NEWS & VIEWS

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Med-Net Concepts, LLC

Preventing Healthcare Fraud Before It Happens

By:
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Healthcare fraud, waste and abuse within Medicare and Medicaid programs is reportedly costing taxpayers more than $160 billion per year!

Here are some statistics about Medicare and Medicaid that viewed in consideration of fraud, waste and abuse clearly demonstrate the seriousness of this issue and the need for every person and healthcare provider in the United States to take an active interest in helping to curtail the problem. An article from Dun & Bradstreet cited these statistics:

- Medicaid pays out $415 billion per year
- Medicare spends almost $600 billion
- U.S. Government is spending $98 billion to combat fraud and provide inspections to enforce the Federal compliance regulations
- Total healthcare spending in America is $2.7 trillion or 17% of the country's Gross Domestic Product (GDP)

A September 2017 publication from the Centers for Medicare & Medicaid Services (CMS), "Medicare Fraud & Abuse Prevention, Detection and Reporting describes fraud and its expanse like this-

Anyone can commit health care fraud. Fraud schemes range from solo ventures to broad-based operations by an institution or group. Even organized crime has infiltrated the Medicare Program and masqueraded as Medicare providers and suppliers.

CMS is particularly committed to combating and reducing Medicaid healthcare provider fraud, waste and abuse that costs taxpayers so much money and diverts much needed resources from the very people who need it most. Contractors are hired to: review the activities of Medicaid healthcare providers, audit claims, identify overpayments, educate providers about program integrity issues and provide support and assistance to States'

Medicaid programs. "Medicaid uses the following audits to identify improper payments":

- CMS Payment Error Rate Measurement Program - measures and reports improper payments and identifies common errors;
- Audit Medicaid Integrity Contractors - CMS contractors who audit and identify Medicaid overpayments and
- Medicaid Recovery Audit Contractors - State contractors who audit providers and identify overpayments.

The following are some of the most frequently violated Federal laws that govern Medicare fraud and abuse:

False Claims Act (FCA) - protects the Federal Government from being overcharged or sold substandard goods or services by persons who, knowingly or with deliberate ignorance or with reckless disregard of the truth, falsify claim information.

Anti-Kickback Statute (AKS) - involves persons who "knowingly and willfully offer, pay, solicit or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal healthcare program."

Physician Self-Referral Law (Stark Law) - "prohibits a physician from referring certain designated health services payable by Medicare or Medicaid to an entity in which the physician (or an immediate family member) has an ownership/investment interest or has a compensation arrangement."

The Social Security Act - requires Long-Term Post-acute Care (LTPAC) Facilities, Assisted Living Communities and Home and Community Based Services (HCBS) to provide a high quality of care for their residents and to submit accurate and fully documented claims to maintain program integrity.

Here are some of the most frequently used types of fraud, waste and abuse described in the "CMS Nursing Home Toolkit":

- Billing for Unnecessary Services or Items
- Billing for Services Not Rendered
- Upcoding - "Billing for services at a level of complexity higher than the service actually provided or documented in the file."
- Unbundling - "Increasing income by billing for services separately instead of as together, e.g., a panel of laboratory tests."
- Kickbacks - "Knowingly and willfully soliciting, receiving, offering or paying "in kind" or in cash to induce or in return for referring individuals for items or services payable from Federal healthcare programs."
- Medical Identity Theft - "Appropriating or misusing a patient's or provider's unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services."

What Can Skilled Nursing Facilities Do to Prevent Healthcare Fraud?

Skilled nursing facilities provide much needed care for people in differing circumstances-the elderly, terminally ill, persons with physical and psychological limitations, etc. Nursing facilities also receive reimbursement for the services they provide from both Medicare and Medicaid programs. Consequently, program integrity and quality of care are key factors behind the CMS' concerns and the enforcement of its compliance standards and rules.

Fraud, waste and abuse, quality of care and freedom from abuse and neglect form a kind of three-legged stool and a nursing home's goal should be to keep from damaging and breaking any of the three legs.

Errors in Medicare/Medicaid billing can end up costing nursing facilities large amounts of money and can trigger a Medicare/Medicaid audit or review. One of the easiest steps that a nursing facility can take to avoid potential problems with its claims billing process is to implement the Medicare Triple Check Process. This is a solid process designed to internally audit claims before they are submitted and reduce the likelihood of having to deal with overstated claims resulting in overpayment by Medicare. A facility must promptly repay the government for any overpayments; and, while not as likely to occur as often as overstating a claim, submitting understated claims represents lost income to the facility and both have a negative effect on the facility's cash flow. A properly designed and implemented triple-check program is one of the best things a nursing facility can do to ensure that its billing process is efficient and free of costly errors.

Rehabilitation therapy is a core part of a nursing facility's billing, so facilities need to make sure rehab data is airtight. It is critical that the RUG category from the accepted MDS matches the RUG on the claim, and that the level of services submitted on the UB-04 was appropriate for the resident and supported by accurate documentation. Nursing facilities with fully integrated software systems may not have this concern; but, for facilities without a fully integrated system, this is often an area where human error can occur. Errors in coding can result in an overstated claim adding up to thousands of dollars. For example, one facility is reported to have had to repay approximately $1 million due to such coding errors.

A nursing facility may potentially violate the False Claims Act through its failure to provide an acceptable level of quality care. CMS has specific guidelines and rules governing what it considers to be acceptable standards of practice that meet the individual preferences and needs of nursing home residents. Nursing facility staff should be continuously educated and trained regarding what constitutes substandard quality of care and potentially worthless services.

Nursing home residents deserve, and by-law are guaranteed the freedom to live without fear of abuse and neglect. It is important that staff understand the difference between neglect and abuse and are trained to recognize the signs and how to report a concern or incident. Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." Neglect is the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Nursing home residents also have the "right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion."

Inadequate staffing is one of the most common complaints made about nursing home quality of care. Federal staffing requirements are defined as sufficient nursing staff with the appropriate competencies and skills sets to meet the needs of residents. Many individual states have specific staffing ratio requirements. The Five Star Quality Rating System compares each facility's actual reported staffing against desired staffing numbers, and issues "stars" based on that measure. Every facility should be aware of these requirements and maintain and post appropriate records that support their compliance with staffing levels.

Taxpayers, regulators, Medicare and Medicaid programs, and third-party payors want the dollars being spent through Medicare and Medicaid programs to ensure quality care for the elderly, ill and disabled. Where there may be bad apples in the barrel, the remainder of facilities strive to follow best practices in care delivery, billing, and overall compliance. A system of audits and triple checks designed to improve billing accuracy is an important activity in this effort.

ADMINISTRATORS: NAB Approved Fraud Modules, 9-16 Worth 3.75 CEUs Available on *mednetcompliance.com* Starting 09/24/18

A new set of NAB approved fraud modules worth 3.75 CEUs will be available on our website, mednetcompliance.com on September 24, 2018. These new modules as well as modules 1 -8 now on our website are offered through our educational arm, Med-Net Academy and provide education on fraud, waste and abuse prevention with NAB/NCERS approved continuing education credits for successful completion. All courses were developed and produced by Betty Frandsen, our Director of Healthcare Education Development and her staff. Visit our website to learn more.

https://www.mednetcompliance.com/med-net-academyu/nab-ce-course

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