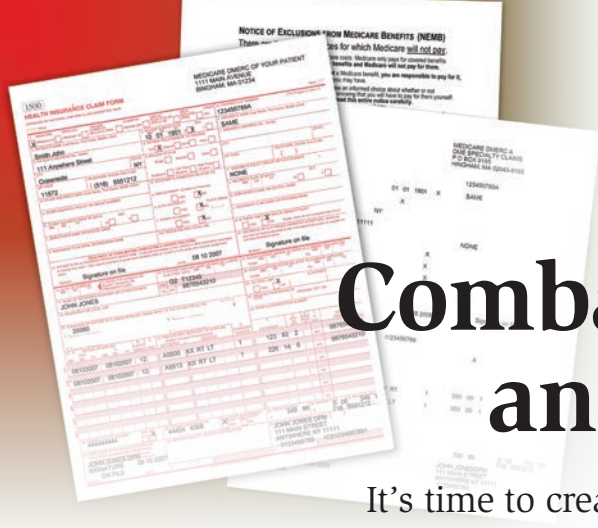

Combating Fraud and Waste

It's time to create a level playing field for all.

BY PAUL KESSELMAN, DPM

It is quite apparent that the medical directors, policy writers at CMS, DME contractors, and all members of the council are dedicated to protecting the future of the Medicare Trust Fund. There is no doubt that all ethical healthcare professionals share this commitment. However, one may rightfully argue that, with some exceptions, CMS and its many contractors have not sufficiently alerted the public about the scope of healthcare fraud, nor has CMS taken any serious actions based on patient complaints. One can argue that insurance companies themselves also commit fraud—by wrongfully denying claims, prior authorizations, and submitting claims for services not performed, they too commit fraud.

Several recent programs and bulletins begin to address these issues. A recent OIG broadcast addresses DME fraud in Medicare (to access, scan the QR code at right). This broadcast brings attention to the dramatic amount of fraud that exists in Medicare, especially the DME program.

There were also recent postings by the *NY Times* (to access, scan the QR code at right) and *Newsday* (see Figure 1 on page 36).

Other programs mentioned in last month's column spoke of the WISeR program and its attempt to reduce spending on 17 healthcare issues in several MAC jurisdictions as well as the new CTP LCD. Whether these programs will backfire and result in more physicians shying away from using CTP remains to be seen. If this happens (as some believe), the result may just be more patients losing limbs, ultimately costing the system more money.

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Licensed healthcare providers can also promote ethics in billing for medical services to ensure that our patients can obtain the care they need when they need it. Simply having your staff provide patients with a statement of what will be sent to the carrier at the time of service should be promoted. Most if not all of the healthcare systems servicing the suburban NYC area do this. Alerting the patients as to what you are submitting at the time of service provides them with a reflection of their future insurance statements.

Each practice should have a compliance plan. This plan should incorporate policies and procedures regarding who in your office has access to and can enter, copy, and/or edit your patients' billing information. Additionally, employees' cell phone and personal computers should not have access to the Wi Fi of your EHR/EMR or have access to your guest Wi-Fi while in the office.

Several years ago, a two-doctor practice contacted me regarding a potential embezzlement situation and

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the submitting of claims for services not performed. One of the problems was that all the employees had the same username and password. Therefore, it was almost impossible to identify who was committing various illegal acts.

Each employee should have their own username and password to access your practice's healthcare information systems. This seems like a very basic precaution, but one that the above practice refused to follow. Every entry into the system should be traceable so that the workflow can be attributable to an individual employee. Each employee should have their functions within the EHR/EMR limited to their job description. For example, a scribe should not have access to the patient's insurance and billing information; likewise, only the treating physician and scribe should have access to edit the medical records. In group practice, only the physician who treated the patient on a specific DOS should have the ability to amend that specific DOS chart entry.

If you use a billing service, all protected health information (PHI) should be communicated in both directions with a high level of encryption and security.

Marketing companies, both domestically but particularly ones offshore, are hungry for your patient's medical data and there are OIG reports on almost a daily basis of fraud committed by these companies. Marketing companies cannot typically commit fraud without the cooperation of licensed healthcare providers.

Calling the 1-800 Medicare number to report suspected fraud is an option all patients should be aware of.

Figure 1

A recent Internet search revealed that your patient's demographic data (social security number, DOB, insurance policy information, etc.) is worth $250-$1,000 on the black market. This information is used particularly to bill for services never provided. Presently DME, genetic testing, and billing for home healthcare services—all never provided—are particularly hot items. Other uses of your patients' PHI include using your patient's data to obtain medical services for imposter patients, opening credit cards and lines of credit, and other criminal enterprises.

This hurts patients because they can't obtain care when they most need it. Recently, a judge was denied a wheelchair by Medicare because he allegedly received two from a medical supply company within the past few years. Personally, within the past year, my Medicare account was compromised and billed for two continuous glucose monitors without any documentation or diagnosis of diabetes. Calling the 1-800 Medicare number to report suspected fraud is an option of which all patients should be aware. However, the lack of enthusiasm on the part of Medicare representatives to investigate many of these actions is appalling, yet it is understandable given the breadth of the problem.

These are only two examples of hundreds of thousands of alleged claims of fraud reported on almost a daily basis. It provides a strong rationale for why Medicare has dramatically tightened up the DME enrollment process.

The flip side is fraud on the side of insurance carriers, both inside and outside of Medicare. The DME enrollment process, particularly since the division of the National Supplier Clearinghouse (NSC) into NPE East and West, has been a disaster, espe-

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cially for those under the jurisdiction of NPE East. Stalled and inappropriately denied applications do not just economically impact providers, they endanger patient safety by delaying care.

Fraud is often directly perpetrated by the payers themselves, especially the post-payment carriers. These insurance carriers (e.g., RAC, UPIC), while their stated goal is to stamp out fraud, frequently commit fraud themselves. How is that possible? The system is rigged if the payers are only paid if they recoup money from providers. Think of them as bounty hunters. It's quite simple. If no money is recovered from the provider, they lose money, as it costs these bounty hunters money to conduct these audits. Many ethical and honest healthcare providers fail RAC and UPIC audits, not because they did not provide the services they billed for, and not for lack of documentation, but because the system is designed to frustrate and fail them, and at what cost? Healthcare providers often prevail at higher levels of appeal (particularly at the ALJ level). However, the level of mistrust it creates in ethical providers drives them away from performing certain essential services; patients may end up paying out-of-pocket simply because the provider feels that it is just too difficult to prove that such services are covered. This is ubiquitous to all types of medical specialties and is not unique to podiatrists, DME providers, or those who serve podiatric patients.

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The wait for an ALJ (level 3) hearing is now often less than a year, down from five years just a few years ago. However, providers should not have to go through two or more levels of appeal prior to a hearing where the outcome is not predicated upon the hearing officer being paid.

The costs to medical practices for obtaining both pre-authorizations and pre-determination (organizational determination) of benefits have skyrocketed over the past decade. Even after receiving prior authorization approvals, or an organizational determination of benefits, many providers have experienced claim denials. The costs of appealing these denials affect the provider, the insurance carrier, and mostly the patients. The latter may ultimately have to pay for those services. Is that not a fraud committed by the carrier who was paid a premium by the patient or their employer to cover such services?

We need policies which do not endanger patient welfare and at the same time do not create an absurd administrative burden for the provider.

The lay press, *PM News*, and *Podiatry Management* have all reported past fraudulent activities of Medicare "Advantage" Part C carriers in the risk-adjustment arena. This drives up costs to the tune of billions of dollars. Yet, not one employee of a Medicare Part Carrier has been imprisoned for such criminal activity.

Recently, a carrier contracted to administer the health benefits for the employees of the State of New Jersey was fined $100M for violating the False Claims Act. Apparently, this carrier submitted claims to New Jersey for services that were not provided. The carrier was also accused of bribing state officials in order to keep their contract.

In these last two types of fraud, the wolf is indeed watching the hen house, and these wolves have become so brazen that they think they can get away with just about anything. Have any of the individuals responsible for these acts been criminally indicted, found guilty, or imprisoned? Not one!

It is almost comical that an e-mail came from CMS entitled the Medicare "Trust" Survey, which asked several questions regarding how providers view Medicare. Do we trust Medicare to have the best interests of our patients as priority one? Having shared this with a few colleagues, each of us independently came up with these answers: Medicare is looking for the cheapest way out, has policies which are difficult to decipher, and certainly do not act in the best interests of the provider or patient.

It is time the healthcare system got things right and created a level playing field for all. We need policies which do not endanger patient welfare and at the same time do not create an absurd administrative burden for the provider. Medicare and others talk about the "Paperwork Reduction Act." What a joke! Post-payment carriers must be paid the same regardless of the outcome of the audit. There are no bonuses or incentives to find someone guilty!

Lastly, as providers, we must guard our patients' PHI with the same sacred trust we swore when treating them. Do No Harm! **PM**

Dr. Kesselman is board certified by ABFAS and ABMSP. He is a member of the Medicare Jurisdictional Councils for the DME MACs and a member of the enrollment subcommittee. He is a noted expert on durable medical equipment (DME) and consultant for DME manufacturers worldwide. He is the owner of Park DPM and co-owner of PARE Compliance. He is also co-owner of Codinghelpline.com, a new online forum for coding and reimbursement and was elected to the *PM* Podiatry Hall of Fame.