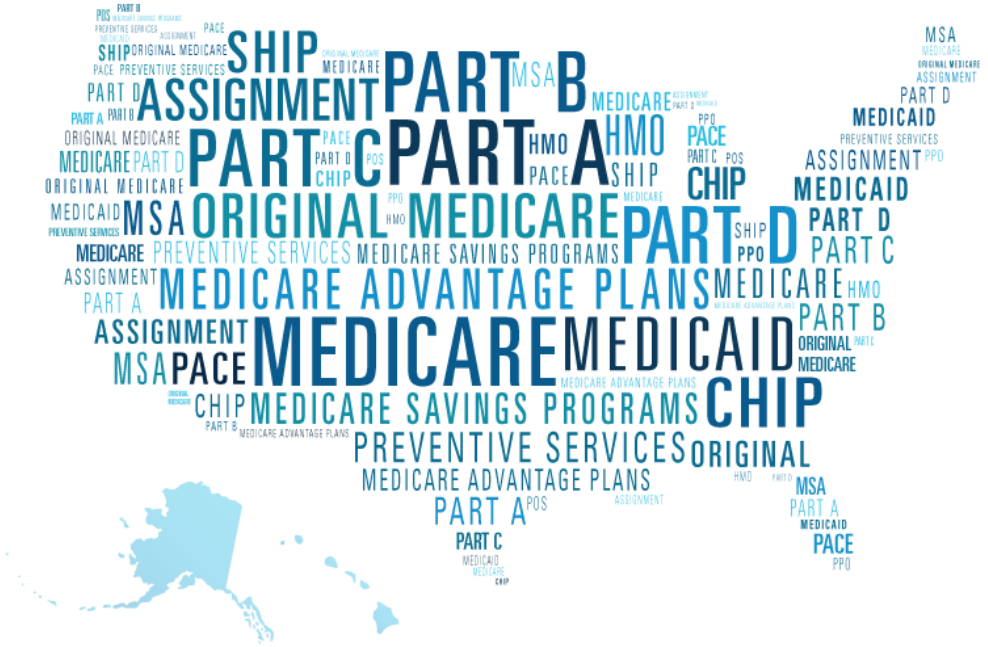
2015 National Training Program

Workbook

Module: 10

Medicare and Medicaid Fraud and Abuse Prevention



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Centers for Medicare & Medicaid Services (CMS)
National Training Program (NTP)
Instructor Information Sheet

Module 10—Medicare and Medicaid Fraud and Abuse Prevention

Module Description

The lessons in this module, "Medicare and Medicaid Fraud and Abuse Prevention," explain Medicare and Medicaid fraud and abuse prevention, detection, recovery, and reporting.

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

Objectives

- Define fraud and abuse
- Identify causes of improper payments
- Discuss how CMS fights fraud and abuse
- Explain how you can fight fraud and abuse
- Recognize sources of additional information

Target Audience

This module is designed for presentation to trainers and other information givers. It can be easily adapted for presentations to groups of beneficiaries.

Time Considerations

The module consists of 48 PowerPoint slides with corresponding speaker's notes, media used, activities, and quiz questions. It can be presented in about 45 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be allocated for add-on activities.

Course Materials

No additional materials are needed.

References

"Protecting Medicare and You From Fraud" CMS Product No. 10111.

Module 10: Medicare and Medicaid Fraud and Abuse Prevention

Contents

Introduction 1
Session Objectives 2
Lesson 1—Fraud and Abuse Overview 3
Definition of Fraud and Abuse 4
Protecting Taxpayer Dollars 5
Examples of Fraud 6
Consequences of Sharing a Medicaid Card or Number 7
Who Commits Fraud? 8
Improper Payment Transparency 9
Causes of Improper Payments 10
Preventing Fraud in Medicare Parts C and D 11
Telemarketing and Fraud—Durable Medical Equipment (DME) 12
Quality of Care Concerns 13
Lesson 2—CMS Fraud and Abuse Strategies 16
CMS Center for Program Integrity 17
CMS Program Integrity Contractors 18
Zone Program Integrity Contractors (ZPICs) 19
Zone Program Integrity Contractors (ZPICs) Map 20
National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) 21
Recovery Audit Program 22
Outreach & Education MEDIC (O&E MEDIC) 23
Medicaid Integrity Contractors (MICs) 24
CMS Administrative Actions 25
Law Enforcement Actions 26
Health Care Fraud Prevention Partnership 27
Health Care Fraud Prevention and Enforcement Action (HEAT) Team 28
Medicare Fraud Strike Force Teams 29
Fraud Prevention Toolkit 30
Provider and Beneficiary Education 31

Contents (continued)

Lesson 3—How You Can Fight Fraud 33
4Rs for Fighting Medicare Fraud 34
STOPMedicareFraud.gov 35
Medicare Summary Notice (MSN) 36
MyMedicare.gov 37
1-800-MEDICARE (TTY 1-877-486-2048) 38
Fighting Fraud Can Pay 41
The Senior Medicare Patrol 42
Protecting Personal Information 43
Identity Theft 44
Reporting Suspected Medicaid Fraud 45
Key Points to Remember 46
Medicare Fraud & Abuse Resource Guide 47
Acronyms 48
CMS National Training Program Contact Information 49

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 Federally-facilitated Health Insurance Marketplace.

The information in this module was correct as of May 2015. To check for an updated version, visit CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html.

The CMS National Training Program provides this as an informational resource for our partners. It's not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

Session Objectives

This session should help you

- Define fraud and abuse
- Identify causes of improper payments
- Discuss how CMS fights fraud and abuse
- Explain how you can fight fraud and abuse
- Recognize sources of additional information

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 2

This session should help you

- Define fraud and abuse
- Identify causes of improper payments
- Discuss how CMS fights fraud and abuse
- Explain how you can fight fraud and abuse
- Recognize sources of additional information

Lesson 1—Fraud and Abuse Overview

- Definition of fraud and abuse
- Protecting the Medicare Trust Funds and other public resources
- Examples of Medicare and Medicaid fraud
- Who commits fraud?
- Causes of improper payments
- Quality of care concerns

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 3

Lesson 1 provides an overview of fraud and abuse, including the following:

- Definition of fraud and abuse
- Protecting the Medicare Trust Funds and other public resources
- Examples of Medicare and Medicaid fraud
- Who commits fraud?
- Causes of improper payments
- Quality of care concerns

Definition of Fraud and Abuse

Fraud

When someone intentionally executes or attempts to execute a scheme to obtain money or property of any health care benefit program

Abuse

When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program

The primary difference between fraud and abuse is intention.

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 4

Medicare and Medicaid fraud, waste, and abuse affect every American by draining critical resources from our health care system, and contribute 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 executes or attempts to execute a scheme to obtain money or property of any health care benefit program.

Abuse occurs when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

The primary difference between fraud and abuse is intention.

Protecting Taxpayer Dollars

- CMS must
  - Protect Medicare Trust Funds
    - Medicare Hospital Insurance (Part A) Trust Fund
    - Supplementary Medical Insurance (Part B) Trust Fund
  - Protect the public resources that fund the Medicaid programs
  - Manage the careful balance between
    - Paying claims quickly and limiting burden on the provider community with conducting reviews that prevent and detect fraud

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 5

The Centers for Medicare & Medicaid Services' (CMSs') mission is to be an effective steward of public funds. CMS must protect the Medicare Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund.

- The Medicare 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. It’s 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 Medicare 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 (Medicare Prescription Drug Coverage) premiums, and interest earned on trust fund investments.
- The federal government contributes to the annual Medicaid expenditure, and CMS must protect the public resources that fund the 56 state-run Medicaid programs operated by the states, District of Columbia, and U.S. Territories.
- CMS has to manage the careful balance between paying claims quickly and limiting provider burden, versus conducting reviews that prevent and detect fraud.

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

For recent examples of fraud by region visit, medic-outreach.rainmakerssolutions.com/fraud-in-the-news/.

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 6

Examples of possible fraud include the following:

- 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 else uses your Medicare/Medicaid card with or without your permission
- A company uses false information to mislead you into joining a Medicare plan

For recent examples of Medicare fraud by region, visit CMS Outreach & Education Medic at medic-outreach.rainmakerssolutions.com/fraud-in-the-news to view the U.S. Department of Justice's (DOJ) "Fraud in the News" press releases. The following are 2 of over 20 cases on fraud that occurred in January 2015.

- A press release on January 26, 2015, from the DOJ, Office of Public Affairs (OPA), shows that the owner and operator of a Miami home health care agency was sentenced to over 8 years in prison, and $21 million in restitution for participating in a Medicare fraud scheme. Approximately $30 million in claims for home health services that weren't medically necessary or weren't provided were submitted, and Medicare paid approximately $21 million for these fraudulent claims.
- Another press release on January 29, 2015, from the DOJ OPA shows that 4 people were sentenced to up to 10 years in federal prison. Each of the 4 people played a role in a $6 million Medicare fraud scheme involving a home health care agency that claimed to provide home health care and therapy services, but didn't.

Consequences of Sharing a Medicaid Card or Number

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

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 7

If you share your Medicaid card or number with anyone other than your health care providers, there are programs in place and consequences.

- The Medicaid lock-in program limits you to certain doctors, drug stores, and hospitals. Lock-in may be used for Medicaid beneficiaries in these circumstances:
  - Visiting hospital emergency departments for non-emergency health concerns
  - Using 2 or more hospitals for emergency room services
  - Using 2 or more doctors resulting in duplicated medications and/or treatments
  - Exhibiting possible drug-seeking behavior
    - Requesting a specific scheduled medication (narcotics)
    - Requesting early refills of scheduled medications
    - Reporting frequent losses of scheduled medications
    - Using multiple pharmacies to fill prescriptions
- Your medical records could be wrong—the next time you go to the doctor, you'll have to explain what happened so you don't get the wrong kind of care
- You may have to pay money back or be fined
- You could be arrested and spend time in jail if found guilty of fraud
- You might lose your Medicaid benefits

Who Commits Fraud?

- Most individuals and organizations that work with Medicare and Medicaid are honest
- However, anyone can commit fraud
  - Doctors and health care practitioners
  - Suppliers of durable medical equipment
  - Employees of doctors or suppliers
  - Employees of companies that manage Medicare billing
  - People with Medicare and Medicaid

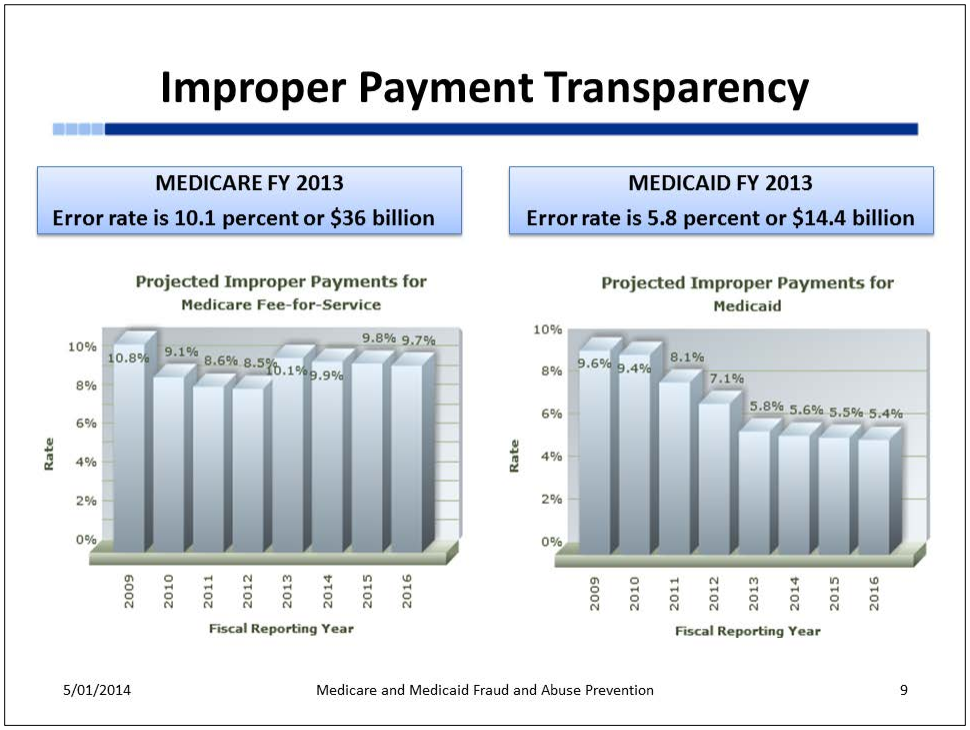
5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 8

Most individuals and organizations that work with Medicare and Medicaid are honest, but there are some bad actors. The Centers for Medicare & Medicaid Services 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
- Employees of doctors or suppliers
- Employees of companies that manage Medicare billing
- People with Medicare and Medicaid

Medicare fraud is prevalent, so it's important for you to be aware of the various entities that have been implicated in fraud schemes. Those who commit fraud could be individuals who are in, or pretend to be in, any of the above-mentioned groups.



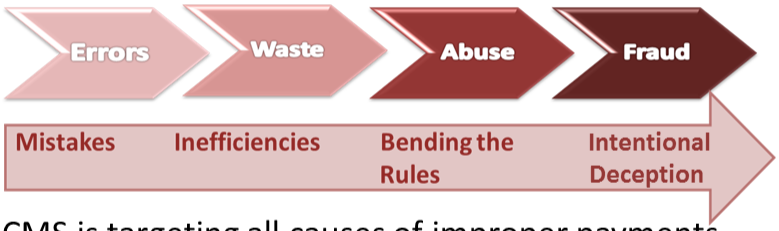
An improper payment, according to the Government Accountability Office, is "any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements." President Obama established a goal to reduce government-wide improper payments. You can see from this graph the goal of reduction in each fiscal year. As part of the Accountable Government Initiative, Medicare and Medicaid are considered high-error programs. Medicare processes over 1 billion fee-for-service claims per year, and pays over $357 billion for more than 55 million beneficiaries. The FY 2013 improper payment rate was 10.1 percent, representing $36 billion in improper payments.

Each year, Medicaid processes 3.9 billion claims representing more than $430 billion paid annually. The FY 2013 improper payment rate was 5.8 percent, representing $14.4 billion in improper payments.

NOTE: Error rates can be viewed at paymentaccuracy.gov/.

Causes of Improper Payments

- Not all improper payments are fraud, but all payments made due to fraud schemes are improper



- CMS is targeting all causes of improper payments
  - From honest mistakes to intentional deception
- Most common error is insufficient documentation

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 10

Causes of improper payments include errors, waste, abuse, and fraud—also known as mistakes, inefficiencies, bending the rules, and intentional deception.

The Centers for Medicare & Medicaid Services (CMS) program integrity activities target all causes of improper payments, from honest mistakes to intentional deception.

Contrary to common perception, not all improper payments are fraud (i.e., an intentional misuse of funds). In fact, the vast majority of improper payments are due to unintentional errors. For example, an error may occur because a program doesn't have documentation to support a beneficiary's eligibility for a benefit, or an eligible beneficiary receives a payment that is too high—or too low—due to a data entry mistake or inefficiencies.

Also, many of the overpayments are payments that may have been proper, but were labeled improper due to a lack of proper documentation. We believe that if agencies had this documentation, it would show that many of these overpayments were actually proper, and the amount of improper payments actually lost by the government would be even lower than the estimated net loss discussed previously.

CMS uses provider education and outreach for billing errors, and will use its payment suspension authorities in cases of suspected fraudulent conduct.

These activities are designed to ensure that correct payments are made to legitimate providers and suppliers for appropriate and reasonable services and supplies for eligible beneficiaries.

Preventing Fraud in Medicare Parts C and D

- Plan agents and brokers must follow CMS's Marketing Guidelines. Examples of what plans can't do include
  - Send you unwanted emails
  - Come to your home uninvited to get you to join
  - Call you unless you're already a member
  - Offer you cash to join their plan
  - Give you free meals while trying to sell you a plan
  - Talk to you about their plan in areas where you get health care
- If you think a Medicare plan broke the rules
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users should call 1-877-486-2048

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 11

Providers aren't the only focus in preventing Medicare fraud. Medicare health plans and Medicare Prescription Drug Plans that contract with Medicare have responsibilities beyond billing. Plans are responsible for ensuring that they market to beneficiaries in responsible ways that protect the beneficiary and the Medicare program from marketing practices that could result in fraud. This includes the plan's agents or brokers who represent them.

Below are some examples of activities Medicare plans and people who represent them aren't allowed to do:

- Send you unwanted emails or come to your home uninvited to sell a Medicare plan.
- Call you unless you're already a member of the plan. If you're a member, the agent who helped you join can call you.
- Offer you cash to join their plan.
- Give you free meals while trying to sell you a plan.
- 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.

NOTE: Although the Medicare Drug Integrity Contractor fights fraud, waste, and abuse in Medicare Advantage Plans (Part C) and Medicare Prescription Drug Coverage (Part D), they don't handle Parts C and D marketing fraud. Call 1-800-MEDICARE (1-800-633-4227) to report plans that ask for your personal information over the telephone or that call unsolicited to enroll you in a plan. TTY users should call 1-877-486-2048.

Telemarketing and Fraud— Durable Medical Equipment (DME)

- DME telemarketing rules
  - DME suppliers can't 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're 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

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 12

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 DME scams include the following:

- Calls or visits from people saying they represent Medicare
- Telephone or door-to-door selling techniques
- Equipment or service is offered free and you're 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

NOTE: Call 1-800-MEDICARE (1-800-633-4227) to report suspected DME scams. TTY users should call 1-877-486-2048.

Quality of Care Concerns

- Patient quality of care concerns aren't necessarily fraud
  - Medication errors
  - Change in condition not treated
  - Discharged from the hospital too soon
  - Incomplete discharge instructions and/or arrangements
- Contact your Beneficiary and Family-Centered Care Quality Improvement Organization
  - Visit Medicare.gov/contacts and click on Find Helpful Contacts
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users should call 1-877-486-2048

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 13

There is a specific Quality Improvement Organization (QIO) just to address the concerns of people with Medicare and their families, called a Beneficiary and Family-Centered Care (BFCC) QIO.

Patient quality of care concerns aren't necessarily fraud. Examples of quality of care concerns that your BFCC-QIO can address include the following:

- Medication errors, like being given the wrong medication, being given medication at the wrong time, being given a medication to which you're allergic, or being given medications that interact in a negative way. They can evaluate if it merits Medicare Drug Integrity Contractor intervention.
- 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 BFCC-QIOs will help you with these issues. To get the address and phone number of the BFCC-QIO for your state or territory, visit Medicare.gov/contacts 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). TTY users should call 1-877-486-2048.

Check Your Knowledge—Question 1

Those who commit Medicare fraud can include

a. People with Medicare
b. Suppliers of durable medical equipment
c. Doctors and health care practitioners
d. All of the above

05/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 14

Check Your Knowledge—Question 1

Those who commit Medicare fraud can include

a. People with Medicare
b. Suppliers of durable medical equipment
c. Doctors and health care practitioners
d. All of the above

ANSWER: d. All of the above

Medicare fraud is prevalent, so it's important for you to be aware of the various entities that have been implicated in fraud schemes. Those who commit fraud could be individuals who are in, or pretend to be in any of these groups:

- Doctors and health care practitioners
- Suppliers of durable medical equipment
- Employees of doctors or suppliers
- Employees of companies that manage Medicare billing
- People with Medicare and Medicaid

Check Your Knowledge—Question 2

It's considered fraud if someone else uses your Medicare card with your permission

a. True
b. False

05/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 15

Check Your Knowledge—Question 2

It's considered fraud if someone else uses your Medicare card with your permission

a. True
b. False

ANSWER: a. True

It's considered fraud if someone else uses your Medicare or Medicaid card with or without your permission.

Lesson 2—CMS Fraud and Abuse Strategies

- The Center for Program Integrity
- CMS Program Integrity Contractors
- CMS Administrative Actions
- Law Enforcement Actions
- The Health Care Fraud Prevention Partnership
- Health Care Fraud Prevention and Enforcement Action (HEAT) Team
- The Fraud Prevention Toolkit at CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/fwa.html
- Provider and Beneficiary Education

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 16

Lesson 2 discusses the following:

- The Center for Program Integrity
- The Centers for Medicare & Medicaid Services (CMS) Program Integrity Contractors
- CMS Administrative Actions
- Law Enforcement Actions
- The Health Care Fraud Prevention Partnership
- Health Care Fraud Prevention and Enforcement Action (HEAT) Team
- The Fraud Prevention Toolkit at CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/fwa.html
- Provider and Beneficiary Education

CMS Center for Program Integrity

- Consolidates CMS anti-fraud components
- Authorities from the Affordable Care Act
  - More rigorous screenings for health care providers
  - Reciprocal termination of providers from Medicare, Medicaid, and the Children's Health Insurance Program
  - May temporarily stop enrollment in high-risk areas
    - Used first in July 2013 and extended into 2015
  - Temporarily stop payments in cases of suspected fraud

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 17

The Center for Program Integrity 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.

Rules permitted by the Affordable Care Act have helped Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) move beyond the "pay and chase" approach to health care fraud to a more proactive and transparent approach:

- Creating a rigorous screening process for providers and suppliers enrolling in Medicare, Medicaid, and CHIP.
- Requiring 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, are 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 are 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. CMS used this authority for the first time in July 2013 on new home health agencies in Miami and Chicago, and ambulance companies in Houston, based on their risk of fraud to Medicare and Medicaid.
- In the 2 years after the implementation of the Affordable Care Act, CMS doubled the number of providers who've had their billing privileges revoked compared to the 2 years prior, thanks to the new screening requirements and other proactive initiatives.

CMS Program Integrity Contractors

- A nationally coordinated Medicare/Medicaid program integrity strategy that cuts across regions
  - Zone Program Integrity Contractors (ZPIC)
  - National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
  - Recovery Audit Program
  - Outreach & Education MEDIC (O&E MEDIC)
  - Medicaid Integrity Contractors

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 18

The Centers for Medicare & Medicaid Services Program Integrity Contractors are a nationally coordinated Medicare/Medicaid program integrity team of contractors that cuts across regions. They include the following:

- Zone Program Integrity Contractors (ZPIC)
- National Benefit Integrity (NBI) MEDIC
- Recovery Audit Program
- Outreach & Education MEDIC (O&E MEDIC)
- Medicaid Integrity Contractors

NOTE: See also "Contractor Entities At-a-Glance" at CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf.

Zone Program Integrity Contractors (ZPICs)

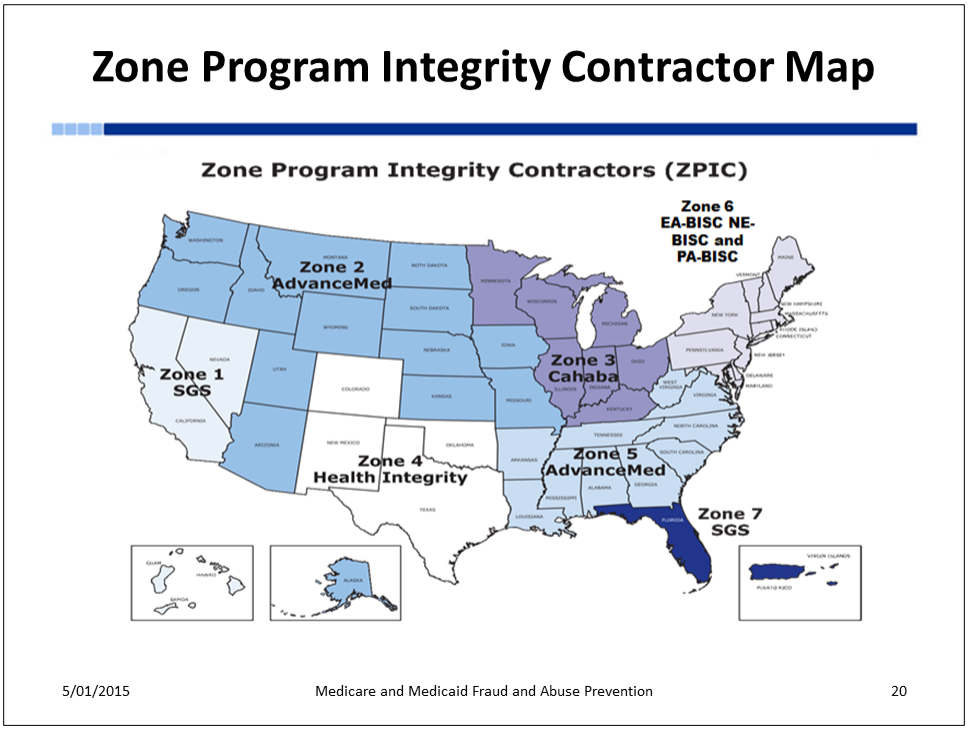
- Investigate leads generated by the new Fraud Prevention System (FPS) and a variety of other sources
- Provide feedback to CMS to improve the FPS
- Perform data analysis to identify and investigate cases of suspected fraud, waste, and abuse
- Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars
- Make referrals to law enforcement for potential prosecution
- Provide support for ongoing law enforcement investigations
- Identify improper payments to be recovered by Medicare Administrative Contractors

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 19

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

ZPICs main responsibilities include the following:

- Investigate leads generated by the new Fraud Prevention System (FPS) and a variety of other sources.
- Provide feedback and support to CMS to improve the FPS.
- Perform data analysis to identify and investigate cases of suspected fraud, waste, and abuse.
- Make referrals to law enforcement for potential prosecution.
- Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars.
- Provide support for ongoing law enforcement investigations.
- Identify improper payments to be recovered by Medicare Administrative Contractors (MACs). CMS relies on a network of MACs to process Medicare claims, and MACs serve as the primary operational contact between the Medicare Fee-for-Service program and approximately 1.5 million health care providers enrolled in the program.



The Zone Program Integrity Contractor operates in 7 zones. They align with Medicare Administrative Contractor jurisdictions.

- 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 EA-BISC, NE-BISC, and PA-BISC and includes Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and the District of Columbia.
- Zone 7 is covered by SGS and includes Florida and Puerto Rico.

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)

- 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
- Works with law enforcement and other stakeholders
- Key responsibilities include
  - 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 agencies
- The Outreach and Education MEDIC provides tools to combat Part C and Part D fraud, waste and abuse

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 21

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) supports the CMS Center for Program Integrity, (CPI). NBI monitors and investigates 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 who work with federal, state, and local law enforcement authorities and other stakeholders. For more information, visit healthintegrity.org/contracts/nbi-medic.

Health Integrity is the Medicare Part C and Part D program integrity contractor for the Centers for Medicare & Medicaid Services (CMS) under NBI MEDIC. Their key responsibilities include the following:

- 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 agencies

Medicare Part C and Part D programs lose millions of dollars to fraud, waste, and abuse each year. The CMS Outreach & Education MEDIC, on behalf of the CMS (CPI), has created a website to help those committed to stopping Part C and Part D fraud, waste, and abuse by providing relevant general news and information, and industry-specific tools and resources. For more information, visit medic-outreach.rainmakerssolutions.com/.

Recovery Audit Program

- Recovery Audit Program's mission
  - Reduce improper Medicare payments by
    - Detecting and collecting overpayments
    - Identifying underpayments
    - Implementing actions to prevent future improper payments
  - Ensure that each Medicare Advantage Plan under Part C and Prescription Drug Plan under Part D has an anti-fraud plan in effect
- States and territories establish Medicaid Recovery Audit Contractors
  - Identify overpayments and underpayments
  - Coordinate efforts with federal and state auditors

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 22

The Recovery Audit Program's mission is to reduce 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.

The Recovery Audit Contractor (RAC) program was permanently implemented for Medicare Parts A and B on a nationwide basis. Under the Patient Protection and Affordable Care Act (ACA), CMS is required to expand the RAC program to the Medicare Parts C/D. Medicare Parts C/D RACs must ensure that each Medicare Advantage Plan under Part C and Prescription Drug Plan under Part D has an anti-fraud plan in effect, and review the effectiveness of each anti-fraud plan.

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. As of March 26, 2014, all except 2 states reported Medicaid RAC data. For more information, visit the Medicaid "RACs At-a-Glance" webpage at w2.dehpg.net/RACSS/Map.aspx.

Outreach & Education MEDIC (O&E MEDIC)

- Created the CMS O&E MEDIC website on behalf of the CMS Center for Program Integrity
  - To help those committed to stopping Parts C/D fraud, waste, and abuse, by providing
    - Outreach and education materials
    - Professional education
    - Regulation and guidance
    - Fraud - fighting resources
    - General news

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 23

Medicare Part C and Part D programs lose millions of dollars to fraud, waste, and abuse each year. CMS Outreach & Education (O&E) MEDIC on behalf of the Centers for Medicare and Medicaid Services (CMS) Center for Program Integrity (CPI) has created the CMS O&E MEDIC website to help those committed to stopping Medicare Part C and Part D fraud, waste, and abuse, Visit medic-outreach.rainmakerssolutions.com/ for relevant

- Outreach and education materials
- Professional education
- Regulation and guidance
- Fraud - fighting resources
- General news

Medicaid Integrity Contractors (MICs)

- Support, not replace, state Medicaid program integrity efforts
- Conduct post-payment audits of Medicaid providers
- Identify overpayments, and refer to the state for collection of the overpayments
- Doesn't adjudicate appeals, but supports state adjudication process
- Three types of MICs: review, audit, and education

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 24

Medicaid Integrity Contractors (MICs)

- Support, not replace, state Medicaid program integrity efforts
- Conduct post-payment audits of Medicaid providers
- Identify overpayments, and refer to the state for collection of the overpayments
- Don't make an official decision about who's right in appeals, but support state adjudication process

There are 3 types of MICs:

a. Review
b. Audit
c. Education

State Medical Assistance (Medicaid) Offices have their own program integrity unit in addition to Medicaid Recovery Audit Contractors, and sometimes states have additional program integrity contractors. The in-house program integrity staff in states perform many of the same functions as Medicare contractors, including data mining, case development, investigations, and provider audits.

For more information, visit CMS.gov/medicare-medicaid-coordination/fraud-prevention/medicaidintegrityprogram.

CMS Administrative Actions

- When CMS suspects fraud, administrative actions include the following:
  - Automatic denials of payment
  - Payment suspensions
  - Prepayment edits
  - Civil monetary penalties
  - Revocation of billing privileges
  - Referral to law enforcement
  - Overpayment determinations

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 25

When fraud is detected, the appropriate administrative actions are imposed by CMS:

- Automatic denials are a "don't 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 pay all or part of a claim, automatically deny all or part of a claim, or suspend 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 monetary penalties 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. Visit oig.hhs.gov/fraud/enforcement/cmp/ for more information.
- Revocation of billing privileges occurs for noncompliance, misconduct, felonies, falsifying information, and other such conditions set forth in 42 CFR,§424.535. Medicare payments are halted and providers are in limbo until the corrective action plan or request for reconsideration process is complete.
- Referrals are made to law enforcement.
- Conducts post-payment reviews to determine if there were overpayments.

Law Enforcement Actions

- When law enforcement finds fraudulent activities, enforcement actions include
  - Providers/companies are barred from the programs
  - Providers/companies can't bill Medicare, Medicaid, or Children's Health Insurance Plan (CHIP)
  - Providers/companies are fined
  - Arrests and convictions occur
  - Corporate Integrity Agreements may be negotiated

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 26

When law enforcement finds fraudulent activities, enforcement actions include the following:

- Providers/companies are barred from the program.
- Providers/companies can't bill Medicare, Medicaid, or Children's Health Insurance Programs.
- Providers/companies are fined.
- Arrests and convictions occur.
- Corporate Integrity Agreements may be negotiated between the U.S. Department of Health & Human Services, Office of Inspector General (OIG), and health care providers and other entities as part of the settlement of federal health care program investigations arising under a variety of civil false claims statutes. Providers or entities agree to the obligations, and in exchange OIG agrees not to seek their exclusion from participation in Medicare, Medicaid, or other federal health care programs.

Health Care Fraud Prevention Partnership

- Includes the federal government, state officials, private health insurance organizations, and other health care anti-fraud groups
  - Shares information and best practices
  - Improves detection
  - Prevents payment of fraudulent health care billings across public and private payers
  - Enables the exchange of data and information among the partners

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 27

The Health Care Fraud Prevention Partnership is designed to reduce health care fraud by partnering 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 health care anti-fraud groups, is designed to accomplish the following:

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

Health Care Fraud Prevention and Enforcement Action (HEAT) Team

- Joint initiative between U.S. Department of Health & Human Services and U.S. Department of Justice
- Improve interagency collaboration on reducing and preventing fraud in federal health care programs
- Increase coordination, data sharing, and training among investigators, agents, prosecutors, analysts, and policymakers

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 28

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is a joint initiative between the U.S. Department of Health & Human Services (HHS) and the U.S. Department of Justice (DOJ) to combat fraud. HEAT task forces are interagency teams comprising 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 interagency 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 forth health care fraud cases and prosecuting them quickly and effectively.

The mission of the HEAT team is as follows:

- Gather resources across the 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 HHS and DOJ to reduce fraud and recover taxpayer dollars

Medicare Fraud Strike Force Teams

- Medicare Fraud Strike Force Teams
  - Located in fraud "hot spot" locations
  - Use advanced data analysis to identify high-billing levels in health care fraud hot spots
  - Coordinate national takedowns
- CMS supports Strike Force takedowns
  - Perform data analysis
  - Suspends payment

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 29

The joint U.S. Department of Health & Human Services/U.S. Department of Justice 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 hot 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 state law enforcement partners to increase the recovery of improper payments and fraud by providing data and other support during Health Care Fraud Prevention and Enforcement Action investigations and prosecutions, and suspending payments for providers subject to credible allegations of fraud.

See also stopmedicarefraud.gov/aboutfraud/heattaskforce/index.html.

Fraud Prevention Toolkit

- Visit CMS.gov to access the Fraud Prevention Toolkit that includes
  - The 4Rs brochure
  - Fact sheets on preventing and detecting fraud
  - Frequently Asked Questions
- CMS.gov also has information about the Center for Program Integrity and fraud prevention efforts in Medicare fee-for-service, Parts C and D, and Medicaid

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 30

- On CMS.gov, we provide a fraud prevention toolkit that includes
  - The 4Rs, brochure which we will discuss in Lesson 3
  - Fact sheets on preventing and detecting fraud
  - Frequently Asked Questions

For more information on the fraud prevention toolkit, visit CMS.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit.html.

For the latest news and information from the Center for Program Integrity, visit CMS.gov/about-cms/components/cpi/center-for-program-integrity.html.

Provider and Beneficiary Education

- 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 identify and report suspected fraud

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 31

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 submissions 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 report suspected fraud. For a copy of the "Program Integrity: Beneficiary Card Sharing Toolkit," visit CMS.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/beneficiary-education-toolkits/beneficiary-toolkit.html.

Check Your Knowledge—Question 3

When CMS detects fraud, administrative actions may include the following:

a. Civil monetary penalties
b. Revocation of billing privileges
c. Referral to law enforcement
d. All of the above

05/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 32

Check Your Knowledge—Question 3

When CMS detects fraud, administrative actions may include the following:

a. Civil monetary penalties
b. Revocation of billing privileges
c. Referral to law enforcement
d. All of the above

ANSWER: d. All of the above

When fraud is detected, the appropriate administrative action is imposed by CMS. Such action includes but isn't limited to the following:

- Civil monetary penalties 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. Visit oig.hhs.gov/fraud/enforcement/cmp/ for more information.
- Revocation of billing privileges occurs for noncompliance, misconduct, felonies, falsifying information, and other such conditions set forth in 42 CFR,§424.535. Medicare payments are halted and providers are in limbo until the corrective action plan or request for reconsideration process is complete.
- Referrals are made to law enforcement.

Lesson 3—How You Can Fight Fraud

- 4Rs for Fighting Medicare Fraud
- stopmedicarefraud.gov
- Medicare Summary Notices
- MyMedicare.gov
- 1-800-MEDICARE
- Senior Medicare Patrol
- Protecting Personal Information and ID Theft
- Reporting Medicaid Fraud
- Helpful Resources

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 33

In Lesson 3, we will learn about how people with Medicare and Medicaid can fight fraud:

- Review 4Rs for Fighting Medicare Fraud
- Learn about the resources available at stopmedicarefraud.gov
- Review Medicare Summary Notices
- Highlight the advantages of using MyMedicare.gov
- Learn how to report fraud and abuse by using 1-800-MEDICARE
- Review the Senior Medicare Patrol program
- Learn helpful tips that people with Medicare and Medicaid can use to protect their personal information and how to handle ID theft
- Discuss reporting Medicaid fraud
- Helpful resources

4Rs for Fighting Medicare Fraud

- You're the first line of defense against Medicare fraud and abuse. Here are some ways you can protect yourself from fraud:
  1. ***Record*** appointments and services
  2. ***Review*** services provided
     - Compare services actually received with services on your Medicare Summary Notice
  3. ***Report*** suspected Fraud
  4. ***Remember*** to protect personal information, such as your Medicare card and bank account numbers

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 34

- **Record** the dates of doctor's appointments on a calendar. Note the tests and services you get, and save the receipts and statements from your providers. If you need help recording the dates and services, ask a friend or family member. Contact your local Senior Medicare Patrol (SMP) program to get a free "Personal Health Care Journal". To locate the SMP program in your area, use the SMP locator at smpresource.org, or call 1-877-808-2468.
- **Review** for signs of fraud, including claims you don't recognize on your Medicare Summary Notices (MSNs), and advertisements or phone calls from companies offering free items or services to people with Medicare. Compare the dates and services on your calendar with your MSNs to make sure you got each service listed and that all the details are correct. If you find items listed in your claims that you don't have a record of, it's possible that you or Medicare may have been billed for services or items you didn't get. Visit MyMedicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to review your Medicare claims. TTY users should call 1-877-486-2048. If you're in a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization) or Medicare Prescription Drug Plan, call your plan for more information about a claim. You can get help from your local SMP program with checking your MSNs for errors or suspected fraud.
- **Report** suspected Medicare fraud by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. When using the automated phone system, have your Medicare card with you and clearly speak or enter your Medicare number and letter(s). If you identify errors or suspect fraud, the SMP can also help you make a report to Medicare.
- **Remember** to protect your Medicare number. Don't give it out, except to your doctor or other health care provider. Never give your Medicare number in exchange for a special offer. Medicare will never contact you and ask for personal information, like your Medicare or bank account numbers. Never let someone use your Medicare card, and never use another person's card.

The "4Rs for Fighting Fraud," CMS Product No. 11610, is available at Medicare.gov/Pubs/pdf/11610.pdf.

STOPMedicareFraud.gov

- Learn about fraud
- Find resources
- Report fraud online
- Access videos
- See recent Health Care Fraud Prevention and Enforcement Action Team HEAT Task Force results by state

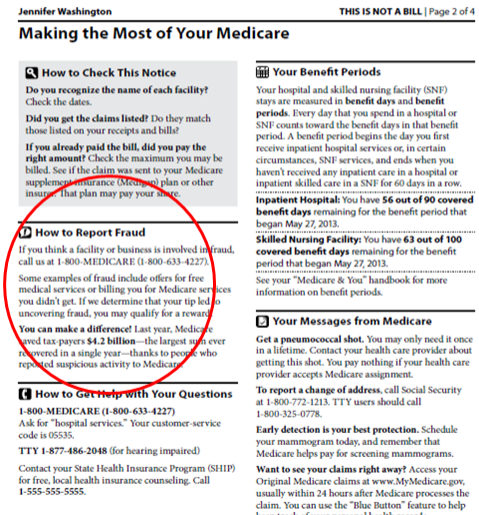
05/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 35

The website stopmedicarefraud.gov is a good place for you to learn about Medicare fraud resources available for beneficiaries and providers.

- Learn about fraud and ways to prevent it
- Find resources
- Report fraud online
- Access videos
- See recent Health Care Fraud Prevention and Enforcement Action Team HEAT Task Force results by state available at stopmedicarefraud.gov/newsroom/your-state/index.html.

Medicare Summary Notice (MSN)

- CMS redesigned the MSN for Part A and Part B to make it easier to read and spot fraud
- Shows all your services or supplies
  - Billed to Medicare in 3-month period
  - What Medicare paid
  - What you owe
- Read it carefully



Jennifer Washington — THIS IS NOT A BILL | Page 2 of 4

Making the Most of Your Medicare

How to Check This Notice

Do you recognize the name of each facility? Check the dates.

Did you get the claims listed? Do they match those listed on your receipts and bills?

If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

How to Report Fraud

If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

You can make a difference! Last year, Medicare saved tax-payers **$4.2 billion**—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

How to Get Help with Your Questions

1-800-MEDICARE (1-800-633-4227)
Ask for "hospital services." Your customer-service code is 05535.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call **1-555-555-5555.**

Your Benefit Periods

Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.

Inpatient Hospital: You have **56 out of 90 covered benefit days** remaining for the benefit period that began May 27, 2013.

Skilled Nursing Facility: You have **63 out of 100 covered benefit days** remaining for the benefit period that began May 27, 2013.

See your "Medicare & You" handbook for more information on benefit periods.

Your Messages from Medicare

Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.

To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

Want to see your claims right away? Access your Original Medicare claims at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can use the "Blue Button" feature to help keep track of your personal health records.

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 36

There is a Part A, a Part B, and a durable medical equipment Medicare Summary Notice (MSN). It was redesigned to make it easier for people with Medicare to spot fraud. This 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 for which Medicare was billed.

CMS redesigned the MSN to make it simpler to understand, spot, and report fraud (on page 2). It provides additional information, like a quarterly summary of claims.

Get help reading your MSN at Medicare.gov/forms-help-and-resources/mail-about-medicare/medicare-summary-notice-msn.html.

Visit Medicare.gov/pubs/pdf/summarynoticea.pdf to see how to read your Part A MSN.

Visit Medicare.gov/pubs/pdf/summarynoticeb.pdf to see how to read your Part B MSN.

MyMedicare.gov

- Secure site to manage personal information
  - Review eligibility, entitlement, and plan information
  - Track preventive services
  - Keep a prescription drug list
- Review claims "if you have Original Medicare"
  - Available almost immediately after they are processed

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 (if you have Original Medicare) and identify fraudulent claims. You don't have to wait to get your Medicare Summary Notice (MSN) in the mail to view your Medicare claims. Visit MyMedicare.gov to track your Medicare claims or view electronic MSNs. Your claims will generally be available within 24 hours after processing.
  - If there's a discrepancy, you should call your doctor or supplier. Call 1-800-MEDICARE if you suspect fraud. TTY users should call 1-877-486-2048.

NOTE: To use this service you must register on the site. Newly eligible beneficiaries are automatically registered and sent a personal identification number.

1-800-MEDICARE (TTY 1-877-486-2048)

- Beneficiary fraud complaints received
  - Help target certain providers/suppliers for review
  - Show where fraud scams are heating up
- Using the Interactive Voice Response System
  - Access up to 15 months of claims
  - Check for proper dates, services, and supplies received
    - If not checking claims on MyMedicare.gov

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 38

CMS is also using 1-800-MEDICARE (1-800-633-4227) for beneficiary complaints to make identifying and reporting fraud easier. TTY users should call 1-877-486-2048. The data gathered helps CMS

- 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.

CMS also has implemented an Interactive Voice Response (IVR) system for beneficiaries who haven't registered or don't use MyMedicare.gov to identify and report fraud. The IVR can access 15 months of Original Medicare claims processed on their behalf if it's available. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

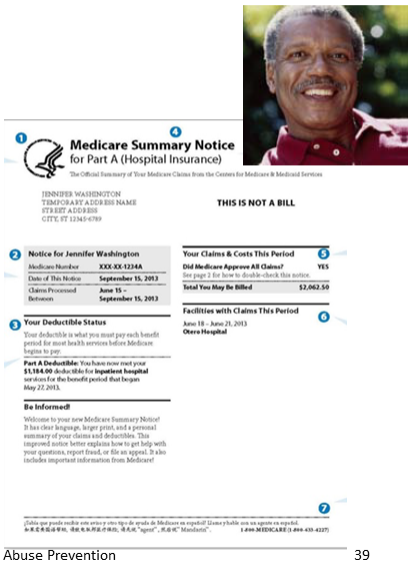
NOTE: Before you report errors, fraud, or abuse, carefully review the facts and have the following information ready:

- The provider's name and any identifying number you may have
- Information on the service or item you're questioning
- The date the service or item was supposedly given or delivered
- The payment amount approved and paid by Medicare
- The date on your Medicare Summary Notice
- Your name and Medicare number (as listed on your Medicare card)
- The reason you think Medicare shouldn't have paid
- Any other information you have showing why Medicare shouldn't have paid

Learning Activity

John has concerns and wants to discuss his Medicare Summary Notice with you.

What are some things that might indicate fraud?



Medicare Summary Notice
for Part A (Hospital Insurance)

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME
678 EST ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	XXX-XX-1234A
Date of This Notice	September 15, 2013
Claims Processed Between	June 15 – September 15, 2013

Your Claims & Costs This Period

Did Medicare Approve All Claims?	YES
See page 2 for how to double-check this notice.	
Total You May Be Billed	$2,062.50

Facilities with Claims This Period

June 18 – June 21, 2013
Otero Hospital

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You have now met your **$1,184.00** deductible for **inpatient hospital** services for the benefit period that began *May 22, 2013.*

Be Informed!

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
1-800-MEDICARE (1-800-633-4227)

05/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 39

Learning Activity

John has concerns and wants to discuss his Medicare Summary Notice with you. What are some things that might indicate fraud? (Discussion is on the next slide).

Learning Activity
What Might Indicate Fraud?

- Was he charged for any medical services he didn't get?
- Do the dates of services look unfamiliar?
- Was he billed for the same thing twice?
- Does his credit report show any unpaid bills for medical services or equipment you didn't receive?
- Has he received any collection notices for medical services or equipment he didn't receive?

Medicare Summary Notice — Activity - What questions should you ask?

- Was he charged for any medical services he didn't get?
- Do the dates of services look unfamiliar?
- Was he billed for the same thing twice?
- Does his credit report show any unpaid bills for medical services or equipment he didn't receive?
- Has he received any collection notices for medical services or equipment he didn't receive?

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 call 1-800-MEDICARE (1-800-633-4227) to report suspected fraud. TTY users should call 1-877-486-2048.
  - The suspected Medicare fraud you report must be investigated and validated by CMS's contractors.
  - The reported fraud must be formally referred to the Office of Inspector General for further investigation.
  - You aren't an excluded individual.
  - 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.

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 41

You may get a reward of up to $1,000 if you meet all of these conditions:

- You call either 1-800-HHS-TIPS (1-800-447-8477) or call 1-800-MEDICARE (1-800-633-4227) to report suspected fraud. TTY users should call 1-877-486-2048.
- The suspected Medicare fraud you report must be proven as potential fraud by 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.

Also, you may want to read the press release at HHS.gov/news/press/2013pres/04/20130424a.html and the Code of Federal Regulations at CFR 420.405 "Rewards for information relating to Medicare fraud and abuse."

The Senior Medicare Patrol

- Education and prevention program aimed at educating beneficiaries on preventing, identifying, and reporting health care fraud
- Active programs in all states, the District of Columbia, Puerto Rico, Guam, and U.S. Virgin Islands
- Seeks volunteers to represent their communities
- Nationwide toll-free number: 1-877-808-2468

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 42

The Senior Medicare Patrols (SMPs) empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. SMPs are grant-funded projects of the U.S. Department of Health & Human Services (HHS), U.S. Administration for Community Living (ACL). Their work is in 3 main areas:

- Conduct Outreach and Education. SMPs give presentations to groups, exhibit at events, and work one-on-one with Medicare beneficiaries. In 2013, more than 1 million people were served nationally by the SMP program's outreach and education efforts.
- Engage Volunteers. Protecting older persons' health, finances, and medical identity while saving precious Medicare dollars is a cause that attracts civic-minded Americans. The SMP program engages over 5,000 volunteers nationally who collectively contribute approximately 150,000 hours each year.
- Receive Beneficiary Complaints. When Medicare beneficiaries, caregivers, and family members bring their complaints to the SMP, the SMP makes a determination about whether or not fraud, errors, or abuse is suspected. When fraud or abuse is suspected, they make referrals to the appropriate state and federal agencies for further investigation.

There are 54 SMP programs, including one in each state, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. SMPs seek volunteers to represent the program in their communities.

NOTE: For an in-depth overview of the SMP program, and for information for your local area, visit smpresource.org/ or call the nationwide toll-free number at 1-877-808-2468. Callers receive information about the SMP program and are connected to the SMP in their state for individualized assistance. This number can also be found in the "Medicare & You" handbook and other national Medicare and anti-fraud publications that reference the SMP program. You can also email them at info@smpresource.org.

Protecting Personal Information

- Only share with people you trust
  - Doctors, other health care providers, and plans approved by Medicare
  - Insurers who pay benefits on your behalf
  - Trusted people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security
- Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare
  - TTY users should call 1-877-486-2048

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 43

Keep your personal information safe, such as your Medicare, Social Security, and credit card numbers. Only share this information with people you trust, such as

- Your doctors, other health care providers, and plans approved by Medicare
- Insurers who pay benefits on your behalf
- Trusted people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security

Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a provider is approved by Medicare. TTY users should call 1-877-486-2048.

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 should call 1-800-325-0778

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 44

Identity theft is when someone else uses your personal information, like your Social Security or Medicare number. It's a serious crime. Currently, CMS is aware of 5,000 compromised Medicare provider numbers (Parts A/B/D) and 284,000 compromised beneficiary numbers.

If you think someone is using your information, you have options:

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

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

Reporting Suspected Medicaid Fraud

- Medicaid Fraud Control Unit (MFCU) investigates and prosecutes
  - Medicaid fraud
  - Patient abuse and neglect in health care facilities
  - Call the Office of the Inspector General at 1-800-447-8477 (TTY 1-800-377-4950)
    - They also certify and annually re-certify the MFCU
- State Medical Assistance (Medicaid) office
  - See state listing for Medicaid
    - Download contacts at oig.hhs.gov/fraud/Medicaid-fraud-control-units-mfcu/files/contact-directors.pdf

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 45

There are organizations to which you may report suspected Medicaid errors, fraud, or abuse:

- Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. The Office of Inspector General (OIG) certifies and annually re-certifies each MFCU. You may direct complaints of suspected Medicaid fraud directly to an MFCU. Download contacts at oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/contact-directors.pdf.
- U.S. Department of Health & Human Services (HHS) OIG.
- Call: 1-800-447-8477. TTY users should call 1-800-377-4950.
- Online: Report Fraud Online (forms.oig.hhs.gov/hotlineoperations/.)
- Mail: HHS Tips Hotline, P.O. Box 23489, Washington, DC 20026-3489.
- You can also report suspected fraud and abuse to your State Medical Assistance (Medicaid) office. You may locate them at CMS.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/downloads/smafraudcontacts-october2013.pdf.
- Learn more about Medicaid fraud at Medicaid.gov/medicaid-chip-program-information/by-topics/program-integrity/program-integrity.html .

Key Points to Remember

- ✓ The key difference between fraud and abuse is intention
- ✓ Improper payments are often mistakes
- ✓ CMS fights fraud and abuse with support from Program Integrity Contractors
- ✓ You can fight fraud and abuse with the 4Rs – Record, Review, Report, Remember
- ✓ There are many sources of additional information

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 46

Key points to remember include the following:

- The difference between fraud and abuse is intention
- While there are many causes of improper payments, many are honest mistakes
- The Centers for Medicare & Medicaid Services fights fraud and abuse with support from Program Integrity Contractors and partnerships with organizations such as Senor Medicare Patrols and the private industry
- You can fight fraud and abuse with the 4Rs: record, review, report, and remember
- There are many sources of additional information

Medicare Fraud & Abuse Resource Guide

Medicare Fraud & Abuse Resource Guide

Resources		Medicare Products
Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) Medicare.gov **MyMedicare.gov** - MyMedicare.gov/ **CMS Program Integrity** CMS.gov/ About-CMS/Components/CPI/Center-for-program-integrity.html **STOPMedicarefraud.gov** **Office of Inspector General** oig.hhs.gov/ U.S. Department of Health & Human Services ATTN: HOTLINE (forms.oig.hhs.gov/hotlineoperations/) P.O. 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 **HealthCare.gov** HealthCare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/ **Social Security Administration** SSA.gov 1-800-772-1213 TTY 1-800-325-0778	**Senior Medicare Patrol Program** SMPresource.org Find the SMP resources in your state under Find Help - SMP locator **Fraud Scams** SMPResource.org/AM/Template.cfm?Section=Scams1&Template=/CM/HTMLDisplay.cfm&ContentID=5912 **NBI Medic's Parts C&D Fraud Reporting Group** 1-877-7SAFERX (1-877-772-3379) healthintegrity.org/contracts/nbi-medic/reporting-a-complaint Fax a Complaint Form to 410-819-8698 Mail to: Health Integrity, LLC, 7102 Ambassador Road, Suite 100, Windsor Mill, MD 21244 healthintegrity.org/contracts/nbi-medic **National Health Care Anti-Fraud Assoc.** NHCAA.org **Medicaid Beneficiary Education** CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html **Prevention Toolkit** CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html **CMS Outreach & Education MEDIC** medic-outreach.rainmakerssolutions.com/	**"Medicare Authorization to Disclose Personal Information" form** CMS Product No. 10106 **"Help Prevent Fraud: Check Your Medicare Claims Early!"** CMS Product No. 11491 and No. 11492 **"Protecting Medicare and You From Fraud"** CMS Product No. 10111 **"Quick Facts About Medicare Plans and Protecting Your Personal Information"** CMS Product No. 11147 **"4Rs for Fighting Fraud"** CMS Product No. 11610 **"You Can Help Protect Yourself and Medicare From Fraud Committed by Dishonest Suppliers"** CMS Product No. 11442 **To access these products:** View and order single copies: Medicare.gov/publications Order multiple copies (partners only): productordering.cms.hhs.gov (You must register your organization.)

5/01/2015 Medicare and Medicaid Fraud and Abuse Prevention 47

Acronyms

BFCC-QIO	Beneficiary and Family-Centered Care
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
DME	Durable Medical Equipment
DOJ	Department of Justice
FFS	Fee-for-Service
FPS	Fraud Prevention System
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	Health and Human Services
IVR	Interactive Voice Response
MA	Medicare Advantage
MAC	Medicare Administrative Contractors
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Unit
MICs	Medicaid Integrity Contractors
MSN	Medicare Summary Notice
NBI	National Benefit Integrity
NTP	National Training Program
O&E	Outreach and Education
OIG	Office of Inspector General
OPA	Office of Public Affairs
QIO	Quality Improvement Organization
RAC	Recovery Audit Contractor
SMP	Senior Medicare Patrol
TTY	Teletypewriter
ZPIC	Zone Program Integrity Contractor

CMS National Training Program (NTP)

To view all available NTP training materials, or to subscribe to our email list, visit

CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html

For questions about training products email

training@cms.hhs.gov

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