



**REDUCING MEDICARE AND MEDICAID FRAUD  
IN THE MEDICAL EQUIPMENT INDUSTRY**

Fall 2008

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## The Situation with Medicare

It is a sad commentary on government and business that Medicare has been so completely plagued with systematic fraud from every facet of Health Care. Doctors, home health providers, testing centers, hospitals and medical equipment businesses have defrauded the American tax payer out of hundreds of millions of dollars for far to long.

Recently Medicare has begun the long awaited crackdown on some industries, specifically the Medical Equipment Industry which had hundreds of million of dollars in fraud. As Home Medical Equipment Providers, we have seen our small (2% of Medicare's Gross Revenue) portion of the Medicare pie tainted by gross abuse, but more disturbing, gross negligence by Medicare's existing bureaucracy which has not endeavored to improve its monitoring ability and control a broken system. Worsening the situation, Medicare implemented a systematic effort to blame all fraud on our industry, as only 2% of their budget, we cannot accept that blame but we pledge as an industry to reverse fraud where we can, which often will require CMS's action.

As quality businesses, which earn the majority of their revenues from government programs, we find it is incumbent on us to act to save an industry that if not improved, can and will be altered to a point beyond recognition. If that occurs millions of patients will be underserved and in more difficult situations than they already find themselves. Because we are involved in many aspects of Medicare, from providing service and equipment to billing and interacting with Doctors and hospitals, we know better than much of the staff of Medicare how their policies and ineffective procedures can and are interrupted and we see first hand how easily they can be abused.

To reverse the critical crisis in Health Care, we the Accredited Medical Equipment Providers of America are offering the following suggestions, which if implemented will significantly reduce if not eliminate fraud as it is perpetrated today and which costs our tax payers so much of their hard earned money. All of the changes presented are relatively simple, they will reduce fraud, they do not require massive overhauls of a system that at its core is the best system conceived to provide health care to America's most in need.

As legitimate small businesses, operating independently in specific MSA's across the nation, medical equipment providers do not have the ability to stop fraud. Our advice though, can and will go a long way to preventing it, if headed by those in power. CMS has always had the ability to eliminate fraud, unfortunately, often because they do not understand how their own systems function on the ground, they do not understand how they can be manipulated. By implementing the simple suggestions attached, fraudulent behavior can be seriously reduced.

We pledge assist CMS in its efforts to implement the below initiatives.

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## Immediate Fraud Initiatives

The efforts below are designed to catch and control fraud before it gets out of hand; These proposed measures will counter what has been the incompetence of Medicare.

*1. Random probe letters to Physicians to verify the validity of DME orders.*

Claims must be approved through prescriptions by registered physicians. Verification of their orders must be checked. In a short time, and with the current CMS computer system, fake orders are often paid by the government to the unlawful. Random contact to Doctors will cut significantly into the ability to issue false orders.

*2. Triggers in CMS system to identify billing increase by predetermined percentage for any individual provider number.*

Individual providers often develop a pattern in their orders. Often their orders increase over time, but significant increase in orders, especially of singular items, is easily a red flag, demonstrating the potential for quick 'in and out' fraud. If CMS implements a program to be alerted to increases in orders, much of the illegitimate ordering will be caught in advance.

*3. Triggers in system by Diagnosis to identify "upcoding" (billing for higher level item with no justification).*

Often times less than honorable Providers up-code orders, delivering and billing for times that are more expensive than those that were not requested by Doctors for their patients, this practice is an abuse of the system and cost Medicare untold sums. Triggers to identify misorders are essential to keep providers honorable.

*4. Identification of "cookie cutter" billing patterns by Provider Number.*

Replication has often worked as a way to extort money from Medicare. If a pattern of ordering un-requested items is paid for and not questioned, it will be replicated. This is a fast and easy way to overcome the system. A system that identifies billing patterns will identify these actions immediately.

*5. Triggers in CMS system of the top 10 Health Care Procedure Coding System HCPCS (Procedure codes) paid by CMS per state.*

By understanding who the top 10 providers are per each item in each state or MSA over a particular time frame, over billing can be revealed. Quick rises in the average billing of a Provider often reveals fraudulent behavior. There is currently no trigger in the system to reveal this. Even though national organizations will likely be the leaders in most categories, followed by specialty providers, there will be others in and out of the top ten. Those Providers who spike into the top ten should be given closer scrutiny.

If this simple procedure were enacted regarding HIV clinics, it would have revealed the egregious inaccurate billing that accounted for over \$100 million in fraud.

*6. Triggers in CMS's system to reveal all of the top 10 largest payouts per month by Provider Number.*

Providers know each other in their areas, everyone is aware of each others business in a congenial yet competitive manner. Providing this information will allow Providers

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the opportunity to review the most successful companies and know who is real and is not real. If they believe there is a problem, they will inform CMS.

7. *Triggers in CMS's system to reveal aberrant billing patterns (i.e. all new equipment and no used equipment billing, same type of wheelchair for every patient).* There are very common billing practices, such as DME suppliers take back or "pick up" equipment frequently but very few providers bill for used equipment. The legitimate Providers of Medical equipment are ready to work to explain and establish baseline billing patterns which can be used a reference to Medicare to watch for abuses of the system.

8. *Triggers in CMS system to look for a lack of recent physician or hospital visits to coincide with DME order.*

Medical equipment orders are the direct result of physician referrals or hospital requirements. If a patient has had no doctor visits and no hospital visits or stays, it is exceedingly unlikely that new equipment has been prescribed to the patient. CMS needs to implement a system of checks and balances which verify that new orders correspond with doctors visits.

9. *Expand post payment audits to include a number of mandatory files based on volume randomly chosen by computer on a rotational basis.*

Audits are proven successful tools to combat fraud, post payment audits in particular verify that work has occurred. The threat of a post payment audits will help to keep legitimate Providers honest and with mandatory post payment audits for new companies, illegitimate Providers will be more quickly discovered.

10. *Triggers in CMS' system for excessive billing to single Medicare or Health Insurance Claim Number (HICN).*

Anyone who can get a Medicare number, the patient's address and birth date, can bill for anything and be paid within 14 to 21 days. This is why Medicare numbers need to be protected, in the same manner as credit cards.

A few years ago, there was an epidemic of Medicare patients who were selling their Medicare numbers to fraudulent Physicians, Providers and others. Those fraudulent companies were using the HICN's to bill every possible piece of equipment and procedure possible, all to one number. Excessive billing only occurs in two instances, on behalf of the severely infirmed or fraud. There were triggers added to freeze payments for excessive billing, but they were since removed. They need be reinstated and reviewed more often.

11. *Institute interest assessments for items billed past their pick up or return date.*

Items are over billed for dates after they were returned or no longer used. The government will pay until the provider is honest enough to disclosure the overpayment or are involuntary reported, such as if a patient reports them. There is no incentive to bill properly. Currently the worst case scenarios for over billing is that Providers must return their over payments to government, it is important to charge the Providers interest for the time they kept government money.

Currently when a person dies, Medicare has a process to inform Providers of the loss, and if necessary they request repayment of overpayments. Patients families

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may neglect to inform Medicare or their Providers of a death for long periods of time. The Provider should not be faulted for that error, but usually have to pay the government back for the time since the death. These often unfair situations could be resolved through credit card system with Patient authentication.

*12. Expand additional documentation requests nationwide for medical justification to include more O&P. (orthotics and prosthetics.)*

The Medicare billing category, Orthotics and Prosthetics is the most highly up-coded category, though it receives the least amount of review. Often Providers and others bill for items beyond the need of the patients, for example a Doctor may prescribe a wrist brace ( which retails for \$40), but unethical Providers bill for a high tech wrist protection device (often retailing for (\$350). Medicare does not provide an item code to significantly differentiate orthotic products , without such codes ( or serial numbers) Medicare must demand justification for the items released.

*13. Triggers in CMS' system for high volume increases billed to a Physician National Provider Identifier (NPI) number.(bribe, kickback violations).*

The system needs to recognize when physicians' billings spike in business or products. Due to bribes, kickback and other violations physicians sometime bill excessively to one Provider or allow their numbers to be used to bill excessively on one product or service. Ongoing business normally will not show wild increase in billing, such increases are often a sign of fraud.

*14. Require reasonable surety bond as fraud deterrent.*

To prevent unprofessional persons from joining the industry and to assure that professionals guarantee their efforts, a reasonable surety bond is a legitimate and prudent device. It should be imposed industry wide as a standard operating procedure.

*15. Random sample of beneficiaries to verify products and services received. Provide toll free fraud hotline to the benefit integrity unit on remittance notices rather than the 1-800-Medicare number which has excessive hold times and confusing instructions for the elderly.*

Random sampling will give the beneficiaries an opportunity to speak out, when normally they would not. It will again put the Providers on their toes and it can be targeted to areas of concern, helping to stop systemic abuse before it starts.

*16. Random hardcopy file request.*

CMS should make requests for hardcopy files of those companies which demonstrate concern regarding their billing, or at random of companies in various regions. An initial request of 10 random files is not excessive, but if errors are found, the request could be increased to 25 files, and so on.

*17. Pre-authorizations.*

CMS should adopt a Pre-Authorization program. If Medicare would first receive pre authorizations from physicians or hospital they could approve or deny claims prior to delivery. This would save Providers efforts to get payments, it would reduce the burden on Medicare to review files after the fact and it would reduce fraud by giving Medicare control over what occurs in advance. This would help Medicare to track doctors efforts as well as the efforts of Providers.

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18. *Severe punishments need to be implemented, to all companies regardless of size and service.*

The withdrawal of Medicare numbers and other such measure are essential for keeping Providers honest. If the threat that a number will be removed is used effectively, and often for preventable mistake and multiple billing errors, Providers will be more careful to guarantee accuracy when it comes to billing.

Large nationwide companies have been required to pay substantial fines in exchange for illegal billing practices, but never has their ability to bill the government been threatened. This almost guarantees that this behavior can and will continue.

CMS must realize that it is not beholden to the large Providers, it must treat large companies as it treats small companies, even handed and legitimate ways and remove those from the system who have showed repeated violations of the rules.

19. *CMS must audit more often and threaten to more audits.*

When CMS sends out 1000 requests for audits, 100 Providers do not respond. Those are the Providers who need to be targeted. Often fraudulent providers understand that by the time it takes CMS to investigate suspicious companies, they can have milked substantial funds and closed their businesses. CMS must target areas of concern and send out audit request, moving quickly to act against those companies they do not respond. If CMS does not send out audit requests, they lose the opportunity to have an easy gauge of quality Providers versus fraudulent ones.

There are not enough post-pay audits for an honor based system. CMS needs to prioritize post-pay audits, especially for newer companies and put an emphasis on Post pay audits for the future.

### Conclusion

CMS has shot blame in many directions for Fraud, specifically at the medical equipment industry, yet they have kept the door open to fraud with very little oversight. The triggers recommended will reveal many problems and illegal activities and will cut fraud greater than any other effort anticipated or enacted. The processing of claims is the easiest way to catch problems, and that is what the suggestion mainly address. Government can and should do it.

AMEPA and its members know better than any government official the need to efficiently process claims and get paid in order to keep up with cash flow, however, AMEPA and its members understand that combating fraud is essential to preserving the industry and the patients they love to serve. We are committed to work with CMS to combat fraud at every level.

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## Long Term Strategy

### *Advanced Technology*

In the most technologically advanced nation on earth, it is disappointing that the one of the most expensive governmental programs is not regulated by comprehensive computer system that can analyze billing and cost to catch fraud.

CMS needs to adopt a new computer system, similar to those used in the credit card industries that can analyze orders against prescriptions, verify serial numbers and report if companies are close or if physicians are retired or passed on. In today's world, where credit card companies are alerted if your credit card is used for high and atypical purchases, it is possible that a more comprehensive and modern CMS system will save money and lower administrative cost while lowering fraud.

These new systems should allow for scanned document review. Currently Providers must submitted dozens of copies of papers, via by fax or mail. Scanned Documents, on a central database would make access by Medicare much easier, and would save time of the Providers and Medicare reviewers. Most major insurance companies are paperless, saving effort and costs.

AMEPA will work with CMS through committees or anyway they chose to inform them of ways to improve and create their systems.

### *Authentication*

The Committee to review government errors which contributed to the 9/11 attacks concluded that the inability of the FBI and the CIA and other intelligence networks to speak to one another and share information, created gaps in the intelligence network that allowed terrorist to avoid detection in time to complete their destructive missions.

There is a similar situation which allows for Fraud in Medicare, but instead of not being mandated not to speak to each other, various department in Medicare chose not to communicate with each other in a way that will prove effective to combating fraud.

Prescription processors, order reviewers billing processors and payment specialist need to be able to communicate and verify the request, need and cost of the orders processed by Medicare, in order to authenticate charges. n the long term, every Medicare number and order needs to be authenticated. Medicaid has been able to achieve this goal in many states using a swipe care system, even though the specificity of their ordering is much more exacting than Medicare's. The change in systems required to do this seems excessive and expensive but the amount of money that will be saved, and the generated information about the nations needs, will be so great, any system that can authenticate will pay for itself.

### *Understanding Service*

CMS must recognize that Medicare Equipment Providers are not delivery services, they are Home Health Providers, on call 24 hours a day to take care of patients' needs. The service of Providers keeps patients, especially the elderly, out of emergency rooms and away from long hospital stays. Yet their payments are based on the costs of equipment. Basing payments on the cost of a product diminishes the more important role of the Providers. In the long term it would be wise to follow the successful example of the

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Veteran Administration and pay Providers based on an accurate scale, for the items used and time for the service provided. Accuracy based on the type of equipment and the service calls made will help CMS to better understand those in their care and to organize and plan for the growing number of persons who will soon be entering the system .

### *Accreditation*

Accreditation of businesses is vital to controlling the Home Medical Equipment Industry. Accreditation offers self policing of the industry, standardization of procedures and education opportunities. Currently there are more than 10 Accreditation Organizations nationwide, each with different standards and expertise. Standardization of Accreditation companies, and specification of the types of accreditation offered is essential understanding companies' capabilities and to the policing of the hundreds of thousand of business in the industry.

Prior to the due date of Competitive Bidding applications many companies wanted to become accredited. Many accreditation companies competed for the surge of applicants, with some lowering their standards to guarantee the desire title. This was a gaming of a good system. To combat that type of action from re-occurring, CMS must undertake to establish standards and policies for those organizations so the title Accreditation is not abused and misused. If done properly CMS will have a wonderful resource through accreditation

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The Accredited Medical Equipment Providers of America (AMEPA) is a Grassroots Membership Organization meeting the needs of Home Medical Equipment Providers nation wide to voice their concerns about what affects their industry. The organization was founded by HME Providers who wanted to bring to light the inequities and problems associated with CMS's Competitive Bidding Program. Now, with a few hundred members in 7 states, AMPEA is one of the largest and most effective grass roots organizing bodies for the HME industry, nationwide.

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