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

Jean Stone, Director
Northeast Program Integrity Office
Center for Program Integrity
Centers for Medicare & Medicaid Services
212-616-2541
Jean.Stone@cms.hhs.gov

Alphabet Soup: *H*ealth Care Fraud Prevention & *E*nforcement *A*ction *T*eam = *HEAT*

HEAT

- In May 2009, the Department of Justice (**DOJ)** and the Department of Health and Human Services (**HHS)** announced creation of the ***H***ealth Care Fraud Prevention and ***E***nforcement ***A***ction ***T***eam (**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.

HEAT BACKGROUND

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.

MEDICARE EXPENDITURES

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

MEDICARE EXPENDITURES

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 (fe 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.

Medicare Strike Force Expansion

- 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**.

HEAT RESULTS TO DATE

- 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 ***H***ealth Care Fraud Prevention and ***E***nforcement ***A***ction ***T***eam (***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.

ANTI-FRAUD RESULTS TO DATE

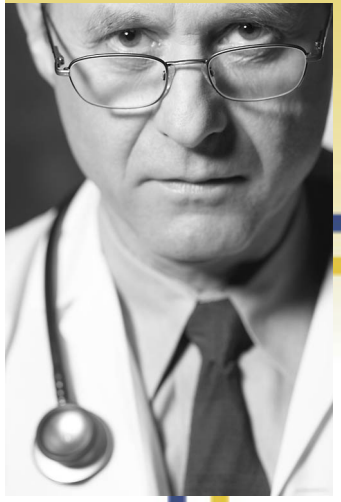
- The ***$4 billion*** recovered in FY 2010 includes recoveries from ***$2.5 billion*** in settlements & judgments obtained in FY 2010 by DOJ in False Claims Act matters alleging health care fraud.

- 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.

FRAUD SUMMITS

- 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)



MDs - Physician Fraud

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**

Durable Medical Equipment (DME) Fraud

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)

HOSPITAL FRAUD

- 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)

AMBULANCE FRAUD

- 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

Affordable Care Act Remedy

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

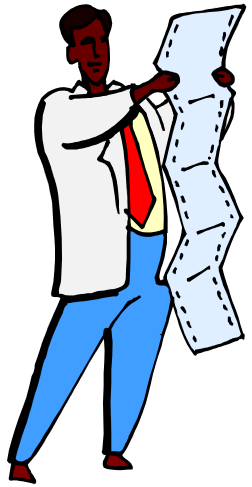
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Florida Medicare Infusion Fraud

- **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

- Denial of >$2 Billion in Medicare billings (2005/2006)
- 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**

Miami *Strike Force*

- (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.**

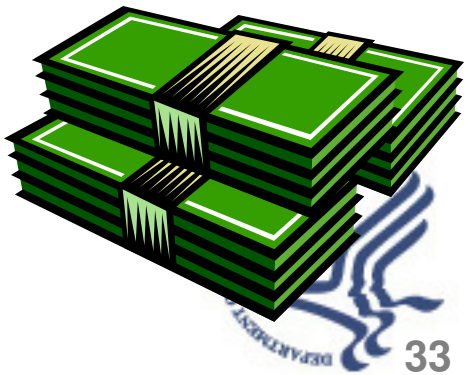
- **HCCA & NHCAA meetings such as this to raise awareness & share information.**

Spread of Infusion Fraud

- **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

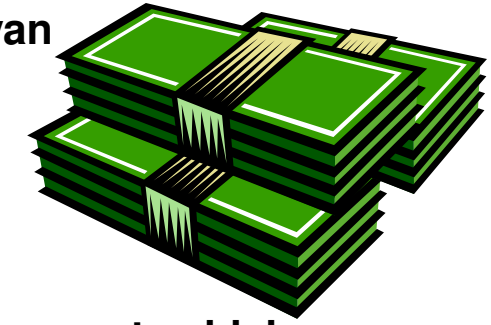
- "Professional" patients
- Solicit kickbacks to participate in fraud
  - receive unnecessary service (surgery/tests)
  - accept free transport, sign logs for services not received
- Obtain physician orders for unnecessary diagnostic tests, drugs, treatments
- "Rent" use of Medicare ID # ("no show" patient)
- Re-sell drugs back to pharmacy after dispensing
- Recruit friends for "finder's fee"



Beneficiary Fraud Examples

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.

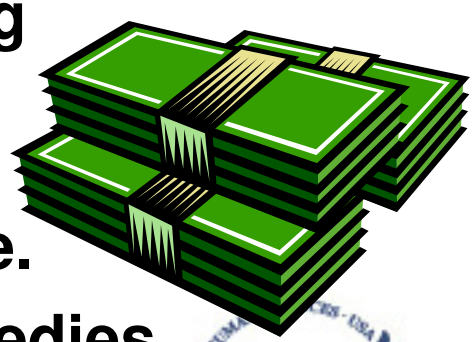


- Arrests marked a major departure for federal law enforcement, which usually goes after clinic owners/providers.
- Prosecutors acknowledge that some patients (along with some clinics, doctors, pharmacies and DME suppliers), are an integral part of health care fraud schemes that, according to the FBI,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

- 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

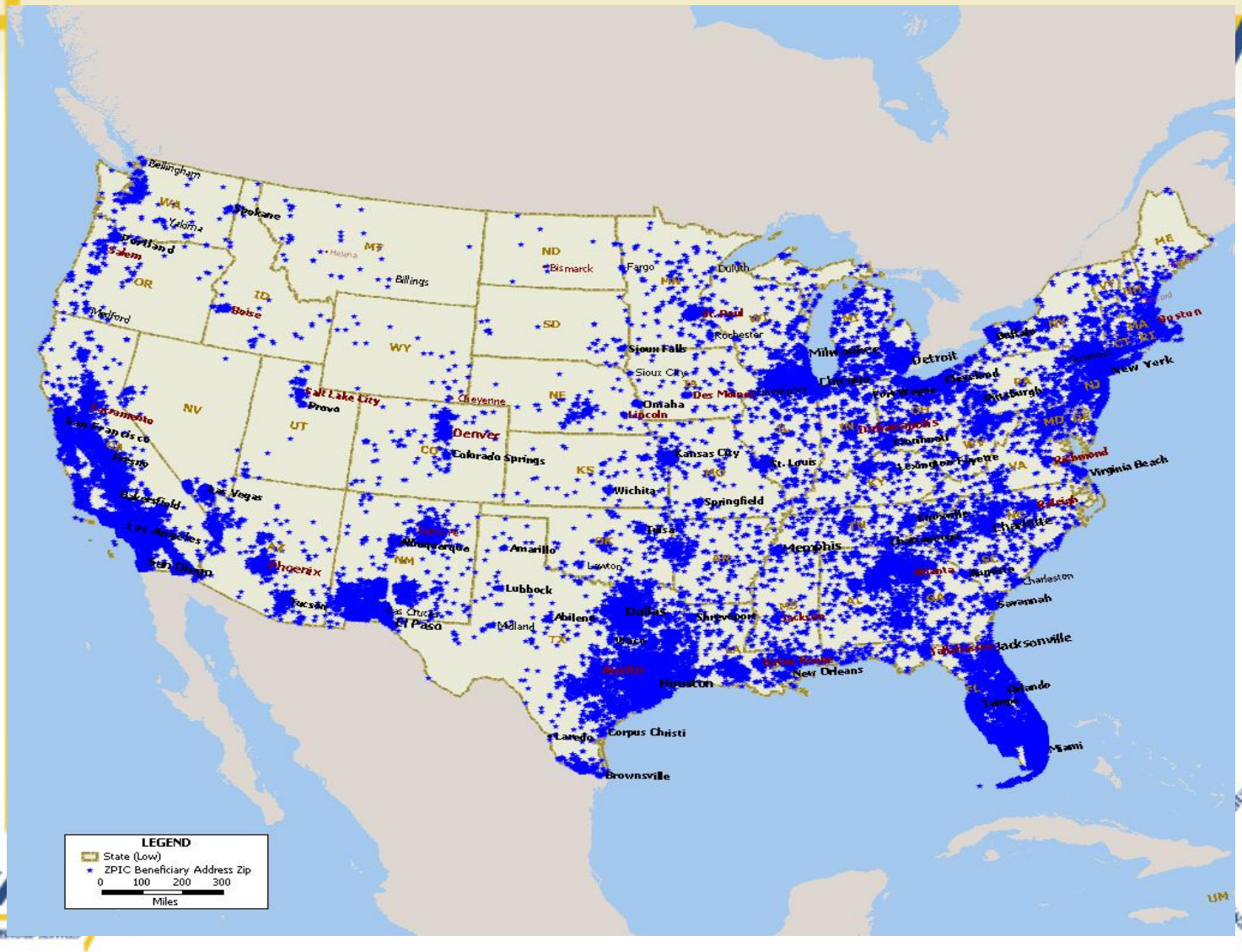
- Sometimes, Medicare numbers are stolen or used *without the provider's or beneficiary's knowledge.* This can happen through outright theft (e.g., "dumpster diving", purse snatching, etc.) - or *theft by staff within a health care setting or insurance company* with access to the numbers.

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

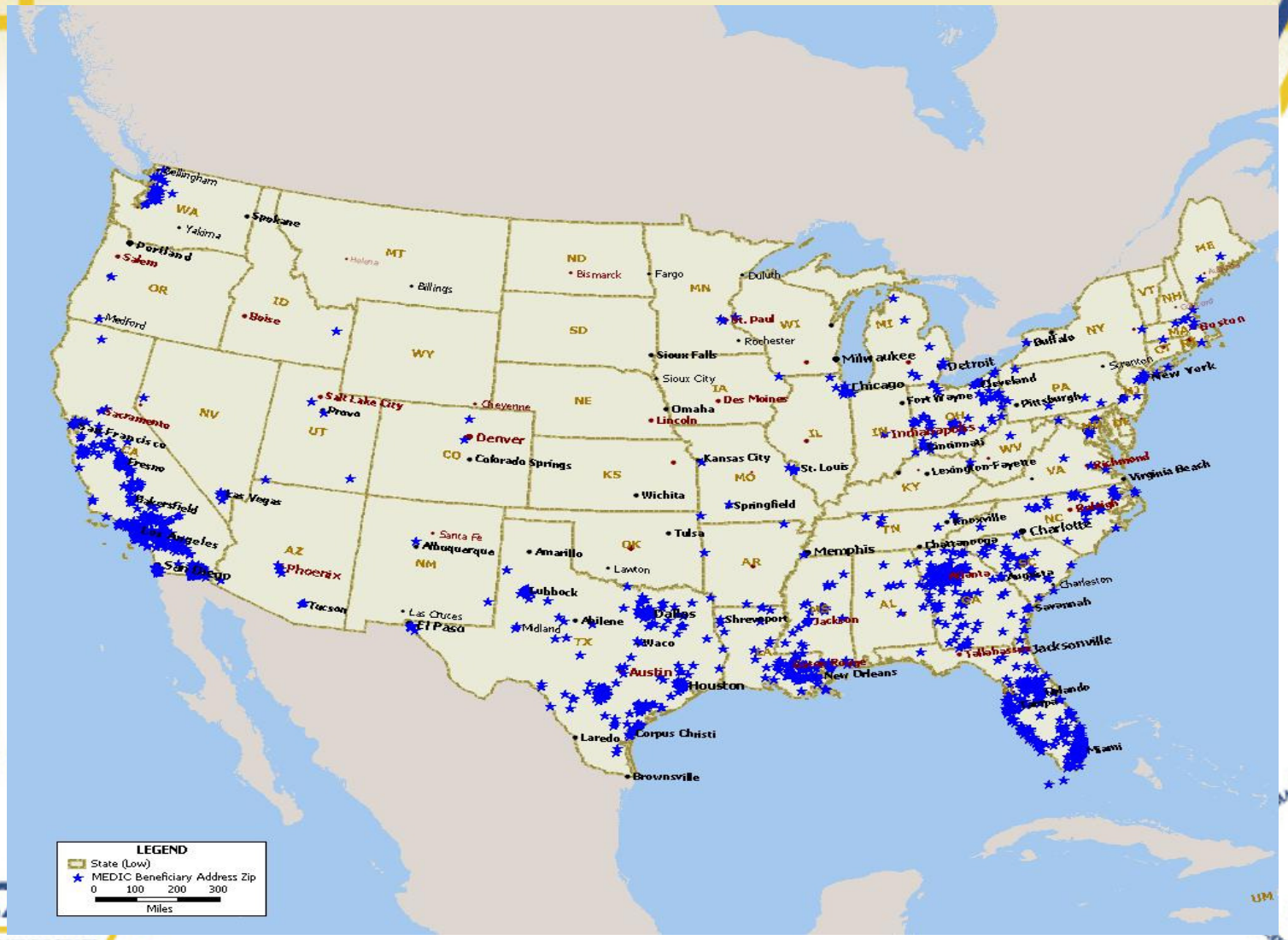
How Numbers Become Compromised

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.

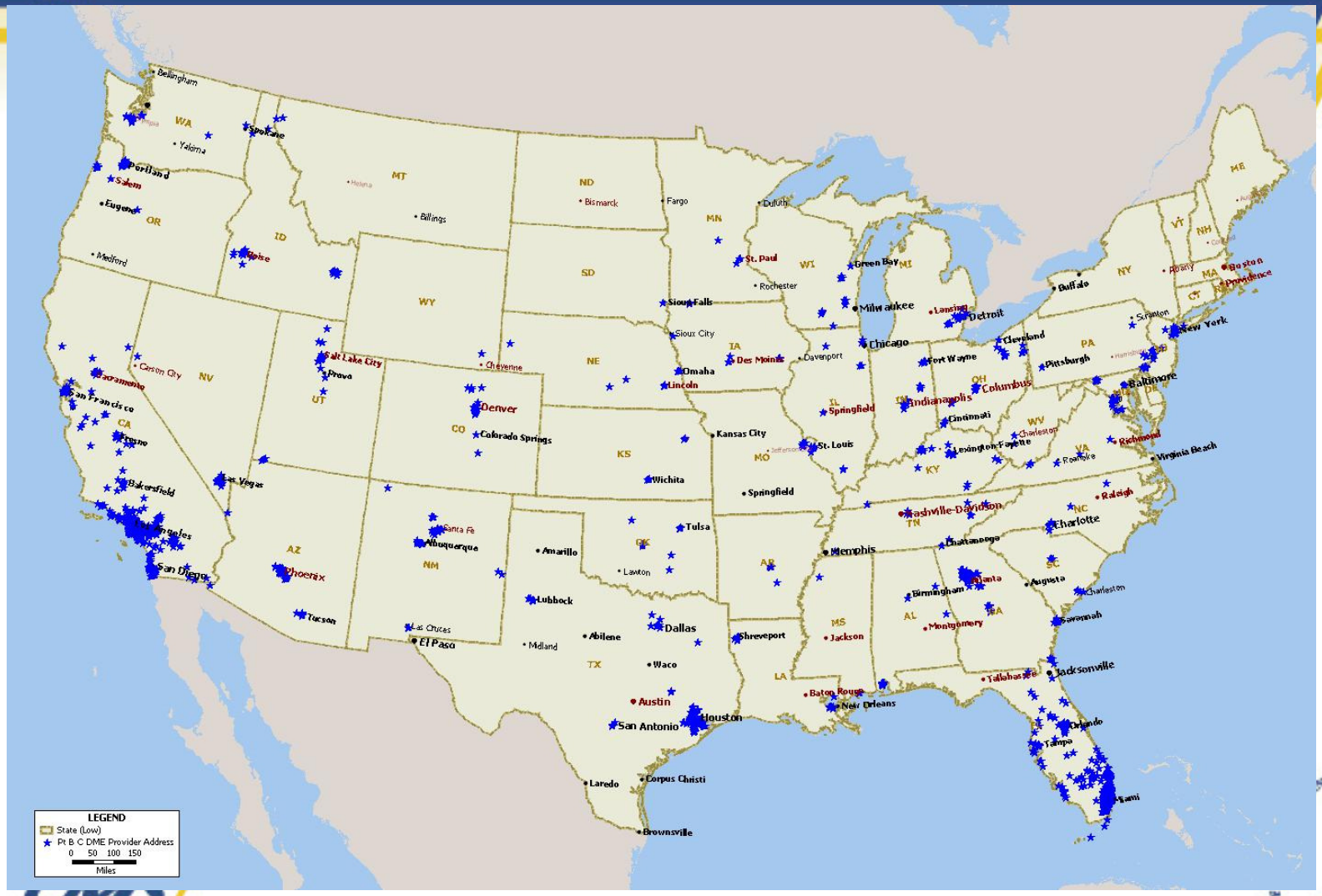
Map of Compromised Medicare Beneficiary Numbers (PSC/ZPIC/PDAC)



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



Distribution of Part D Prescriber Addresses in the CNC Database - April 2011

Demographic Characteristics of the CNC Database (please note that this is only run on a quarterly basis)

Gender/Race	Number of Beneficiaries
1 Male	**97,106**
1 White	51,374
2 Black	18,895
5 Hispanic	17,756
4 Asian	6,565
3 Other	2,199
6 North American Native	163
0 Unknown	154
2 Female	**124,531**
1 White	66,223
5 Hispanic	28,044
2 Black	17,554
4 Asian	9,640
3 Other	2,681
0 Unknown	220
6 North American Native	169
No Gender/Race	**32,846**
Grand Total	254,483

Medicare Status	Number of Beneficiaries
10 Aged without ESRD	179,072
20 Disabled without ESRD	38,143
No Status	32,846
21 Disabled with ESRD	2,078
11 Aged with ESRD	2,071
31 ESRD only	273
Grand Total	**254,483**

Coverage	Number of Beneficiaries
Part A	211,666
Part B	220,678
Part C	34,203

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**

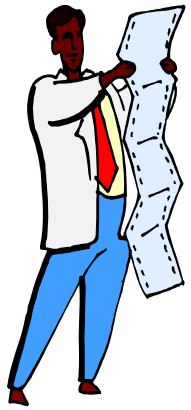
DME Stop Gap Plan – 4 Areas of Focus

CMS and its contractors (PDAC, NSC, DME PSCs and ZPICs) implemented 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.**



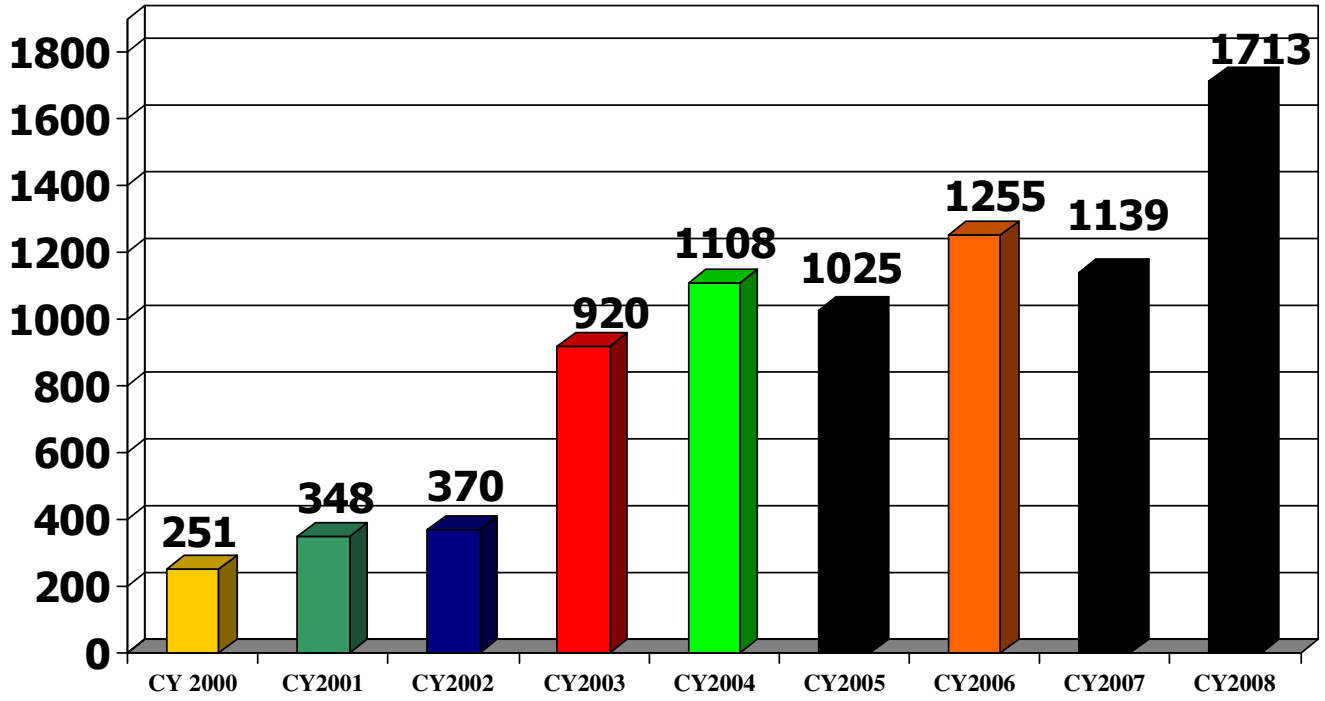
DME Stop Gap - Results 09/09-12/10

- ***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

NSC Supplier Audit and Compliance Unit

DME Revocations by Year

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



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

Email: Jean.Stone@cms.hhs.gov

Telephone: (212) 616-2541

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