CMS
CENTERS for MEDICARE & MEDICAID SERVICES

SafeGuard
Services
LLC

CONFIDENTIAL

June [redacted], 2011

[redacted]
[redacted]
[redacted], Florida [redacted]

Re: Provider Education
NPI #: [redacted]
WMM: [redacted]

Dear [redacted]:

SafeGuard Services, LLC (SGS), is the Zone 7 - Zone Program Integrity Contractor (ZPIC) chosen by the Centers for Medicare & Medicaid Services (CMS) to perform specific program safeguard functions for the Medicare program. Some of the program integrity functions are in the following areas: medical review, cost report audit, data analysis, provider education, and fraud detection, and prevention.

The Zone 7 - ZPIC responsibilities include reviewing the accuracy and justification of all services reimbursed by the program. The Zone 7 - ZPIC must ensure that the correct amount has been paid for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The purpose of this letter is to describe the steps involved in this audit process and the results, highlight billing discrepancies, and provide educational information to assist with your future claims for Medicare reimbursement.

FINDINGS

The purpose of this letter is to educate and inform you that on June [redacted], 2011, our office received a complaint alleging that [redacted] knowingly process Medicare claims as if the patient is paying their co-payments but the patients are not although Medicare shows the patients have paid their percentage and pays the remainder.

EDUCATIONAL INFORMATION

Under the federal law, Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Centers for Medicare & Medicaid Services (CMS) defines Fraud as intentional deception or misrepresentation that the individual makes, knowing it to be false and that it could result in some unauthorized benefit to them. Abuse describes incidents or practices of providers,

physicians or suppliers, or services and equipment which, although not usually fraudulent, are inconsistent with accepted sound medical, business or fiscal practices. These practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services which fail to meet professionally recognized standards of care, or which are medically unnecessary. Individuals convicted under these felony provisions may be fined up to $25,000 or imprisoned up to five years, or both.

The Medicare and Medicaid Patient Protection Act of 1987, as amended, 42 U.S.C. §1320a-7b (the "Antikickback Statute"), provides for criminal penalties for certain acts impacting Medicare and state health care (e.g., Medicaid) reimbursable services. Enforcement actions have resulted in principals being liable for the acts of their agents. Of primary concern is the section of the statute which prohibits the offer or receipt of certain remuneration in return for referrals for or recommending purchase of supplies and services reimbursable under government health care programs. Section 1320a-7b(b) provides:

> (1) whoever knowingly and willfully solicits, receives or willfully offers and pays any remuneration including any kickback, bribe or rebate- directly or indirectly, overtly or covertly, in cash or in kind –
>
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [Medicare] or a State health care program, or
>
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [Medicare] or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

Thus, the Antikickback Statute prohibits certain solicitations or receipt of remuneration and the offer or payment of certain remuneration. Section 1320a-7b(b)(2) has generally been applied to broker-style arrangements, whereby an individual offers remuneration to another individual for the purpose of recommending or referring an individual for the furnishing or arranging for an item or service. In an Antikickback Statute analysis, it is immaterial whether remuneration induces one in a position to refer or recommend. It is sufficient that the remuneration may induce one to refer or recommend. United States v. Greber, 760 F.2d 68, 71 (3rd Cir.), cert. denied, 474 U.S. 988 (1985). Under Greber, it is also irrelevant that there are other legitimate reasons for the remuneration. If one purpose is to induce referrals, then the Antikickback Statute is violated. Id. at 71.

The Antikickback Statute contains certain exceptions, which allow conduct that would otherwise violate the statute, such as certain discounts given by suppliers to cost-reporting providers. Finally, the statute permits the Secretary of DHHS to promulgate regulations which identify other practices which do not violate the Antikickback Statute. In this latter case, the Secretary of DHHS has promulgated approximately numerous "safe harbors", found at 42 C.F.R. §1001.952, which, if the requirements are met, insulate individuals and entities from prosecution under the Antikickback Statute for conduct which would otherwise violate the Antikickback Statute.

Although compliance with a regulatory safe harbor is not required if the written agreements or arrangements between parties under consideration do not fall within the Antikickback Statute in the first instance, the safer course is to evaluate "gray area" agreements in the context of the regulatory safe harbors. The safe harbor regulations, however, are rather narrowly drafted and therefore make compliance with them difficult.

Please be advised that the Office of Inspector General released an alert regarding the issue on routinely waving copayments for Medicare patients. Here is what it says, "In certain cases, a provider, practitioner or supplier who routinely waives Medicare copayments or deductibles also could be held liable under the Medicare and Medicaid anti-kickback statute. 42 U.S.C. 1320a-7b(b). The statute makes it illegal to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid. When providers, practitioners or suppliers forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them." Ref: http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.

The criminal statute applies regardless of whether the payment for referral is made directly or indirectly, overtly or covertly, in cash or in kind.

Your office should review the CMS manuals, guidelines and regulations to ensure you are in compliance with all Medicare rules and regulations.

Please be advised, this letter is intended to be educational in regards to the appropriate submission of Medicare claims. You may be subject to a follow-up review of your billing practice in the future to ensure compliance with the information and recommendations in this letter. Additionally, continuation of identified problems can result in exclusion from the Medicare Program in accordance with Section 1128(b) of the Social Security Act; Civil Monetary Penalties; and/or suspension of Medicare payments under Title 42 of the C.F.R., Section 405.370 et seq.

If you have any questions or concerns, please contact SGS Complaint Analyst [redacted] at our customer service number (954) 433-6200.

Sincerely,

[redacted]

Evelyn G. Morgan
Complaints Fraud Manager
SafeGuard Services, LLC - A CMS Zone Program Integrity Contractor
Medicare Integrity Program