

2013 National Training Program

Module: 10

Medicare and Medicaid Fraud Prevention



Module 10: MEDICARE & MEDICAID FRAUD PREVENTION

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This module can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

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National Training Program



Module 10 Medicare and Medicaid Fraud and Abuse Prevention

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

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Health Insurance Marketplace (also known as Exchanges).

The information in this module was correct as of May 2013.

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

To view the Affordable Care Act, visit <http://www.HealthCare.gov/law/index.html>.

To check for an updated version of this training module, visit [http://cms.gov/Outreach-and-Education/Training/CMSNational Training Program/index.html](http://cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html).

This set of CMS National Training Program materials isn’t a legal document. Official Medicare Program legal guidance are contained in the relevant statutes, regulations, and rulings.



Session Objectives

This session will help you to

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

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This session will help you to

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



Lesson 1 - Fraud and Abuse Overview

- Definition of fraud and abuse
- Protecting the Medicare Trust Funds
- Medicare and Medicaid program overviews
- Who can commit fraud?
- Spectrum of fraud and abuse
- Quality of care concerns

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Lesson 1 provides an overview of fraud and abuse:

- Definition of fraud and abuse
- Protecting the Medicare Trust Funds
- Medicare and Medicaid program overviews
- Who can commit fraud?
- Spectrum of fraud and abuse
- Quality of care concerns

Definition of Fraud and Abuse

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, improper payment, or services that aren't medically necessary

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Medicare and Medicaid fraud, waste, and abuse affects every American by draining critical resources from our health care system, and contributes to the rising cost of health care for all. Taxpayer dollars lost to fraud, waste, and abuse harm multiple parties, particularly some of our most vulnerable citizens.

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.

Inappropriate practices that begin as abuse can all too quickly evolve into fraud.

NOTE: The difference between fraud and abuse is intention.

Protecting the Medicare Trust Funds

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

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CMS must protect the Medicare Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund.

- The Medicare Hospital Insurance Trust Fund pays for Part A (Hospital Insurance) benefits such as inpatient hospital care, skilled nursing facility care, home health care, and hospice care. It is funded by payroll taxes, income taxes paid on Social Security benefits, interest earned on trust fund investments and Part A premiums from people who aren't eligible for premium-free Part A.
- The Supplementary Medical Insurance Trust Fund pays for Part B benefits including doctor services, outpatient hospital care, home health care not covered under Part A, durable medical equipment, certain preventive services and lab tests, Medicare Part D prescription drug benefits, and Medicare program administrative costs, including costs for paying benefits and combating fraud and abuse. It's funding is authorized by Congress from Part B premiums, Part D premiums, and interest earned on trust fund investments.

CMS has to manage the careful balance between paying claims on time vs. conducting reviews, preventing and detecting fraud, and limiting the burden on provider community.

Medicare Overview

Each Work Day	Monthly	Yearly
<ul style="list-style-type: none"> ▪ 4.6M claims processed <ul style="list-style-type: none"> • 200,000 of those are for durable medical equipment (DME) ▪ From 1.5M fee-for-service providers 	<ul style="list-style-type: none"> ▪ 39,000 Part A and Part B provider initial enrollment applications ▪ 500 DME enrollment applications received 	<ul style="list-style-type: none"> ▪ Over \$566B in claims paid ▪ Over 50 million beneficiaries <ul style="list-style-type: none"> • Includes managed care

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Each working day Medicare processes over 4.6 million claims, of which 200,000 are for durable medical equipment (DME), from a total of 1.5 million in fees for service providers.

Each month, Medicare receives almost 39,000 Part A & B provider initial enrollment applications and 500 DME applications.

Every year Medicare pays over \$566 billion for more than 50 million beneficiaries. (Both sets of these numbers include managed care.)

For more information, please see 2012 data updates at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html> or CMS Fast Facts (www.cms.gov/fastfacts/)

Medicaid Overview

Yearly	Program Scope	Regions Covered
<ul style="list-style-type: none"> ▪ 3.9B claims paid ▪ Over \$430B in claims paid 	<ul style="list-style-type: none"> ▪ Over 57M beneficiaries ▪ 9M are eligible for both Medicare and Medicaid 	<ul style="list-style-type: none"> ▪ 56 state and territory-administered programs

The Medicaid program is growing. By 2014, in states that adopt Medicaid expansion, Americans who earn less than 133% of the Federal poverty level will be eligible to enroll.

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Each year, Medicaid processes 3.9 billion claims, representing more than \$430 billion annually, for more than 57 million beneficiaries.

Over 9 million Medicaid beneficiaries qualify for both Medicare and Medicaid coverage.

There are 56 state and territory-administered programs.

Medicaid is growing. By 2014, in states that adopt Medicaid expansion, Americans who earn less than 133% of the Federal poverty level (approximately \$29,000 for a family of four) will be eligible to enroll in Medicaid.

NOTE: The Health and Human Services (HHS) Assistant Secretary for Planning and Evaluations (ASPE) updates the Federal poverty level annually through the Federal Register and publishes it on their website.

For more information please visit: CMS Fast Facts (www.cms.gov/fastfacts/) or Medicaid Management Information Systems (MMIS) (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MMIS/index.html>) and [Medicare & Medicaid Statistical Supplement > 2011 Edition](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2011.html) <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2011.html>.

Who commits fraud?

- Most individuals and organizations that work with Medicare and Medicaid are honest
- However, anyone can commit fraud
 - Health care providers and suppliers
 - Business owners and employees
 - 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.

Any of the following may be involved in Medicare fraud and abuse:

- Doctors and health care practitioners;
- Suppliers of durable medical equipment (DME);
- Employees of physicians or suppliers;
- Employees of companies that manage Medicare billing; and
- People with Medicare and Medicaid

Medicare fraud is prevalent. It is important for you to be aware of the various entities that have been implicated in fraud schemes. Those who commit fraud could also be individuals who are pretending to be in any of these groups.

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 are lost due to improper payment rates, not just fraud



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The CMS spectrum of improper payments runs from errors, to waste, to abuse, to fraud, resulting in improper payments.

CMS enforcement activities target the causes of improper payments, from honest mistakes to intentional deception.

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.

3–10% of health care funds (billings) are lost due to improper payment rates. It is not all fraud.

NOTE: CMS estimates that the Federal government distributed about \$65 billion in improper payments (payments that shouldn't have been made **or** were for an incorrect amount) through Medicare and Medicaid combined in fiscal year 2011. We have however, through the Affordable Care Act and its programs, recovered more than \$10 billion in the last three years.

Examples of Fraud

- Medicare or Medicaid is billed for
 - Services you never received
 - Equipment you never got or was returned
- Documents are altered to gain a higher payment
- Misrepresentation of dates, descriptions of furnished services, or the identity of the beneficiary
- Someone uses your Medicare or Medicaid card with or without your permission
- A company uses false information
 - To mislead you into joining a Medicare plan

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Examples of possible fraud are:

- Medicare or Medicaid is billed for services you never received, equipment you never got or was returned.
- Documents that are altered to gain a higher payment.
- Misrepresentation of dates, descriptions of furnished services, or the identity of the beneficiary.
- Someone uses your Medicare/Medicaid card.
- A company uses false information to mislead you into joining a Medicare plan.

NOTE: Instructors may wish to have audience members give personal examples of fraud that they have encountered.

Quality of Care Concerns

- Patient quality of care concerns are **NOT** fraud
 - Examples include
 - Medication errors
 - Unnecessary or inappropriate surgery or treatment
 - Change in condition not treated
 - Discharged from the hospital too soon
 - Incomplete discharge instructions and/or arrangements
- Contact Quality Improvement Organizations (QIO)
 - Visit www.medicare.gov and click on Help & Resources
 - Call 1-800-MEDICARE or TTY 1-877-486-2048

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Patient quality of care concerns are not fraud. 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.
 - Discharged from the hospital too soon, like 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, or 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.medicare.gov under Help & Resources, phone numbers & websites, and search for information on the topic of "Complaints about my care or services." Or, you can call 1-800-MEDICARE (1-800-633-4227) for help contacting your QIO. TTY users should call 1-877-486-2048.

Check Your Knowledge – Lesson 1



Answer the following question:

Who can commit fraud?

- a. Suppliers of durable medical equipment
- b. Employees of physicians or suppliers or billers
- c. Someone using your Medicare or Medicaid card with or without your permission
- d. Any of the above



Refer to page 54 to check your answers.



Lesson 2 - CMS Fraud and Abuse Strategies

- Center for Program Integrity (CPI)
- Approaches to Combat Fraud, Waste and Abuse
- Fraud Prevention Initiative
- Strategies
- Healthcare Fraud Prevention Partnership
- Education
- Enforcement Actions

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In this lesson we will discuss:

- Program Integrity
- Approaches to Combating Fraud, Waste and Abuse
- Strategies
- Healthcare Fraud Prevention Partnerships
- Education
- Fraud Prevention Initiative
- Enforcement Actions

CMS Center for Program Integrity

- Consolidates CMS anti-fraud components
- New authorities from the Affordable Care Act
 - More rigorous screenings for health care providers
 - Termination from Medicare and Medicaid Programs
 - May temporarily stop enrollment in high risk areas
 - Temporarily stop payments in cases of suspected fraud

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The Center for Program Integrity (CPI) was created in April 2010. It brings together the Medicare and Medicaid program integrity groups under one management structure to strengthen and better coordinate existing and future activities to prevent and detect fraud, waste and abuse.

New rules permitted by the Affordable Care Act will help the Medicare, Medicaid and Children's Health Insurance (CHIP) programs do less "paying and chasing" of fraudulent health care claims and perform more proactive and transparent fraud protection, including:

- Creating a rigorous screening process for providers and suppliers enrolling in Medicare, Medicaid and CHIP.
- Requiring a cross-termination among Federal and state health programs, so providers and suppliers whose Medicare billing privileges are revoked or whose participation has been terminated by a Medicaid or CHIP program will be barred or terminated from all other Medicaid and CHIP programs.
- Temporarily stopping enrollment of new providers and suppliers in high risk areas. Medicare and state agencies will be watching for trends that may indicate a significant potential for health care fraud, and can temporarily stop enrollment of a category of providers or suppliers, or enrollment of new providers or suppliers in a geographic area that has been identified as high risk.
- Temporarily stopping payments to providers and suppliers in cases of suspected fraud if there has been credible fraud allegation. Payments can be suspended while an action or investigation is underway.

The New Approach to Combating Fraud, Waste and Abuse

Yesterday...	CMS Today...
<ul style="list-style-type: none">▪ Providers suspected of fraudulent activity were put on prepay review, sometimes indefinitely▪ CMS initiated overpayment recovery▪ Law enforcement determined if an arrest was appropriate	<ul style="list-style-type: none">▪ Denies individual claims▪ Its contractors use prepay review as an investigative technique▪ Revokes providers for improper practices▪ Collaborates with law enforcement before, during and after case development▪ Addresses the root cause of identified vulnerabilities

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CMS anticipates that its use of sophisticated analytical technologies will enable it to better combat fraud, waste, and abuse.

Yesterday:

- Providers suspected of fraudulent activity were put on prepay review, sometimes indefinitely
- CMS initiated overpayment recovery
- Law enforcement determined if an arrest is appropriate

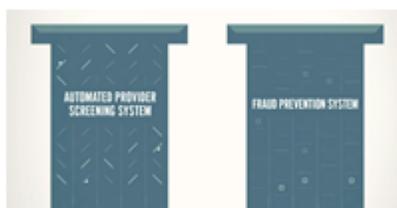
CMS Today:

- Denies individual claims
- Its contractors use prepay review as an investigative technique
- Revokes providers for improper practices
- Collaborates with law enforcement before, during and after case development
- Addresses the root cause of identified vulnerabilities

This enhanced and targeted approach has enabled CMS to pursue a more strategic and coordinated set of proactive program integrity policies and activities across Medicare and Medicaid.

The National Fraud Prevention Program

- The CMS *Fraud Prevention Initiative* employs twin pillars
- Fraud Prevention System
 - Automated provider screening technology
 - Predictive analytics in processing claims



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The National Fraud Prevention Program streamlines CMS' strategic projects into one coordinated program that is stronger and more efficient than any stand-alone effort. It focuses on enrollment and payment. By integrating predictive analytics in processing claims, and provider screening during enrollment, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS' automated provider screening technology, which was implemented in early 2012:

- In FY 2012, CMS began the process of screening all 1.5 million Medicare-enrolled providers through the new Automated Provider Screening system that quickly identifies ineligible and potentially fraudulent providers and suppliers prior to enrollment or revalidation to verify the data.
- From May 2011 through the end of 2012, more than 400,000 providers were subject to the new screening requirements and nearly 150,000 lost the ability to bill the Medicare Program due to the Affordable Care Act requirements and other proactive initiatives.
- In its first year of implementation, the Fraud Prevention System has screened every Medicare claim since the system was implemented in 2011. Flags from the system have initiated 536 new investigations, and data from the system has been used to support 511 investigations already in progress. In the first year of the system, we have stopped, prevented, or identified an estimated \$115 million in fraudulent payments. This comes out to an estimated \$3 in savings for every \$1 spent.

Fraud Detection Strategies

- Incorporate sophisticated new technologies
- Share data to fight fraud
 - Medicare
 - Medicaid
 - Veteran Affairs (VA)
 - Department of Defense
 - Social Security Disability Insurance program
 - Indian Health Service
- Expand Recovery Audit Contractor (RAC) program

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Fraud detection strategies include:

- Incorporating sophisticated new technologies and innovative data sources. These new technologies will help to identify patterns associated with fraud and avoid paying fraudulent claims.
- Sharing data to fight fraud. The law requires certain claims data from Medicare, Medicaid and CHIP, the Veteran's Affairs (VA), the Department of Defense (DoD), the Social Security Disability Insurance (SSDI) program and the Indian Health Service (IHS) to be integrated, making it easier for agency and law enforcement officials to identify criminals and prevent fraud on a system-wide basis.
- Expanding overpayment recovery efforts. The Affordable Care Act expands the Recovery Audit Contractors (RACs) program, requiring RACs to identify and recover improper payments across Medicare Parts C (Medicare Advantage) and D (Medicare prescription drug coverage) and in Medicaid. The Center for Program Integrity (CPI) awarded a contract for a Medicare Part D RAC in January 2011. Providers must also report and return Medicare and Medicaid overpayments within 60 days of identification.

Recovery Audit Contractor (RAC) Program

- Recovery Audit Contractor (RAC) Program's mission
 - Reduce improper Medicare payments by
 - Detecting and collecting overpayments
 - Identifying underpayments
 - Implementing actions to prevent future improper payments
- Establish Medicare Part C and D programs
 - Ensure plans have anti-fraud plans
- States and territories establish Medicaid RACs
 - Identify overpayments and underpayments
 - Coordinate efforts with Federal and state auditors

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The Recovery Audit Contractor Program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments.

In May 2013, CMS started the procurement process for the *new* Medicare Fee for Service (Part A and B) Recovery Audit Program contracts. CMS plans to contract with four A/B Recovery Auditors and one national Durable Medical Equipment (DME) and Home Health/Hospice Recovery Auditor.

CMS is establishing Medicare Parts C/D Recovery Audit Contractor (RAC) programs in accordance with the requirements specified in the Affordable Care Act. The Center for Program Integrity (CPI) awarded a contract for a Medicare Part D RAC in January 2011. The Part C contract is pending.

- Medicare Parts C/D RACs must ensure that each Medicare Advantage and Medicare Drug Plan has an anti-fraud plan in effect, and to review the effectiveness of each plan. RACs will retroactively examine claims for reinsurance to determine if drug plan sponsors submitted claims exceeding allowable costs. RACs will review estimates submitted by plans for high cost beneficiaries and compare to numbers of beneficiaries actually enrolled in such plans.

States and territories must establish Medicaid RAC programs.

- Medicaid RACs must identify and recover overpayments and 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.

42 States have implemented Medicaid RAC programs as of January 11, 2013. For more information, visit the Medicaid RACs At-A-Glance webpage: <http://w2.dehpg.net/RACSS/Map.asp>

Strategies

- Prevent fraud before it occurs using cutting edge technology
- Health Care Fraud Prevention and Enforcement Action Team (HEAT) Strike Force Teams
- Partner with the private sector and engage beneficiaries in the fight against fraud

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Fraud strategies also include:

- Preventing fraud before it occurs using cutting edge technology
- Health Care Fraud Prevention and Enforcement Action Team (HEAT) Strike Force Teams
- Partner with the private sector and engage beneficiaries in the fight against fraud

We will also further discuss the following:

- Strike Force Teams
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Zone Program Integrity Contractor (ZPIC)
- The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)

Strike Force Teams

- Strike Force Teams
 - Fraud “Hot Spot” locations
 - Use advanced data analysis to identify high-billing levels in health care fraud hot spots
 - Identify potential fraud cases
 - Partner with HEAT teams
- CMS suspends payment
 - In conjunction with Fraud Strike Force arrests

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- The joint Department of Justice (DOJ)-Health and Human Services (HHS) Medicare Fraud Strike Force is a multi-agency team of Federal, state, and local investigators designed to fight Medicare fraud.
 - Medicare Fraud Strike Force team locations are evidence of the geographic dispersion of Medicare fraud, with current operations in the identified fraud hot spots of Baton Rouge, Brooklyn, Chicago, Dallas, Detroit, Houston, Los Angeles, Miami-Dade, and Tampa Bay.
 - Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud spots.
 - Interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers.
- 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.



Health Care Fraud Prevention and Enforcement Action (HEAT) Team

- Joint initiative between Department of Health and Human Services and Department of Justice
- Improve inter-agency collaboration on reducing and preventing fraud in Federal health care programs
- Increase coordination, data sharing, and training among investigators, agents, prosecutors, analysts, and policymakers
- Expanded to 9 Fraud Strike Force cities




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The Health Care Fraud Prevention and Enforcement Action (HEAT) Team is a joint initiative between the Department of Health & Human Services and the Department of Justice (DOJ) to combat fraud. 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.

- Their goal is to improve inter-agency collaboration on reducing and preventing fraud in Federal health care programs. By deploying law enforcement and trained agency personnel HHS and DOJ increase coordination, data sharing, and training among investigators, agents, prosecutors, analysts, and policymakers. Project HEAT has been highly successful in bringing health care fraud cases and prosecuting them quickly and effectively.
- A central feature of the HEAT initiative is the use of Strike Force teams. The first Fraud Strike Force team was launched in Miami in March 2007; in 2009 it expanded to 7 cities and is currently in 9 cities as mentioned in this slide.

The mission of the HEAT Team is to:

- Gather resources across government to help prevent waste, fraud and abuse in the Medicare and Medicaid programs, and crack down on the fraud perpetrators who are abusing the system and costing the system billions of dollars.
- Reduce skyrocketing health care costs and improve the quality of care by ridding the system of perpetrators who are preying on Medicare and Medicaid beneficiaries.
- Highlight best practices by providers and public sector employees who are dedicated to ending waste, fraud and abuse in Medicare.
- Build upon existing partnerships between the Department of Justice and the Department of Health and Human Services to reduce fraud and recover taxpayer dollars.

2012 HEAT Team Results

- In October 2012 Fraud Strike Force operations
 - Led to charges against 91 people including doctors, nurses and other professionals
 - \$432 million in false billing (fraud)
 - \$230 million in home health care
 - \$100 million in community mental health care
 - \$49 million in ambulance transportation

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In October 2012, Medicare Fraud Strike Force operations in seven cities (Dallas, Miami, Chicago, Brooklyn, Houston, Baton Rouge, and Los Angeles)

- Led to charges against 91 individuals – including doctors, nurses and other licensed medical professionals for their alleged participation in Medicare fraud schemes involving approximately \$432 million in false billing.
 - That total includes more than \$230 million in home health care fraud; more than \$100 million in community mental health care fraud and more than \$49 million in ambulance transportation fraud.

More than 500 law enforcement agents from the Federal Bureau of Investigations (FBI), HHS-OIG, multiple Medicaid Fraud Control Units, and other state and local law enforcement agencies participated in the takedown.

In coordination with the criminal charges, HHS also suspended or took other administrative action against 30 health care providers following a data-driven analysis and credible allegations of fraud. Under the Affordable Care Act, HHS is able to suspend payments until an investigation is complete.

Strike Force operations in the nine cities where teams are based resulted in 117 indictments, information and complaints involving charges against 278 defendants who allegedly billed Medicare more than \$1.5 billion in fraudulent schemes. In FY 2012, 251 guilty pleas and 13 jury trials were litigated, with guilty verdicts against 29 defendants, in Strike Force cases. The average prison sentence in these cases was more than 48 months.

Recoveries and Results

In 2012

Nearly \$4.2B fraud recoveries

826 defendants were convicted of healthcare fraud-related crimes

Obtained settlements and judgments of more than \$3B in FY 2012 under the False Claims Act

In The Last 4 Years

1,131 new criminal health care fraud investigations with 2,148 potential defendants

\$14.9B recovered

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The Departments of Justice (DOJ) and Health and Human Services announced record-breaking recoveries resulting from joint efforts to combat health care fraud. The Government's health care fraud prevention and enforcement efforts recovered a record \$4.2 billion in taxpayer dollars in Fiscal Year (FY) 2012, up from nearly \$4.1 billion in FY 2011, from individuals and companies who attempted to defraud Federal health programs serving seniors and taxpayers or who sought payments to which they were not entitled. Over the last four years, the administration's enforcement efforts have recovered \$14.9 billion, up from \$6.7 billion over the prior four-year period.

DOJ opened 1,131 new criminal health care fraud investigations involving 2,148 potential defendants. A total of 826 defendants were convicted of health care fraud-related crimes during the year.

DOJ also opened 885 new civil investigations. DOJ's Civil Division Fraud Section, with their colleagues in U.S. Attorneys' offices throughout the country, obtained settlements and judgments of more than \$3 billion in FY 2012 under the False Claims Act (FCA).

These matters included unlawful pricing by pharmaceutical manufacturers; illegal marketing of medical devices and pharmaceutical products for uses not approved by the Food and Drug Administration; Medicare fraud by hospitals and other institutional providers; and violations of laws against self-referrals and kickbacks.

For more information, please visit: <http://www.hhs.gov/news/press/2013pres/02/20130211a.html>

Zone Program Integrity Contractors (ZPIC)

- The ZPIC's main responsibilities are to:
 - Investigate leads generated by the new Fraud Prevention System (FPS) and a variety of other sources
 - Perform data analysis to identify cases of suspected fraud, waste, and abuse
 - Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars

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Zone Program Integrity Contractors (ZPICs) were created to perform program integrity functions in zones for Medicare Parts A and B; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Home Health and Hospice; and Medicare-Medicaid data matching.

The ZPIC's main responsibilities are to:

- Investigate leads generated by the new Fraud Prevention System (FPS) and a variety of other sources
- Perform data analysis to identify cases of suspected fraud, waste, and abuse
- Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars

NOTE: Continued on the next slide

ZPIC Continued

- The ZPIC's main responsibilities are to:
 - Make referrals to law enforcement for potential prosecution
 - Provide support for ongoing investigations
 - Provide feedback and support to CMS to improve the FPS
 - Identify improper payments to be recovered

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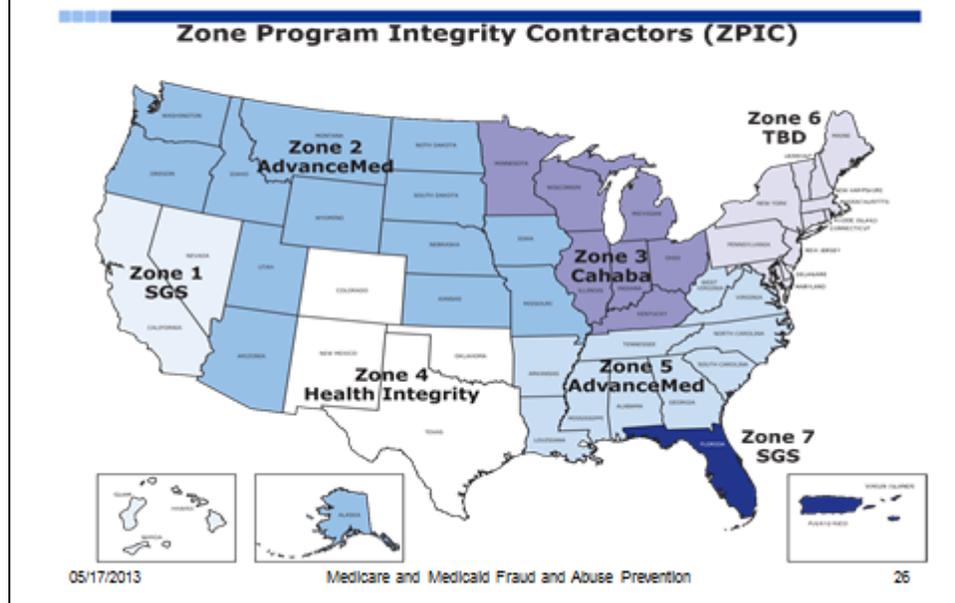
25

The ZPIC's main responsibilities (continued) are to:

- Make referrals to law enforcement for potential prosecution
- Provide support for ongoing investigations
- Provide feedback and support to CMS to improve the FPS
- Identify improper payments to be recovered

NOTE: CMS began the process of consolidating the scope of all Program Safeguard Contractor (PSC) and Medicare Prescription Drug Integrity Contractor (MEDIC) contracts into ZPIC contracts in 2008. Formerly known as "Program Safeguard Contractors," Zone Program Integrity Contractors (ZPICs) began operating in 2009.

ZPIC Map



ZPIC zones align with Medicare Administrative Contractor (MAC) jurisdictions. 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, Vermont, and Washington, DC.
- Zone 7 is covered by SGS and includes Florida and Puerto Rico.

National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)

- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
 - Supports CMS Center for Program Integrity
 - Monitors fraud, waste, and abuse in the Part C and Part D programs
 - In all 50 States, the District of Columbia, and U.S. Territories
 - Has investigators throughout the country
 - Works with Federal, state, and local law enforcement
 - Other stakeholders

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The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) supports the CMS Center for Program Integrity.

- NBI monitors fraud, waste, and abuse in the Part C and Part D programs in all 50 states, the District of Columbia, and U.S. Territories.
- NBI has investigators throughout the country that work with Federal, state, and local law enforcement authorities and other stakeholders.

NBI Medic Key Responsibilities

- NBI MEDIC Responsibilities
 - Investigate potential fraud, waste and abuse
 - Receive complaints
 - Resolve beneficiary fraud complaints
 - Perform proactive data analyses
 - Identify program vulnerabilities
 - Refer potential fraud cases to law enforcement

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NBI Medic has a number of key responsibilities, including:

- Investigating potential fraud, waste and abuse
- Receiving complaints
- Resolving beneficiary fraud complaints
- Performing proactive data analyses
- Identifying program vulnerabilities
- Referring potential fraud cases to law enforcement agencies

Examples of Cases NBI MEDIC Handles

- Someone pretends to represent Medicare or SSA and asks for your Medicare number
- Someone asks you to sell your Medicare prescription drug card
- Someone offers to pay you cash to visit specific providers, suppliers, or pharmacies
- You were billed for drugs you didn't receive
- Your Medicare Summary Notice or Explanation of Benefits lists products or services you did not receive

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The type of complaints the NBI MEDIC is interested in receiving include:

- An individual or organization pretends to represent Medicare and/or Social Security, and asks you for your Medicare or Social Security number, bank account number, credit card number, money, etc.
- You had your personal information stolen or suspect someone has stolen your personal information.
- Someone asks you to sell your Medicare prescription drug card or Medicare Advantage Plan membership card.
- Someone offers to pay you cash to visit specific providers, suppliers, or pharmacies.
- Someone asks you to get drugs for them using your Medicare prescription drug card or Medicare Advantage Plan membership card.
- Your pharmacy did not give you all of your drugs.
- You were billed for drugs or services that you did not receive.
- You received a different drug than your doctor ordered.
- Your explanation of medical benefit forms list products or services you did not receive or does not accurately reflect the nature of the products or services you received.

Healthcare Fraud Prevention Partnership

- Partnership announced July 2012 designed to
 - Share information and best practices
 - Improve detection
 - Prevent payment of fraudulent health care billings across public and private payers
 - Enable the exchange of data and information among the partners

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The National Fraud Prevention Partnership was announced in July 2012. It is designed to reduce healthcare fraud by pooling resources with the private sector and using data analysis techniques to sort through claims data. The voluntary partnership, which includes the Federal government, state officials, private health insurance organizations, and other healthcare anti-fraud groups, is designed to:

- Share information and best practices.
- Improve detection.
- Prevent payment of fraudulent health care billings across payers.
- Enable the exchange of data and information. The potential long-range goal of the partnership is to use sophisticated technology and analytics on industry-wide healthcare data to predict and detect health care fraud schemes (using techniques similar to credit card fraud analysis).

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.
- This includes Regional Fraud Summits that are coordinated among the Office of the Inspector General (OIG), the Department of Justice, the Secretary of Health and Human Services (HHS), and CMS. These summits provide an opportunity for beneficiaries, providers, insurers, hospitals and law enforcement to discuss shared concerns and collaboration strategies.

Enforcement Actions

- When fraud is detected and confirmed enforcement actions include:
 - Automatic denials
 - Payment suspensions
 - Prepayment edits
 - Civil monetary penalties
 - Revocation of billing privileges
 - Referral to law enforcement

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When fraud is detected, the appropriate administrative action is imposed.

Administrative actions include the following:

- Automatic denials are a “do not pay claim” status for items or services ordered or prescribed by an excluded provider.
 - Payment suspensions are a hold on paying claims until an investigation or request for information is completed.
 - Prepayment edits are coded system logic that either automatically pays all or part of a claim, automatically denies all or part of a claim, or suspends all or part of a claim so that a trained analyst can review the claim and associated documentation to make determinations about coverage and payment.
 - Civil Money Penalties (CMP’s) are a punitive fine imposed by a civil court on an entity that has profited from illegal or unethical activity. They may be imposed to punish individuals or organizations for violating a variety of laws or regulations.
 - Revocation of billing privileges. Revocation occurs for noncompliance, misconduct, felonies, falsifying information, and other such conditions set forth in [42 CFR, §424.535](#). Medicare payments will be halted and providers will be in limbo until the corrective action plan or request for reconsideration process is complete.
 - Referral to law enforcement.

Enforcement Actions (continued)

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

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Enforcement Actions (continued):

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

Educate Providers and Beneficiaries

- Provider education helps correct vulnerabilities
 - Maintain proper documentation
 - Reduce inappropriate claims submission
 - Protect patient and provider identity information
 - Establish a broader culture of compliance
- Beneficiary education helps them identify and report suspected fraud

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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 they occur. Educating providers and beneficiaries applies to both the Medicare and Medicaid programs.

- Provider education helps correct vulnerabilities
 - Maintain proper documentation
 - Reduce inappropriate claims submission by educating providers on common billing mistakes
 - Protect patient and provider identity information
 - Establish a broader culture of compliance
- Beneficiary education helps them join in the fight against fraud by learning to identify and learn how to report suspected fraud.

Check Your Knowledge – Lesson 2



Answer the following question:

The new approach to combating fraud, waste and abuse will:

- a. Rely on new technologies
- b. Revoke providers for improper practices
- c. Collaborate with law enforcement before, during and after case development
- d. All of the above



Refer to page 55 to check your answers.



Lesson 3 How You Can Fight Fraud

- www.stopmedicarefraud.gov
- Medicare Summary Notices
- www.MyMedicare.gov
- 1-800-MEDICARE
- Reporting Medicaid Fraud
- Senior Medicare Patrol
- Protecting Personal Information and ID Theft
- Helpful Tips
- Part C and D Plan Marketing Fraud

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In lesson 3 we'll learn about how people with Medicare can fight fraud.

We will:

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

www.stopmedicarefraud.gov

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



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The website www.stopmedicarefraud.gov is a good place for you 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 are available at <http://www.stopmedicarefraud.gov/newsroom/your-state/index.html>

To report suspected errors, fraud, or abuse, you can contact either:

Centers for Medicare & Medicaid Services

Call: 800-633-4227

TTY: 877-486-2048

Mail: Medicare Beneficiary Contact Center

P.O. Box 39

Lawrence, KS 66044

Or

HHS Office of Inspector General

Call: 800-447-8477

TTY: 800-377-4950

Online: [Report Fraud Online](#)

Mail: HHS Tips Hotline

P.O. Box 23489

Washington, DC 20026-3489

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 and services dates
 - Compare them to your MSN



Newly designed MSN
will be mailed in 2013

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There is a Part A, a Part B, and a Durable Medical Equipment (DME) Medicare Summary Notice (MSN). This notice isn't a bill. Medicare Advantage 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 you owe each provider. You should review your MSN carefully to ensure that you received the services and supplies that Medicare was billed for.

CMS has redesigned the MSN to make it simpler to understand, spot and report fraud (on page 2). The new MSN will be mailed to beneficiaries beginning June in 2013. It will be easier to understand and read. It will provide additional information, like a quarterly summary of claims. There is a pilot program in some higher fraud areas to send MSNs monthly.

Visit http://www.cms.gov/apps/files/msn_changes.pdf to view a side by side comparison of the MSN changes.

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

Get help reading your Medicare Summary Notice at www.medicare.gov/basics/SummaryNotice.asp

[www/MyMedicare.gov](http://www.MyMedicare.gov)

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



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MyMedicare.gov is Medicare's free, secure online service for accessing personalized information regarding Medicare benefits and services. 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 and prescription drug enrollment information as well as any applicable Part B deductible information.
- Manage your prescription drug list and personal health information.
- Review claims and identify fraudulent claims. You don't have to wait for your Medicare Summary Notice 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.
- If there is a discrepancy, you should call your doctor or supplier. Call 1-800-MEDICARE if you suspect fraud. TTY users call 1-877-486-0428.

NOTE: To use this service you must register on the site. (Newly eligible beneficiaries are automatically registered and sent a PIN.)

1-800-MEDICARE

- Making identifying and reporting fraud easier
- 1-800-MEDICARE beneficiary complaints are used to
 - Target certain providers/suppliers for review
 - Show where fraud scams are heating up
- 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.

CMS is now also using 1-800-MEDICARE for beneficiary complaints to:

- Target providers or suppliers with multiple beneficiary complaints for further review.
- Track fraud complaints to show when fraud scams are heating up in new areas based on beneficiary calls to 1-800-MEDICARE that raise a question about possible fraud. Using existing data in this innovative way enables CMS to target providers and suppliers with multiple beneficiary complaints for further investigation.
- Interactive Voice Response on 1-800-MEDICARE allows beneficiaries that have not registered 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. TTY users call 1-877-486-0428.

NOTE: Effective July 2013, all beneficiary calls about fraud will be handled by 1-800-MEDICARE, not the Office of the Inspector General.

Reporting Suspected Medicaid Fraud

- Medicaid Fraud Control Unit (MFCU or Unit)
 - Investigates and prosecutes
 - Medicaid fraud
 - Patient abuse & neglect in health care facilities
 - Call OIG at 1-800-447-8477 (TTY 800-377-4950)
 - They also certify, and annually recertify the MFCU
- State Medical Assistance (Medicaid) office
 - See state listing for Medicaid:
 - <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/downloads/smafraudcontacts.pdf>

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You may direct complaints of suspected Medicaid fraud directly to a Medicaid Fraud Control Unit (MFCU or Unit).

- MFCUs investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. The Office of the Inspector General certifies, and annually recertifies, each MFCU.
- **HHS Office of Inspector General**
Call: 800-447-8477
TTY: 800-377-4950
Online: [Report Fraud Online](#)
Mail: HHS Tips Hotline
P.O. Box 23489
Washington, DC 20026-3489
- You may also report suspected Medicaid fraud to your state Medical Assistance (Medicaid) office. For a listing of State Medical Assistance (Medicaid) offices, visit <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/downloads/smafraudcontacts.pdf>

The Senior Medicare Patrol (SMP)

- Education and prevention program aimed at educating beneficiaries on preventing, identifying, and reporting health care fraud
- Active programs in all states, DC, Puerto Rico, Guam, and U.S. Virgin Islands
- Seeks volunteers to represent their communities
- CMS has SMP liaisons in each Regional Office



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- The mission of the Senior Medicare Patrol (SMP) program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report healthcare fraud, errors, and abuse through outreach, counseling, and education
- SMPs recruit and train retired professionals and other volunteers about how to recognize and report instances or patterns of health care fraud. SMPs nationwide recruit and teach nearly 5,700 volunteers every year to help in this effort. 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. SMPs teach you how to protect your identity, how to detect errors, and how to report fraud. SMPs receive training about how threats to financial independence and health status may occur when citizens are victimized by fraudulent schemes.
- There are 54 SMP programs, including one in each state, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. SMP seeks volunteers to represent the program in their communities.
- CMS established SMP liaisons in each Regional Office to serve as the point of contact for compliance/marketing issues identified by SMPs, to proactively engage with SMPs and to share relevant program information, changes, and Medicare updates.

NOTE: For an in-depth overview of the Senior Medicare Patrol program, and for information for your local area, please visit <http://www.smpresource.org/>

Senior Medicare Patrol Continued

- HHS dedicated \$18M 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
 - Made 7,000 referrals
 - Led to the recovery of \$5M in Medicare funds
 - Led to the recovery of \$106M in other funds

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In 2010 and 2011, CMS dedicated approximately \$9 million in funding for grants to expand state-based Senior Medicare Patrol (SMP) programs. The grants:

- Doubled the existing funding for the program
- Target additional funding to current hot spots for fraud

In 2012, this funding continued through grants provided directly to the SMP grantees from the Administration for Community Living (ACL).

Since 1997, Administration on Aging (AoA) has funded SMP projects to recruit and train retired professionals and other volunteers about how to recognize and report instances or patterns of health care fraud. AoA is now a part of the Administration for Community Living (ACL).

Since 1997, the Senior Medicare Patrol has:

- Provided group training sessions to approximately 3.5 million individuals, and one-on-one counseling to approximately 1.2 million beneficiaries
- Led to the recovery of \$5 million dollars of Medicare funds
- Led to the recovery of \$106 million dollars in total to Medicare, Medicaid, beneficiary, and other payers funds

See also: <http://www.hhs.gov/news/press/2013pres/04/20130424a.html>

NOTE: For an in-depth overview of the Senior Medicare Patrol program, and for information for your local area, please visit <http://www.smpresource.org/> or call the nationwide toll-free Number: 877-808-2468 available Monday through Friday, 9:00 a.m. – 5:30 p.m. Eastern Time. Callers receive information about the SMP program and are connected to the SMP in their state for individualized assistance. This number is published in the Medicare & You handbook and other national Medicare and anti-fraud publications that reference the SMP program.

If You Share Your Medicare or Medicaid Card or Number

- You could lose your benefits
- Your medical records could be wrong
- You may have to pay money back or be fined
- You could be arrested
- Medicaid specific lock-in program
 - Limits you to certain doctors/drug stores/hospitals
 - For activities like ER visits for non-emergency care, using multiple physicians that duplicate treatment/medication

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If you share your Medicare or Medicaid card or number with anyone other than your healthcare providers, you could have serious problems.

- You might lose your 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.
- You can be required to pay a fine.
- The Medicaid lock-in program limits you to certain doctors, drug stores and hospitals. Lock-in may be used for Medicaid beneficiaries who:
 - Visit hospital emergency departments for non-emergency health concerns
 - Use two or more hospitals for emergency room services
 - Use two or more physicians resulting in duplicated medications and or treatments
 - Exhibit possible drug-seeking behavior by:
 - Requesting a specific scheduled medication
 - Requesting early refills of scheduled medications
 - Reporting frequent losses of scheduled medications (narcotics)
 - Using multiple pharmacies to fill prescriptions
- You could be arrested and spend time in jail if found guilty of fraud.

Protecting Personal Information

- Only share with people you trust
 - Your doctors or other health care providers
 - Your Medicare Health or Drug Plan
 - Your insurance company
 - Medigap or Employer/Union
 - Your State Health Insurance Assistance Program (SHIP)
 - Social Security, Medicaid and Medicare

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Keep your personal information safe such as your Medicare, Social Security, and Credit Card numbers. Share this information only with people you trust like your doctors and healthcare providers, your insurer, your State Health Insurance Assistance Programs (SHIP) and Social Security, Medicaid and Medicare

Sharing Information with Family/Caregiver

- Medicare requires written permission to protect personal information
 - You 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 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 beneficiary's Medicare issues directly with Medicare.
 - Power of attorney is not enough. Family members/caregivers can contact Medicare at 1-800-MEDICARE to request a Medicare Authorization to Disclose Personal Information CMS Form No. 10106.
 - Or they can visit www.medicare.gov/MedicareOnlineForms/AuthorizationForm/online to complete the process online.

Identity Theft

- 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 at
 - 1-877-438-4338
- If your Medicare card is lost or stolen, report it right away
 - Call Social Security at 1-800-772-1213
 - TTY users 1-800-325-0778

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Identity theft is when someone else uses your personal information, like your Social Security or Medicare number. It is a serious crime.

If you think someone is using your information:

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

If your Medicare card is lost or stolen, report it right away.

- Call Social Security at 1-800-772-1213.
- TTY users should call 1-800-325-0778 for a replacement. If a Medicare ID number is stolen, it can't be cancelled or changed by Medicare.

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

Additional Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at:

<http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf>

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

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>.

Helpful Tips

- Ask questions
 - You have the right to know what is billed
- Educate yourself about Medicare and Medicaid
 - Know your 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”

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These are helpful tips that can help people with Medicare protect themselves from fraud.

- Ask questions. You have the right to know what is billed to Medicare and Medicaid.
- Educate yourself about Medicare and know your rights and what a provider can and can't bill to Medicare.
- Be wary of providers who tell you that you can get an item or service that is not usually covered by Medicare, but they know “how to bill Medicare.”

Medicare Part C & D Plan Marketing Rules

- Examples of Marketing Rules
 - 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 (TTY 1-877-486-0428)

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Below 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. TTY users call 1-877-486-0428.

NOTE: 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. However, please note that the NBI MEDIC does not handle C & D marketing fraud. You should refer those issues to 1-800-MEDICARE.

Telemarketing & Fraud

- Durable Medical Equipment (DME) telemarketing rules
 - DME suppliers cannot make unsolicited sales calls
- Potential DME 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 include:

- 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 if you meet **all** of these conditions
 - You call either 1-800-HHS-TIPS (1-800-447-8477) or 1-800-MEDICARE (1-800-633-4227) and report suspected fraud
 - The suspected Medicare fraud you report must be investigated and validated by CMS' contractors
 - The reported fraud must be formally referred to the Office of Inspector General for further investigation
 - You are not an excluded individual
 - The person or organization you are reporting is not already under investigation by law enforcement
 - Your report leads directly to the recovery of at least \$100 of Medicare money

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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.

You may also wish to read the following press release: <http://www.hhs.gov/news/press/2013pres/04/20130424a.html>

Check Your Knowledge – Lesson 3



Answer the following question:

If you register at www.MyMedicare.gov, you can (mark all that apply)

- a. Review eligibility, entitlement and plan information
- b. Request a new Medicare card
- c. Track preventive services
- d. Review claims



Refer to page 56 to check your answers.

Medicare Fraud & Abuse Resource Guide

Resources		Medicare Products
<p>Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) www.Medicare.gov</p> <p>MyMedicare.gov https://www.mymedicare.gov/</p> <p>www.stopmedicarefraud.gov</p> <p>Office of the Inspector General U.S. Department of Health & Human Services ATTN: HOTLINE PO Box 23489 Washington, DC 10026</p> <p>Fraud Hotline 1-800-HHS-TIPS (1-800-447-8477) TTY – 1-800-337-4950 Fax 1-800-223-8162</p> <p>HealthCare.gov www.healthcare.gov</p> <p>Social Security Administration www.ssa.gov 1-800-772-1213 TTY – 1-800-325-0778</p>	<p>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</p> <p>NBI Medic’s Parts C&D Fraud Reporting Group 1-877-7SAFERX (1-877-772-3379) http://www.healthintegrity.org/contracts/nbi-medic/reporting-a-complaint</p> <p>NBI MEDIC 877-7SAFERX (877-772-3379) Fax a Complaint Form to 410-819-8698 Mail to: Health Integrity, LLC, 9240 Centreville Road, Easton, Maryland 21601 http://www.healthintegrity.org/contracts/nbi-medic</p> <p>National Health Care Anti-Fraud Assoc. www.nhcaa.org</p> <p>Video - http://vimeo.com/39669496 Prevention Toolkit http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html</p>	<p><i>Medicare Authorization to Disclose Personal Information form</i> CMS Product No. 10106</p> <p><i>Help Prevent Fraud: Check your Medicare claims early by visiting MyMedicare.gov or by calling 1-800-MEDICARE!</i> CMS Product No. 11491</p> <p><i>Protecting Medicare and You from Fraud</i> CMS Product No. 10111</p> <p><i>Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information</i> CMS Product No. 11147</p> <p>To access these products: View and order single copies: www.Medicare.gov</p> <p>http://www.medicare.gov/navigation/help-and-support/fraud-and-abuse/fraud-and-abuse-overview.aspx</p> <p>Order multiple copies (partners only): productordering.cms.hhs.gov (You must register your organization.)</p>



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Answer Key

Check Your Knowledge Lesson 1- Fraud and Abuse Overview



Who can commit fraud?

- a. Suppliers of durable medical equipment
- b. Employees of physicians or suppliers or billers
- c. Someone using your Medicare or Medicaid card with or without your permission
- d. Any of the above

ANSWER: d. Any of the above

Answer Key

Check Your Knowledge Lesson 2- CMS Fraud and Abuse Strategies (from p. 34)



The new approach to combating fraud, waste and abuse will:

- a. Rely on new technologies
- b. Revoke providers for improper practices
- c. Collaborate with law enforcement before, during and after case development
- d. All of the above

ANSWER: d. All of the above

Answer Key

Check Your Knowledge Lesson 3 - How You Can Fight Fraud (from p. 51)



If you register at www.MyMedicare.gov, you can (mark all that apply)

- a. Review eligibility, entitlement and plan information
- b. Request a new Medicare card
- c. Track preventive services
- d. Review claims

ANSWER: a, c, and d. You can review eligibility, entitlement and plan information, and track which preventive services you have received. Claims can also be reviewed so you can see your activity before you get your Medicare Summary Notice (MSN).

Acronyms

ACA	Affordable Care Act
AoA	Administration on Aging
CHIP	Children’s Health Insurance Program
CMHC	Community Mental Health Care
CMP	Civil Money Penalties
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
DME	Durable Medical Equipment
DoD	Department of Defense
DOJ	Department of Justice
FBI	Federal Bureau of Investigation
FCA	False Claims Act
FPS	Fraud Prevention System
FY	Fiscal Year
HCFAAC	Health Care Fraud and Abuse Control
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	(Department Of) Health and Human Services
ID	Identity
IHS	Indian Health Service
MAC	Medicare Administrative Contractor
NBI MEDIC	National Benefit Integrity Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Units
MSN	Medicare Summary Notice
NTP	National Training Program
OIG	Office of the Inspector General
PDF	Portable Document Format
PIN	Personal Identification Number
QIO	Quality Improvement Organization
RAC	Recovery Audit Contractors
SHIP	State Health Insurance Assistance Program
SMP	Senior Medicare Patrol
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSN	Social Security Number
TTY	Text Telephone
VA	Veteran’s Affairs
ZPIC	Zone Program Integrity

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Website: [cms.gov/www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram](https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram)

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