AdvanceMed's Response to Durable Medical Equipment (DME) Fraud in ZPIC Zones 2 and 5

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The Centers for Medicare and Medicaid Services (CMS) initiated the Zone Program Integrity Contractors (ZPIC) program in 2008. Seven zones were created based on the newly established Medicare Administrative Contractor (MAC) jurisdictions. As a result of the seven zones, new entities entitled Zone Program Integrity Contractors (ZPICs) were created to perform program integrity for Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H) and the Medicare-Medicaid (Medi–Medi) Data Match Program. The ZPIC Umbrella Statements of Work (SOW) encompass all of the fundamental activities that may be required of a ZPIC. However, work is not performed under the umbrella SOW since individual Task Orders are awarded under the Indefinite Delivery Indefinite Quantity (IDIQ) contract for specific requirements. Medicare Parts C & D were also included in the ZPIC Umbrella contract, but have not yet been exercised as Task Orders under the current contracts.

CMS awarded the Umbrella IDIQ contract for ZPIC Zone 5 to AdvanceMed in February of 2009. As the ZPIC for Zone 5, AdvanceMed currently conducts fraud, waste, and abuse detection and investigation in 10 states (Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia). AdvanceMed has established four operational Medi-Medi data matching programs with Arkansas, Georgia, Mississippi, and North Carolina. The Medi-Medi project for Alabama is currently in the implementation phase with an anticipated operational date in July 2013.

The value of the Zone 5 contract (including Task Orders 1 and 2), including all funding actions to date and the value of unexercised options is $113,564,992.

CMS awarded the Umbrella IDIQ contract, along with Task Orders 1 and 2, for ZPIC Zone 2 to AdvanceMed in September 2009. AdvanceMed currently conducts fraud, waste, and abuse detection and investigation in the 14 states located in Zone 2 (Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming). Zone 2 also has three fully operational Medi-Medi programs in Utah, Missouri and Iowa and is currently implementing two more programs in Nebraska and Arizona.

The value of the Zone 2 contract (including Task Orders 1 and 2), including all funding actions to date and the value of unexercised options is $81,893,564.

The ZPIC contract vehicle includes provisions for an Award Fee. The current award fee for Task Order One (Fee-For-Service Task) is based on a performance evaluation of the contractor's overall Quality of Service and a self-evaluation of performance related to improvement of administrative actions by the contractor and demonstration of a mechanism to track overpayment recoupments completed by the MACs. The Task Order Two (Medi-Medi) Award Fee Criteria is based on a performance evaluation of either Quality of Deliverables (if the state is still in implementation) or Quality of Service (if fully operational) and Business Relations.

The Award Fee Plans detail the criteria and evaluation process for determining any Award Fee to be paid to the contractor.

Fundamental activities of ZPICs are those that help ensure payments are appropriate and consistent with Medicare and/or Medicaid coverage, coding, and audit policy. Furthermore, these activities are aimed at identifying, preventing, or correcting potential fraud, waste and abuse and include, but are not limited to, the following:

- performing benefit integrity investigations;
- implementing appropriate administrative actions such as prepayment review, auto deny edits etc.;
- coordinating potential fraud, waste and abuse activities with the appropriate Medicare contractors and other stakeholders;
- referring cases to law enforcement;
- conducting post payment medical review activities;

- proactive data analysis
- screening of reactive leads (i.e., complaints);
- matching and analysis of Medicare and Medicaid data; and
- responding to law enforcement requests and providing subject matter expertise to law enforcement

The following are examples of common fraud schemes which have been identified within the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Medicare benefit:

- **Telemarketing fraud scheme**

  In this fraud scheme, a supplier uses telephone or other electronic communications to contact individual Medicare beneficiaries in order to solicit them for equipment, prosthetics, orthotics, or supplies. Typically suppliers identify a general medical complaint such as back or neck pain, and then a neck or back brace is shipped to the beneficiary. Subsequently, the item is billed to and paid by Medicare.

  Telemarketing scams by suppliers have become more sophisticated with the sharing of beneficiary identifying information between suppliers and clearinghouses used to make mass calls. Companies many times will offer free items such as cookbooks, glucometers, and other items in an attempt to get beneficiaries to provide their identifying information.

  DME suppliers are prohibited from soliciting beneficiaries absent meeting one of the following criteria:

  1. The beneficiary has given written permission to the supplier to make contact by telephone;
  2. The contact is regarding a covered item that the supplier has already furnished the beneficiary; or
  3. The supplier has furnished at least one covered item to the beneficiary during the preceding 15 months.

  As part of CMS' efforts to identify and resolve complaints more efficiently, effectively and timely, AdvanceMed has been contracted to conduct a Pilot Project that involves receiving, reviewing, and resolving complaints that are received by 1-800 Medicare. The Beneficiary Complaint Pilot Project (BCPP) was initiated in Zone 5 during 2011. The project involves the receipt of all Medicare complaints (Medicare Parts A, B, DME, Home Health and Hospice) alleging fraud that are within the Zone 5 jurisdiction. This process does not rely on the MAC to screen and forward those complaints to the ZPIC that they believe involve potential fraud, as is the process in all other Zones. The ZPIC (Zone 5) receives all complaints and screens them within 5 days and then notifies the MACs of those that are not issues involving potential fraud, so that they may complete the process of resolving the complaints that the ZPIC will not pursue. As a result of this project, the ZPIC (Zone 5) has been able to take actions to stop fraudulent activity much more quickly than under the old process, that sometimes resulted in delays of 4-6 weeks to receive the complaint (by which time the fraudulent provider may have moved on to other beneficiaries or locations) and many complaints were not forwarded at all.

  The BCPP receives allegations of telemarketing from beneficiaries alleging they have been contacted by DME companies, or their subcontractors, promising medical equipment. When AdvanceMed receives these complaints, beneficiaries are interviewed by staff and subsequently asked to sign an attestation affirming that the contact was made without their consent and that the beneficiary does not want or need the offered DME. AdvanceMed then places an auto deny edit in the claims processing system to prevent the suspect supplier from billing the unnecessary equipment for the beneficiary. The beneficiary's health insurance claim number (HIC) is also added to the national compromised HIC number database for further tracking and future analysis. Additionally, the supplier is sent an educational warning letter about the telemarketing practice and the matter is referred to the National Supplier Clearinghouse (NSC) for review and consideration of revocation should the practices continue.

In October 2011, Zone 2 conducted proactive data analysis to review beneficiaries receiving excessive amounts of glucose strips. Based on the proactive study, an investigation was opened. Subsequent analysis and beneficiary interviews showed that multiple DME suppliers were selling glucose test strips and other diabetic supplies to the same beneficiaries at the same time. It was discovered that some DME suppliers were making unwanted and unsolicited marketing phone calls to beneficiaries for glucose test strips and other DME supplies. Often, the telemarketers were successful in obtaining Medicare beneficiary information, resulting in orders and bills for unwanted and unnecessary supplies.

Further data analysis of claims data and information from CMS DME complaint logs was made regarding telemarketing complaints made to CMS. The analysis showed a number of DME suppliers who shared beneficiaries and who could be linked through the complaint logs to telemarketing companies. Zone 2 staff compiled a "target" list consisting of beneficiaries purportedly receiving supplies from more than one DME supplier. Staff also compiled a "source" list of beneficiaries for each DME supplier. By cross-referencing the two lists, analysts found between 12% and 63% of shared beneficiaries for each DME supplier.

Since October 2011, Zone 2 has opened at least six investigations involving prohibited telemarketing by DME suppliers. Four of these investigations have been referred to and accepted by the HHS OIG and are actively being investigated. In addition, several immediate advisements were sent and accepted by the OIG.

- **Services not provided fraud scheme**

  In this fraud scheme, a supplier bills Medicare for equipment, prosthetics, orthotics, or supplies which were never delivered or provided to the Medicare beneficiary.

- **Items not medically necessary fraud scheme**

  In this fraud scheme, a supplier bills Medicare for equipment, prosthetics, orthotics, or supplies which the beneficiary did not require, or for which there was no medical need.

- **No relationship with the ordering physician fraud scheme**

  In this fraud scheme, a supplier has an arrangement with a physician where the DME supplier submits orders for equipment, prosthetics, orthotics, or supplies for approval, although the physician has no prior relationship with the patient, having never assessed them for the need for the supplies. Typically these physicians are paid a fee for their services based on the volume of orders they sign.

- **False front suppliers**

  In this fraud scheme, a supplier number is established for a DME supplier which does not exist. There is no physical location for this supplier, nor do they possess the appropriate equipment or supplies to be able to deliver to the Medicare beneficiaries. This "supplier" subsequently obtains Medicare beneficiary numbers, through identity theft or by purchasing them directly from beneficiaries, and bills for supplies which are never delivered or provided to the Medicare beneficiary.

  Zone 2 performs national False Front Provider detections for CMS. False Front Providers are the products of individuals who work alone or in concert with others to steal the identity of valid Medicare providers and then submit false claims directing Medicare payments to new locations. In 2011 and 2012, Zone 2 detected 195 such instances of which 13 were investigated by Zone 2 and 182 were referred by Zone 2 to other ZPICs for investigation. The majority of these false front suppliers portray themselves as ambulance companies, laboratories, and/or physician practices.

  The goal of this effort is to detect these situations before any payments can be made. Of the 195 detected in 2011 and 2012, 87 were identified before payments were made. We estimate that the early detection of the 87 saved $24,900,000 based on amounts that fully operating False Front Provider

schemes have achieved. Over the entire history of the project, Zone 2 has detected 488 false Front Providers.

- **Provision of DME while a patient is under hospice care or residing in a skilled nursing facility fraud scheme**

  When a Medicare beneficiary is under the care of a hospice or a skilled nursing facility, the equipment or supplies necessary for the treatment of the diagnosis related that admission is often covered under the hospice benefit or within the payment to the skilled nursing facility. In this fraud scheme, the supplier (who may be affiliated with the hospice or with the skilled nursing facility) "unbundles" the equipment or supplies and bills them to Medicare separately, rather than including it within the reimbursement for the hospice or skilled nursing care.

ZPICs have a number of administrative tools available for use when dealing with the types of allegations described above. The ZPICs can take the following action(s) against suppliers:

- **Prepay medical review:** This action allows the ZPIC to stop all claim payments for suppliers until the medical records for each claim can be ordered, received, and reviewed to determine if the DME supplies should be paid for.

- **Postpay medical review:** This administrative action involves the medical review of claim payments that have been made to a supplier. ZPICs identify claims to be reviewed through data analysis and may determine that statistical sampling is necessary. The use of statistical sampling allows the ZPIC to extrapolate overpayments to a universe of claims related to the fraud issue being reviewed. Statistical sampling and overpayment extrapolation is overseen by statisticians following protocols approved by CMS and the Office of Inspector General (OIG).

- **Payment suspension:** This action, with approval from CMS, allows the ZPIC to stop payments from being made directly to a DME supplier for claims that have been processed. The claim payments are placed in an escrow account pending review by the ZPIC. Payment suspensions are used when a credible allegation of fraud is being reviewed or a potential overpayment exists but has not yet been calculated.

- **Initiation of auto deny edits:** Auto deny edits are placed in the claims payment system in order to deny payments for supplies and services that have been determined to be unnecessary or inappropriate based on previous medical reviews, investigational determinations, MAC local coverage determinations, and/or CMS policy. These edits can be initiated based on a specific beneficiary HIC, supplier number, or a co de or set of codes that identify specific pieces of DME. These edits create automatic claims denials before payments are made, and they do not require medical review prior the denial being effectuated in the system.

- **Revocation:** Revocations involve the termination of a supplier or provider's ability to bill Medicare for services rendered. Revocation actions are reviewed by CMS for approval. Referrals for revocation of a DME supplier typically involve behavior such as failing to meet conditions of participation, failure to adhere to education, and/or continued telemarketing following warnings and education.

- **Referral to law enforcement:** In addition to the administrative actions listed above, ZPICs can also refer suspected allegations of fraud to state and federal law enforcement for further investigation and prosecution.

The table below shows requested outcomes of AdvanceMed's DME related actions and activities taken between January 1, 2011 and December 31, 2012 as reported monthly during the time period. The information includes data from Task Orders 1 and 2, as well as results from Zone 5's DME Stop Gap Project in North Carolina.

Activity	Zone 2	Zone 5
Value of overpayments referred to MAC for collection	$810,768.53[1]	$115,477,435.26[2]
Number of overpayment actions referred for collection	6[3]	128[4]
Overpayment amounts recovered by MAC	$46,016.47[5]	$ 13,971,864.39
Number of cases referred to law enforcement	13	32
Total estimated dollars associated with cases referred	$41,663,941.02	$ 21,203,541.19
Dollar value of prepay claims denied	$3,106,705.15	$ 19,021,822.92
Number of payment suspension requests	0	7
Number of recommended auto-deny edits	50	1,730
Dollar value of recommended auto-deny edits	$13,094.00	$ 21,709,959.00
Number of revocations recommended	0	23

[1] This figure represents the total reported in CMS monthly reports during the time period. The initial response provided on April 16, 2013 was understated by $3,920.76.
[2] This figure includes the totals from the North Carolina DME Stop Gap Project. The DME Stop Gap information was not included in the April 16, 2013 response.
[3] This total represents the number reported in CMS monthly reports during the time period. The initial response provided on April 16, 2013 was understated by one (1) referral. See footnote number 1 for related amount.
[4] This figure represents the total number of overpayment referrals reported in CMS monthly reports. CMS does not capture the number of overpayment referrals for Task Order 2. The total number of overpayment referrals, including Task Order 2 is 135.
[5] This figure represents the total reported in CMS monthly reports during the time period. The initial response provided on April 16, 2013 was overstated by $583.30. This difference was caused by a calculation error.