

Chapter 11: Program Safeguard Contractor

DME MAC Contracts

TriCenturion is a Program Safeguard Contractor (PSC) under contract with the Centers for Medicare & Medicaid Services (CMS) to perform all Benefit Integrity functions for DME MAC Jurisdictions A/B. These functions include fraud investigations, audit activities which may include prepay and post pay medical review of claims, and data analysis. While the focus of the Medical Review program is to reduce the error rate through medical review and provider notification and feedback; medical review for BI purposes focuses on addressing situations of potential fraud, waste and abuse. In this contract, TriCenturion works closely with NHIC, Corp. DME MAC A and National Government Services (NGS) DME MAC B.

The PSCs will continue to perform the Benefit Integrity functions, however, in the near future, the PSCs performing BI functions will transition the BI work to Zone Program Integrity Contractors (ZPICs). This transition of PSC BI functions to ZPICs is noted in MLN Matters article 5765 and the PIM Chapter 5 revision.

TriCenturion will contact suppliers directly in the event that they require information in carrying out their activities, and any such request will contain explicit instructions on when, where, and how to respond.

Supplier Information

TriCenturion maintains a Web site at <http://www.tricenturion.com>. Suppliers can access the PSC Web site, via the “TriCenturion” link on the DME MAC Jurisdiction A Related Web sites page, <http://www.medicarenhic.com/dme/dmprovlink.shtml>, for PSC Benefit Integrity information.

The following sections provide an overview of Fraud and Abuse, Audits, Civil Monetary Penalties, and Supplier Responsibilities in relation to Benefit Integrity. For more information and current updates, visit the PSC Web site.

Note: Updated information regarding Fraud and Abuse, Alerts, and Referral to Benefit Integrity Forms are located at <http://www.tricenturion.com/>

Fraud and Abuse

When a contractor is investigating potentially fraudulent behavior by a supplier, it will be the **supplier's** responsibility to prove the authenticity/validity of the claim(s) under investigation. The PSC may require the supplier to prove the authenticity/validity of the signature on the Certificate of Medical Necessity (CMN) or order, or any other questionable portion of the claim(s) under investigation.

Fraud is defined as knowingly and willfully executing or attempting to execute a scheme to defraud any health care benefit program or to obtain, by means of false pretenses or promises, any of the money or property owned by, or under the custody or control of any health care benefit program.

Examples of Fraud:

- Billing for services not rendered
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Using an incorrect or inappropriate provider number in order to be paid (e.g. using a deceased provider's number)
- Signing blank records or certification forms that are used by another entity to obtain Medicare payment
- Selling or sharing patient's Medicare numbers so false claims can be filed
- Offering incentives to Medicare patients that are not offered to non-Medicare patients (e.g. routinely waiving or discounting the Medicare deductible and/or coinsurance amounts)
- Falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government
- Misrepresenting as medically necessary, non-covered services by using inappropriate procedure or diagnosis codes

Abuse may, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, or payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented the facts to obtain payment. Although many types of inappropriate practices may be considered abusive, they may evolve into fraud.

Examples of Abuse:

- Using procedure or revenue codes that describe more extensive services than those actually performed
- Collecting more than the 20% coinsurance or the deductible on claims filed to Medicare. Providers may, of course, bill patients for services not covered (e.g. service exclusions)
- Routinely submitting duplicate claims
- Billing for services grossly in excess of those needed by patients
- Incorrectly apportioning costs on cost reports for Part A providers
- Charging more than the actual purchase price of a service, item, or drug

Beneficiaries are advised to report any instances of fraudulent or abusive practices to the DME MAC Jurisdictions.

A **complaint** is a statement, oral or written, alleging that a provider, supplier, or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.

Audits

The PSC Benefit Integrity (BI) Unit routinely conducts audits of the billing practices of suppliers. These audits may be the result of inquiries from beneficiaries, providers, or an internal inquiry from the DME MACs customer service, provider relations, or medical review units. Audits may also result from statistical analyses that indicate that a supplier's billing pattern is aberrant. Suppliers may be asked to forward documentation to support the services that were billed. Suppliers may also be asked to provide financial records pertaining to their business to verify that they are properly collecting co-payments. The request for documentation or records will be in writing. **Note:** Suppliers should read the **entire** letter, because contact information is provided for any questions that suppliers may have.

In some instances, onsite audits may be conducted at the supplier's place of business. If requested information is not received, the service or equipment will be considered as not documented and a refund will be requested. Therefore, it is vitally important that suppliers keep accurate records. During the course of the audit, the BI Unit may also contact the prescribing physician and the beneficiary in order to verify that the services were received as billed and that the medical necessity requirements are met.

When the BI Unit performs an audit, the following items must be available for review:

- Certificate of Medical Necessity (CMN)

- Physician's orders
- Signed and dated delivery slip
- Signed and dated pickup slip, when equipment has been returned
- Completed description of equipment supplied, including the appropriate serial numbers
- Signed authorization for Medicare payment
- Billing and financial records

Suppliers should also:

- Document all contact with the patient, or authorized representative, and maintain the contact report in the file
- Identify all rented equipment with the supplier's name and telephone number
- Give explicit instructions on how and when to return the equipment, and advise the patient and/or representative that the supplier is to be contacted if the patient deceases, moves, and/or is admitted to a nursing home or hospital, or the equipment is no longer needed
- Retain and have available Medicare beneficiary records for seven (7) years

Suppliers who fail to permit examination of records may be terminated from participation in the Medicare program.

Civil Monetary Penalties

In 1981, Congress added Section 1128A (42 U.S.C. 1320a-7a) to the Social Security Act to authorize the Secretary of the Department of Health and Human Services (HHS) to impose civil money penalties (CMPs). Since the enactment of the first CMP authority in 1981, Congress has increased both the number and types of circumstances under which CMPs may be imposed. Most of the specific statutory provisions authorizing CMPs also permit the Secretary to impose an assessment in addition to the CMP. An assessment is an additional monetary payment in lieu of damages sustained by the government because of the improper claim. Also, for many statutory violations, the Secretary may exclude the individual or entity violating the statute from participating in Medicare and other federal healthcare programs for specified periods of time.

In October 1994, the Secretary realigned the responsibility for enforcing these CMP authorities between the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG). CMS was delegated the responsibility for implementing CMPs that involve program compliance. The OIG was delegated the responsibility for implementing CMPs that involve threats to the integrity of the Medicare or Medicaid programs; i.e., those which involve fraud or false representations. On August 21, 1996, the Health Insurance Portability and Accountability Act of

1996 (Public Law 104-191, referred to as HIPAA) was enacted. This law provides for higher maximum CMPs (\$10,000 per false item or service on a claim or instance of noncompliance, instead of \$2,000 per item or service), and higher assessments (three times the amount claimed, instead of twice the amount) for some of the violations. Other less severe administrative remedies may precede the more punitive sanctions affecting participation in the Medicare program.

In order to avoid any sanctions being levied against them, suppliers should ensure that the Medicare program rules and regulations are appropriately followed.

Supplier Responsibilities

The PSC BI Unit realizes that most suppliers operate reputable businesses and are only interested in serving their customers in an honest and straightforward manner. This is why all suppliers are treated fairly when there is a suspicion of fraud or abuse.

Suppliers have a number of responsibilities as participants in the Medicare program:

- Suppliers must maintain proper documentation and provide it to the DME MACs, HHS/OIG, or any other federal law enforcement agency upon request. The documentation must be complete, accurate, and legible. Suppliers should keep original copies, not facsimiles or photocopies. Suppliers must also make sure the documents bear no alterations, such as white-out.
- Suppliers must read the supplier manual and any Medicare bulletins, including updates to policies and procedures. Suppliers are responsible for understanding the information contained in these documents.
- Suppliers must report individuals or companies who they suspect are committing Medicare fraud to the BI Unit.

For more information on fraud and abuse, suppliers should refer to Chapter 4 of Pub. 100-8, *Medicare Program Integrity Manual*, <http://www.cms.hhs.gov/manuals/downloads/pim83c04.pdf>