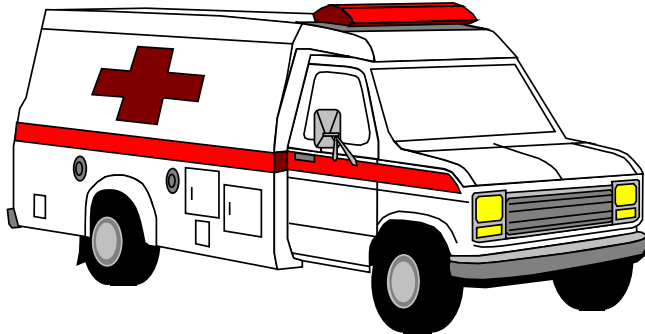


CURRENT MEDICARE FRAUD SCHEMES



Ambulance

Fraud Schemes and things to look for

- Billing for advanced life support services (ALS) when basic life support (BLS) was provided. Documentation is often falsified to indicate the patient needed oxygen -- which is a key indicator to establish medical necessity for ALS.
- Ambulance transports are provided to ambulatory dialysis patients to and from the dialysis center and billed as medically necessary transports. In one case, patients were filmed walking to the vehicle and riding in the front seat of the ambulance or were transported in a regular automobile. In addition, two or three patients were transported in the same vehicle, yet Medicare was billed as if they were individual trips.
- Billing for more miles than traveled for transport. Air ambulance services have reported their mileage in ground miles instead of nautical miles.
- Falsification of documentation to substantiate the need for a transport from a hospital back to the patient's home. Medicare will only cover transport from hospital to home if the patient could not go by any other means (e.g., car, taxicab).

Clinical Laboratories

Fraud schemes

- Labs have added tests not ordered by the physician and billed them separately to Medicare.
- Labs market their tests as panels to the physicians, but split certain tests out of the panels and bill them separately to Medicare. For example, a physician will order a “Chem 14”, which the lab has identified as a panel containing 14 specific lab tests. The physician understands that the lab will bill the service as a 14-test automated panel. However, the lab bills Medicare for a 12-test panel and bills separately for two of the tests, increasing their Medicare payment.
- “Rolling labs” have gone to senior centers, shopping malls, etc. and offered “free” diagnostic tests. Patients are required to complete a registration form that includes their insurance billing number. The insurers are then billed for a variety of tests the beneficiary never received.
- Labs have billed for services not ordered or provided. In a 60-day period, one lab submitted to Medicare 717 claims for 416 beneficiaries (many of whom were already dead) and received \$330,000. One of the “referring” physicians listed on the claims had been dead for 2 years. In a random sample, nearly a third of the beneficiaries had never received services from the lab or did not know the referring physician listed on their claims.

Things to look for

- “Free” services billed to Medicare or other insurers.
- Dates of service on laboratory claims should generally be within 7-10 days of a practitioner visit. A physician or other licensed practitioner must order (Lab services.)
- Review Medicare Summary Notices (MSNs) to insure services billed coincide with services provided.

Durable Medical Equipment (DME) Suppliers

Fraud Schemes

- Unscrupulous suppliers use a variety of means to obtain Medicare numbers, knowing that having a supply of these numbers is an open door to obtaining Medicare dollars fraudulently. Some of their methods include:
- Calling beneficiaries under the guise of conducting a “health survey”-- one of the questions is “What is your Medicare number?”
- Offering beneficiaries a free “health screening” (e.g., blood pressure check, cholesterol test, etc.) and asking the same question.
- Paying beneficiaries for their Medicare number.
- Offering beneficiaries “free” services or supplies (e.g., milk, bread, clothing, etc.) in exchange for their Medicare number.
- Obtaining lists of Medicare beneficiaries and their Medicare numbers from nursing homes or board and care homes by selling the operators/ administrators on “new” Medicare benefits that will help their facility.
- Adult diapers have been billed as Female Urinary Collection Devices (FUCD). These diapers are not covered under Medicare. Suppliers misrepresented the item and patients’ conditions in billing. Medicare paid nearly \$9 per FUCD; the diapers cost the suppliers 26¢. Charges to Medicare have been as high as \$5,200 per month per patient.
- Lymphedema pumps are supplied to beneficiaries who did not meet medical necessity requirements; suppliers falsified claim forms and certificates of medical necessity (CMNs). Medicare was billed for higher-priced pumps; pumps costing nearly \$3,000 less were actually supplied.
- Medicare has been billed for Nebulizer drugs that are used to relieve symptoms of emphysema and bronchitis. Claims review showed inappropriate quantities and combinations were billed. In fact, the suppliers were not even providing the drugs billed to Medicare.

- Oxygen concentrators have been provided to patients who have no need for oxygen. Because Medicare requires patients to be tested by an independent laboratory before paying oxygen, suppliers have engaged in schemes with physicians and labs to falsify oximetry results.
- Hospitals have allowed DME companies to provide them with “discharge planners”. These employees work in the hospital but their salaries are paid by, and they represent, the supplier. They make sure that patients receive every item imaginable (e.g., hospital beds, wheelchairs, walkers, etc.), whether they need them or not.
- Vendors offer “free” case of milk supplements or groceries, then bill Medicare for costly enteral/parenteral supplies.
- Some suppliers have ownership in or arrangements with physiological laboratories that falsify oximetry tests to certify patients’ need for home oxygen.
- Ineligible items such as trips, club memberships, dinner and drinks have been billed to Medicare via the cost report.

Things to look for

- In facilities, look for DME items that have been provided to all or most residents (for example, all patients in a nursing home have air fluidized beds).
- Does it appear that the consumer required the supplies or equipment received?
- Beware of fraudulent attempts to obtain Medicare numbers (telemarketing, health screenings, medical surveys, offers of “free” items or cash).
- Did the supplier waive co-pays and deductibles in the absence of financial need?
- Be cautious of “free” services billed to Medicare or other insurers.

- Review Medicare Summary Notices (MSNs) to insure services billed coincide with services provided.

Home Health Agencies (HHA) and Hospices

Fraud schemes

- Billing for services to patients that do not meet the definition of homebound.
- Billing for more visits than provided.
- Billing housekeeping or custodial services as skilled nursing or therapy services.
- Unfair marketing practices--Some home health agencies have offered incentives, such as free groceries or free transportation, to beneficiaries in exchange for their Medicare number or for switching to their agency.
- Kickbacks--Some home health agencies have offered cash or other benefits to physicians for referring patients and/or signing treatment plans for patients who do not meet the conditions for home health care.
- The hospice personnel have enrolled patients who do not meet the eligibility requirements for hospice.
- Some hospices have received duplicate payments, billing both Medicare and Medicaid.
- Some home health agencies have provided home health aides to patients in assisted living facilities. Services provided by the aides should be provided by the assisted living facility.
- Some board and care facilities are owned by some home health agencies. In these cases, most of the residents of the board and care homes receive home health from the home health agencies that owns the facility. In addition, the home health services are often not necessary.

Things to look for

- Beneficiaries who are not homebound but receive home health services.
- Beneficiaries who are not terminally ill but are enrolled in hospice.
- Review Medicare Summary Notices (MSNs) to insure services billed coincide with services provided.
- All or most residents in board and care homes or assisted living facilities receiving home health care from the same HHA.

Hospitals

Fraud schemes

- For outpatient services, billing multiple view x-rays when only one view was taken.
- Misrepresentation of discharge date in order to obtain inpatient and outpatient reimbursement. One drug and alcohol rehabilitation facility discharged their inpatients on paper but not in reality. The hospital received the DRG reimbursement for the inpatient stay and then also billed for outpatient services. Since the patients never left the hospital, the facility should have only received the diagnosis related group (DRG) payment.
- Misrepresentation of the patient's condition (diagnosis code) on the claim form in order to change the DRG category and, therefore, increase the reimbursement.
- Some patients have been held in observation status for 3 or 4 days, rather than admitted as a hospital inpatient. Hospital observation services are reimbursed as a percentage of charges (through Part B), and therefore, the Medicare payment is usually higher than what the facility would have received through the DRG reimbursement.
- Ineligible items such as trips, club memberships, dinner and drinks have been billed to Medicare via the cost report.

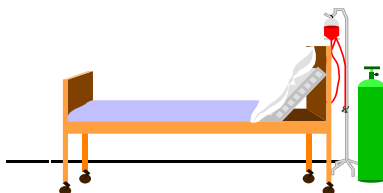
Things to look for

- Review Medicare Summary Notices (MSNs) to insure services billed coincide with services provided.
- Review itemized statements from the hospital to assure that the patient has not been charged for items not provided. Remember, however, that for inpatient services, the itemized charges *usually* do not have an impact on the Medicare reimbursement.

Managed Care Plans (MCPs)

Fraud schemes

- Failure to deliver services or underutilization of services. Because many plans pay contact providers a monthly capitated rate, some practitioners have failed to provide needed care so as not to exceed their monthly plan payment.
- In order to limit or discourage services to plan members, some providers allot very limited office hours for MCP patients. These patients may not be able to schedule an appointment with the practitioner when they need it.
- Some MCPs have offered cash incentives to consumers to enroll in their plan.
- The contract practitioner or the MCP, itself, has encouraged beneficiaries to disenroll from the MCP in order to receive costly treatment or procedures. Beneficiaries are told they can re-enroll following completion of the course of treatment.



- Because most managed care plans require referral to non-plan providers (specialists, hospitals, etc.); some plan physicians have accepted kickbacks in exchange for their referrals.
- **Any of the schemes that have been described for the traditional “fee-for-service” providers can be perpetrated in the managed care environment.**

Things to look for

- Beneficiary complaints of having to wait several days or weeks to see the provider.
- Beneficiaries who have received incentives for enrolling or disenrolling in managed care plans.
- Allegations of services not received; medical supplies, equipment not as ordered; or continued billing to the plan when the beneficiary no longer has or needs equipment.

Mental Health Services

Partial Hospitalization Programs (PHPs) are designed to keep patients with severe mental conditions from becoming hospitalized by providing intensive psychotherapy in a day outpatient setting.

Community Mental Health Centers (CMHCs) are outpatient mental health facilities that may be authorized to provide partial hospitalization services.

Fraud Schemes

- Routine upcoding of psychotherapy sessions by the mental health provider (psychiatrist, clinical psychologist (CP), clinical social worker (CSW)). There are several variations to this scam, for example:
- A psychiatrist conducts group sessions in a nursing or residential facility but bills for individual therapy.

- Trips to the store, cooking classes, listening to music and other recreational activities have been billed as psychotherapy.
- A CP bills for 50 minutes but actually saw patients for only 20-30 minutes. Some PHPs are enrolling patients who either cannot benefit from the therapy or who receive little more than social or recreational activities. Typically, the patients have not authorized the services and are not told that they are receiving psychotherapy
- Non-licensed staff has performed therapy sessions that have been billed as though provided by or under the direct supervision of a licensed practitioner.
- Billing for inpatient psychiatric treatment for weight reduction programs. Frequently, these programs include transportation to the facility. Clients are told their insurance will cover the costs of the program but are not made aware that the services will be billed as mental health services. The program usually ends when the insurance money runs out.
- “Coffee, cookies and conversation”--one CMHC advertised a social gathering to seniors in the community. The seniors went to the CMHC, met the staff and subsequently received Medicare EOBs indicating they had received psychotherapy services.

Things to look for

- Group therapy sessions where recreational or diversional activities are being provided.
- The presence of mental health providers with patients who are non-communicative or cannot benefit from psychotherapy (patients in coma, patients in the late stages of Alzheimer’s, etc.).
- Review Medicare Summary Notices (MSNs) to insure services billed coincide with services provided.

Nursing Facilities

Fraud Schemes

- Providing medically unnecessary physical, occupational and speech therapies (PT, OT, ST). Group therapy provided but billed as if provided to individual patients. For example, a physical therapist spends 30 minutes with a group of 10 patients; Medicare is billed for 30 minutes of PT for each patient.
- Billing social activities or life services as psychotherapy.
- Billing for medical supplies not provided when a patient is not under a Medicare Part A covered stay. Certain facility medical supplies may be billed to Part B. Numerous instances of billing for supplies not received by the beneficiary have been detected.
- Irrigation kits are often supplied to nursing facilities for ostomy patients in quantities far greater than needed. In many cases, sterile kits are not medically necessary. Many nursing homes break kits down and add individual components to their central supply area.
- Suppliers --Actual item supplied are plain, wrap-around corsets secured by Velcro straps. Medicare is billed for custom-fitted, molded body jackets. Reimbursement was often several hundred dollars for an item that cost \$30.
- “Gang visits”--Practitioners (such as optometrists, podiatrists, etc.) stopping by all or most patients in a facility without rendering any service but billing as if a service had been provided. Most of the patients do not have prior symptom or condition warranting the practitioner’s service.

Things to look for

- Kits marked for individual patients used for other patients or held in extremely large supply in storage areas. This may be a sign that unnecessary supplies are being provided or that necessary supplies are being provided in a quantity much greater than required.
- Therapies (PT/OT/ST) being provided to groups of patients. These services may be billed to Medicare as if provided individually.
- Therapies (including psychotherapy) being provided to patients who cannot benefit from the services (especially patients with Alzheimer's Disease or in a coma).
- ***Every patient*** has the same medical equipment (for example, the same brand and type of wheelchair, walker, etc.). It is highly unlikely that every patient needs or uses the same equipment. Moreover, the government may be paying twice for the equipment: Medicare pays on behalf of each patient, and Medicaid factors the cost of durable medical equipment (DME) into the per diem rate that it establishes for the facility.
- Patient file access provided to persons who are not actual practitioners for specific patients.



Physicians/Practitioners

(Medical doctors, optometrists, chiropractors, podiatrists, physical therapists, etc.)

Fraud Schemes

- Toenail clipping (routine foot care) is only covered if there is some underlying medical condition warranting professional services. To obtain payment, some podiatrists or other physicians have misrepresented the diagnoses on the claim, indicating fungal infection when none exists. Another scam is to bill routine foot care as foot surgery.
- An optometrist always bills the comprehensive level of eye exam even when he/she performed the lower level exam.
- A chiropractor sees his patients two times per week but routinely bills for three services each week.
- An ophthalmologist falsified documentation for a test that is used to establish the need for cataract surgery. The doctor performed and billed Medicare for more than 100 unnecessary surgeries.
- A provider bills acupuncture (non-covered) as a covered service. In one instance, a physician billed acupuncture services as physical therapy. In another case, the physician misrepresented the acupuncture services as joint injections.

Things to look for

- Statements by beneficiaries that no physician was present at any time during the service or that he/she has never seen the physician/practitioner.
- Payments (in cash or kind) in return for providing the Medicare number or for visiting a clinic or office.

- Compare the physician statement provided at the time of the service to the services shown on the EOB/MSN.
- Review Medicare Summary Notices (MSNs) to insure services billed coincide with services provided.

