

A Guide to . . .



Medicare Error, Fraud and Abuse
and
Quality of Care Concerns

Produced by the Vermont SMP

***A Special Project of Community of Vermont Elders**

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INTRODUCTION

For nearly a quarter century, the **Community of Vermont Elders (COVE)** team of elder volunteers, policy specialists, and staff has worked to improve the quality of life for Vermont's senior citizens. COVE's mission is to promote public initiatives and policy and protect social programs that promote independence, dignity and respect for Vermont's elder population.

The Vermont SMP, one of 57 located in the United States, is a special project at COVE that is aimed at educating and assisting Medicare beneficiaries and advocates who work with them concerning health care billing errors, fraud and abuse issues. COVE formed the Vermont SMP as a result of a federal grant. This project brought together representatives of the Medicare Advocacy Project of Vermont Legal Aid, the State Health Insurance Assistance Program, the Northeast Health Insurance Company (a Medicare contractor for claims processing), elders, health care providers and Vermont Medicaid officials.

One issue identified by advocates who work with elders on Medicare billing and coverage problems was a lack of a practical guide on Medicare error, fraud and abuse. Therefore, this guide was produced after substantial research and review for use by advocates serving the Medicare population to help identify and remedy errors or resolve problems with Medicare billing and services.

The Vermont SMP wishes to thank Paula McCann, Esq. the Director of the Medicare Advocacy Project for her direction and commitment to this project, and Mr. David Lindsay, a third year law student at Vermont Law School, for his tireless efforts in researching, writing, and revising this guide. Mr. Lindsay is a law clerk with the **Medicare Advocacy Project at Vermont Legal Aid**, based in Springfield, Vermont.

For updates or questions, please contact either **The Vermont SMP at COVE** by calling **(802) 229-4731**, or the **Medicare Advocacy Project at Vermont Legal Aid** at **(802) 885-5181**

Guide to Medicare Error, Fraud and Abuse and Quality of Care Concerns

ERROR

Error, in the context of Medicare, refers to a mistake without intent to misrepresent or deceive.

Error can occur at 2 levels in the Medicare system:

- The **first** is at the provider level, where for example, a provider mistakenly enters the wrong code for a service that was not performed
- The **second** is at the carrier/intermediary level where, for example, the intermediary (the company which handles Medicare claims for your geographic area) incorrectly approves a service that was performed or approves an incorrect service. These are typically human errors and are not committed with the intent to defraud Medicare (see FRAUD below for definition of Medicare fraud).

A Medicare beneficiary or advocate for a beneficiary should take the following steps if they believe that there has been an error in their Medicare bill:

1. Call the provider and explain the concern:
2. If the provider can not help and the error is at the intermediary/carrier level, then call the carrier/intermediary and explain the concern.

The beneficiary should have the following information available when they call:

- The provider's name and any identifying number
 - The service or item in question
 - The date the service or item was rendered
 - The payment amount approved and paid by Medicare
 - The date on the Medicare Summary Notice (MSN) or Explanation of Medicare Benefits (EOMB)
 - The beneficiary's name and Medicare Number (HIC#)
 - The reason Medicare should NOT have paid for the item or service
 - Any information to show why Medicare should not have paid for any item or service
3. If there is any possibility that Medicare fraud has been committed, please refer to the FRAUD section of this guide.

FRAUD

Fraud is knowingly making a false statement or misrepresentation with the intent to deceive and receive an unauthorized benefit. Typically, fraud arises from a false statement or misrepresentation that is material to the entitlement or payment under the Medicare program. The violator may be a physician or other practitioner, supplier of Durable Medical Equipment or any person in a position or business to bill Medicare. Medicare fraud may take many forms.

The following are examples of Medicare Fraud:

- Billing for services or supplies that were not provided
- Altering claim forms to obtain a higher reimbursement amount
- Applying for duplicate reimbursements in order to get paid twice
- Completing Certificates of Medical Necessity (CMN) for patients not personally and professionally known by the provider
- Soliciting, offering, or receiving kickback, bribe or rebate
- False representation with respect to the nature of the services rendered, charges for such services, identity of the person receiving or rendering the services, or dates of the services, etc.
- Filing claims for services that are non-covered but billed as if they were covered services
- Use of another person's Medicare card in obtaining medical care
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If a Medicare beneficiary or their advocate suspects Medicare fraud they should follow the 3 step approach below.

1. Call the health care provider to ensure that the beneficiary understands and agrees with all of the charges and services listed on your MSN or EOMB as many times the discrepancy is a mistake or oversight by the provider or a lack of understanding on the part of the beneficiary.
2. Call your Medicare Carrier or Fiscal Intermediary (the phone number will be listed on your MSN or EOMB) to ensure that the beneficiary understands and agrees with all of the charges and services listed on the MSN or EOMB. Many times the discrepancy is a billing mistake or oversight by the carrier or intermediary.
3. If either the provider or intermediary can help, call the United States **Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477)** or the Vermont Inspector General's office at.

Prior to calling the Inspector General's hotline, the advocate or beneficiary should carefully review the facts, and have the following information ready:

- The provider's name and any identifying number you may have
- The service or item in question
- The date the service or item was rendered
- The payment amount approved and paid by Medicare

- The date on your MSN or EOMB
- The beneficiary's name and Medicare Number (HIC#)
- The reason you think Medicare should NOT have paid for the item or service
- Any information to show why Medicare should not have paid for any item or service
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When fraud has been committed the government can:

- Seek 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
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ABUSE

Federal law defines abuse, under 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. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented the facts to obtain payment.

Examples of Medicare abuse include:

- Excessive charges for services or supplies
- Claims for services that lack documentation to support medical necessity
- Breach of Medicare participation agreements
- Billing the client in excess of limiting charges for specific services
- Billing Medicare at a higher fee schedule than for non-Medicare clients

Some abuse is ultimately found to be fraudulent. If an advocate or Medicare beneficiary suspects Medicare abuse they should follow this 3 step approach:

1. Call the health care provider to ensure that the beneficiary understands and agrees with all of the charges and services listed in the MSN or EOMB. The discrepancy is usually a mistake or oversight by the provider.
2. Call the Medicare Carrier or Fiscal Intermediary to ensure that the beneficiary understands and agrees with all of the charges and services listed in your MSN or EOMB as many times the discrepancy is a billing mistake or oversight by the carrier or intermediary.
3. If, neither, the provider or intermediary can help, the beneficiary should call the United States **Inspector General's hotline at 1-800-HHS-TIPS (1-800-447-8477).**

The Inspector General's hotline will carefully review the facts; so prior to calling have the following information ready:

- The provider's name and any identifying number
- The service or item in question
- The date the service or item was rendered
- The payment amount approved and paid by Medicare
- The date on your MSN or EOMB
- The beneficiary's name and Medicare Number (HIC#)
- The reason Medicare should NOT have paid for the item or service
- Any information show why Medicare should not have paid for any item or service
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When abuse is committed, the government can:

- Recover payment made in error
- Invoke civil monetary penalties congruent with the degree of abuse
- Suspend the provider from the Federal Healthcare Programs
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QUALITY OF CARE CONCERNS

A quality of care concern involves a concern about medical care rendered by a provider that does not meet commonly accepted standards of medical practice. Good quality of care includes the rendering of the proper health care at the right time, in the right way, for the right person in order to achieve the best possible results of the treatment.

Examples of quality of care concerns:

- The necessary health care services were not provided to the patient
- Health care that did not meet recognized standards of quality
- Health care services that were not provided in the appropriate setting
- A patient was discharged when they were unstable
- A patient was left naked in a public area while awaiting treatment

Both the State of Vermont and the Federal government, via the Department of Health and Human Services, define the rights of Vermont Medicare beneficiaries in Patient Bills of Rights. In broad terms, a Vermont Medicare beneficiary has the right to receive easily understood information to assist them in making informed decisions about their choice of health care, the right to respectful and considerate care, the right to refuse treatment, and the right to privacy. However, when a Vermont Medicare beneficiary receives inadequate medical care, there are many state and federal agencies and organizations with whom a complaint may be filed:

At the Vermont state level:

Vermont Medicare beneficiary complaints, concerning the quality of care rendered by a hospital, can be filed with the hospital itself and/or the Division of Licensing and Protection of the Vermont Department of Aging and Disabilities. When a Medicare beneficiary expresses a desire to file a complaint with the hospital about the quality of medical care, Vermont hospitals are required by state law to implement and make hospital patients aware of internal patient complaint procedures. A Medicare beneficiary may also file a complaint concerning the hospital's quality of care with the Vermont Division of Licensing and Protection. A beneficiary may call the **Division of Licensing and Protection at 1-800-564-1612 or 1-802-241-2345** to verbally file a complaint or send a written complaint to:

**Division of Licensing and Protection
Adult Protective Services
Ladd Hall 103
103 South Main Street
Waterbury, VT 05671**

Vermont Medicare beneficiary complaints concerning the quality of care rendered by a nurse may be filed with the Vermont Office of Professional Regulation. A Vermont Medicare beneficiary may call the **Vermont Office of Professional Regulation at 1-802-828-3180** to verbally submit a complaint or to request a complaint form. Complaint forms can also be downloaded from www.vtprofessionals.org. Written complaints should be sent to:

**The Vermont Secretary of State
Office of Professional Regulation
Attn: Anita Ristau, Unit Administrator
81 River Street, Drawer 09
Montpelier, VT 05609-1106**

Vermont Medicare beneficiary complaints concerning the quality of care rendered by a physician should be directed to The Board of Medical Practice at Vermont Department of Health. A Vermont Medicare beneficiary may call the **Board of Medical Practice at 1-800-464-4343 or 1-802-863-7200** to verbally submit a complaint or to request a complaint form. Complaint forms can also be downloaded from <http://healthvermont.gov>. Written complaints should be sent to:

**Vermont Department of Health
Board Of Medical Practice
PO Box 70
Burlington, VT 05402-0070**

Vermont Medicare beneficiary complaints concerning the quality of care in nursing homes or assisted living facilities can be directed to the **Vermont Long Term Care Ombudsman Project of Vermont Legal Aid, Inc, (VOP)**. The VOP serves people sixty and older who live in nursing homes, residential care homes and assisted living facilities. The project's primary responsibility is to identify, investigate and resolve complaints about residents' quality of life and the quality of care. Ombudsmen investigate every complaint they receive, including complaints about, food, medication or privacy. Ombudsmen also educate families and facility staff about the rights of long term care residents. In addition, the project reviews and comments on any laws, regulations or policies that effect long term care residents.

Call 1-800-889-5620 to contact the ombudsman who serves your community.

**Jackie Majoros
State Long Term Care Ombudsman
Vermont Legal Aid, Inc.
P.O. Box 1367
Burlington, VT 05402**

At the Federal level:

Vermont Medicare beneficiary complaints concerning the quality of care rendered by a hospital or agency can be filed with the **Northeast Health Care Quality Foundation (NHCQF)** and/or the **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**.

The **NHCQF**, under their contract with the **Centers for Medicare and Medicaid Services (CMS)**, works to ensure that people with Medicare receive the best possible care. The **NHCQF** handles Medicare beneficiary complaints that would otherwise be filed with the **Office of the Inspector General of the United States Department of Health and Human Services**. All complaints filed with the **NHCQF** should relate directly to the medical care rendered. A Vermont Medicare beneficiary may call the **NHCQF, Quality of Care Department, at 1-800-772-0151** to verbally file a complaint. Written complaints should be sent to:

**Northeast Health Care Quality Foundation
15 Old Rollinsford Road, Suite 302
Dover, NH 03820-2830**

Vermont Medicare beneficiary complaints filed with **JCAHO**, must concern hospitals or agencies, which are **JCAHO** accredited. Complaints may be faxed, e-mailed or mailed. If the complaint is faxed or mailed the Medicare beneficiary may request a **Quality Incident Report Form** to record the complaint by calling **1-800-994-6610**. An Incident Report Form can also be downloaded from the **JCAHO website at www.jcaho.org**. Complaints directed to **JCAHO** can be e-mailed to **complaint@jcaho.org** or faxed to **630-792-5636**. A written complaint may be mailed to:

**Office of Quality Monitoring
Joint Commission on Accreditation of Healthcare Organizations
Oakbrook Terrace, IL 60181**

Vermont Medicare beneficiary complaints concerning the quality of care rendered by a nurse or physician should also be made to the **NHCQF**. See above for contact information regarding verbal and written complaints.