DEPARTMENT OF HEALTH & HUMAN SERVICES

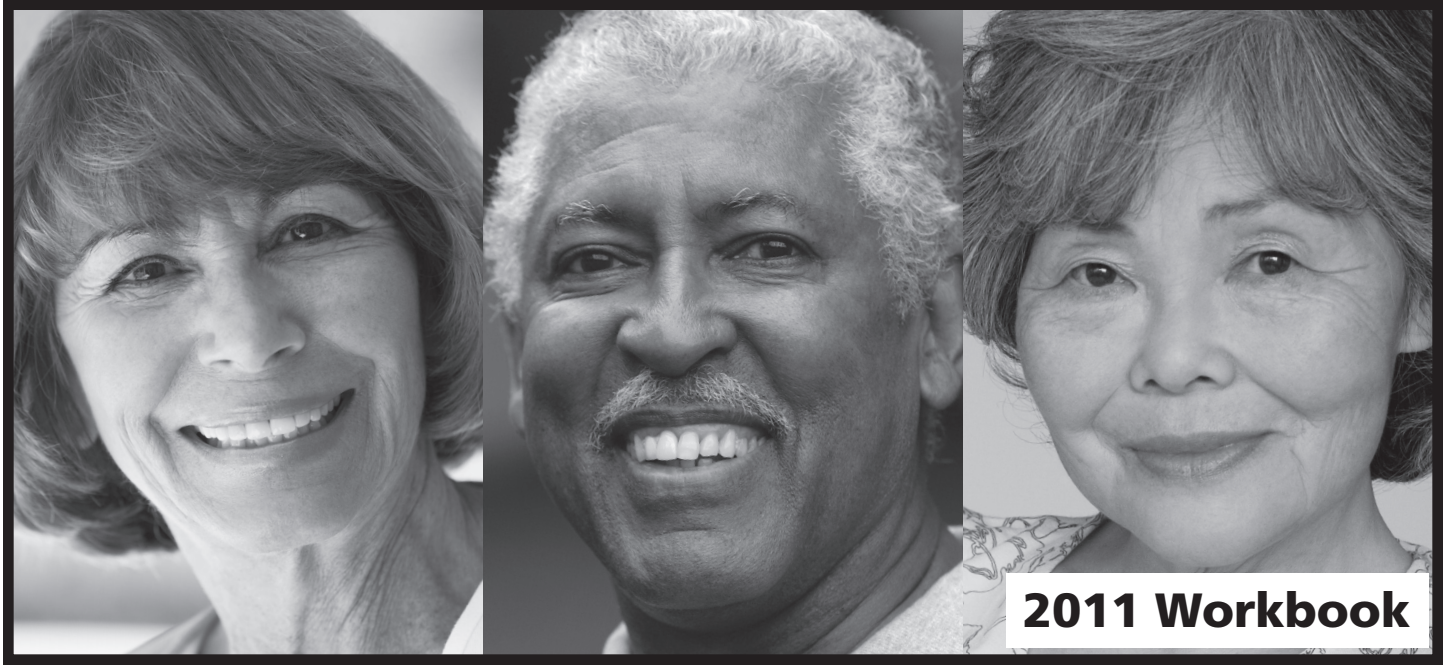
National Medicare

TRAINING PROGRAM

CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare and Medicaid Fraud & Abuse Prevention: Module 10

...helping people with Medicare make informed health care decisions



2011 Workbook

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Centers for Medicare & Medicaid Services
National Train-the-Trainer Workshops
Instructor Information Sheet
Module 10 - Medicare Fraud & Abuse

Module Description

The lessons in this module, *Medicare Fraud & Abuse,* explain Medicare and Medicaid fraud and abuse prevention, detection, reporting and recovery strategies.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers that are familiar with the Medicare program, and would like to have prepared information for their presentations.

The following sections are included in this module:

Slides	Topics
2	Session Objectives
3-16	Fraud & Abuse Overview
17-29	Medicare's Fraud & Abuse Strategies

Slides	Topics
30 – 44	How to Fight Fraud
45-46	Senior Medicare Patrol Q&A
47	Information Sources

Objectives

- **Recognize the scope of fraud and abuse**
- **Understand CMS' plans to fight fraud and abuse**
- **Explain how you can fight fraud**
- **Identify sources of additional information**

Target Audience

This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

Learning Activities

This module contains seven interactive learning questions that give participants the opportunity to apply the module concepts in a real-world setting.

Handouts

Appendix A is a two page Senior Medicare Patrol Question & Answer guide that you may want to refer to during your training. Or, you may wish to make copies of the handouts and distribute them as learning aids.

Time Considerations

The module consists of 48 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers.

References

- www.stopmedicarefraud.gov
- www.healthcare.gov
- National Health Care Anti-Fraud Association - www.nhcaa.gov
- Senior Medicare Patrol Program - www.smpresource.org
- Report Suspected Drug Plan Issues - 1-877-7SAFERX (1-877-772-3379)
- *Medicare Authorization to Disclose Personal Information form (CMS* Product No. 10106)
- *Help Prevent Fraud: Check your Medicare claims early by visiting MyMedicare.gov or by calling 1-800-MEDICARE!*
- (CMS Product No. 11491)
- *Protecting Medicare and You from Fraud (*CMS Product No. 10111)
- *Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information* (CMS Product No. 11147)

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Medicare and Medicaid
Fraud & Abuse Prevention

Module 10 explains Medicare and Medicaid fraud and abuse prevention, detection, reporting and recovery.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2011.

To check for updates on the new health care legislation, visit www.healthcare.gov.

To check for an updated version of this training module, visit www.cms.gov/NationalMedicareTrainingProgram/TL/list.asp .

To learn more about CMS' fraud and abuse plans visit www.stopmedicarefraud.gov.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Session Objectives

This session will help you to

- Recognize the scope of fraud and abuse
- Understand CMS' plans to fight fraud and abuse
- Explain how you can fight fraud
- Identify sources of additional information

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Lessons

1. Fraud and Abuse Overview
   - Medicare
   - Medicaid
2. Fraud and Abuse Initiatives
3. How You Can Fight Fraud

This module is divided into four lessons.

1. Fraud and Abuse Overview
   - Medicare
   - Medicaid
2. Fraud and Abuse Initiatives
3. How You Can Fight Fraud

1. Fraud and Abuse Overview

- What are fraud and abuse?
- Quality of care concerns
- Who commits fraud?
- Spectrum of fraud and abuse
- Medicare overview
  - Trust Funds
- Medicaid overview

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Lesson 1 provides an overview of fraud and abuse.

- What are fraud and abuse?
- Quality of care concerns
- Who commits fraud?
- Spectrum of fraud and abuse
- Medicare overview
  - Trust Funds
- Medicaid overview

Medicare Dictionary

Fraud

When someone intentionally falsifies information or deceives Medicare.

Abuse

When health care providers or suppliers don't follow good medical practices, resulting in unnecessary costs to Medicare, improper payment, or services that aren't medically necessary.

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- Fraud occurs when someone intentionally falsifies information or deceives Medicare.
- Abuse occurs when health care providers or suppliers don't follow good medical practices, resulting in unnecessary costs to Medicare, improper payment, or services that aren't medically necessary.

Quality of Care Concerns

- Quality Concerns are **NOT** fraud
- May include:
  - Medication errors
  - Unnecessary or inappropriate surgery
  - Unnecessary or inappropriate treatment
  - Change in condition not treated
  - Discharged from the hospital too
  - Incomplete discharge instructions and/or arrangements
- Contact Quality Improvement Organizations
  - 1-800-MEDICARE or TTY 1-877-486-2048

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- Patient quality of care concerns are not fraud. They should be handled by the appropriate Quality Improvement Organization.

Examples of quality of care concerns that your QIO can address are:

- Medication errors, like being given the wrong medication, or being given medication at the wrong time, or being given a medication to which you are allergic, or being given medications that interact in a negative way.
- Unnecessary or inappropriate surgery, like being operated on for a condition that could effectively be treated with medications or physical therapy.
- Unnecessary or inappropriate treatment, like being given the wrong treatment or treatment that you did not need, or being given treatment that is not recommended for patients with your specific medical condition
- Change in condition not treated, like not receiving treatment after abnormal test results or when you developed a complication, such as an infection after surgery or a bedsore while in a skilled nursing facility.
- Discharged from the hospital too soon, like being sent home while still having severe pain.
- Incomplete discharge instructions and/or arrangements, like being sent home without instructions for the changes that were made in your daily medications while you were in the hospital, or during an office visit, you receive inadequate instructions about the follow-up care you need

- Medicare Quality Improvement Organizations will help you with these issues.

To get the address and phone number of the QIO for your state or territory, visit www.ahqa.org on the web and click on “QIO Locator.”

Or, you can call 1-800-MEDICARE (1-800- 633-4227) for help contacting your QIO. TTY users should call 1-877-486-2048.

Who commits fraud?

- Most people and organizations are honest
  - There are some "bad actors"
- Fraud and Abuse may be committed by
  - Business owners
  - Health care providers and suppliers
  - People with Medicare
  - People with Medicaid

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- Most individuals and organizations that work with Medicare and Medicaid are honest. But there are some bad actors. CMS is continually taking the steps necessary to identify and prosecute these bad actors.
- Who commits fraud?
  - Business owners
  - Health care providers and suppliers
  - Medicare and Medicaid beneficiaries

Spectrum of Fraud and Abuse

- Results in improper payments
- Targeting causes of improper payments
  - From honest mistakes to intentional deception
- 3–10% of health care funds lost due to fraud

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Spectrum of Fraud and Abuse

- CMS enforcement activities target the causes of improper payments. They are designed to ensure that correct payments are made to legitimate providers and suppliers for appropriate and reasonable services and supplies for eligible beneficiaries.
- The CMS spectrum of improper payments runs from error to waste to abuse to fraud.
- CMS recognizes the differences between honest mistakes and intentional deception, and implements actions appropriately. For example, we educate providers to address billing mistakes, and prosecute those committing outright fraud.
- It is estimated that 3-10% of health care funds are lost due to fraud.

Examples of Fraud

- Medicare/Medicaid is billed for
  - Services you never got
  - Equipment you never got or was returned
- Someone uses your Medicare/Medicaid card
- A company uses false information
  - To mislead you into joining a Medicare plan

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- Examples of possible Medicare fraud are:
  - A healthcare provider bills Medicare for services you never got.
  - A supplier bills Medicare for equipment you never got.
  - Someone uses another person's Medicare card to get medical care or equipment.
  - Someone bills Medicare for home medical equipment after it has been returned.
  - A company offers a Medicare drug plan that hasn't been approved by Medicare.
  - A company uses false information to mislead you into joining a Medicare plan.

When Fraud is Detected

- Improper payments must be paid back
- Providers/companies barred from program
  - Can't bill Medicare, Medicaid or CHIP
- Fines are levied
- Law enforcement gets involved
- Arrests and convictions

- Improper payments must be paid back
- Providers/companies care barred
  - Can't bill Medicare, Medicaid or CHIP
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- Arrests and convictions

If You Share Your Medicaid or Medicare Card or Number

- You could lose your benefits
- Your medical records could be wrong
- You may be limited to certain doctors, drug stores, and hospitals
  - This is called a "lock-in" program
- You may have to pay money back or be fined
- You could be arrested

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- If you share your Medicaid or Medicare card you could have serious problems.
- If you share you Medicaid card you might lose your Medicaid benefits
- The next time you go to the doctor, you will have to explain what happened so you don't get the wrong kind of care
- Lock- in may be used for Medicaid beneficiaries who:
  - Visit hospital emergency departments for non-emergent health concerns
  - utilize two or more hospitals for emergency room services
  - Utilize two or more physicians resulting in duplicated medications and or treatments
  - Exhibit possible drug-seeking behavior by:
  - Request a specific scheduled medication
  - Request early refills of scheduled medications
  - Report frequent losses of scheduled medications (narcotics)
  - Use multiple pharmacies to fill prescriptions
- You can be required to pay a fine or spend time in jail if found guilty of fraud

Medicare Overview

Each Work Day	Monthly	Yearly
▪ 4.4 million claims processed ▪ From 1.5 million providers ▪ Worth $1.1 billion	▪ Almost 19,000 provider enrollment applications received	▪ Over $430 billion in claims paid ▪ Over 48 million beneficiaries

- Each working day Medicare over 4.4 million claims, to 1.5 million providers, worth $1.1 billion.
- Each month, Medicare receives almost 19,000 provider enrollment applications.
- Every year Medicare pays over $430 billion for more than 45 million beneficiaries.
- CMS is required by Federal statute to pay Medicare claims within 30 days.

Protecting the Medicare Trust Funds

- CMS has to balance how to
  - Pay claims on time vs. conduct reviews
  - Prevent/detect fraud vs. limit burden on providers
- CMS must protect the Trust Funds
  1. Medicare Hospital Insurance Trust Fund
  2. Supplementary Medical Insurance Trust Fund

- CMS has to manage the careful balance between:
  - Paying claims on time vs. conducting reviews and
  - Preventing and detecting fraud and limit burden on provider community
- CMS must protect the Trust Funds
  1. Medicare Hospital Insurance Trust Fund
  2. Supplementary Medical Insurance Trust Fund

1. Medicare Hospital Insurance Trust Fund

Pays for	Funded by
Part A (Hospital Insurance) benefits	▪ Payroll taxes ▪ Income taxes paid on Social Security benefits ▪ Interest earned on trust fund investments ▪ Part A premiums from people who aren't eligible for premium-free Part A

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- **Hospital Insurance Trust Fund**

  What it pays for: The Hospital Insurance Trust Fund pays for Medicare Part A benefits, such as inpatient hospital care, skilled nursing facility care, home health care, and hospice care.

  How it's funded: It is funded through payroll taxes paid by most employees, employers, and people who are self-employed. Other funding sources include income taxes paid on Social Security benefits, interest earned on the trust fund investments, and Part A premiums from people who aren't eligible for premium-free Part A.

2. Supplementary Medical Insurance Trust Fund

Pays for	Funded by
Part B (Medical Insurance) and Part D (Medicare Prescription Drug coverage) benefits	▪ Funds authorized by Congress ▪ Part B premiums ▪ Part D premiums ▪ Interest earned on trust fund investments

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- **Supplementary Medical Insurance Trust Fund**

  What it pays for: The Supplementary Medical Insurance Trust Fund pays for Medicare Part B benefits, such as doctor services, outpatient hospital care, home health care not covered under Part A, durable medial equipment, certain preventive services and lab tests, Medicare part D prescription drug benefits, and Medicare program administration, including costs for paying benefits and combating fraud and abuse.

  How it's funded: It is funded by authorization of Congress, premiums from people enrolled in Part B and Part D, and other sources, like interest earned on the trust fund investments.

Medicaid Overview

Yearly	Program Scope	Regions Covered
▪ Over $300 billion in claims paid	▪ Over 54 million beneficiaries ▪ 8.8 million dual eligible (both Medicare and Medicaid)	56 state and territory-administered programs

The Medicaid program is growing.
By 2014, Americans who earn less than 133% of the Federal Poverty Level will be eligible to enroll.

Medicaid Overview

- Each year, Medicaid pays over $300 billion, for more than 54 million beneficiaries.
- There are 56 state and territory-administered programs.
- Medicaid is growing. By 2014, Americans who earn less than 133% of the poverty level (approximately $29,000 for a family of four) will be eligible to enroll in Medicaid.
- 8.8 million (18%) of Medicaid beneficiaries are “dual eligible's” who also qualify for Medicare coverage.

2. Fraud and Abuse Strategies

- Prevention
- Detection
- Recovery
- Reporting

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Lesson 2 provides information on Fraud and Abuse Initiatives. These include

- CMS has implemented a strong plan to tackle Medicare fraud and abuse, including:
  - Preventing fraud before payments are made
  - Detecting improper claims before payment
  - Recovery of improper payments and fraud
  - Increase reporting of improper payments and fraud

Prevention

- Engage beneficiaries and providers
- Educate providers on billing mistakes
- Enhance private and public partnerships
  - Share information and detection methods
- Utilize sophisticated technologies
  - Stops improper payments
    - For medically and clinically unlikely services
  - Quickly identify new fraud schemes

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- CMS is working to shift the focus to the prevention of improper payments and fraud while continuing to be vigilant in detecting and pursuing problems when the occur by Educating providers on common billing mistakes.
  - Engaging beneficiaries and health care providers to join in the fight against fraud.
  - Enhancing partnerships with the private sector to share information and methods to detect and prevent fraud.
- CMS utilizes a number of sophisticated technologies to stop improper payments for medically and clinically unlikely services and to quickly identify new fraud schemes.
- During 2009 CMS prevented more than $450 million in improper payments through the use of these analytic strategies.
- The Deficit Reduction Act (DRA) created the Medicaid Integrity Program (MIG) within CMS. Under the MIG, CMS is responsible for hiring contractors to educate providers, managed care entities, beneficiaries, and other with respect to payment integrity.

Prevention

- Nine Anti-fraud Strike Force Teams
  - In fraud hot spots around the country
  - Hundreds of convictions
  - Criminals had billed Medicare $100s of millions
- Senior Medicare Patrol
  - Senior volunteers
  - Educate people with Medicare to recognize fraud

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- The number of anti-fraud Strike Force Teams operating in fraud hot spots around the country has increased from two to nine, bringing hundreds of convictions against criminals who had billed Medicare for hundreds of millions of dollars.
- The Strike Force Teams are located in:
  - Miami, FL - Houston, TX
  - Los Angeles, CA -Detroit, MI
  - Brooklyn, NY -Dallas, TX
  - Baton Rouge, LA -Chicago, IL
  - Tampa, FL
- And we've empowered the group that's more passionate about keeping criminals out of Medicare than any other: seniors themselves. Last year, volunteers in our Senior Medicare Patrol reached people with critical information about how to protect themselves from fraud. The more seniors know how to recognize and report these crimes, the more reluctant criminals will be to try them.

See Section 6401 of the Affordable Care Act.

Prevention

- New authorities from the Affordable Care Act
  - Tougher screenings for health care providers
  - Keep fraudulent providers out of programs
    - Medicare, Medicaid and CHIP
  - More thorough screening for types identified as higher risk
- Coordinate with states to share fraud information
- Increase penalties for fraud

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- New steps we'll be taking as part of the Affordable Care Act to keep criminals on the defensive.
  - Under the new rules we'll have tougher screenings for health care providers who want to participate in Medicaid or Medicare to keep fraudulent providers out of those programs.
  - The different types of providers and suppliers have been determined to have varying levels of risk:

Type	Risk Level
Physicians	Limited Risk
Hospitals	Limited Risk
Community Mental Health centers	Moderate Risk
Physical Therapists	Moderate Risk
Outpatient Rehabilitation Facilities	Moderate Risk
Currently Enrolled DME & Home Health Agencies	Moderate Risk

Note: Moderate Risk groups will receive site visits to verify thy are in operation and complying with program standards

Newly enrolling home health and DME will undergo an extra level of scrutiny – owners with a 5% or more ownership stake will go through a criminal background check.

See Section 6408 of the Affordable Care Act.

Prevention

- Identify trends that indicate fraud
  - Help law enforcement identify suspicious patterns
- Authority to suspend payments
  - When credible allegation is being investigated
- $350 million for fraud fighting resources
- Face-to-face visits for home health and hospice
- Pilot programs to identify and prevent fraud

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- Additional steps to fight fraud and abuse include the following.
  - We're going to make it easier for law enforcement to see health care claims information from different government agencies in one place so they can identify suspicious patterns.
  - Withhold Medicare and Medicaid payments while an investigation is pending.
- Provide $350 million in new resources to get more boots on the ground fighting fraud in communities across the country.
- Require new face-to-face visits for covered home health and hospice care.
- CMS is also conducting multiple pilots that will explore new technology to identify and prevent fraud, such as credit-card like technology and the use of heat mapping tools

See Section 6401 of the Affordable Care Act.

Detection

- Streamline processes
  - Reporting, analyzing and investigating fraud
- Access and training on CMS data systems
  - Identify and develop potential fraud cases
- Leverage and share best practices
- Expand oversight controls
  - Pre-payment review for high-risk items/services
- Provide compliance training

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- CMS is working to increase the detection of improper payments and fraud. Methods will include:
  - Streamlining processes for reporting, analyzing, and investigating fraud complaints
  - Providing provider access and training on CMS data systems to increase the identification and development of potential fraud cases
  - Leveraging and sharing best-in-class knowledge, practices, and technology available in the public and private sectors, including new analytic and predictive modeling tools
  - Expanding oversight controls including claims pre-payment review for high-risk items and services
  - The Office of the Inspector General was allocated $1.5 million for compliance training and data mining activities. HHS/OIG is planning a series of compliance training programs that will provide free or low cost, high quality compliance training for providers, compliance professionals, and attorneys. The training will focus on methods to identify fraud risk areas and compliance best practices so that providers can strengthen their own compliance efforts and more effectively identify and avoid illegal schemes.
    - $1.25 million of this funding will support HHS/OIG's enhancement of data analysis and mining capabilities for detecting health care fraud. These extended capabilities will allow law enforcement officials to use sophisticated software to analyze near-time data, allowing them to identify providers that appear to have submitted improper claims, groups that have assumed multiple identities to circumvent fraud detection, and other systemic vulnerabilities, leading to the identification of potential fraud with unprecedented speed and efficiency.

Recovery

- Identify potential fraud cases
- Work to suspend payments
  - Providers subject to credible fraud allegations
  - Healthcare Fraud Prevention & Enforcement Action Team (HEAT) Task Forces
    - Expand to other cities
- Over $2.5 billion in fraud recoveries
  - Identified in 2010

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- CMS is working collaboratively with Federal and law enforcement partners to increase the recovery of improper payments and fraud by working toward suspending payments for providers subject to credible allegations of fraud.
- Partnering in expansion of the Healthcare Fraud Prevention & Enforcement Action Team (HEAT) task forces to additional cities throughout the country.
  HEAT task forces are inter-agency teams composed of top-level law enforcement and professional staff. The team builds on existing partnerships, including those with state and local law enforcement organizations to prevent fraud and enforce anti-fraud laws.
- More than $2.5 billion stolen from federal health care programs was identified for return to the Medicare Health Insurance Trust Fund, the Treasury, and others in FY 2010. This is an unprecedented achievement for the Health Care Fraud and Abuse Control Program (HCFAC), a joint effort of the two departments to coordinate Federal, state, and local law enforcement activities to fight health care fraud and abuse.

Recovery Audit Contractor Programs

- Establish Medicare Part C and D programs
  - Ensure Medicare Advantage organizations have anti-fraud plans
  - Retroactive Part D claims review
    - Review estimates from drug plans for high cost beneficiaries
  - Collect overpayments
- States and territories establish Medicaid RACs
  - Identify overpayments and underpayments
  - Coordinate efforts with Federal and state auditors

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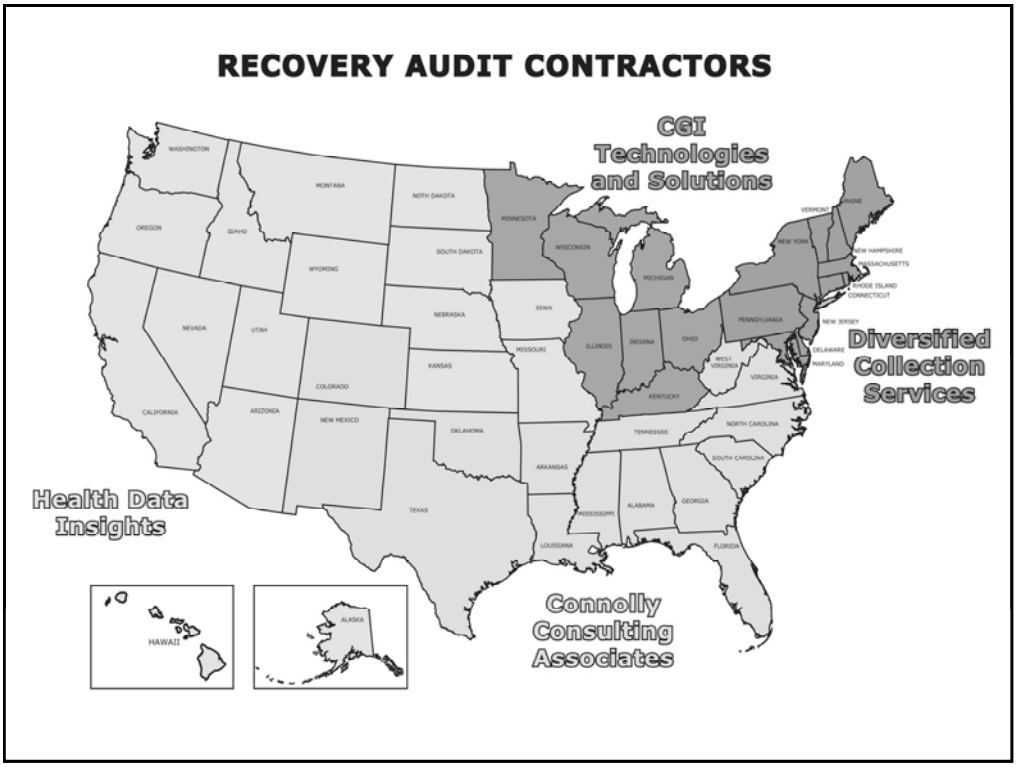
- CMS has established Medicare parts C/D Recovery Audit Contractor (RAC) programs in accordance with the requirements specified in the Affordable Care Act.
  - Medicare parts C/D RACs must ensure that each MA and drug plan has an anti-fraud plan in effect, and to review the effectiveness of each plan.
  - Part D RACs will retroactively examine claims for reinsurance to determine if drug plan sponsors submitted claims exceeding allowable costs.
  - Part D RACs will review estimates submitted by drug plans for high cost beneficiaries and compare to numbers of beneficiaries actually enrolled in such plans.
  - RACs collect overpayments.
  - RACs are paid on a contingency fee basis
- States and territories must establish Medicaid RAC programs (ACA § 6411(a)) CMS-6034-***Proposed***
  - Medicaid RACs must identify and recover overpayments and identify underpayments.
  - States must pay Medicaid RACs on a contingency fee basis for identification and recovery of overpayments and will determine the fee paid to Medicaid RACs to identify underpayments.
  - Medicaid RACs must coordinate their efforts with other auditing entities, including State and Federal law enforcement agencies. CMS and States will work to minimize the likelihood of overlapping audits.



Expanded Overpayment Recovery Efforts via Recovery Audit Contractors

- There are four RACs
  - Diversified Collection Services
  - CGI Technologies and Solutions
  - Connolly Consulting Associates
  - HealthDataInsights

Reporting

- Share information and performance metrics
  - On key program integrity activities
- Enhance private sector partnerships
  - Share how to detect and prevent fraud
- Coordinate law enforcement initiatives
- Regional Fraud Summits
  - Share concerns and collaborate on strategies

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- CMS is working to increase the reporting of improper payments and fraud through the following.
  - Sharing information and performance metrics on key program integrity activities broadly to engage key stakeholders.
  - Enhancing partnerships with the private sector to share information and methods to detect and prevent fraud.
  - Continuing to coordinate with law enforcement on initiatives that will strengthen relationships with key stakeholders such as the Regional Fraud Summits.
  - Regional Fraud Summits are coordinated among the Office of the Inspector General, the Department of Justice, the Secretary of HHS, and CMS. These summits provide an opportunity for beneficiaries, providers, hospitals and law enforcement to discuss shared concerns and collaboration strategies.

Zone Program Integrity Contractors

- Zone Program Integrity Contractors (ZPICs)
  - Analyze claims data
  - Identify billing and utilization trends that suggest fraud
  - Work closely with law enforcement agencies
- CMS is transitioning from Program Safeguard Contractors to ZPICs
- ZPIC regions align with Medicare Administrative Contractor regions

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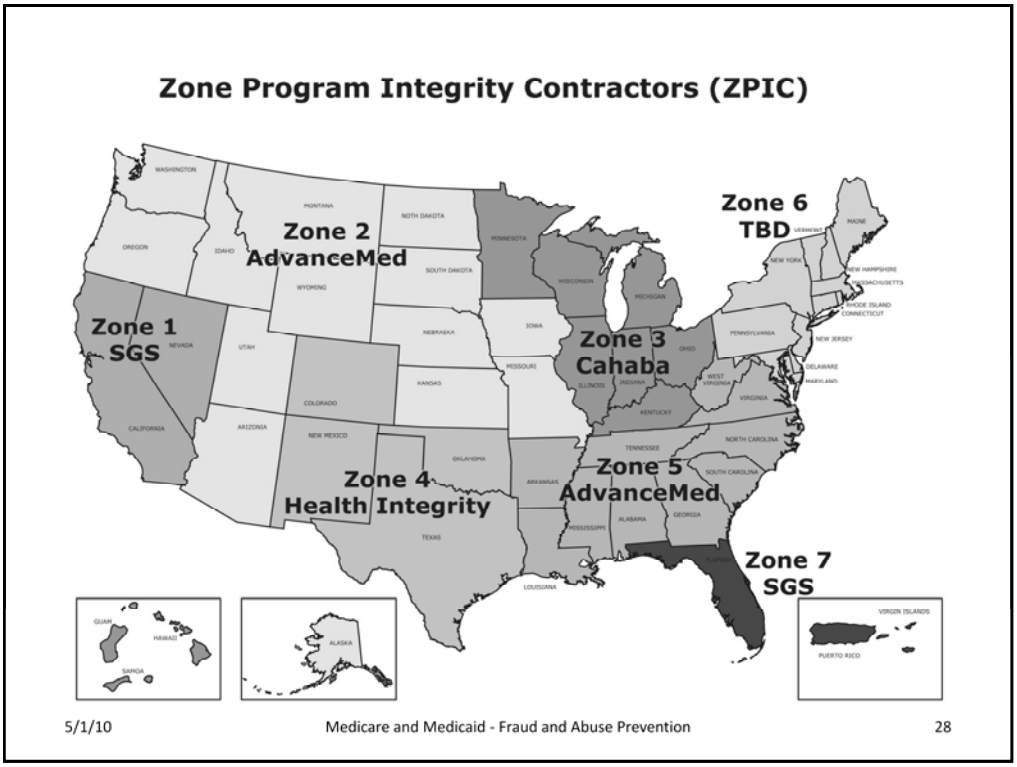
- The primary goal of the Zone Program Integrity Contractors (ZPICs) is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped. They work to identify fraudulent activities before payment is made.
- CMS has been transitioning from Program Safeguard Contractors to Zone Program Integrity Contractors over the last several years, and is nearing full transition. Only one area remains to be awarded.
- The seven ZPIC regions align with the Medicare Administrative Contractor (MAC) regions. MACs manage the provider and beneficiary enrollment, and process claims.



- There are seven Zone Program Integrity Contractors.
- Zone 1 is covered by SGS and includes California, Hawaii, and Nevada.
- Zone 2 is covered by AdvanceMed and includes Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.
- Zone 3 is covered by Cahaba and includes Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.
- Zone 4 is covered by Health Integrity and includes Colorado, Oklahoma, New Mexico and Texas.
- Zone 5 is covered by AdvanceMed and includes Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.
- Zone 6 is covered by TBD and covers Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.
- Zone 7 is covered by SGS and includes Florida and Puerto Rico.

Exercise

1. **Which of the following statements is *not* true about Medicare Recovery Audit Contractors (RACs)?**

   A. RACs coordinate with Federal and state auditors
   B. RACs identify improper Medicare payments
   C. RACs identify overpayments only
   D. RACs are paid on a contingency fee basis

3. How You Can Fight Fraud

- Medicare Summary Notices
- www.MyMedicare.gov
- 1-800-MEDICARE
- Senior Medicare Patrol
- www.stopmedicarefraud.gov
- 1-877-SAFERX
- Tips

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In this lesson we will learn about how people with Medicare can fight fraud. We will

- Review your Medicare Summary Notices
- Highlight the advantages of using www.MyMedicare.gov
- Learn how to report fraud and abuse by using 1-800-MEDICARE
- Review the Senior Medicare Patrol program
- Learn about the resources available at www.stopmedicarefraud.gov
- Learn about other ways to fight fraud
- Learn tips people with Medicare can use to protect themselves
- Fraud and abuse terms

Medicare Summary Notice (MSN)

- Part A and Part B MSNs
- Shows all your services or supplies
  - Billed to Medicare in 3-month period
  - What Medicare paid
  - What you owe
- Read it carefully
  - Keep your receipts and bills
  - Keep note of appointments/ services dates
  - Compare them to your MSN

Medicare Summary Notice

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- There is a Part A and a Part B Medicare Summary Notice (MSN).
  - MA plans provide an Explanation of Benefits that provides similar information.
- The MSN shows all services and supplies that were billed to Medicare, what Medicare paid, and what the beneficiary owes each provider.
- You should review your MSN carefully, to ensure that you received the services and supplies that Medicare was billed for.
- CMS is currently redesigning the Medicare Summary Notices to make them simpler to understand and spot fraud. The new MSN will be ready in early 2012. It will be easier to understand and read. It will provide additional information, like a quarterly summary of claims.
- If there is a discrepancy, you should call your doctor or supplier.

Visit http://www.medicare.gov/navigation/medicare-basics/understanding-claims/read-your-msn-part-a.aspxto see 'how to read MSN' samples.

Call 1-800-MEDICARE if you suspect fraud.

MyMedicare.gov

- Secure site to manage personal information
  - Review eligibility, entitlement and plan information
  - Track your preventive services
  - Keep a prescription drug list
- Review claims
  - Don't have to wait for MSN

Click the "Blue Button" to download your data to a text file

- Medicare's free, secure online service for accessing personalized information regarding Medicare benefits and services.
- www.MyMedicare.gov provides you with access to your personalized information at any time.
- View eligibility, entitlement and preventive service information.
- Check personal Medicare information, including Medicare claims as soon as they are processed.
- Check your health prescription drug enrollment information your Part B deductible information.
- Manage your prescription drug list personal health information.
- Review claims – identify fraudulent claims. You don't have to wait for your Medicare Summary Notice (MSN) to view your Medicare claims. Visit www.MyMedicare.gov to track your Medicare claims or view electronic MSNs. Your claims will generally be available within 24 hours after processing.
- In order to use this service you must register on the site.

1-800-MEDICARE

- Making identifying and reporting fraud easier
- 1-800-Medicare beneficiary complaints used to
  - Target those with multiple complaints for review
  - Create 'heat maps' of fraud complaints
    - Show new fraud scams are heating up in new area
- Review claims for past 18 months
  - Interactive Voice Response on 1-800-MEDICARE
  - TTY users call 1-877-486-0428

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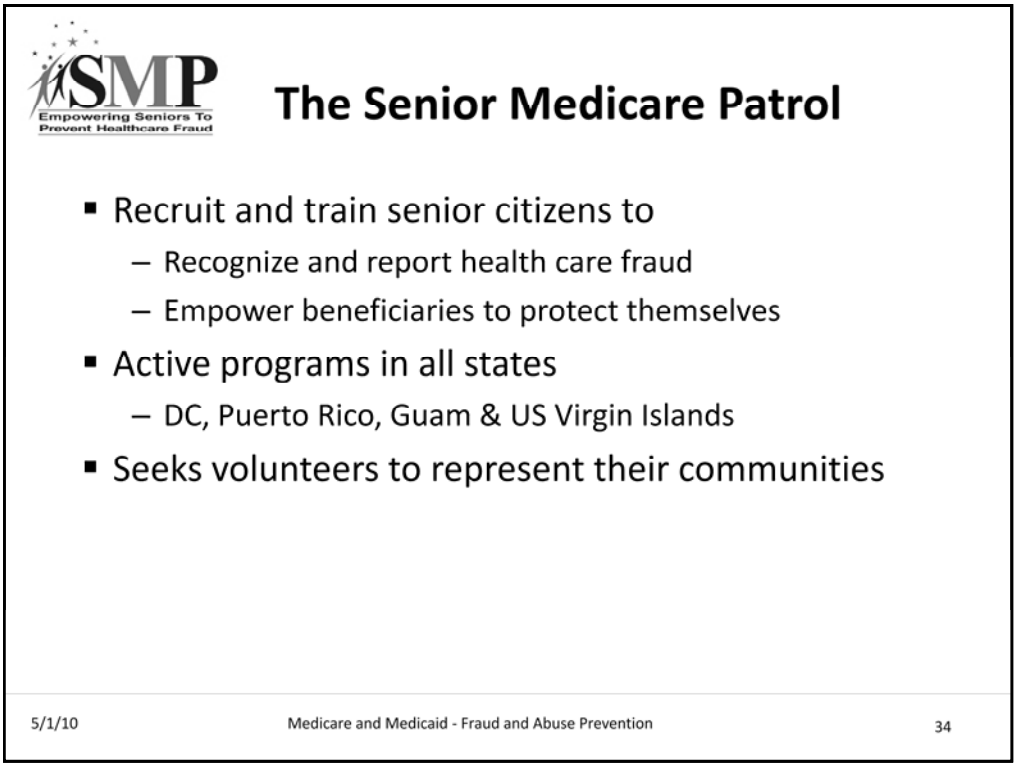
- CMS has implemented an interactive voice response system for beneficiaries to identify and report fraud.
  - Interactive Voice Response on 1-800-Medicare allows beneficiaries that have not registered on or do not use www.MyMedicare.gov to listen to the most recent five claims processed on their behalf for any month in the last year.
    CMS is now using 1-800-Medicare beneficiary complaints to:
    - Target providers or suppliers with multiple beneficiary complaints for further review
    - Create 'heat maps' of fraud complaints that will show when fraud scams are heating up in new areas.



- Senior Medicare Patrols (SMPs) recruit and train retired professionals and other senior citizens about how to recognize and report instances or patterns of health care fraud.
- They empower Medicare beneficiaries to protect themselves against fraud.
- SMPs partner with community, faith-based, tribal, and health care organizations to educate and empower their peers to identify, prevent and report health care fraud.
- SMP's teach you
  - How to protect your identity
  - How to detect errors
  - How to report fraud
- SMPs are educated about how threats to financial independence and health status may occur when citizens are victimized by fraudulent schemes.
- There are SMP programs in all states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. The SMP seeks new volunteers to represent the SMP in their communities
- The SMP program empowers seniors through increased awareness and understanding of healthcare programs. This knowledge helps seniors to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error and abuse.
- SMP projects also work to resolve beneficiary complaints of potential fraud in partnership with state and national fraud control/consumer protection entities, including Medicare contractors, state Medicaid fraud control units, state attorneys general, the OIG and CMS.

The Senior Medicare Patrol

- CMS dedicated $9 million in funding for grants
  - Doubles existing funding for the program
  - Targets additional funding to fraud 'hot spots'
- SMP successes since 1997
  - Trained/counseled almost 2M beneficiaries
  - Led to the recovery of $5M in Medicare funds
  - Led to the recovery of $101M in other funds
- Additional information in Appendix A

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- Since 1997 AoA has funded SMP projects to recruit and train retired professionals and other senior citizens about how to recognize and report instances or patterns of health care fraud. CMS has dedicated $9 million in funding for grants to expand state-based Senior Medicare Patrol programs.
- The grants will:
  - Double existing funding for the program
  - Target additional funding to current 'hot spots' for fraud
- Since 1997, the Senior Medicare Patrol has:
  - Has provided group training sessions to 75,000; and individual counseling to over 1 million beneficiaries
  - Have led to the recovery of $5 million dollars of Medicare funds
  - Have led to the recovery of $101 million dollars of Medicaid, beneficiary, and other payers funds

NOTE: For more information on the Senior Medicare Patrol see Appendix A.

For an in-depth overview of the Senior Medicare Patrol program, and for information for your local area, please visit www.aoa.gov/AoAroot/AoA_Programs/Elder_Rights/SMP/index.aspx

stopmedicarefraud.gov

- Learn about fraud
- Find resources
- See recent HEAT Task Force results by state

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www.stopmedicarefraud.gov is a good place for visitors to learn about:

- Medicare fraud
- Resources available for beneficiaries and providers
- Ways you can prevent fraud
- Recent Health Care Fraud Prevention and Enforcement Action Team (HEAT) operations and results listed by state

Protecting Personal Information

- Keep your personal information safe
  - Like your Medicare, Social Security, Credit Card #s
  - Only share with people you trust like
    - Doctors
    - Health care providers
    - Plans approved by Medicare
    - Your insurance company (Medigap or Employer/Union)
    - Your State Health Insurance Assistance Program (SHIP)
    - Social Security, Medicaid and Medicare

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- Sometimes beneficiaries need to share their medical information with family members or caregivers.
- By law, Medicare must have written permission to use or give our beneficiary medical information.
- The beneficiary needs to designate the family member/caregiver as an authorized person to whom Medicare can disclose their personal information. Once Medicare has this authorization on file, the family member/caregiver will be able to discuss the beneficiaries Medicare issues directly with Medicare.

Family members/caregivers can contact Medicare at 1-800-MEDICARE to request a Medicare Authorization to Disclose Personal Information form 10106.

Or they can visit www.medicare.gov/MedicareOnlineForms/AuthorizationForm/online to complete the process online.

Identity Theft

- Identity theft is a serious crime
  - e.g.; someone else uses your personal information
    - Like your Social Security or Medicare number
- If you think someone is using your information
  - Call your local police department
  - Call the Federal Trade Commission's ID Theft Hotline
    - 1-877-438-4338
- Report lost/stolen Medicare card right away
  - Call SSA for replacement

- Identity theft is a serious crime
  - Someone else uses your personal information
  - Like your Social Security or Medicare number
- If you think someone is using your information

Call your local police department. Call the Federal Trade Commission's ID Theft Hotline – 1-877-438-4338. TTY users should call 1-866-653-4261.

For more information about identity theft or to file a complaint online, visit www.ftc.gov/idtheft .

You can also visit www.stopmedicarefraud.gov/fightback_brochure_rev.pdf to view the brochure, "Medical Identity Theft & Medicare Fraud."

Sharing Medical Information with Family/Caregiver

- Medicare requires written permission
  - Must designate an authorized person
    - Power of attorney is not enough
    - Must submit Medicare Authorization to Disclose Personal Information form (CMS Form No. 10106)

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- Sometimes beneficiaries need to share their medical information with family members or caregivers.
- By law, Medicare must have written permission to use or give out your information. If you want to share your information, you need to designate the family member/caregiver as an authorized person to whom Medicare can disclose their personal information. Once Medicare has this authorization on file, the family member/caregiver will be able to discuss your Medicare issues directly with Medicare.

However, you or your family member/caregiver can contact Medicare at 1-800-MEDICARE to request a Medicare Authorization to Disclose Personal Information form 10106. Mailing instructions are included in the form.

Or visit www.medicare.gov/MedicareOnlineForms/AuthorizationForm/online to complete the process online.

Tips

- Ask questions
  - You have the right to know what is billed
- Educate yourself about Medicare/Medicaid
  - Know you rights
  - Know what a provider can/can't bill to Medicare
- Be wary of providers who tell you
  - You can get an item or service not usually covered, but they know "How to bill Medicare"

- Ask questions
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  - But they know "How to bill Medicare"

Medicare Plans Marketing Rules

- Examples
  - Plans can't send you unwanted emails
  - Come to your home uninvited to get you to join
  - Call you unless you are already a member
  - Offer you cash to join their plan
  - Give you free meals while trying to sell you a plan
- If you think a Medicare plan broke the rules
  - Call 1-800-MEDICARE or the Medicare Drug Integrity Contractor at **1-877-SAFERX**

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- Below is are some examples of activities Medicare plans and people who represent them are not allowed to do.
  - Send you unwanted emails or come to your home uninvited to sell a Medicare plan.
  - Call you unless you are already a member of the plan. If you are a member, the agent who helped you join can call you.
  - Offer you cash to join their plan or give you free meals while trying to sell a plan to you.
  - Talk to you about their plan in areas where you get health care like an exam room, hospital patient room, or at a pharmacy counter.
  - Call 1-800-MEDICARE to report any plans that ask for your personal information over the telephone or that call to enroll you in a plan. You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). The MEDIC fights fraud, waste, and abuse in Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) Programs.

For more information on protecting yourself from identity theft view *Quick Facts About Medicare Prescription Drug Coverage and How to Protect Your Personal Information,* CMS Product. No. 11147 at http://www.medicare.gov/Publications/Pubs/pdf/11147.pdf .

Telemarketing Fraud

- Durable Medical Equipment Telemarketing Rules
  - DME suppliers cannot make unsolicited sales calls
- Potential scams
  - Calls or visits from people saying they represent Medicare
  - Telephone or door-to-door selling techniques
  - Equipment or service is offered free and you are then asked for your Medicare number for "record keeping purposes"
  - You're told that Medicare will pay for the item or service if you provide your Medicare number

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- There are Durable Medical Equipment (DME) rules for telemarketing.
- DME suppliers (people who sell equipment such as diabetic supplies and power wheelchairs) are prohibited by law from making unsolicited telephone calls to sell their products
- Potential scams
  - Calls or visits from people saying they represent Medicare
  - Telephone or door-to-door selling techniques
  - Equipment or service is offered free and you are then asked for your Medicare number for "record keeping purposes"
  - You're told that Medicare will pay for the item or service if you provide your Medicare number

Fighting Fraud Can Pay

- You may get a reward of up to $1,000 if
  - You report suspected Medicare fraud and
    - The reported fraud creates a new investigation
    - CMS and law enforcement confirms fraud has occurred
    - Action is taken to recover lost monies
    - At lease $100 of Medicare money is recovered due to CMS/law enforcement action
    - You are not an 'excluded' individual
- Call 1-800-MEDICARE for information

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- You may get a reward of up to $1,000 if you meet **all** these conditions.
  - You report suspected Medicare fraud.
  - The suspected Medicare fraud you report must be proven as potential fraud by the program Safeguard Contractor or the Zone Program Integrity Contractor (the Medicare contractors responsible for investigating potential fraud and abuse) and formally referred as part of a case by one of the contractors to the Office of Inspector General for further investigation.
  - You aren't an "excluded individual." For example, you didn't participate in the fraud offense being reported. Or, there isn't another reward that you qualify for under another government program.
  - The person or organization you're reporting isn't already under investigation by law enforcement.
  - Your report leads directly to the recovery of at least $100 of Medicare money.
- For more information, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048.

Exercise

2. The Medicare Summary Notice shows which of the following?

A. The health care services provided
B. The costs of services and supplies
C. The amount Medicare paid the provider
D. All of the above

Medicare Fraud & Abuse Resource Guide

Resources

Centers for Medicare & Medicaid Services (CMS)
1-800-MEDICARE
(1-800-633-4227)
(TTY 1-877-486-2048)
www.Medicare.gov

www.stopmedicarefraud.gov

www.healthcare.gov

National Health Care Anti-Fraud Assoc.
www.nhcaa.gov

MyMedicare.gov

How to read an MSN Webpage link
http://www.medicare.gov/navigation/medicare-basics/understanding-claims/read-your-msn-part-a.aspx

Senior Medicare Patrol Program
www.smpresource.org
Find the SMP resources in your state:
www.smpresource.org/AM/Template.cfm?Section=SMP_Locator1&Template=/custom/SmpResults.cfm

Office of the Inspector General
U.S. Department of Health & Human Services
ATTN: HOTLINE
PO Box 23489
Washington, DC 10026
Fraud Hotline
1-800-HHS-TIPS (1-800-447-8477)
TTY – 1-800-337-4950
Fax 1-800-223-8162

Report Suspected Drug Plan Issues
1-877-7SAFERX (1-877-772-3379)

Social Security Administration
www.ssa.gov
1-800-772-1213
TTY – 1-800-325-0778

Medicare Products

Medicare Authorization to Disclose Personal Information form
CMS Product No. 10106

Help Prevent Fraud: Check your Medicare claims early by visiting MyMedicare.gov or by calling 1-800-MEDICARE!
CMS Product No. 11491

Protecting Medicare and You from Fraud CMS Product No. 10111

Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information
CMS Product No. 11147

To access these products:
View and order single copies:
Medicare.gov

Order multiple copies (partners only):
productordering.cms.hhs.gov
(You must register your organization.)

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SMP Program Q and A

Who are the SMPs?

Senior Medicare Patrol programs, or SMPs, help Medicare and Medicaid beneficiaries prevent, detect and report health care fraud. They not only protect older persons, they also help preserve the integrity of the Medicare and Medicaid programs. Because this work often requires face-to-face contact to be most effective, SMPs nationwide recruit and train nearly 4,500 volunteers every year to help in this effort. Most SMP volunteers are both retired and Medicare beneficiaries and thus well-positioned to assist their peers.

SMP staff and their highly trained volunteers conduct outreach to Medicare beneficiaries in their communities through group presentations, exhibiting at community events, answering calls to the SMP help lines and one-on-one counseling. Their primary goal is to teach Medicare beneficiaries how to protect their personal identity, identify and report errors on their health care bills and identify deceptive health care practices, such as illegal marketing, providing unnecessary or inappropriate services and charging for services that were never provided.

In some cases, SMPs do more than educate: When Medicare and Medicaid beneficiaries are unable to act on their own behalf to address these problems, the SMPs work to address the problems, making referrals to CMS contractors, state attorney general's offices, local law enforcement, State Health Insurance Assistance Programs, state insurance divisions and other outside organizations that are able to intervene.

What is the background of the program?

In 1995, the Administration on Aging (AoA) became a partner in a government-led effort to fight fraud, error and abuse in the Medicare and Medicaid programs through the implementation of a ground-breaking demonstration project called Operation Restore Trust (ORT). ORT's purpose was to coordinate and target federal, state, local and private resources on those areas most plagued by abuse. Operation Restore Trust was announced at the 1995 White House Conference on Aging.

During its demonstration phase, ORT returned $23 for every $1 spent looking at the fastest-growing areas of Medicare fraud, including home health care, skilled nursing facilities and providers of durable medical equipment. This comprehensive anti-fraud initiative began in five states: California, Florida, Illinois, New York and Texas. It created a partnership in the Department of Health and Human Services between the Centers for Medicare & Medicaid Services, the Office of Inspector General and the Administration on Aging, which continue to work as a team in a coordinated anti-health care fraud effort at the local, state and national levels.

AoA became a key player in the fight against fraud through the enactment of P.L. 104-209, the Omnibus Consolidated Appropriations Act of 1997. Language in this legislation, offered by Senator Tom Harkin (D-IA), was adopted, directing the AoA to establish demonstration projects that utilize the skills and expertise of retired professionals in identifying and reporting error, fraud and abuse.

continued

www.smpresource.org

Based on the success of the demonstration projects, the SMP program has grown to 54 projects, including every state and the District of Columbia, Puerto Rico, Guam and the Virgin Islands. Under Title IV of the Older Americans Act, approximately $10 million in grants was provided during FY 2009.

Tell me about SMP volunteers.

The SMP program provides an opportunity for seniors to step up and make an impact in the fight against fraud. The dedicated corps of SMP volunteers makes a difference. In 2009, the SMP projects had a total of 4,444 active volunteers.

SMP projects recruit and train retired professionals and other senior citizens. These volunteers work in their communities, senior centers and elsewhere to educate Medicare and Medicaid beneficiaries, family members and caregivers to actively protect themselves against fraudulent, wasteful and abusive health care practices.

Since 1997 more than 23.8 million people have been reached during community education events, more than 2.8 million beneficiaries educated and more than 19,400 volunteers have been active. Total savings to Medicare, Medicaid, beneficiaries and other payers attributed to the SMP projects is $106 million. (Source: May 2010 OIG Performance Report)

How can people volunteer?

Protecting older persons from criminals and saving precious health care dollars at the same time is a mission that attracts many civic-minded Americans. People wishing to volunteer for this cause can find their state SMP contact person on the homepage of **www.smpresource.org.** The SMP will match volunteers with a task that fits their time and interest. Volunteers can work with individual beneficiaries to review Medicare Summary Notices for accuracy, make presentations to groups about how to avoid getting taken by scam artists, help at an SMP exhibit at community health fairs and more.

What are examples of fraud and waste seen by SMPs?

- Equipment or insurance plan providers tricking senior center participants into giving up their personal information (including Medicare numbers) on “sign-in” sheets
- Medicare Summary Notices showing billing for services or supplies that were never provided
- Equipment suppliers providing expensive “scooter” wheelchairs not ordered by a physician or needed by the beneficiary
- Luring beneficiaries into providing their Medicare number for “free” services, then billing Medicare
- Kickbacks—paying beneficiaries to receive service from a particular provider or company

Where can I learn more?

Go to **www.smpresource.org** for detailed information about fraud and abuse as well as the SMP program.

Fraud and Abuse Terms	
Abuse/Neglect	Abusing, neglecting, or exploiting Medicare/Medicaid patients, including committing physical and mental abuse, withholding medically necessary services, or neglecting to provide appropriate care
Drug Diversion	The illegal distribution, abuse or unintended use of prescription drugs
Excluded Individuals	Claiming reimbursement for services that were furnished, ordered, or prescribed by individuals or entities excluded from participating in Federal healthcare programs
Kickbacks	Soliciting or receiving remuneration (in kind or in cash) in return for referring individuals, goods, or services for which payment may be made under Federal healthcare programs
Provider Identity Theft	Billing for items or services using another Medicaid provider's number without permission
Services or Supplies Not Rendered	Billing for services or supplies not provided to a beneficiary and not appropriately documented
Upcoding	Billing for services at a level of complexity that is higher than the service actually provided or documented

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E-mail: NMTP@cms.hhs.gov
Website: cms.gov/NationalMedicareTrainingProgram

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