

PART B



Fraud & Abuse Billing Guide July 2009

J14 A/B MAC

NHIC, Corp.

Fraud & Abuse Billing Guide

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Fraud & Abuse information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the Centers for Medicare & Medicaid Services (CMS), are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-8, Chapter 4 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.hhs.gov/manuals/>

If you have questions or comments regarding this material, please call the appropriate NHIC Customer Service Center for your state. The telephone numbers are listed at the end of this guide.

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GENERAL INFORMATION

Medicare fraud and abuse are important national topics. The U.S. General Accounting Office estimates that \$1 out of every \$10 spent for Medicare and Medicaid is lost to fraud. This translates into fewer resources for health care due to the strains on federal and state budgets. During FY 2005, the Federal Government won or negotiated approximately \$1.47 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings. NHIC, Corp. has an aggressive program to combat fraud and abuse, but we need your help in reporting problems.

The purpose of this guide is to increase your awareness of integrity issues and prevention of potential fraudulent and abusive practices against Medicare Part B. Most providers of health care are honest businessmen and women who want to provide quality health care to Medicare beneficiaries. However, there remains a relatively small group of providers who take advantage of the Medicare program and engage in schemes or practices that result in inappropriate payments.

As a Medicare Contractor, NHIC, Corp. is required to safeguard Medicare funds. It is our goal, as well as the goal of all honest, ethical providers, to wipe out Medicare fraud and abuse. Our efforts are extensive but we need your cooperation in submitting appropriate claims that are reasonable and necessary according to Medicare rules and policies. We are actively ensuring the continued well-being and fair treatment of Medicare beneficiaries and the provider community.

SafeGuard Services (SGS), a Program Safeguard Contractor, has a contract to perform fraud and abuse detection and prevention activities for Medicare claims. This contract is known as the New England Benefit Integrity Support Center (NE BISC).

Responsibilities of the NE BISC include the following:

- Identify and deter Medicare fraud and abuse in the NHIC claims jurisdiction.
- Reduce the number of fraudulent or abusive claims submitted.
- Develop quality fraud cases for referral to the Office of Inspector General and other law enforcement agencies.
- Develop and validate methodologies for the early detection and prevention of fraud schemes and abusive use of services.

All fraud case development and handling of complaints alleging fraud is the responsibility of the NE BISC. To be responsive to CMS, law enforcement, and providers, the NE BISC operations cover NHIC claims' jurisdictions for Maine, Massachusetts, New Hampshire, Rhode Island and Vermont for Part A and B and Maine, Massachusetts, New Hampshire, Rhode Island, Vermont and Connecticut for Home Health and Hospice.

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The NE BISC operation is located at the following address:

New England: 75 Sgt. William Terry Drive
Hingham, MA 02043

43 Landry Street,
Biddeford, ME 04005

800 Connecticut Blvd.,
East Hartford, CT 06108

Please direct questions concerning the NE-BISC to:

Maureen Akhouzine, Benefit Integrity Manager
SafeGuard Services, LLC
New England Benefit Integrity Support Center
Medicare Integrity Program
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@eds.com

FRAUD

Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in an unauthorized benefit to himself/herself or another person. The most frequent kind of fraud arises from a false statement or misrepresentation made or caused to be made, that is material to entitlement or payment under the Medicare program. The violator may be a physician or other practitioner, supplier of durable medical equipment, an employee of a physician or supplier, a carrier employee, a billing service, a beneficiary, or any other person or business entity in a position to bill the Medicare program or to otherwise benefit from such billing.

Attempts to defraud the Medicare program may take a variety of forms. The following are some examples of how fraud may be perpetrated:

- Billing for services or supplies that were not provided
- Altering claim forms to obtain a higher reimbursement amount
- Deliberately applying for duplicate reimbursement in order to get paid twice
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider
- Unbundling or “exploding” charges
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- False representation with respect to the nature of the services rendered or charges for such services, identity of the person receiving or rendering the services, dates of the services, etc.
- Filing claims for services that are non-covered but billed as if they were covered services
- Claims involving collusion between a provider and a beneficiary, resulting in higher cost or charges to the Medicare program
- Use of another person’s Medicare card in obtaining medical care
- Collusion between a provider and a carrier employee
- Any act that constitutes fraud under applicable federal or state law

Although some of the practices noted above may be initially considered to be abusive, rather than fraudulent activities, they may evolve into fraud.

When **fraud** has been committed, the government can:

- Seek federal 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

Federal law defines **abuse**, as applied to the Medicare program, as incidents or practices by providers, which although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices that directly or indirectly create unnecessary costs to the Medicare program. Improper reimbursement or reimbursement for services which fail to meet professionally recognized standards of care or which are not reasonable and necessary are examples of such practices.

Abuse takes such forms as, but is not limited to:

- Over-utilization of medical and health care services
- Claims for services that are not reasonable and necessary, or if deemed medically necessary, not to the extent rendered or billed
- Breaches of the assignment agreement which result in beneficiaries being billed for amounts disallowed by the carrier on the basis that such charges exceeded the Medicare Fee Schedule
- Exceeding the Limiting Charge for non-participating providers
- Violations of the Medicare Participating Agreements by physicians, suppliers or practitioners

Many other forms of abuse exist and some, including those described above, are ultimately found to be fraudulent.

When **abuse** is committed, the government can:

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

SAFEGUARDING THE MEDICARE PROGRAM

The effort to prevent and detect fraud, abuse, and waste is a cooperative one involving beneficiaries, Medicare contractors, providers, and Federal agencies such as the Department of Health and Human Services (DHHS), the Federal Bureau of Investigations (FBI), and the Department of Justice (DOJ). These entities are committed to help protect the Medicare Trust Funds from being depleted by fraudulent and abusive practices.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services is the Federal agency that is responsible for the Medicare program. Title XVIII of the Social Security Act provides the statutory authority for the broad objectives and operations of the Medicare program. CMS authorizes Medicare carriers to maintain the integrity of the Medicare program by conducting activities that ensure that only appropriate payments are made. The CMS Publications provide the practical operating instructions needed for contractors to administer Medicare Part B.

NHIC, Corp.

As a Medicare Part B carrier, NHIC, Corp. has established procedures to identify cases of suspected fraud or abuse, and take the necessary actions to ensure that the Medicare Trust Fund

monies are utilized appropriately. In the event of mistaken payments, NHIC may pursue the recovery of overpaid funds. Suspected fraud and abuse cases are forwarded to the appropriate Benefit Integrity Support Center (NE BISC) for investigation. At the conclusion of their investigation, the NE BISC may refer the matter to the Office of Inspector General (OIG) for further consideration and initiation of criminal, civil monetary penalties and/or administration sanction actions.

In order to maintain the integrity of the Medicare program, audits and prepayment reviews are periodically performed. As a Medicare carrier, we are required by the Centers for Medicare & Medicaid Services to maintain within our claims processing system a mechanism designed to detect potentially abusive billing patterns and/or over utilization of services. As a result of this requirement, we have established criteria for determining the point at which further information is needed from the provider to properly adjudicate a claim. These parameters are not releasable to the public, even if requested under the Freedom of Information Act. Therefore, all providers must maintain documentation on file for all services rendered and submitted to Medicare for reimbursement.

Documentation

Documentation should substantiate the level of care provided and the medical reasonableness for the services rendered. Upon request, documentation should promptly be provided to the carrier. Failure to provide requested information might result in further review, overpayment requests, and/or the assessment of civil monetary penalties. The following types of reviews may require the provider to supply Medicare with medical documentation.

Focused Medical Review (FMR)

In recent years carriers have been required to focus on patterns of unnecessary services and improper or incorrect billing. In order to achieve this, carriers have formed Focused Medical Review (FMR) units. The objectives of these FMR units are to maximize program protection and to conduct a cost-effective medical review. This translates to concentration of review efforts on Medicare bills and claims that are most likely to be for services that are unnecessary. By concentrating only on bills and claims that are problems, Medicare providers who submit requests for medically necessary services will not have to supply more than a minimum amount of information.

Potential problems are identified from bi-annual CMS reports generated from the national history database that compare our carrier frequencies against national frequencies. The FMR units analyze these procedures where there are frequencies that are grossly out of line with the national statistics. While there are often legitimate reasons for carrier aberrancies of certain procedure codes, reviews that uncover actual problems are referred to the NE BISC.

The results of the FMR efforts have been published as policy in the Medicare B Resource. The final policy or Local Coverage Determination (LCD) provides indications/limitations of coverage, documentation requirements, and covered ICD-9-CM codes.

Complex Medical Review Audits (CMRA)

CMRA consists primarily of pre-pay chart reviews of randomly selected medical records. Edits are established on any codes or procedures that have been specifically targeted by the Data Processing/Policy Development areas, as well as any documentation of providers or procedures referred by the Appeals, Adjustments, Correspondence, and/or Education and Training. Documentation received with the claim or as a result of development is reviewed.

Documentation must support the service code billed, the level of service billed, and the reasonableness and necessity of the service. A percentage of claims that are randomly selected from the entire universe of claims that are billed to NHIC are also reviewed. Post-pay chart reviews on any providers or codes may be conducted if enough information to make a judgment using the pre-pay methodology is not obtained.

Pre-payment review of medical records can be, but are not limited to:

- Specifically targeted or abused CPT codes
- Providers who seem to be billing incorrect code(s)
- Providers who appear to be abusive because they are either not rendering the service they bill for, or they consistently bill for a higher level service than provided.

Comprehensive Medical Review (CMR)

Comprehensive Medical Review (CMR) consists of postpayment medical reviews of a provider's claims and medical documentation. A CMR may be initiated based on historical data collected during an analysis of Medicare claims. Often a CMR requires a statistical sampling of claims and allows for projection of sample overpayments to the universe of claims. In such cases, all claims in the statistical sample from the provider being examined are individually reviewed. Physician consultants or practitioners of the same specialty of the provider undergoing the CMR carry out chart review. The following are some of the reasons a provider may be reviewed in a post payment CMR:

- Failure to submit requested medical documentation
- Overutilization
- Continuous improper coding
- Submitting altered documentation
- Alerts from other carriers, intermediaries, peer review organizations, or internal carrier payment staff referrals
- Non-compliance with provider enrollment or certification, physician orders, or similar requirements

The reason for the Comprehensive Medical Review will be detailed in a letter to the provider along with the findings. Appeal rights may be exercised in the event of a CMR. Even if you request an appeal, any overpayments that are calculated must be refunded to Medicare. If the decision is later overturned through the reconsideration process, the carrier will refund as required based upon the determination.

CASE DEVELOPMENT

The carrier originates reviews internally or receives allegations of fraud and abuse from numerous sources. These matters are referred to the NE BISC for review. Reviews of fraud differ from reviews of abuse essentially as follows:

- **Suspected fraud** requires a determination of whether billed services were, in fact, rendered; and
- **Suspected abuse** situations involve reviews of the reasonableness of the billed services.

Complaints

Complaints may be presented to the Medicare Administration by telephone, in writing, or in-person. 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 regulation or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.

Sources

The following are possible sources of allegations of fraud and abuse:

- Beneficiaries
- Other providers
- Social Security Administration (SSA)
- Anonymous sources
- Hospitals
- The media (television, radio, and newspapers)
- Employees of medical providers and practitioners
- Billing service or agency
- Electronic software vendors
- Medicare contractors
- Senior Citizen Groups
- United States Postal Service
- Federal Bureau of Investigations (FBI)
- Peer Review Organizations (PROs)
- Office of Inspector General (OIG)

Process

Initial Actions - When an allegation of fraud or abuse is received, or a potentially fraudulent or abusive situation is identified, it is immediately referred to the NE BISC and reviewed to determine the facts.

Contacts - Contacts are made with the provider, complainant, and/or beneficiary whenever necessary to clarify all aspects of the alleged situation.

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Requests for Documentation - During the review process, if medical records are needed, providers are asked to provide the necessary information.

Control - Incoming or new complaints are checked against existing records for prior complaints involving the same provider.

Review - The review includes claim documents, medical records, hospital progress notes, and any previous educational contact letters that relate to similar complaints. During this process, past Medicare B Resource articles might also be reviewed to help determine notice – whether or not a provider should have known about an issue, policy or guideline.

Medical Opinion - When medical opinion is necessary, the case or issue is reviewed by a NE BISC nurse or referred to a NE BISC medical consultant for advice. The medical consultants are physicians or practitioners who have the same specialty as the provider being reviewed.

Overpayment - When we have determined that an overpayment has occurred, we research it to assess the liability of the provider. If an amount is assessed, the provider will be notified in writing.

Educational Contact - The provider is given an educational contact usually in writing regarding the review findings. Follow-up reviews will then be conducted to ensure that the identified aberrancies and problems have been corrected.

Reconsideration - Medicare law provides that a provider, who is dissatisfied with a review decision may request a hearing.

Referrals - The Benefit Integrity Safeguard Contractor (NE BISC), at the conclusion of their investigation, may refer the matter to the Office of Inspector General (OIG) for further consideration and initiation of criminal, civil monetary penalties and/or administration sanction actions.

FALSE CLAIMS ACT

The Civil False Claims Act, 31 U.S.C. Section 3729, imposes civil liability, in part, on any person who:

- a) Knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
- b) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
- c) Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

Incentive Programs — Fraud and Abuse

The Code of Federal Regulations (42 CFR Part 420) sets forth a final rule that will allow Medicare beneficiaries, Medicare providers, and any other individual that may be eligible, the opportunity to receive a reward for reported information regarding Medicare fraud that leads to the recovery

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of Medicare funds. Certain individuals such as government employees, contractor employees, or grantees are excluded from this provision as they may personally gain from such reporting due to the nature of their employment. As a responsibility of their position, these excluded individuals are already obligated to take the necessary steps to properly report fraud and abuse in the program to the necessary authorities.

The premise of this ruling is to preserve and protect the Medicare Trust Funds by rewarding those individuals who report fraud and abuse. The government anticipates that the implementation of this rule will encourage individuals to report potentially fraudulent and abusive activities that such report will facilitate the expeditious recovery of money owed to the Medicare Trust Funds.

Qui Tam Provision

The “Qui Tam” or “Whistle Blower” provision allows persons having knowledge of a false claim against the government to bring an action against the fraudulent individual or entity in cooperation with the United States Government. The government has the opportunity to decline to be a party to the case. If this occurs, the individual seeking the “Qui Tam” action may pursue the case independently. As an incentive to report fraudulent activities, part of any collected penalty goes to the person who brings the civil action. Anyone who knows about possible false claims may be a party to a whistle blower suit.

SAFE HARBORS

Safe harbor provisions protect certain individuals, providers or entities from criminal prosecution and/or civil sanctions for actions that may appear as unlawful or inappropriate. The Department of Health and Human Services established the “Safe Harbors for Protecting Health Plans” in accordance with the Medicare and Medicaid Patient and Program Protection Act of 1987 – November 5, 1992 Federal Register. The safe harbors are updated annually to consider changes to medical delivery systems and new financial relationships. Comprehensive information on the safe harbor provisions can be obtained from the Code of Federal Regulations (42 CFR 1001.952 and 1001.953).

KICKBACKS

Kickbacks take many forms. They involve the illegal solicitation, offering, bribe, or rebate by or to a provider of service. They generate extra business for the participants, unneeded services for the patient and they drain scarce tax dollars.

The Anti-Kickback Statute, specifically Section 1128(b)(7) of the Social Security Act, states in part that it is a felony for anyone to knowingly and willfully offer, pay, solicit or receive any payment in return for referring an individual to another person for the furnishing, or arranging for the furnishing, of any item or service that may be paid by the Medicare or Medicaid program.

The Anti-Kickback Statute prohibits:

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- Soliciting or receiving remuneration for referrals of Medicare or Medicaid patients, or referral for services or items which are paid for, in whole or in part, by Medicare or Medicaid;
- Soliciting or receiving remuneration in return for purchasing, leasing, ordering, or arranging for, or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part, by Medicare or Medicaid;
- Offering or paying remuneration in return for referrals of Medicare or Medicaid patients or for referrals for services or items which are paid for, in whole or in part, by Medicare or Medicaid; and
- Offering or paying remuneration in return for purchasing, leasing, ordering, arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made, in whole or in part, by Medicare or Medicaid.

UNACCEPTABLE BILLING PRACTICES

Identification of any billing practice noted below may result in referral to the Office of Inspector General for criminal, civil or administration action.

- Using an approved ambulatory surgical center (ASC) procedure code to obtain reimbursement for performing a procedure that is not ASC approved.
- Fragmenting (unbundling) of procedure codes to obtain additional reimbursement.
- Indicating "Signature on File" in the beneficiary signature field of the CMS-1500 or electronic submissions, when no patient signature authorization forms are maintained in the provider's office.
- Intentionally using a "dummy" address for the beneficiary on the Form CMS-1500 or electronic submissions.
- Submitting charges to Medicare for services that were advertised as a "free exam."
- Using an incorrect place of service code to qualify for payment.
- Billing for items/services before they were delivered/performed.
- Billing for non-covered services under a covered procedure code.
- Ping-ponging. For example, providers of different specialties sharing the same patients for services that are not reasonable and necessary.

IMPROPER WAIVERS

Routine waiver of deductibles and copayments by charge-based providers, practitioners, or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.

A "charge-based" provider, practitioner, or supplier is one who is paid by Medicare on the basis of the fee schedule amount for the item or service provided. Medicare typically pays 80 percent

of the fee schedule amount. The amount the beneficiary pays cannot exceed the actual charge for the item or service when provided by a Participating provider or the Limiting Charge amount when provided by a Non-participating provider. In some cases, the provider, practitioner, or supplier will be paid the lesser of his actual charge or an amount established by the fee schedule.

Examples of Improper Waiver of Deductible and Copayments

Listed below are some marketing practices that may be suspect to charge-based providers, practitioners, or suppliers who may routinely waive Medicare deductibles and coinsurance. This list is not exhaustive but, rather, to highlight some indicators of potentially unlawful activity.

- Advertisements which state: “Medicare Accepted As Payment In Full,” “Insurance Accepted as Payment In Full,” or “No Out-Of-Pocket Expense.”
- Advertisements which promise that “discounts” will be given to Medicare beneficiaries.
- Routine use of “financial hardship” forms which state that the beneficiary is unable to pay the coinsurance/deductible (i.e., there is no good faith attempt to determine the beneficiary’s actual financial condition).
- Collection of copayments and deductibles only where the beneficiary has Medicare supplemental insurance (“Medigap”) coverage (i.e., the items or services are “free” to the beneficiary).
- Charges to Medicare beneficiaries which are higher than those made to other persons for similar services and items (the higher charges offset the waiver of coinsurance).
- Failure to collect copayments or deductibles for a specific group of Medicare patients for reasons unrelated to indigence (i.e., a supplier waives coinsurance or deductible for all patients from a particular hospital, in order to get referrals).
- “Insurance programs” which cover copayments or deductible only for items or services provided by the entity offering the insurance. The “insurance premium” paid by the beneficiary is insignificant and can be as low as \$1 a month or even a \$1 a year. These premiums are not based upon actuarial risks, but instead are a sham used to disguise the routine waiver of copayments and deductibles.

In certain cases, a provider, practitioner, or supplier who routinely waives Medicare coinsurance or deductibles also could be held liable under the Medicare and Medicaid anti-kickback statute. When providers, practitioners, or suppliers forgive financial obligations for reasons other than genuine hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them.

Initially, it may appear that that routine waiver of copayments and deductibles helps Medicare beneficiaries. By waiving Medicare coinsurance and deductibles, the provider of services may believe that the beneficiary incurs no costs. In fact, this is not true. Studies have shown that if patients are required to pay even a small portion of their care, they will be better health care consumers, and select items or services because they are medically needed rather than simply because they are free. Ultimately, if Medicare pays more for an item or service than it should, or if it pays for unnecessary items or services, there are less Medicare funds available to pay for truly needed services.

The purpose of requiring the patient to pay a part of the cost of medical care is to encourage the patient to cooperate in limiting cost by not incurring unnecessary expenses and to take an interest in the reasonableness and necessity of all services received. The routine and consistent waiving of the collection of coinsurance and deductibles defeats this purpose.

One important exception to the prohibition against waiving coinsurance and deductibles is that providers, practitioners, and suppliers may forgive the copayment in consideration of a **particular** patient's financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and copayments must be made. Otherwise, claims submitted to Medicare may violate the statutes discussed above and other provisions of the law.

JOINT VENTURES

The Office of Inspector General (OIG) is concerned with arrangements between those in a position to refer business, such as physicians and those providing items or services for which Medicare or Medicaid pays. Sometimes these arrangements are called “**joint ventures.**”

A joint venture may take a variety of forms. It may be a contractual agreement between two or more parties to cooperate in providing services, or it may involve the creation of a new legal entity by the parties, such as a limited partnership or closely held corporation, to provide such services. Of course, there may be legitimate reasons to form a joint venture, such as raising necessary investment capital. However, the OIG believes that some joint ventures may violate the Medicare and Medicaid anti-kickback statutes.

A joint venture becomes ‘suspect’ when, for example, physicians become investors in a business, such as a laboratory to which they refer their patients for services. As investors, the physicians would subsequently share in that business’ profit distribution. If the joint venture was not intended to raise investment capital but to obtain a source of referrals from the investors, the venture becomes suspect. The reason for this status stems from the experience that the profit distribution of the business to the physician investors creates an incentive to refer patients unnecessarily. The temptation of the investors to order medically unnecessary tests to enhance profits thereby may produce indirect kickbacks.

The questionable aspects of “suspect” joint ventures may become apparent analyzing:

1. The manner in which investors were selected, solicited and retained;
2. The business structure of the venture;
3. The financing methods of the business; and/or
4. The profit distribution.

FRAUD AND ABUSE MANDATES

There are many organizations that work together to fight fraud and abuse in the Medicare program. New laws and other recently passed anti-fraud legislation also help to further strengthen the efforts of reducing fraud and abuse in Medicare.

Medicare Reassignment

The Centers for Medicare & Medicaid Services (CMS) has undertaken an aggressive role to combat Medicare/Medicaid fraud and abuse. One of these efforts has been to improve the process for enrolling providers and suppliers into the Medicare program. The application of the Medicare Individual Reassignment of Benefits Application, CMS 855R, enhanced the nationwide uniformity by which providers/suppliers of health care are enrolled in the Medicare program.

With this enrollment process, entities that are not eligible to receive Medicare payment will not be enrolled as providers or suppliers or receive billing numbers. In addition, benefits will not be reassigned to entities that are not eligible to receive Medicare payments.

What the Law Allows

The law generally requires that Medicare payment be sent to the beneficiary or the person, physician, or entity that provided the services (Section 1842(b) (6) and Section 1815 of the Social Security Act). The law allows Medicare to pay someone other than the provider of service or supplier in certain circumstances and if certain conditions are met.

For physician and supplier services, Medicare reassignment is allowed when:

- Payment is to one's employer (issuance of a Form W-2);
- Payment is to the facility where the services are provided; and
- Payment is to a health care delivery system.

In addition to the following definitions refer to Title 42, Code of Federal Regulations 424.70 for further information regarding the criteria that must be met for these exceptions.

Payment to One's Employer

Ordinarily an employer may establish that it qualifies to receive payment for the services of its physicians by submitting a written statement certifying that it will bill the program for such services only where the physicians are its employees and have acknowledged in writing its right to receive the fees under the terms of employment. In order to satisfy the employment requirement, the common law employer/employee relationship must meet the specifications of Section 210 (j)(2) of the Social Security Act, 20 CFR 404.1007, and Section RS 2101.102 of the Retirement and Survivors Insurance part of the Social Security Operation Manual System. An employer relationship is evidenced by the issuance of a form W-2.

Payment to a Facility

The term facility is limited for purposes of this rule to institutions which make provisions for furnishing services to individuals as inpatients, i.e., hospitals, university medical centers that own and operate hospitals, and other institutions of a similar nature. Medicare benefits for covered physician or supplier services furnished in a facility may be paid to the facility under assignment if the facility and the physician have entered into an agreement under which only the facility may bill and receive fees. The Medicare program may pay the facility in which the service was furnished if there is a contractual arrangement between the facility and the physician or other supplier under which the facility bills for the physician's or other supplier's service.

CMS Requirements for Reassignment to a Health Care Delivery System

Basically, in order to be considered a health care delivery system, an organization must be either a clinic, carrier dealing prepayment plan, or a direct dealing HMO or competitive medical plan.

- For the purposes of receiving payment under reassignment, as a health care delivery system, a clinic is an organization which provides diagnostic and/or therapeutic medical services on an outpatient basis in quarters which it owns or leases.
- For payment to be made to a clinic for physician services, the services must be furnished within the physical premises of the clinic. Therefore a clinic provider may not bill for the services performed by a contract physician or supplier, one which receives a Form 1099, if those services were rendered off the premises of the clinic organization.

Staffing Organizations

Notwithstanding certain limited exceptions, Medicare does not allow payment to go to someone other than the provider of service directly. Therefore staffing organizations will not be issued Medicare provider billing numbers or receive direct payments. A staffing organization can act as a billing agent for the physician. Medicare policies regarding billing agreements are outlined in the Code of Federal Regulations, 42 CFR 424-70.

Accountability

Individual members of a group practice, organization, or clinic/association that meet CMS' criteria must sign a Reassignment of Benefits Statement that allows an employer or contractor to receive payment for the provider's services. This statement is contained in the CMS 855R, Medicare Individual Reassignment of Benefits Application. It reads:

"I acknowledge that under the terms of my employment or contract, (Legal Business Name or Entity) is entitled to claim or receive any fees or charges for services."

We believe that it is incumbent upon any practitioner who allows another entity to receive payment for his/her services, to fully understand the regulations for reassignment of benefits prior to entering into an agreement with that entity.

If you have any questions or concerns regarding provider enrollment, feel free to contact our Provider Enrollment Department.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) enacted in 1996, protects the health insurance coverage for workers and their families when they lose or change their jobs. The HIPAA has also brought tangible results to efforts to combat Medicare fraud and abuse:

- The HIPAA establishes the crime of "health care fraud";
- The HIPAA increased penalties and fines for health care fraud;
- The Office of Inspector General hired additional auditors, analysts, and investigators to look for and to investigate Medicare fraud and abuse;
- The U. S. Attorney Offices, the DHHS Office of General Counsel, and FBI offices throughout the country assigned new attorneys and investigators to health care and Medicare fraud and abuse;
- The Medicare contractors received additional funding to increase their medical review and anti-fraud activities.

Advisory Opinions

In accordance with Section 205 of the Health Insurance Portability and Accountability Act of 1996, the Department of Health and Human Services (DHHS) is required to provide a formal guidance process to requesting individuals and entities regarding the application of the anti-kickback statute, safe harbor provisions, and other OIG health care fraud and abuse sanctions. The DHHS with consultation advice from the Department of Justice (DOJ) will issue written advisory opinions to parties with regard to the following:

- What constitutes prohibited remuneration under the anti-kickback statute;
- Whether an arrangement satisfies the criteria in Section 1128B(b)(3) of the Social Security Act, or established by regulation, for activities which do not result in prohibited remuneration;
- What constitutes an inducement to reduce or limit services to Medicare or Medicaid program beneficiaries under Section 1128A(b) of the Act; and
- Whether an activity or proposed activity constitutes grounds for the imposition of civil or criminal sanctions under Section 1128, 1128A, or 1128B of the Act.

The procedures for submitting a request and obtaining an advisory opinion were published in the Federal Register on February 19, 1997. This final rule was effective on July 16, 1998.

The Balanced Budget Act (BBA)

The Balanced Budget Act (BBA) of 1997 contains many provisions, which reduces Medicare's vulnerability to fraud and abuse. Some of the changes pertain to Medicare Part A, however, everyone involved in the Medicare program needs to be made aware of the varied aspects of fraud and abuse that may arise with certain entities such as durable medical equipment suppliers, nursing home, hospices, and home health agencies.

Examples:

- A ten year exclusion from Medicare or any State health care program, for an individual who has been convicted on one previous occasion of one or more health related crimes for which a mandatory exclusion could be imposed, including Medicare and state health care program related crimes, patient abuse, or felonies related to health care fraud or controlled substances. It also permanently excludes an individual who has been convicted on two or more previous occasions of such crimes.
- Home health agencies and durable medical equipment suppliers are required to obtain surety bonds in order to bill Medicare.
- Skilled nursing facilities are required to assume additional responsibility for therapy services, and medical equipment and supplies provided to their patients as a result of new consolidated billing and prospective payment systems.
- Home health agencies are paid under a new system of prospective payment, which will reduce the incentive to agencies to provide unnecessary services.

PENALTIES AND SANCTIONS

Providers of health care and services found to have been billing for services not provided, not covered, or in excess of recognized standards of care, are subject to a variety of sanctions. These include:

- Administrative overpayment recoveries
- Expanded prepayment review
- Payment suspension
- Administrative civil monetary penalties
- Criminal and civil prosecutions and penalties
- Administrative sanctions
- Exclusion from the Medicare and Medicaid programs

Civil Monetary Penalties (CMP)

The Secretary has the authority to impose civil monetary penalties under the provision of 1128A of the Social Security Act. This authority has been delegated to the Office of Investigations (OI). Violators of the statute are subject to penalties and assessments when it has been determined that a person has presented or caused to be presented a claim which is for an item or service that is inclusive but not limited to the following:

- Violation of the Medicare Assignment Agreement
- Violation of the Participating Provider Agreement
- Exceeding the Limiting Charge
- The person knew or had reason to know the service was not provided as claimed
- Fragmented services that should have been billed with one procedure code
- Upcoding services to obtain a higher reimbursement

Under the CMP, violators may be fined a penalty and assessed as follows:

- On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) was enacted. This law provides for higher maximum CMPs (\$10,000 per false item or service on a claim or instance of non-compliance, instead of \$2,000 per item or service),
- An assessment of up to three times the amount falsely or improperly claimed, rather than the amount paid or the actual damages resulting from fraud.

Criminal and Civil Prosecutions and Penalties

It is a federal crime to defraud the United States Government or any of its programs. Therefore, an individual may be sent to prison, fined or both in the event of such a crime. Criminal convictions usually include restitution and significant fines. The provider's state license may also be revoked. The U.S. Attorney may file a civil suit or settle the case. In these circumstances, the amount of damages plus additional money is paid to the government in the form of penalties and fines.

Administrative Sanctions

The Office of Investigations (OI) Regional Office is responsible for initiating, evaluating, and recommending administrative sanctions including:

1. Exclusion of convicted individuals from participation in the Medicare and Medicaid programs – Section 1128 of the Social Security Act.
2. Exclusion of individuals and institutional providers from the Medicare program based on fraudulent or abusive acts discovered by Medicare contractors, CMS, OIG, or other government entities – Section 1128(b)(6)(B) of the Social Security Act.

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3. Exclusion of individuals and institutional provider based on reports prepared by Peer Review Organizations (PROs) – Section 1156 of the Social Security Act, including the imposition of monetary penalties in lieu of exclusion.
4. Imposition of Civil Monetary Penalties based on false or improper claims – Section 1128(a) of the Social Security Act.
5. Participation in administrative hearings concerning excluded or suspended providers.

Exclusion Authority

The Office of the Inspector General (OIG) under the Department of Health and Human Services has the authority to exclude providers who have been convicted of a health care related offense. Exclusion means that for a designated number of years, Medicare, Medicaid and other government programs will not pay the provider for services performed or for services ordered by the excluded party.

A mandatory exclusion exists if there is a conviction of fraud. Mandatory exclusion includes the following Social Security Act Sections:

- 1128(a)(1) Program related conviction
- 1128(a)(2) Conviction for patient abuse or neglect

In the absence of a conviction, the OIG may permissively exclude providers if certain conditions and requirements are met. Listed below are the sections of permissive exclusions from the Social Security Act:

- 1128(b)(1) Conviction relating to fraud
- 1128(b)(2) Conviction relating to obstruction of an investigation
- 1128(b)(3) Conviction relating to controlled substances
- 1128(b)(4) License revocation or suspension
- 1128(b)(5) Suspension or exclusion under a federal or state health care program
- 1128(b)(6) Excessive claims or furnishing of unnecessary or substandard items or services
- 1128(b)(7) Fraud, kickbacks and other prohibited activities
- 1128(b)(8) Entities owned or controlled by a sanctioned individual
- 1128(b)(9) Failure to disclose required information
- 1128(b)(10) Failure to supply requested information on subcontractors and suppliers
- 1128(b)(11) Failure to provide payment information
- 1128(b)(12) Failure to grant immediate access
- 1128(b)(13) Failure to take corrective action
- 1128(b)(14) Default on health education loan or scholarship obligations

FRAUD SCHEME

The NE BISC is aware that persons are soliciting physicians for employment in order to gain access to their Medicare Provider Identification Number. Victim physicians are usually recruited by an advertisement in a newspaper's classified ads section, solicitation through residency programs, telephone calls to the physicians home offering clinical work; or even by word-of-mouth. Once the advertisement is responded to, the physician may be directed to either a

Fraud & Abuse Billing Guide

personnel agency, or to the clinic where he or she would be employed. The physician may be asked to render services in the following ways:

- Perform duties as a physician
- Supervise physician assistants
- Perform interpretations for radiology, neurology, cardiology, etc. tests
- Review chart notes
- Supervise Independent Diagnostic Testing Facilities (IDTF's)

If you respond to such an employment offer, your license number and/or Medicare NPI (National Provider Identifier) may be requested. You may either receive a percentage fee, flat monthly fee or an annual salary for your service. The employer may bill all of your claims through their billing agency and you may be asked to sign a contract which allows them to your NPI as the billing provider for their clinic. The employer may also request that you open a joint bank account where Medicare monies will be deposited, as it would provide the employer direct and full access to the account.

Often the beneficiaries seen at these clinics have been solicited through “capping”, which is a practice of exchanging monetary and/or tangible goods, including offering and/or obtaining kickbacks for services rendered. Medicare has discovered that these tests may have been billed for beneficiaries who have had the same services billed by multiple providers, often within days, a month or several months. If claims are denied, beneficiaries may be directed by these cappers to contact the Carrier in order to justify the services and verify they were actually performed.

If you are performing services for clinics or IDTFs, such as diagnostic interpretations, you may want to ask yourself these two questions: 1) Are the same types of tests consistently being performed on every patient? and 2) Who is the referring physician?

Do not become a victim. As you know Medicare providers are responsible for all claims submitted with their Identification Number(s) (NPI). Physicians who have been victimized are now finding themselves responsible for refunding monies to the Medicare program for services that are medically unnecessary or not rendered. Additionally, all Medicare earnings are reported to the Internal Revenue Service each year. Victim physicians may also be referred to, and investigated by, law enforcement for submission of fraudulent claims. For your own protection, review the billing practice and do not let your Medicare NPI be used for claims for which you are not personally responsible. By reviewing the Medicare Provider Summary Notices, you will be aware of what was billed using your NPI.

BENEFICIARY OUTREACH

Education

The Centers for Medicare & Medicaid Services publishes a Medicare Handbook or Desk Reference annually. Depending on the federal budget, it usually gets distributed the first quarter of every year. The beneficiary handbook summarizes Medicare benefits, rights, and obligations, and it provides a listing of local Medicare carriers, insurance counseling and information services, Peer Review Organization, and Durable Medical Equipment Regional Carriers (DMERCs)/ Durable Medical Equipment Medicare Administrative Contractor (DME MACs).

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The Department of Health and Human Services has established a hotline for reporting suspected fraud and abuse. The number is 1-800-HHS-TIPS (1-800-447-8477). The TTY for hearing and speech impaired is 1-800-377-4950.

The very first step in assuring that beneficiaries are aware of services billed to the program on their behalf is that they are sent a MEDICARE SUMMARY NOTICE (MSN). With the exception of a few services, this notice outlines their medical charges similar to the provider's Remittance Notice. The MSN is applicable to both inpatient and outpatient claims. It provides details of the claim that has been processed and it has some enhanced features. One very important feature is the "Help Stop Fraud" message. These messages instruct beneficiaries on ways to protect themselves and the Medicare program. These messages will change periodically.

Medicare Beneficiary Customer Service Directory

The following numbers are for beneficiaries only. You may share them with your patients.

Beneficiary Customer Service	1-800-MEDICARE (1-800-633-4227)
Non-English Speaking	1-800-MEDICARE (1-800-633-4227)
TTD/TTY (for the deaf)	1-800-410-9600

Other organizations such as Health Insurance Counseling and Advocacy Program (HICAP), Medicare Advocacy Program (MAP), Grey Panthers, and Area Agency on Aging (AAA) all reach out to the beneficiaries and tell them to be aware of possible fraudulent and abusive practices occurring in the community.

REPORTING MEDICARE FRAUD AND ABUSE

You can help protect your tax dollars as well as preserve the Medicare Trust Funds by reporting any suspected instances of fraud, waste, abuse, or mismanagement to Medicare. To report suspected problems, please call or write our office or write to the Benefit Integrity Support Center in your service area.

Many organizations will also accept and review reports suspected Medicare fraud: The DHHS Offices of Inspector General, the FBI, U.S. Attorney Offices, any of the Medicare contractor anti-fraud units, the CMS Regional Offices, the Health Insurance Counseling & Advocacy Program "SCAMS" project, and State Medicaid Fraud.

A single number to report suspected fraud is the national OIG fraud hot line: 1-800-HHS-TIPS. Information provided to hotline operators is sent out to analysts and investigators.

Medicare Fraud Information on the Internet

- The Centers for Medicare & Medicaid Services Home Page includes the latest information about Medicare and Medicaid as well as links to related sites: <http://cms.hhs.gov>

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- The DHHS Office of Inspector General Home Page includes a variety of information about health care fraud, model compliance plans, advisory opinions and recent audit and review reports: <http://oig.hhs.gov>
- The Administration on Aging has an Operation Restore Trust web site with information that is useful to consumers and senior organizations: <http://www.aoa.dhhs.gov/smp/index.asp>
- NHIC has a website that includes general Fraud information: <http://www.medicarenhic.com>

TEN TIPS FOR PROTECTING YOUR PRACTICE

TIP #1 PROTECT YOUR PROVIDER IDENTIFICATION NUMBER(S)

- Do not let anyone bill under your NPI.
- If you relocate or retire, notify Provider Enrollment to de-activate your NPI.

TIP #2 ASSIGN PROCEDURE CODES YOURSELF

- You (the provider) are responsible for accurate billing under your NPI.
- Never use a code because a supplier OR manufacturer suggests it.
- If you delegate this responsibility, conduct periodic checks to ensure accuracy.
- Refer to American Medical Association's Physician's Current Procedural Terminology (CPT) book.
- Use the Healthcare Common Procedure Coding System (HCPCS – pronounced "hick-picks" guide).
- Consult your professional associations and societies for guidance.

TIP #3 DOCUMENT ALL SERVICES RENDERED

- An important element contributing to the high quality of care to the patient is medical record documentation.
- If the service is not documented – it was not done.
- Make sure your medical notes are legible.
- Make sure every entry is signed and dated.
- Remember: Your medical records may serve as a legal document to verify the care provided.

TIP #4 USE CAUTION WHEN SIGNING CERTIFICATES OF MEDICAL NECESSITY (CMN)

- Never sign blank or incomplete forms.
- Never certify supplies for patients you have not seen or examined.
- Question a supplier who tries to coerce you to sign CMNs that you do not professionally agree with or have not examined carefully.
- Certificates of Medical Necessity are required for the prescription of certain medical equipment, devices, and supplies.

TIP #5 MINIMIZE RISK FROM YOUR EMPLOYEES

- Screen new employees carefully.
- Take caution; attempt to hire competent and ethical employees.
- Develop procedures to safeguard your practice.
- Carefully delegate signing authority.
- Conduct periodic checks of sensitive operational procedures.
- Establish an internal compliance plan. A compliance plan is proactive way to protect your practice from the inside out.

TIP #6 DEVELOP WISE BUSINESS RELATIONSHIPS

- Be suspicious if anyone offers you deep discounts for free services or cash incentives for referrals or orders.
- Never allow yourself to be coerced into any questionable fiscal or financial arrangement.
- Do not order tests performed by entities in which you have a financial interest.

TIP #7 USE BILLING SERVICES WISELY

- Check references.
- Instruct the service not to change your codes – procedure and diagnostic as well as other information furnished by you and your office.
- Avoid paying on a percentage basis.
- Get copies of all correspondence between the service and Medicare.
- Pay attention to your billing service's practices.
- Make sure they keep accurate, complete administrative records of the claims it submits to Medicare on your behalf.
- Make sure that if you are a Participating Provider, that your billing service or collectors are not requesting payments above the Medicare Fee Schedule amount.
- If you are a Non-participating Provider, your billing and collecting staff should not bill more than the Medicare Limiting Charge.
- Make sure that your billing staff is aware of Medicare Secondary Payer situations.

TIP #8 KEEP UP WITH MEDICARE

- Attend billing workshops conducted by Medicare's Education and Training Department.
- Implement changes in billing procedures.
- Read, refer to, and retain copies of the Medicare B Resource.
- Periodically check the Electronic Data Interchange (EDI) System – Medicare's computer library of information that you can access using a computer and a modem.
- Take note of Remittance Notice reminders and [Interactive Voice Response \(IVR\) System](#) messages for important information.
- Check out Medicare's publications to determine if a guide is available for your specialty.
- Check our website at <http://www.medicarenhic.com>

TIP # 9 COMMUNICATE WITH YOUR PATIENTS

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- Don't be a victim. Medicare receives hundreds of calls and letters from beneficiaries who have lost their Medicare cards. Some beneficiaries impersonate others and benefit from the use of their Medicare cards as the cost of health care is rising. As a result here are some suggestions to help reduce being prey to such schemes:
 - Photocopy your patient's Medicare card, Driver's License and/or Senior Identification cards.
 - Beware of receiving false, fake, or fabricated cards.
 - Keep your patient's address and telephone numbers current.
 - The Provider is responsible for verifying the identity of each patient.
 - Misunderstandings between you and your patient may cause complaints to the Fraud or Abuse Unit.
- Avoid unnecessary complaints. Take a few minutes to talk to your patient.
- Do's and don'ts about talking to your patients:
 - Do tell your patients about:
 - ✓ Changes in your office name or mergers.
 - ✓ When other providers may bill Medicare (labs, EKGs, x-rays, consultations).
 - Don't tell your patients:
 - ✓ "Don't worry, its not your money."
 - ✓ "Nothing will come out of your pocket."
 - ✓ "I have to bill it this way in order to get paid."

TIP #10 RESPOND TO MEDICARE'S INQUIRIES

- Do not ignore requests for information.
- Provide all requested information or medical records.
- Respond in a timely manner. Call Medicare Customer Service if you have any questions.

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date**. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, redetermination status (formerly Appeals). Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems. This rule applies even if the caller has obtained the code.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

** Requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.hhs.gov/center/coverage.asp>

<http://www.cms.hhs.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

<http://www.cms.hhs.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

<http://www.cms.hhs.gov/CMSForms/>

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Notice of Exclusion from Medicare Benefits (NEMB) (20007)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.hhs.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

<http://www.cms.hhs.gov>
<http://www.medicare.gov>

CMS Correct Coding Initiative

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

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**CMS Physician's Information
Resource for Medicare**

<http://www.cms.hhs.gov/center/physician.asp?>

Evaluation and Management Documentation Guidelines

http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

<http://www.cms.hhs.gov/HIPAAGenInfo/>

National Provider Identifier (NPI)

<http://www.cms.hhs.gov/NationalProvIdentStand/>

NPI Registry

<http://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	8/6/2004	B.Bedard	K. Leary	Original
2.0	8/22/2005	A. Randall/ J. Costa	K. Leary	Updated; added Fraud Scheme section
3.0	9/26/2006	A. Randall/ J. Costa	K. Leary /M. Kelly	Updated with current information; changed name of National Heritage Insurance Company to NHIC, Corp.
4.0	3/30/2007	A. Randall/ J. Costa	K. Leary /M. Kelly	ANNUAL REVIEW Updated information on page 3 to make it more current. Minor corrections, added NPI references.
5.0	10/02/2007	A. Randall/ J. Costa	K. Leary /M. Kelly	Changed name of EDS NE BISC to SGS NE BISC. Updated template and minor edits.
6.0	5/13/2008	A. Randall/ J. Costa	K. Leary /M. Kelly	ANNUAL REVIEW Updated template and minor edits.
7.0	10-01-08	J. Costa	M. Clark	Annual Review Removed CA references
8.0	07-15-09	Jainne Costa	Mylene Clark	Annual Review , Updated to NE BISC, J14 template

Fraud & Abuse Billing Guide

NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

<http://www.cms.hhs.gov>

<http://www.medicare.gov>