



Medicare Basics Segment 5

Welcome to Medicare Basics, a program designed as a general overview of the Medicare program.

Segment 5: Protecting the Medicare Trust fund

The goal of the Medicare Integrity Program (MIP) is to pay it right – pay the right amount, to the right provider or supplier, for the right service, to the right beneficiary. Some of the MIP or payment safeguard activities that Contractors complete include data analysis, medical review (MR), anti-fraud, and Medicare Secondary Payer.

In accordance with the MIP regulation, in 1999 CMS awarded Program Safeguard Contracts (PSCs) to twelve companies, which are now known as Medicare Program Safeguard Contractors. TrustSolutions is one of the twelve PSCs that perform Medicare benefit integrity (fraud and abuse) activities on behalf of CMS for a variety of geographical areas, and performs benefit integrity activities relevant to Medicare Part B services rendered in the states of Wisconsin, Illinois, Michigan, and Minnesota. WPS Medicare and TrustSolutions are currently in partnership to transition the performance of this activity.

The MR process includes:

- Reviewing claims appropriately submitted to Medicare Contractors when atypical billing patterns or particular kinds of problems are identified, and
- Ensuring that MR activities are targeted at identified problem areas and that the corrective actions imposed are appropriate for the severity of the problem through Progressive Corrective Actions.
- Validating claim errors through the use of probe reviews, which can either examine 20 to 40 claims per provider for provider-specific problems or examine approximately 100 claims from multiple providers for widespread, larger problems such as a spike in billing for a specific procedure.
- When a probe review verifies that an error exists, the severity of the problem is classified as minor, moderate, or significant which is determined by the provider-specific error rate, dollar amounts improperly paid, and past billing history. Overpayments are collected and a determination is made as to what steps need to be taken to correct the problem.

Congress mandated that CMS determine the accuracy of paid claims by Medicare contractors. CMS contracts with Program Safeguard Contractors (PSCs) to maintain this program. These contracted organizations work with WPS Medicare to produce error rates. The primary objective at CMS is to insure that the Medicare-Fee-for-Service program pays claims correctly. In order to meet this goal, Medicare contractors must pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers.



The CERT Program calculates various error rates for Medicare claims submitted to Medicare Contractors. The CERT program uses two PSC contractors to accomplish this work:

- The **CERT Documentation Contractor (CDC)** is responsible for requesting and receiving the medical recorded documentation from providers.
- The **CERT Review Contractor (CRC)** is responsible for reviewing the selected claims and associated medical record documentation.

The CDC will make up to four requests for medical records in addition to possibly placing multiple telephone calls. The provider is given a total of 90 days to submit the requested documentation. If the documentation is not received by this deadline, the CDC will notify the Affiliated Contractor (AC) via a secure Website application.

The AC is then responsible for issuing a demand letter requesting a refund of the erroneous Medicare payment for the undocumented services.

If a response is received, but elements of the documentation is still missing, (ex. physician orders, lab reports, treatment plan, etc.) the CDC will send another letter to the provider giving them a “second chance” to send in the addition documentation.

The provider then has 15 days to submit the documentation to the CDC or the claim will be reviewed based on the original documentation and scored as an error. If the documentation is not received by this deadline, the CDC will again notify the AC who will resume with collection efforts for the undocumented services.

There are two types of coverage determinations that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services.

The first type is called a National Coverage Determination (NCD) which sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare Contractors are required to follow NCDs. Prior to an NCD taking effect, the Centers for Medicare & Medicaid Services (CMS) must first issue a Manual Transmittal, ruling, or *Federal Register* Notice. If a NCD and a Local Coverage Determination (LCD) exist concurrently regarding the same coverage policy, the NCD takes precedence.

A NCD is a reasonable and necessary determination made by the Secretary of the Department of Health and Human Services. Therefore, a failure to meet the terms of the NCD will make the item or service not reasonable and necessary, which is one of the categories of items and services Medicare is prohibited from paying and for which a beneficiary is given liability protection if he or she did not know in advance that Medicare was prohibited from paying.

The second type is called a Local Medicare Contractors may develop LCDs to further define a NCD or in the absence of a specific NCD. LCDs are coverage decisions made at the Contractor's own discretion to provide guidance to the public and the medical community within a specified geographic area. LCDs cannot conflict with NCDs.



LCDs are administrative and educational tools that assist providers in submitting correct claims for payment by outlining coverage criteria, defining medical necessity, and providing references upon which a policy is based and codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity.

CMS emphasizes early detection and prevention of Federal health care fraud and program abuse. An estimated 10 percent of Medicare costs are wrongly spent on incidences of fraud and abuse. The efforts of many groups help deter fraud and abuse and protect beneficiaries from harm by:

- Identifying suspicious Medicare charges and activities;
- Investigating and punishing those who commit Medicare fraud and abuse; and
- Ensuring that money lost to fraud and abuse is returned to the Medicare Trust Fund.

Federal health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes to obtain payment for, or to cause another to obtain payment for, items or services payable under a Federal health care program. Some examples of health care fraud are:

- Billing for services that were not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;
- Altering claim forms and/or receipts to receive a higher payment amount;
- Duplicating billings that includes billing both the Medicare program and the beneficiary, Medicaid, or some other insurer in an effort to receive a higher payment than what is allowed;
- Offering, paying, soliciting, or receiving bribes, kickbacks, or rebates, directly or indirectly, in cash or in kind, to induce referrals of patients or the purchase of goods or services that may be paid for by the Medicare program;
- Representing falsely the nature of the services furnished. This encompasses describing a non-covered service in a misleading way that makes it appear as if a covered service was actually furnished;
- Billing a person who has Medicare coverage for services provided to another person not eligible for Medicare coverage;
- Repeatedly violating the participation agreement, assignment agreement, and limiting charge;
- Completing Certificates of Medical Necessity (CMN) for patients not personally and professionally known by the provider;
- Completing a prohibited CMN by suppliers;
- Using another person's Medicare card to obtain medical care;
- Giving false information about provider ownership in a clinical laboratory;



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- Conspiring to submit or manipulate bills by a provider and a beneficiary, two or more providers and suppliers, or a provider and a carrier employee that results in higher costs or charges to the program;
- Billing procedures over a period of days when all treatment occurred during one visit (e.g., split-billing schemes);
- Using the adjustment payment process to generate fraudulent payments; and/or
- Billing for “gang visits” (e.g., a physician visits a nursing home, walks through the facility, and bills for 20 nursing home visits without rendering any specific medically needed service to the individual patients).

In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicare Program. Many abusive practices are subsequently determined to be fraudulent. For example, if a provider or supplier ignores Medicare guidance, education efforts, warnings, or advice that abusive conduct is inappropriate and he or she continues to engage in the same or similar conduct, the conduct could be considered fraudulent.

Examples of abuse include, but are not limited to, the following:

- Charging an excessive amount for services or supplies;
- Providing medically unnecessary services or services that do not meet professionally recognized standards;
- Submitting bills to Medicare that are the responsibility of other insurers under Medicare Secondary Payer (MSP) regulation;
- Violating the participating physician/supplier agreement;
- Breaching the assignment agreement; and/or
- Violating the limiting charge.

It is a Federal crime to commit fraud against the U.S. government, including the Medicare Program. A provider, supplier, or health care organization that has been convicted of fraud may receive a significant fine, prison sentence, or be temporarily or permanently excluded from Medicare and other Federal health care programs. In some states, providers, suppliers, and health care organizations may also lose their licenses.

A Program Safeguard Contractor or Medicare Contractor Benefit Integrity unit investigates and documents potential fraud and abuse and, when appropriate, refers such matters to the Office of Inspector General (OIG).

Many violations of Medicare laws and regulations are subject to the imposition of Civil Monetary Penalties (CMP). Depending on the violation, the CMP amount may be up to \$10,000 per violation.

CMS has the authority to deny an individual or entity’s application for a Medicare provider identifier or revoke a Medicare provider identifier if there is evidence of impropriety (for example., previous convictions, falsifying information on the application, or State or Federal licensure or certification requirements are not met).



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CMS has the authority to suspend payment to individuals and entities when there is reliable information that an overpayment, fraud, or willful misrepresentation exist or that payments to be made may not be correct.

No payment will be made by any Federal health care program for any items or services directly or indirectly furnished, ordered, or prescribed by an excluded or debarred individual or entity.

Report Suspected Fraud or Abuse to:

- OIG National Hotline (800) 447-8477
- Medicare Customer Service Center (800) 633-4227

The role of Medicare as the secondary payer is conceptually similar to the coordination of benefits clause in private health insurance policies. By federal law, Medicare is secondary payer to a variety of government and private insurance benefit plans. Medicare should be viewed as the secondary payer when a beneficiary can reasonably be expected to receive medical benefits through one or more of the listed means.

If the claim involves:	Primary benefits may be paid by:
Automobile Medical or No-Fault Insurance	Terms of an automobile or no-fault insurance
Black Lung	Federal Black Lung Program
Disability	Large group health plan
End Stage Renal Disease (ESRD)	Employer group health plan
Liability Insurance	Terms of a liability settlement
Veterans Administration	Veterans Administration Program
Workers' Compensation	Workers' Compensation law or plan
Working Aged/Spousal Coverage	Employer group health plan

Providers filing claims for Medicare beneficiaries who have more than one insurer should:

- Obtain all pertinent information from the patient or responsible party concerning all relevant insurers.
- Determine which insurer is primary, secondary, tertiary, etc. (Please refer to CMS Publication 100-05 Medicare Secondary Payer manual at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>)
- File claims accordingly, in the order of liability.
- Include a copy of the Explanation of Benefits (EOB) from the primary insurer when filing a Medicare Secondary claim.



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The provider is not required to file a Medicare secondary claim unless the provider has all the information, usually the primary insurer's explanation of benefits, needed to file the Medicare claim. Filing of the secondary claim is required when a primary insurer's explanation of benefits is received from either the insurer or the beneficiary.

Intermediaries and carriers will continue to terminate records on the CWF where the provider has received information that MSP no longer applies (e.g., succession of employment, exhaustion of benefits). Termination requests should continue to be directed to your local intermediary or carrier. MSP records on the CWF that you identify as invalid should be reported to the COB Contractor for investigation and deletion.

Refer all MSP inquiries, including the reporting of potential MSP situations, invalid MSP auxiliary files, and general MSP questions/ concerns, to the COB contractor. Continue to call WPS Medicare regarding claims-related and recovery questions.

The COB Contractor's Customer Call Center toll free number is 1-800-999-1118 or TDD/TYY 1-800-318-8782.

Customer service representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, Eastern Time, except holidays.