Fraud, Waste & Abuse: What is HEAT Strike Force Doing?

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Alphabet Soup: Health Care Fraud Prevention & Enforcement Action Team = HEAT
In May 2009, the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) announced creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). With creation of new HEAT team, fight against Medicare fraud became a Cabinet-level priority.

Secretary Kathleen Sebelius and Attorney General Eric Holder pledged to continue fighting waste, fraud & abuse. Today, DOJ and HHS continue to make progress and succeed in the fight against Medicare fraud.
Health care fraud perpetrators are

- stealing billions of dollars from the federal government, American taxpayers and some of our most vulnerable citizens;
- driving up costs for everyone in the health care system; and
- hurting long term solvency of Medicare and Medicaid, two programs upon which millions of Americans depend.
Per 2007 Medicare Trustees Report:
FY 2006 = $408 billion
  43.2 million beneficiaries
FY 2008 = $456.3 billion
  44.6 million beneficiaries
Per CMS OFM June 2010:
FY 2009 = $497.4 billion
  46.1 million beneficiaries
FY 2010 = $521.7 billion
  47.0 million beneficiaries

Every 8 seconds, someone becomes Medicare eligible
Congressional Budget Office (CBO) projects expenditures to **double** over the next **10 years**.

Majority (approx **75%**) of Medicare spending is for Part A & B benefits (fee-for-service portion of program)

Medicare spending - one of fastest growing sectors of federal budget - - Challenge is to **maintain & ensure** integrity of nation’s largest health insurance program.
MISSION OF HEAT

- To gather resources across government to help prevent waste, fraud & abuse in Medicare & Medicaid programs and crack down on fraud perpetrators abusing the system & costing us all billions of dollars.

- To reduce skyrocketing health care costs & improve quality of care by ridding system of perpetrators preying on Medicare & Medicaid beneficiaries.
MISSION OF HEAT

- To highlight best practices by providers and public sector employees who are dedicated to ending waste, fraud & abuse in Medicare.

- To build upon existing partnerships between DOJ & HHS such as our Medicare Fraud Strike Forces to reduce fraud and recover taxpayer dollars.
Medicare Strike Forces

- Medicare Strike Forces supplement criminal health care enforcement activities of US Attorneys’ Offices by targeting chronic fraud & emerging or migrating schemes perpetrated by criminals operating as health care providers & suppliers.

- Each Strike Force team is led by a federal prosecutor from respective US Attorneys’ Offices or Criminal Division’s Fraud Section.
Medicare Strike Forces

- Each team has a **HHS-OIG agent** & an **FBI Agent**. Also participating are Medicaid Fraud Control Units (**MFCUs**), Office of the Medicaid Inspector General (**OMIG**) & local law enforcement (e.g., Hialeah PD).

- **FORMATION:** In **March 2007**, DOJ’s Criminal Division’s Fraud Section, working with local US Attorneys’ Offices, law enforcement partners in HHS-OIG, and state & local law enforcement agencies, launched the **first Medicare Fraud Strike Force** in **Miami-Dade** County, FL.
DOJ & HHS expanded the Strike Force by rolling out a second phase in Los Angeles, CA metro area in March 2008; a third phase in the Detroit, MI metro area in June 2009; a fourth phase in the Houston, TX metro area in July 2009; and a fifth phase in Brooklyn, NY in December 2009.

Additional Strike Force locations have been added in 2010: a sixth in Baton Rouge, LA & seventh in Tampa, FL; and in 2011: an eighth in Chicago, IL and a ninth in Dallas, TX, for the current total of 9.
Since its inception in March 2007, Medicare Fraud Strike Force operations in 9 locations have charged >1,000 defendants who collectively billed Medicare program for >$2.3 billion.

In addition, HHS’ Centers for Medicare and Medicaid Services, working in conjunction with the HHS-OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

To learn more about the Health Care Fraud Prevention and Enforcement Action Team (HEAT), go to: www.stopmedicarefraud.gov.
ANTI-FRAUD RESULTS TO DATE

● Investments in fraud detection & enforcement to pay for themselves many times over, and the Administration’s tough stance against fraud is already yielding results:

● In FY 2010, >$4 billion was returned to Medicare Health Insurance Trust Fund, U.S. Department of Treasury & others as a result of enforcement activities targeting false claims & fraud perpetrated against government health care programs.

● This was an increase of $1.4 billion, or 56%, over FY 2009.
The $4 billion recovered in FY 2010 includes recoveries from $2.5 billion in settlements & judgments obtained in FY 2010 by DOJ in False Claims Act matters alleging health care fraud.

This $2.5 billion is unprecedented in a single year and represents a 53% increase over FY 2009, in which $1.63 billion was recovered.
On June 8, 2010, President Obama announced a nationwide series of *regional fraud prevention summits* as part of a multi-faceted effort to crack down on health care fraud. Philadelphia Summit in June 2011 will be sixth in series, with an additional summit to follow in coming months.

Previous summits were held in Miami (July 16, 2010), Los Angeles (Aug. 26, 2010), Brooklyn (Nov. 5, 2010), Boston (Dec. 16, 2010) & Detroit (Mar. 15, 2011)
Vast majority of providers are straight-shooters. The following exemplifies fraudulent behavior:

Bad guys:
- Bill for services not rendered
- Up-code, fragment, unbundle
- Bill for medically unnecessary services
- Receive/pay kickbacks
- Sign orders for unnecessary lab & diagnostic tests [from Independent Diagnostic and Testing Facilities (IDTFs),] physical therapy, DME, HHA &/or Hospice care, prescription drugs – often for patients they’ve never seen
The following are examples of fraudulent behavior:

- Pay **kickbacks** for referrals/recruit patients
- Bill for equipment **not provided**
- **Falsify** physician orders & proof of delivery
- **Forge/alter** medical records
- **Misrepresent** patient diagnosis or medical condition
- “Phantom” providers – bill with no inventory, bill after **closing** location
- **Up-code or Swap** – bill high end/substitute lesser equipment
- **Hire** nominee owners
Medicare Hospice Care Fraud

- **Forge/alter** medical records to obtain coverage
- **Misrepresent** patient diagnosis or condition (patient *not* “terminally ill” as defined in § 1879(g)(2) of SSA)
- **Transfer in & out** of hospice for non-palliative care
- **Underutilize** (Quality of Care)
- Bill for services not rendered
- Double bill
- Misrepresent patient diagnosis or up-code DRG’s
  - Submit claim for “septicemia” dx, but medical record shows “urosepsis” (blood cultures negative) with lower DRG $
- Pay kickbacks for physician referrals
- Falsify information in costs reports
- Forge/alter medical records, test results
- Bill Excessive Units
  - Submit 1 claim for 3 colonoscopies for same beneficiary on same day (overpayment = $ value of 2nd/3rd colonoscopies)
- Bill for services **not** rendered
- **Double** bill (Part A & Part B) or **extra** mileage
- Bill **non-emergency** as **emergency** transport &/or emergency **air** transport
- Bill **non-medical** as **non-emergency** transport
- Pay **kickbacks** for referrals (hospital, dialysis center, SNF, physician)
- **Falsify** physician orders
- **Forge/alter** medical records, trip sheets
- Use **non-certified vehicles** and/or **staff**
Medicare Home Health Fraud

- Admit patients **not homebound**
- **Coach** diabetic patients to **not self-inject &/or stop oral medication** to qualify for daily nursing visits to inject insulin (resulting in outlier payments) – for patients able to self-inject &/or with willing caregivers
- **Bill** unnecessary **daily/twice daily aide visits**
- **Bill** therapy **visits provided without therapy order**
- **Up-code** HIPPS codes
- **Bill** for **services not rendered**
- **Recruit patients** (pay kickbacks - incentives of cash and aides)
- **Use** non-licensed staff
ACA Sec. 6407

- Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment under Medicare (as amended by Sec. 10605)

- The provision also allows Secretary to apply the face-to-face encounter requirement to other items or services for which payment is provided under Medicare, based upon a finding that such a decision would reduce the risk of fraud, waste, or abuse.
Pharmacy (Part D) Fraud

- Pay **kickbacks** to physicians to prescribe unnecessary medications
- **Up-code** (bill name brand/give generic)
- **Buy back** drug after dispensing & re-sell
- Bill for **services not rendered** (short count or fail to dispense)
- **Buy prescriptions**
- **Recruit patients/pay kickbacks**
- **Divert drugs/buy black market**, re-label/re-package, sell expired stock or **counterfeit** drugs
Unnecessary treatment

- Primary care physicians were usually unaware of infusion treatments
- Real treatment records’ test results didn’t match clinics’

Recruitment of clinic staff

- Nominee owners
- Medical Directors,
- Treating Physicians, Physician Assistants
  - & unlicensed Technicians

Physician profile: Initially many were older
  - &/or retired but younger doctors are now involved
Florida Medicare Infusion Fraud

- Major diagnoses billed & paid:
  - HIV - Human Immunodeficiency Virus &
  - ITP - Immune Thrombocytopenic Purpura

- 5 highest aberrant HCPCS (then):
  - J1563  IVIG; 1 GM
  - J1440  Filgrastim; 300MCG
  - J1441  Filgrastim; 480 MCG
  - J2792  Rho D Immune Globulin H, SD 100 IU
  - Q0136  Epoetin Alpha; Injection, 1000 Units
Florida Medicare Infusion Fraud

J0800 Escalation 3/04 – 2/05

- March $45
- April $83
- May $6,064
- June $60,643
- July $2,395,496
- Aug $2,354,136
- Sep $2,780,197
- Oct $9,318,290
- Nov $22,268,962
- Dec $30,637,044
- Jan N/A (Clinically Unlikely Edit Implemented)
- Feb $2 M level
Florida Medicare Infusion Fraud

• Shifted from one J code to another
  – As edits were created, aberrant providers quickly reacted & billed new J codes
• Billed multiple lines for same dates & codes up to maximum number of units possible (999)
• Split claims to evade high $ edits, dosage limits
• Obtained multiple PINs to continue billing when/if one PIN was suspended or revoked
CMS/SGS/FCSO
Infusion Fraud Results

- 169 Medicare payment suspensions (>300 Docs/clinics)
- 160 new investigations & 31 LE referrals

**CUEs:** $10M in denials (1/07-4/07)

**Provider-Specific & Widespread Edits:** $22M (1/07-4/07)

**FCSO 18-mo South Florida Pilot Project:**

- Enhanced provider enrollment: 79 responses out of 631 revalidation requests = 532 revocations
- Site Visits: 21% approved unconditionally; 79% denied or on 100% prepay
- Edits: $6M to $10M per month since 1/07
Miami Strike Force

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

- (1) US vs. Frantz Achille, No. 06-20496-CR
- (2) US vs. Onelio Baez, et al., No. 05-20849-CR
- (3) US vs. Gregory Delatour, No. 06-20029-CR
- (4) US vs. Pedro Diaz, et al., No. 05-20869-CR
- (5) US vs. Luis Manuel Fernandez, et al., No. 06-20322-CR
- (6) US vs. Magda Lavin, No. 05-20814-CR
- (7) US vs. Thaiz Parra, et al., No. 06-60167-CR
- (8) US vs. Isaac Nosovsky, et al., No. 06-20178-CR
- (9) US vs. Rafael Walled, No. 06-20030-CR
- (10) US vs. Rosa Walled, No. 06-20031-CR
(11) US vs. Cesar Romero, No. 06-20740-CR
(12) US vs. Arnold Garcia, et al., No. 07-20057-CR
(13) US vs. Luis G. Henriquez Delgado, No. 07-20180-CR
(14) US vs. Jose Prieto, et al., No. 07-20177-CR
(15) US vs. Leider Alexis Munoz, No. 07-20225-CR
(16) US vs. Jorge Luis Mocega, et al., No. 07-20419-CR
(17) US vs. Orestes Alvarez-Jacinto, MD, No. 07-20420-CR
(18) US vs. Lester Miranda, et al., No. 07-20612-CR
(19) US vs. Rupert Francis, No. 07-20631-CR
(20) US vs. Rita Campos Ramirez, No 07-20633-CR (1)
Spread of Infusion Fraud

- **PR:** Infusion fraud spread to 4 clinics in PR in 2006 – payments were suspended & all principals pled guilty or were convicted
- **MI:** In 2007, 4 clinics in Dearborn area were shut down & referred to LE
- **GA:** In 2007, 4 clinics were shut down & referred to LE;
- Recently, additional clinics have sprung up.

- **Managed Care & Private Insurers:** In response to private insurer and managed care plan requests for info, CMS & the MEDIC are partnering with FBI & OIG.

- **HCCA & NHCAA** meetings such as this to raise awareness & share information.
NY-FLA Links:

Miami Herald 12/21/06: “Hialeah, NY arrests target Medicare fraud” - 10 arrested in FLA (racketeering & insurance fraud) & 3 in NY (conspiracy) after undercover LI NY cop who penetrated Russian crime group running NY clinics was offered to purchase a Hialeah infusion clinic for $1 M
Beneficiary Fraud Examples

- “Professional” patients
- Solicit kickbacks to participate in fraud
  - receive unnecessary service (surgery/tests)
  - accept free transport, sign logs for services not received
- Obtain physician orders for unnecessary diagnostic tests, drugs, treatments
- “Rent” use of Medicare ID # (“no show” patient)
- Re-sell drugs back to pharmacy after dispensing
- Recruit friends for “finder’s fee”
On 8/25/07, the Miami Herald reported the arrest of 8 Medicare beneficiaries in Florida a sting that was an outgrowth of a federal law enforcement Medicare Fraud Strike Force.

Beneficiaries who received kickbacks to be picked up in a van & taken to fraudulent clinics were videotaped by the FBI accepting payments of $100 to $400 in marked bills. Each faces up to 10 years in prison.

- Arrests marked a major departure for federal law enforcement, which usually goes after clinic owners/providers.
- Prosecutors acknowledge that some patients (along with some clinics, doctors, pharmacies and DME suppliers), are an integral part of health care fraud schemes that, according to the FBI, approach a billion dollars a year in South Florida.
Beneficiary Fraud Remedy

ACA Sec. 6402(a). Administrative Remedy for Knowing Participation by Beneficiary in Health Care Fraud Scheme

- Effective upon enactment, this provision requires Secretary to impose an administrative penalty on a Medicare, Medicaid, or CHIP-eligible individual, commensurate with the offense or conspiracy, for the knowing participation by the individual in a Federal health care fraud offense or conspiracy to commit such an offense.

- This is in addition to any existing remedies available to Secretary.
Medical identity theft is the misuse of another individual’s personal information to obtain or bill for medical goods or services.

Such theft creates both patient safety risks and financial burdens for those affected. Use of compromised numbers can lead to erroneous entries in beneficiaries’ medical histories and even the wrong medical treatment.

Medical identity theft not only harms beneficiaries and providers, it causes significant financial losses for the Medicare Trust Funds and taxpayers.
How Numbers Become Compromised

- Sometimes, Medicare numbers are stolen or used *without the provider’s or beneficiary’s knowledge*. This can happen through outright theft (e.g., “dumpster diving”, purse snatching, etc.) - or *theft by staff within a health care setting or insurance company* with access to the numbers.

- Other times, the provider and/or beneficiary is complicit in the scheme, receiving payment for use of their Medicare number.
How Numbers Become Compromised

At the current time, CMS is aware of about **5,621** compromised Medicare provider numbers, **166** compromised Medicare Part D provider numbers and approximately **276,842** compromised Medicare beneficiary numbers.
Map of Compromised Medicare Beneficiary Numbers (PSC/ZPIC/PDAC)
Map of Compromised Medicare Beneficiary Numbers (MEDIC Part D only)
Distribution of Part B, Part C and DME Provider Addresses in the CNC Database - April 2011
## Demographic Characteristics of the CNC Database

*(please note that this is only run on a quarterly basis)*

### Medicare Status

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<thead>
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<th>Medicare Status</th>
<th>Number of Beneficiaries</th>
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<tbody>
<tr>
<td>10 Aged without ESRD</td>
<td>179,072</td>
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<tr>
<td>20 Disabled without ESRD</td>
<td>38,143</td>
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<tr>
<td>21 Disabled with ESRD</td>
<td>2,078</td>
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<tr>
<td>11 Aged with ESRD</td>
<td>2,071</td>
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<td>31 ESRD only</td>
<td>273</td>
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<tr>
<td>No Status</td>
<td>32,846</td>
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<tr>
<td>Grand Total</td>
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### Gender/Race

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<tr>
<td>1 White</td>
<td>51,374</td>
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<tr>
<td>2 Black</td>
<td>18,895</td>
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<tr>
<td>5 Hispanic</td>
<td>17,756</td>
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<tr>
<td>4 Asian</td>
<td>6,565</td>
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<tr>
<td>3 Other</td>
<td>2,199</td>
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<tr>
<td>6 North American Native</td>
<td>163</td>
</tr>
<tr>
<td>0 Unknown</td>
<td>154</td>
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<tr>
<td>2 Female</td>
<td>124,531</td>
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<td>66,223</td>
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<tr>
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<td>28,044</td>
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<td>6 North American Native</td>
<td>169</td>
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<tr>
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<td>254,483</td>
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### Coverage

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<th>Number of Beneficiaries</th>
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<td>Part A</td>
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<tr>
<td>Part B</td>
<td>220,678</td>
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<tr>
<td>Part C</td>
<td>34,203</td>
</tr>
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*Image of a certificate from the Department of Health and Human Services.*
CMS Efforts to Reduce Medicare Fraud

- **Field Offices (FOs):** CMS established FOs in High Risk Areas (Miami, Los Angeles & New York)
  - Medicare Program Safeguard Contractors (PSCs), Zone Program Integrity Contractors (ZPICs) & Medicare Part D Integrity Contractors (MEDICs)
    - perform **proactive data analysis** to ID vulnerabilities, investigate & refer potential fraud to OIG
    - perform audits & evaluations
    - assist **law enforcement** (respond to Requests for Information, perform data analysis)
    - lead **Medi-Medi initiative** - combined Medicare-Medicaid data analysis to identify/investigate potential fraud and abuse
    - **Partner** with federal & state law enforcement
      - **HEAT Strike Forces**
      - National & local Health Care Fraud Task Forces
Medicare 7-State DME Stop Gap Project

- Short-term plan to enhance DME fraud, waste and abuse detection and prevention activities in 7 states (CA, FL, TX, IL, MI, NY & NC) with:
- High DMEPOS expenditures & growth rates and focus on highest billed items in each such as:
  - CPAP
  - Oxygen
  - Power Mobility Devices
  - Glucose Monitors/Diabetes Testing Strips
CMS and its contractors (PDAC, NSC, DME PSCs and ZPICs) implemented a 4-pronged approach to address all 4 of DME program’s high risk components by identifying & taking action on:

- (1) highest paid/highest risk DMEPOS suppliers
- (2) highest volume ordering physicians
- (3) highest billed/highest risk DMEPOS equipment and supplies, &
- (4) highest utilizing beneficiaries
DME Stop Gap Plan – High Risk Ordering Physicians

- **Interview physicians to validate their NPIs** & identify NPIs which are invalid, belong to deceased physicians, or are stolen/compromised;

- **Verify clinical relationships** (via claims history data and/or beneficiary interviews) between high ordering/vulnerable physicians & beneficiaries for whom they ordered equipment;

- Implement:
  - *autodenial edits* for NPIs which are invalid, stolen/compromised or for deceased physicians;
  - *install edits & suspend payments* to DME suppliers billing for services the doctors attest they never ordered.
DME Stop Gap - Results 09/09-12/10

- 3,785 Supplier, Ordering Physician & Beneficiary Site Visits/Interviews including 2,346 NSC Supplier Enrollment Onsites
- resulting in:
  - 403 Revocations/Deactivations,
  - 5 Suspensions,
  - 934 New Investigations Opened &
  - 14 LE Referrals Accepted
- >$26 million in Prepay Edit Savings from Claims Denied based on 9,867 Prepay Edits (Supplier, Ordering Physician & Beneficiary)
- >$28.1 million in Overpayments Identified & Requested
61,000 Accredited DMEPOS Suppliers as of 9/10/10; after **16,000 revocations** in 2010 due to failure to seek or qualify for accreditation &/or surety bonds.

**DME Revocations by Year**

- CY 2000: 251
- CY 2001: 348
- CY 2002: 370
- CY 2003: 920
- CY 2004: 1108
- CY 2005: 1025
- CY 2006: 1255
- CY 2007: 1139
- CY 2008: 1713
CMS Efforts to Reduce Medicare Fraud & Improper Payments

- Predictive Modeling & Data analysis to target highest risk providers/services
- New/clarified national/local coverage determinations & Provider Education
- **Prepayment** claim review
  - New edits (automated review)
  - Medical record review (complex review)
- **Postpayment** claim & medical record review
- **Overpayment** recoupment
- *Enhanced* Provider Enrollment screening & more frequent, *unannounced* site visits
- Revocation or Deactivation of Medicare billing privileges
- **Suspension** of Medicare payments
CMS Efforts to Reduce Medicare Fraud – Stop Pay & Chase

New CMS approach:

- Stop the “pay & chase”
- Take administrative actions as early as possible
- “Stop the bleeding”
- No longer “business as usual”

New approach requires closer coordination /more frequent substantive communication between CMS & PSC/ZPIC and OIG and law enforcement regarding implementation of:

- Payment Suspension
- Prepay Edits
- Postpay Review (request & review medical records, compute overpayment and issue demand letter)
Contact Information

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USEFUL WEBSITES:

www.cms.hhs.gov/medlearn
Notices, alerts, bulletins, on-line education

www.stopmedicarefraud.gov
Strike Force & HEAT & prosecution info, press releases, indictments by state