionally sent.

Laws & Administration

- State of Tennessee
  - Administered by Bureau of TennCare
  - Oversight by TennCare Division of Commerce & Insurance
- The State of Tennessee False Claims Act is similar to the federal one, with similar penalties.

Common Types of Health Care Provider Fraud

- Bill for patients not treated
- Bill for services or supplies not provided
- Complete Certificates of Medical Necessity for unknown patients
- Alter claim forms to get larger reimbursements
- Double-bill for services or supplies
- File claims for non-covered services by billing as if they were covered
- Switch to cheaper drugs or equipment and bill for expensive versions
- Receive kickbacks from suppliers or patients
- Fail to refund overpayments to Medicare or patients

Common Types of Health Care Provider Abuse

- Excessive charges for services or supplies
- Claims for services that lack documentation to support medical necessity
- Breach of Medicare participation agreements
- Billing patients for charges in excess of Medicare allowable amounts
- Billing Medicare at a higher fee schedule than charged for non-Medicare patients for the same services or supplies

Common Types of Patient or Individual Fraud & Abuse

- Using someone else's Medicare card to receive care under another person's name
- Receiving duplicate treatment from multiple health care providers for the same conditions
- Receiving kickbacks or rebates from health care providers and/or suppliers

Penalties for Fraud & Abuse

Fraud – if committed, the government can

- Seek criminal conviction of the parties involved in the fraudulent activities
- Negotiate a civil settlement with the parties involved
- Take administrative action to exclude the responsible parties from the federal healthcare programs
- Suspend the provider from the Medicare program

Abuse – if committed, the government can

- Recover payment made in error
- Invoke civil monetary penalties congruent with the degree of abuse
- Suspend the provider from the Federal Healthcare Programs

A Mistake Is not Fraud!

A mistake or oversight by a health care provider or Medicare carrier does not necessarily indicate fraud or abuse.

It is best to investigate and gather facts before jumping to conclusions.

MHF's Compliance Strategy

- Annual required in-service training for all employees
- Required training for all new-hire employees
- Internal review of submitted claims
- Internal compliance review by senior Accounting Department staff
- Internal Fraud & Abuse Hotline

MHF Fraud & Abuse Hotline

- If you are inside MHF
  - dial extension 1234
- If you are outside MHF
  - dial 123-123-1234

You do not need to give your name, but you do need to give patient or employee details so we can follow up.

Your Responsibilities

- As a MHF employee, you are responsible for monitoring yourself, other employees, and patients to ensure no laws are broken.
- If you are aware of possible misconduct, wrong-doing, or violations of state or federal laws, you must report them.

For Additional Information or to Report Fraud or Abuse

- MHF Compliance Officer
  - The Bean Counter, ext. 9876
- TennCare Bureau, Nashville
  - Phone: 1-800-342-3145
  - Web: http://www.state.tn.us/tenncare/
- Centers for Medicare & Medicaid Services
  - Hotline Phone: 1-800-447-8477
  - Hotline Fax: 1-800-223-2164 (no more than 10 pages please)
  - Web: http://www.cms.gov

Evaluation

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