DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

Medicare Fraud & Abuse: Prevention, Detection, and Reporting Facilitator Kit

ICN: 908104 August 2012

Dear CMS Regional Office or Other CMS Partner,

The Division of Provider Information Planning and Development (DPIPD) has created in-person training materials to assist you in teaching provider and other audiences about **Medicare Fraud & Abuse: Prevention, Detection, and Reporting.**

In this package you will find:

1. The Medicare Fraud & Abuse: Prevention, Detection, and Reporting PowerPoint.
2. The Medicare Fraud & Abuse: Prevention, Detection, and Reporting Facilitator Kit.

DPIPD hopes you find these free educational materials helpful and appreciates your willingness to educate health care professionals about fraud, waste, and abuse.

Contents

"Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Facilitator Kit

Preparation

Before you present, thoroughly review this facilitator kit. Ensure that you have all of the necessary equipment and printed documents and are familiar with the speaker notes and the material in the presentation. Then you'll be on your way to successfully teaching "Medicare Fraud & Abuse: Prevention, Detection, and Reporting!"

Required Materials

- Computer, projector(s), and screen(s).
- Obtain these materials from CMS Central Office:
  - Request the most current version of the Fraud and Abuse PowerPoint (PPT) and assure you have the most recent version of this facilitator kit.

Recommended Materials

- We recommend you have internet access for this presentation in order to access some of the URLs in the resources section of the presentation.

Required Printed Documents

- For the facilitator, make one copy of:
  - Sign-in sheet (Type presentation details such as date and location before printing.)
  - Team scoring sheet
  - Answer Keys for both the Pre-assessment and Post-assessment

- For each attendee, make a copy of:
  - Job Aid D from the "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Web-Based Training (WBT) course "Tips for Avoiding Medicare Fraud and Abuse" to use for the game handout. To access the course, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html and click Web-Based Training (WBT) Courses in the Related Links. Then select the Fraud and Abuse course.
  - PPT presentation in Handout View. (They will use this for note taking; remember, omit the pre- and post-assessment when printing for the attendees.)
  - Pre-assessment
  - Post-assessment
  - Course evaluation (The MLN course evaluation can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Opinion.html on the CMS website.)

Instructions

PowerPoint Instructions

Important note: This presentation, including speaker notes, has been vetted and approved by CMS Central Office and should not be changed or added to.

- Speaker notes in bold should be read aloud to the audience.
- Speaker notes not in bold are for the speaker(s)' own reference and instruction; these are not to be read to the audience. However, please note that the non-bold notes may mention reading something directly from the slide to the audience. In that case, the portion of the slide the speaker is instructed to read should be read aloud.
- Sources within the speaker notes are for the speaker(s)' reference; informing the audience of any or all of the sources is up to the speaker(s)' discretion.

Pre-Assessment Instructions

1. Enclosed is a pre-assessment form including a space for each attendee's name, name and date of event and his/her answers.
2. At slide 5, hand out the pre-assessment to the learners. Allow the attendees enough time to answer each question before moving on to the next question.
3. Collect the completed pre-assessments before proceeding with the presentation.

Post-Assessment Instructions

1. Enclosed is a post-assessment form including a space for each attendee's name, name and date of event and his/her answers.
2. Hand out the post-assessment at the end of slide 70. Allow the attendees enough time to answer each question before moving on to the next question.
3. Collect the completed post-assessments and course evaluations as the learners leave the room.

Game Instructions

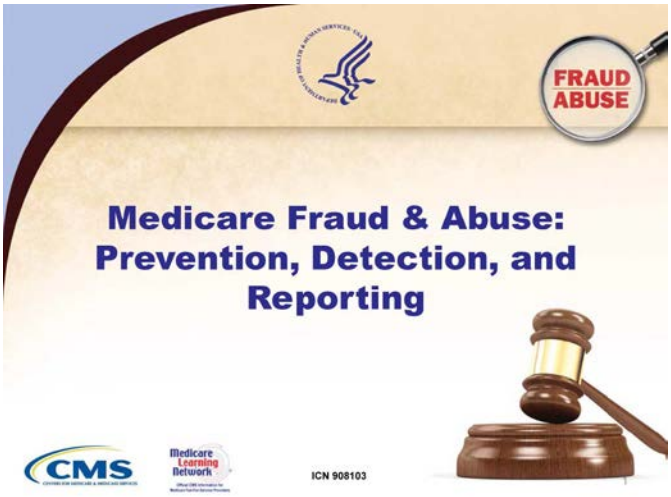
Within the presentation is a game that the learners will play. You will use the enclosed team scoring sheet while playing this game. It is recommended that someone other than the speaker(s) maintain the scores. If you choose to keep track of the scores on the computer, the Team Scoring Sheet is formulated to automatically compile the scores for each team. When a team answers a question correctly, enter a 1 in that score box. If no points are awarded for a question for a specific team, enter a 0 in the corresponding score box. Each team's total will show at the bottom of the Team Scoring Sheet. See the instructions below for further information regarding the game.

- Prior to the presentation, decide on the best way to divide the audience into teams, and adapt the scoring sheet accordingly.
- At slide 9, divide the audience into teams (number of teams and logistics for dividing to be determined by the instructor.)
- Explain that the game questions are just for fun; they don't affect the assessments.

- Explain how they will select their answers to each question. (This may vary depending on the technology available to you.)
- It is recommended that someone other than the speaker(s) maintain the scores.
- In the game, slides 35 and 36 use the “Tips for Avoiding Medicare Fraud and Abuse” handout. Allow the learners a few extra minutes to look through the handout for the answers.
- At slide 41, announce the halftime results. (I.e. announce the teams’ current scores.)
- At slide 74, announce which team is the winner of the game, and hand out prizes to the winning team (if possible to obtain appropriate prizes.)
- Understand that some of the game questions come before you teach the information in order to generate interest; other questions come after a teaching slide to reinforce learning.

Speaker Notes

SLIDE 1



IMPORTANT NOTE: This presentation, including speaker notes, has been vetted and approved by CMS Central Office and should not be changed or added to.

[Insert title of your conference/meeting name if desired]

SLIDE 2

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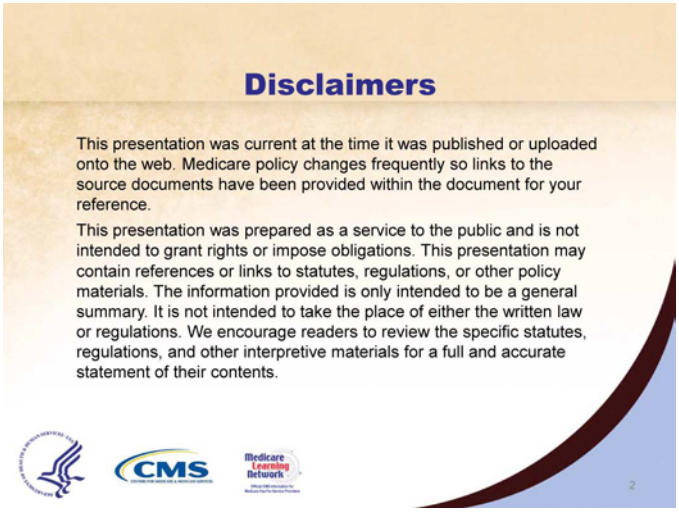

SLIDE 3

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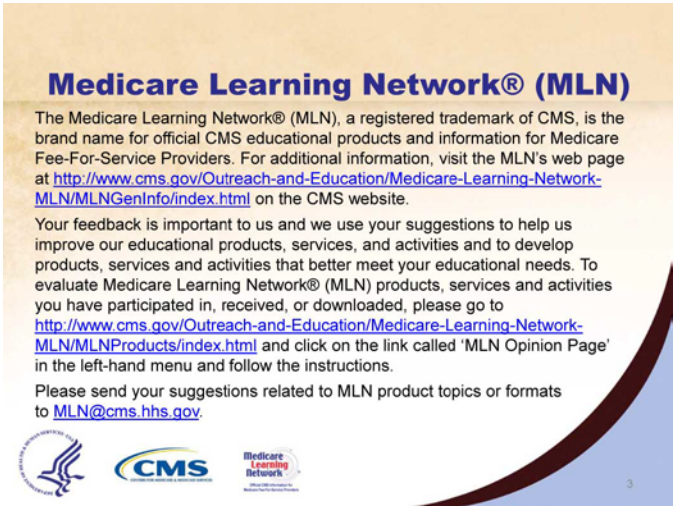
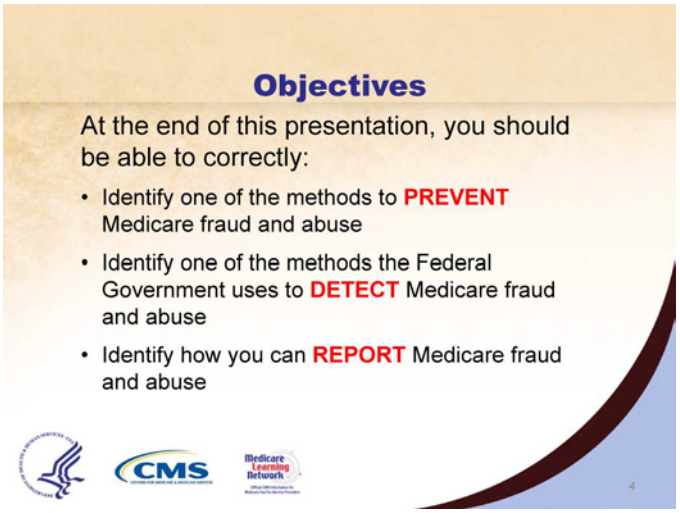


SLIDE 4

Read objectives from slide.

Objectives
At the end of this presentation, you should be able to correctly: • Identify one of the methods to **PREVENT** Medicare fraud and abuse • Identify one of the methods the Federal Government uses to **DETECT** Medicare fraud and abuse • Identify how you can **REPORT** Medicare fraud and abuse

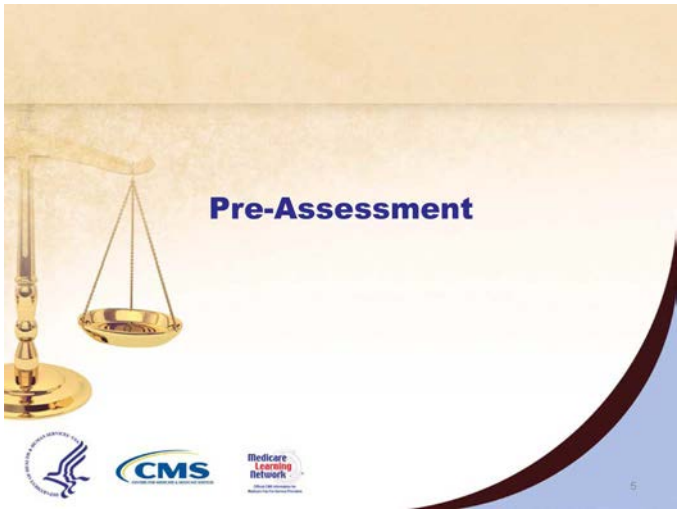
Then say, "**The post-assessment will address these objectives. "**
"Please hold all questions until _____. "(the time you have specified for questions)



SLIDE 5
Distribute the pre-assessments. Remember: there is an answer key document; please refer to the "Fraud & Abuse Facilitator Kit" document for distribution/collection of the forms.

The learners will not receive feedback on their pre-assessment answers.

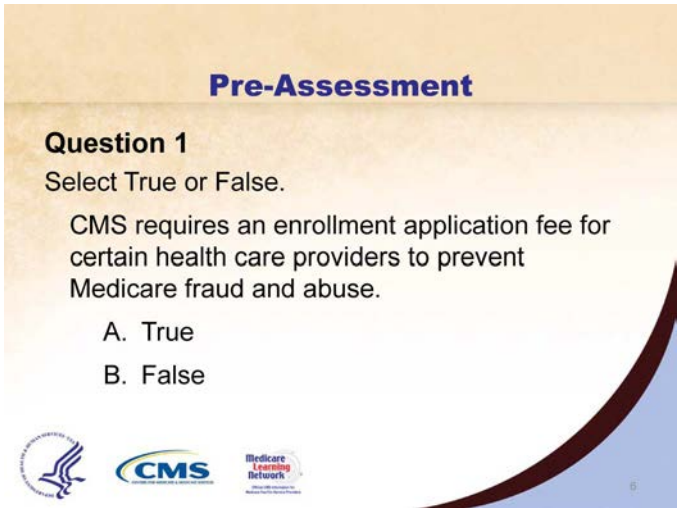
"All answers to these questions will be discussed during the presentation, which will be followed by a similar post-assessment."



SLIDE 6
Read the question and allow time for them to select the answer.

Question 1
Select True or False.
CMS requires an enrollment application fee for certain health care providers to prevent Medicare fraud and abuse.
A. True
B. False

Correct Answer: A.

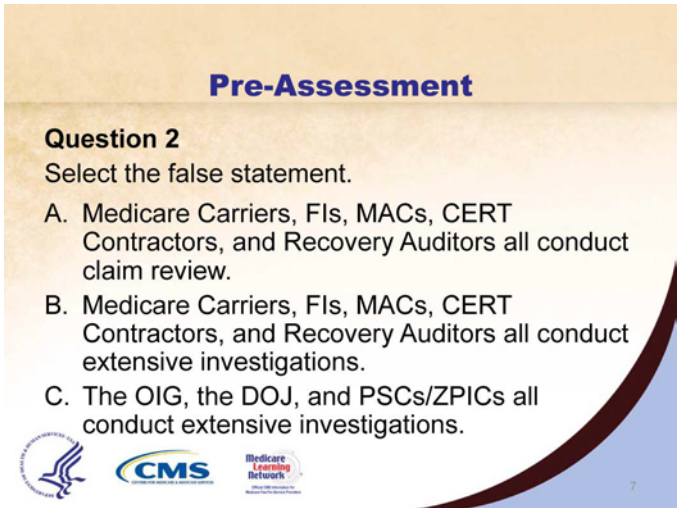


SLIDE 7
Read the question and allow time for them to select the answer.

Question 2
Select the false statement.

A. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Auditors all conduct claim review.
B. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Auditors all conduct extensive investigations.
C. The OIG, the DOJ, and PSCs/ZPICs all conduct extensive investigations.

Correct Answer: B.



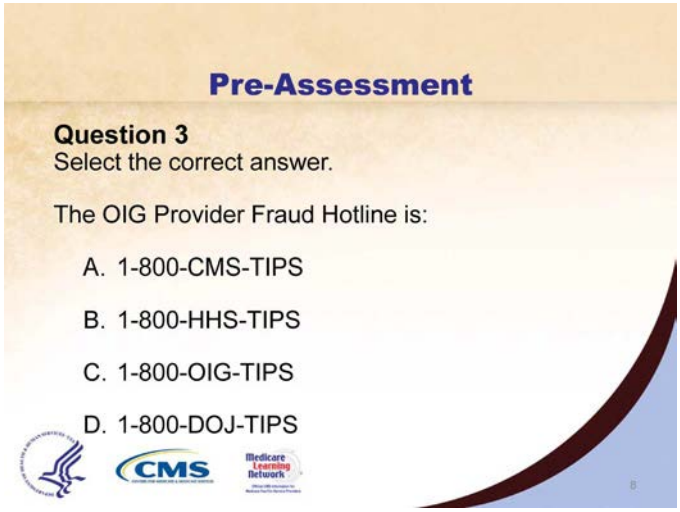
SLIDE 8
Read the question and allow time for them to select the answer.

Question 3
Select the correct answer.

The OIG Provider Fraud Hotline is:
A. 1-800-CMS-TIPS
B. 1-800-HHS-TIPS
C. 1-800-OIG-TIPS
D. 1-800-DOJ-TIPS

Correct Answer: B.

Collect the pre-assessments.



SLIDE 9
"Now that we've completed the Pre-Assessment, we're going to play a game that will continue throughout the presentation. Welcome to Are you smarter than an OIG Fugitive?

Explain the game – (Information is provided in the "Fraud & Abuse Facilitator Kit" document.)

"The logo on the left is from the HHS OIG website."

SLIDE 10

Instead of the slide, read:

"Now that we've explained the game, keep a look out for the OIG fugitive game questions. Until the first question comes up, we will begin discussing Medicare Fraud and Abuse."

SLIDE 11

Read this before reviewing the content on the slide: **"Medicare fraud affects every American. Fraud and abuse take critical resources out of our health care system, and contribute to the rising cost of health care for all Americans. Eliminating fraud will cut costs for families, businesses and the federal government and increase the quality of services for those who need care."**

For 1st point read: "**Most Medicare providers and contractors are honest and well-intentioned. Fraud and abuse persist because some people perceive Medicare as easy money with minimal risk of being caught."**

For 2nd point read:

"In Fiscal Year 2010, Federal health care fraud prevention and enforcement efforts recovered more than $4 billion in taxpayer dollars."

After the last point, read: "**Let's review an example of a guilty provider."**

Source: Fiscal Year 2010 information-
http://www.stopmedicarefraud.gov/aboutfraud/index.html

SLIDE 12

"We've not presented this information yet-this question is to reinforce the previous slide about recoveries by showing you just one example and asking you to guess the amount."

Read the question and answer choices.
Question 1.

How much did these providers plead guilty to?
Two owners of a home health care company that claimed to provide skilled nursing to Medicare beneficiaries pleaded guilty in connection with a **$____** Medicare fraud scheme. Each owner pleaded guilty to:

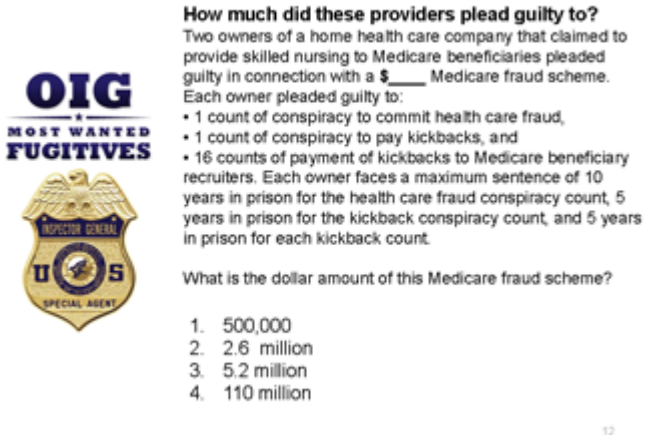
- 1 count of conspiracy to commit health care fraud,
- 1 count of conspiracy to pay kickbacks, and
- 16 counts of payment of kickbacks to Medicare beneficiary recruiters. Each owner faces a maximum sentence of 10 years in prison for the health care fraud conspiracy count, 5 years in prison for the kickback conspiracy count, and 5 years in prison for each kickback count.

What is the dollar amount of this Medicare fraud scheme?

1. 500,000
2. 2.6 million
3. 5.2 million
4. 110 million

Answer: **3. 5.2 million**

Transition to next slide: "**This was fraud; let's review the difference between Fraud and Abuse."** Sources: JOB AID A in the Web-Based Training - MLN vetted Web-Based Training



SLIDE 13
Read the slide.

What is Fraud? Making false statements or representations of material facts to Obtain some benefit or payment For which no entitlement would otherwise exist Includes obtaining something of value through Misrepresentations or Concealment of material facts

SLIDE 14 – What is Abuse?

1st discussion point:

"Abuse DESCRIBES…Practices that, directly or indirectly, result in unnecessary costs to the Medicare Program"

2nd discussion point:

"Abuse includes any practice that is not consistent with the goals of providing patients with services that:

- **are medically necessary,**
- **meet professionally recognized standards,**
- **and are fairly priced."**

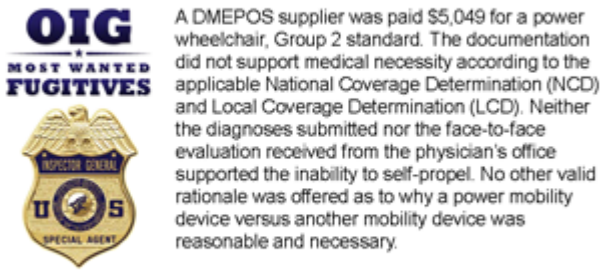
SLIDE 15

"Again, we've not taught you this yet. It's an example of fraud and abuse from the Web-Based Training that you can take on the CMS website, under Outreach and Education."

Read the question.

A DMEPOS supplier was paid $5,049 for a power wheelchair, Group 2 standard. The documentation did not support medical necessity according to the applicable National Coverage Determination (NCD) and Local Coverage Determination (LCD). Neither the diagnoses submitted nor the face-to-face evaluation received from the physician's office supported the inability to self-propel. No other valid rationale was offered as to why a power mobility device versus another mobility device was reasonable and necessary.

Question 2. "**Answers are on following page."**

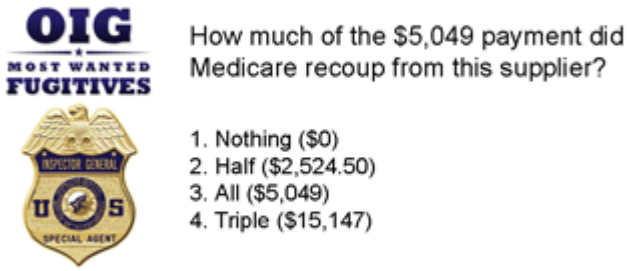


SLIDE 16
Read the question and answer choices.

How much of the $5,049 payment did Medicare recoup from this supplier? 1. Nothing ($0) 2. Half ($2,524.50) 3. All ($5,049) 4. Triple ($15,147)

Answer: **3. All**

Source: Job Aid B of the Web-Based Training: case example of Medicare abuse



SLIDE 17
"In addition to the Social Security Act, there are other statutes that are important to review regarding Medicare F and A. Let's review those now."

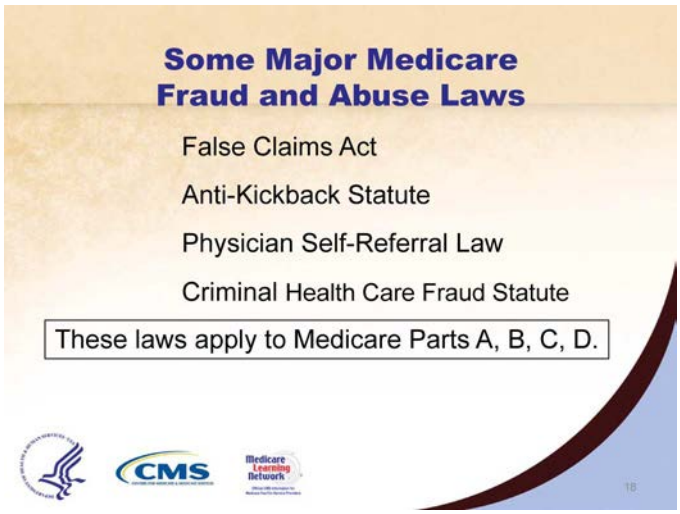
Source of SSA: the Web-Based Training

SLIDE 18
Read list on the slide

Some Major Medicare Fraud and Abuse Laws False Claims Act Anti-Kickback Statute Physician Self-Referral Law Criminal Health Care Fraud Statute These laws apply to Medicare Parts A, B, C, D.

Then say**: "These laws apply to Medicare Parts A, B, (Original Medicare) C (Medicare Managed Care), and D."**

1st talking point: "**Each of these laws will be discussed more in-depth in the following slides."**
2nd talking point: Provide a brief (1-2 sentences) explanation of Medicare Parts A, B, C, and D.



SLIDE 19

Read the 1st point and bullets.

What is the False Claims Act (FCA)? Protects the Federal Government from - Overcharges or - Sold substandard goods or services

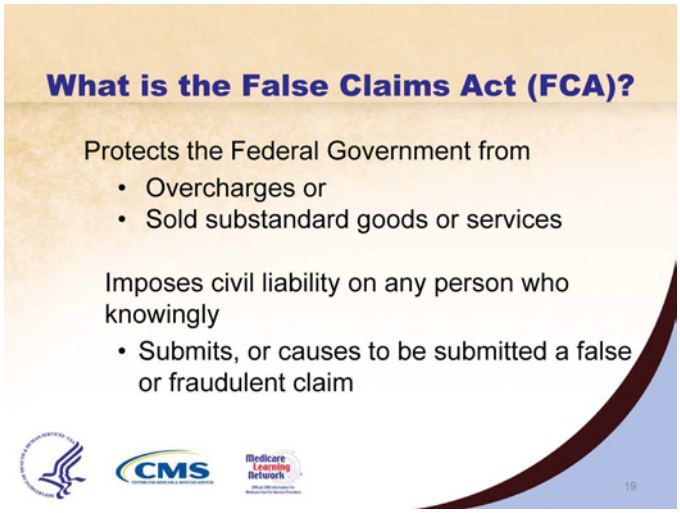
Then mention: "**This law was passed during the Civil War –of course Medicare didn't exist then but apparently fraud did!"**

Read the 2nd point and bullet

Imposes civil liability on any person who knowingly - Submits, or causes to be submitted a false or fraudulent claim

Then say: **"Someone does not have to <u>intend to defraud</u> the Federal Government to violate the FCA. The knowing standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim."**

Sources: Civil War=Wikipedia, rest Web-Based Training



SLIDE 20
Read the slide

What is the Anti-Kickback Statue? • Prohibits knowingly and willfully • To induce or reward referrals of items/ services reimbursable by a Federal health care program Safe harbors exist

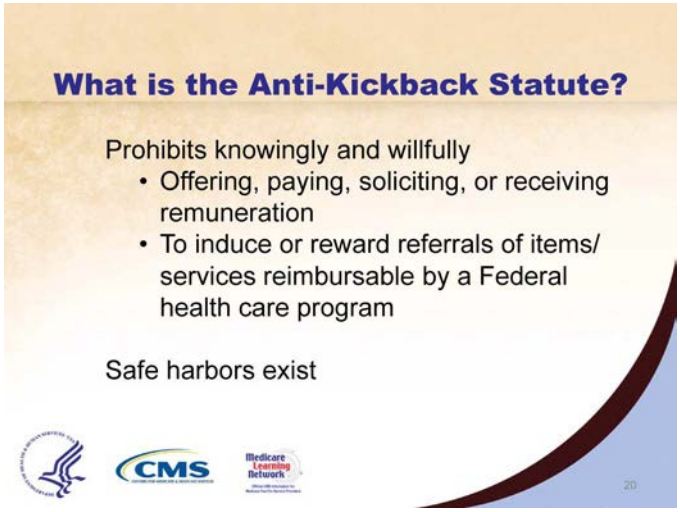
Then say the following regarding safe harbors after you've read the slide:

"Safe harbor regulations <u>allow certain arrangements to avoid being treated as an offense."</u>

And then **"Here are some examples of kickbacks:**

- **Cash for referrals,**
- **Free rent or below fair-market value rent for medical offices,**
- **Free clerical staff, and**
- **Excessive compensation for medical directorships."**

Source: Web-Based Training



SLIDE 21

Read the title

What is the Physician Self-Referral Law (Stark Law)?

Mention **– "By the way this law is not stark defined in the dictionary but rather named after Congressman Stark."**

Read the 1st point

Prohibits referring Medicare beneficiaries for Certain designated health services To an entity in which the physician (or an immediate family member) has An ownership/investment interest, or A compensation arrangement

Then explain:

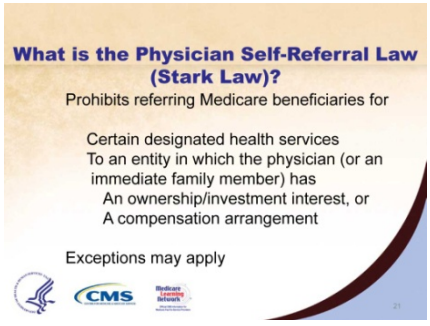
"Examples of Designated Health Services are: clinical lab, physical therapy, home health services."

Then read the last point about exceptions.

Exceptions may apply

After last point read:

"In addition to the Physician Self-Referral Law, further protections were enacted under the Affordable Care Act for Advanced Imaging Services. (Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CT), and Positron Emission Tomography (PET). At the time of an in-office physician referral for Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CT), and Positron Emission Tomography (PET), a physician is required to disclose to a beneficiary in writing that the beneficiary may obtain these services from another supplier. The referring physician must provide the beneficiary with a list of 5 alternative suppliers within a 25-mile radius of the physician's office location at the time of the referral. These suppliers must provide the imaging services ordered."



SLIDE 22

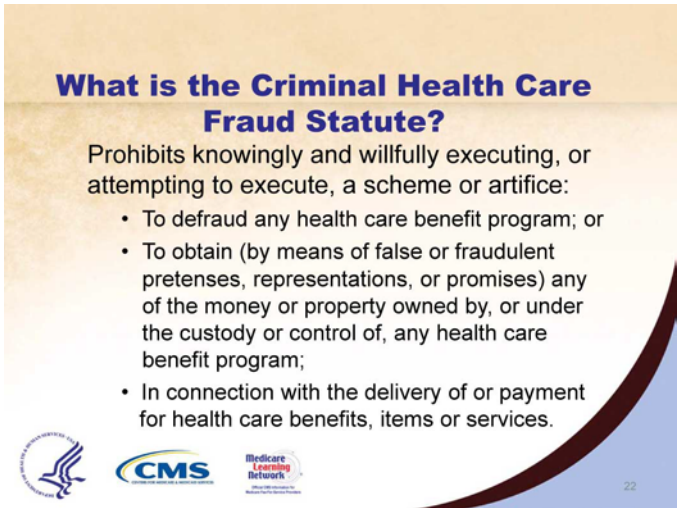
Read the slide.

What is the Criminal Health Care Fraud Statute?

Prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice:

- To defraud any health care benefit program; or
- To obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program;
- In connection with the delivery of or payment for health care benefits, items or services.

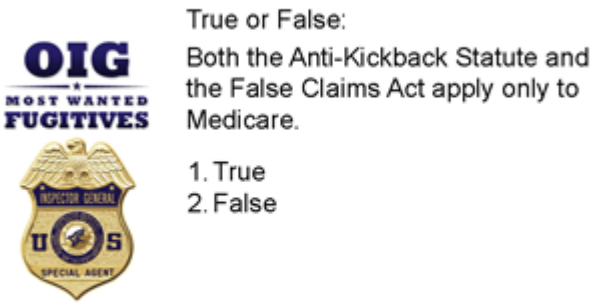
After the last bullet, add from Web-Based Training: "**Proof of actual knowledge or specific intent to violate the law is not required.**"



SLIDE 23
Read the question and answer choices.

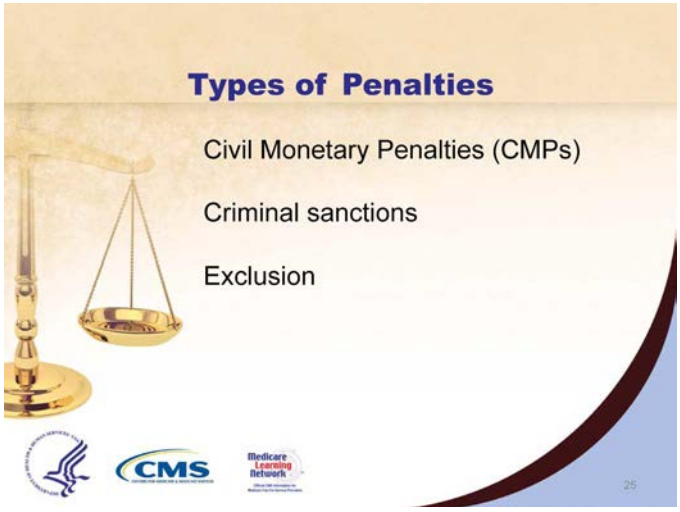
True or False: Both the Anti-Kickback Statute and the False Claims Act apply only to Medicare. 1. True 2. False

Question 3.
Answer: **2. False**



SLIDE 24
Do not read the slide. Instead, read:
"Let's now review the penalties for Medicare Fraud and Abuse."

SLIDE 25
Transition to next slide by reading the slide and then saying: **"<u>Let's review these three types of penalties, but first…Are you Smarter than an OIG Fugitive?"</u>**

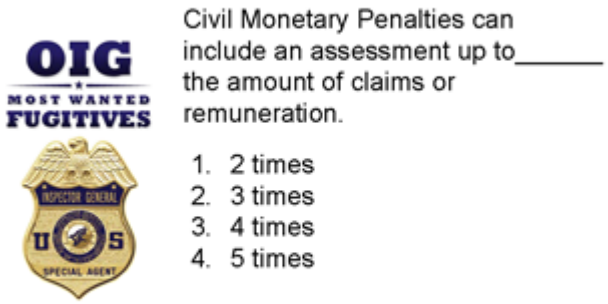


SLIDE 26
Read the question and answer choices.

Civil Monetary Penalties can include an assessment up to_____ the amount of claims or remuneration. 1. 2 Times 2. 3 Times 3. 4 Times 4. 5 Times

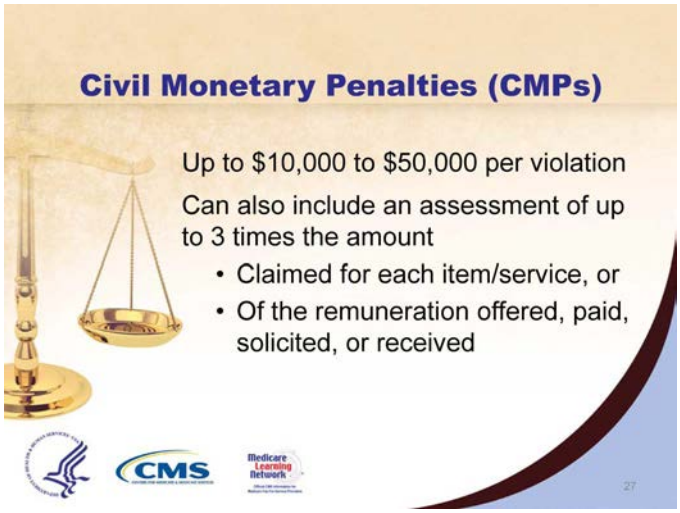
Question 4.
Answer: **2. 3 times**

"The next slide provides info regarding Civil Monetary Penalties."



SLIDE 27
Read slide.

Civil Monetary Penalties (CMPs) Up to $10,000 to $50,000 per violation Can also include an assessment of up to 3 times the amount • Claimed for each item/service, or • Of the remuneration offered, paid, solicited, or received

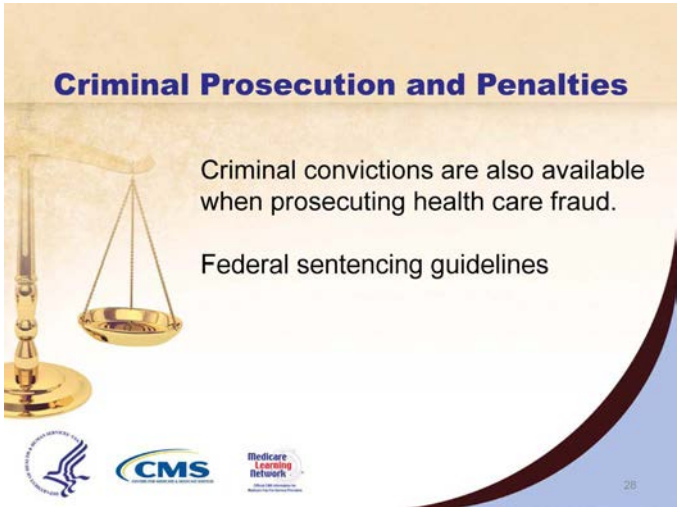


SLIDE 28
Read slide

Criminal Prosecution and Penalties Criminal convictions are also available when prosecuting health care fraud. Federal sentencing guidelines

Then say: **"Criminal penalties for submitting false claims may include imprisonment, fines, or both."**

Source: Web-Based Training.



SLIDE 29
Read the title of the slide.

Mandatory Exclusions by HHS OIG

Then say:

- **"Exclusion means that, for a designated period, Medicare, Medicaid, and other Federal health care programs will not pay the provider for services performed or for services ordered by the excluded party. Mandatory exclusions are imposed for a minimum of 5 years, although aggravating factors could lead to a longer, or even permanent, exclusion."**
- **"OIG is required by law to implement mandatory exclusions when…"**

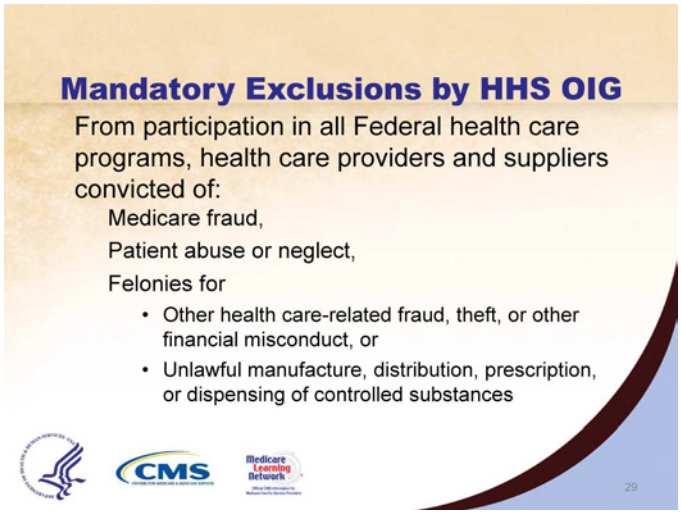
Then read the slide.

From participation in all Federal health care programs, health care providers and suppliers convicted of:

Medicare fraud,
Patient abuse or neglect,
Felonies for

- Other health care-related fraud, theft, or other financial misconduct, or
- Unlawful manufacture, distribution, prescription, or dispensing of controlled substances

Source: Web-Based Training



SLIDE 30
Read this instead of the slide:

"The OIG may issue <u>permissive exclusions</u> for various actions. Permissive exclusions vary in length Some examples include:

- **Misdemeanor convictions related to health care fraud,**
- **Misdemeanor convictions related to controlled substances,**
- **Conviction related to fraud in a non-health care program,**
- **License revocation or suspension, or**
- **Obstruction of an investigation."**

Then say, "**Now that you've learned about the types of offenses for which exclusion may be imposed, let's look at the consequences of the Exclusions Statute for those health care providers who might do business with an excluded party, either as an employer or as a contractor, and how to avoid those consequences."**

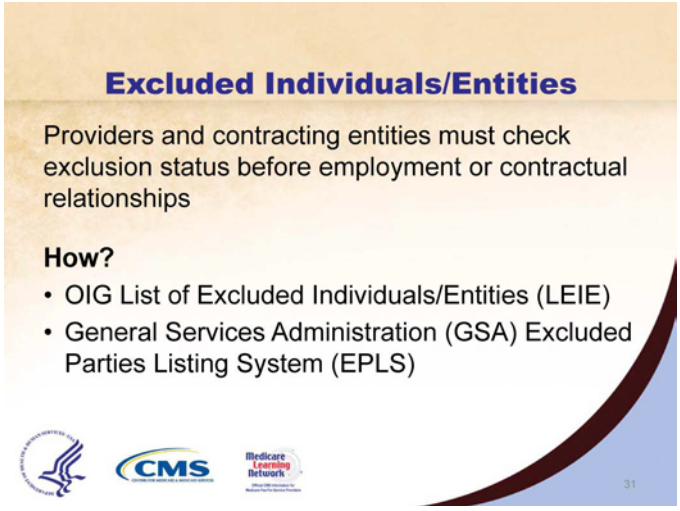
SLIDE 31
Read this instead of the slide:

"Providers and contracting entities have an affirmative duty to check for program exclusion status prior to entering into employment or contractual relationships using the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE). OIG recommends checking the General Services Administration (GSA) Excluded Parties Listing System (EPLS) as well."

"**The LEIE identifies parties excluded from Medicare reimbursement and is regularly updated. The list includes information about the provider's specialty, type of sanction, notice date, and when the sanction ends."**
"The GSA EPLS contains information on parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits. OIG compliance guidelines encourage you to check the EPLS prior to hiring an individual, purchasing supplies, or contracting with an entity (and periodically thereafter.)"
"No payment will be made by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person."

"**Links to the LEIE and EPLS and other resources are provided in the list of resources at the end of this presentation."**

Source: Web-Based Training



SLIDE 32

Read:

"This part of our presentation provides information about preventing Medicare fraud and abuse. You will learn about the following:

- **How the Centers for Medicare & Medicare Services (CMS) and other entities are working to prevent Medicare fraud and abuse, and**
- **How you can assist in the effort to prevent Medicare fraud and abuse."**

Source: Adapted from the Web-Based Training

SLIDE 33

Mention this was a pre-assessment question: "**Remember those pre-assessment questions? There was one about what CMS does to prevent Fraud and Abuse. Let's review CMS preventive actions."**

Read slide.

CMS is Working to Prevent Medicare Fraud and Abuse

Enhanced Medicare enrollment protections

- Fees
- Screening categories
- Revalidation

Automated prepayment claims edits

Predictive analytics technologies

Suspension of payments

Education

Read for fees: **"for some providers"**

Read for screening: "**Enrolling and revalidating providers and suppliers are placed in 1 of 3 screening categories: limited, moderate, or high. These categories represent the level of risk for fraud and abuse to the Medicare Program for the particular provider type and determine the degree of screening performed during the processing of the enrollment application. CMS has authority to impose a moratorium on new enrollments under certain circumstances."**

Read: "**analyze claims data in real time"** and then read "**Prepayment edits: and Predictive Analytics Technologies**"

Suspension of Payments: "**CMS has the authority to suspend payments for up to 180 days based upon possession of reliable information that an overpayment exists or that the payments to be made may not be correct."**

Education: "**The Medicare Learning Network® provides a variety of training and educational materials that break down Medicare policy into plain language. They offer fact sheets, web-based training courses, videos, and podcasts. The MLN Provider Compliance web page contains educational products that inform Medicare providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program."**

Source for suspension of payments and education: Web-Based Training

SLIDE 34
Read slide.

Provider's Role
Provide only medically necessary, high quality services
Properly document all services
Correctly bill and code for services
Check LEIE and EPLS
Comply

For the last point say: **"with all applicable laws and regulations"**

After the last point, mention:
"**We have given you a handout entitled, "Tips for Avoiding Medicare Fraud and Abuse", which includes provider vulnerability, by type of provider, including tips and resources where they can read more. FOR EXAMPLE, EVALUATION AND MANAGEMENT CODING IS A TOPIC THAT NEARLY ALL PROVIDERS MUST be knowledgeable about AND THIS HANDOUT SHOWS THAT CMS PROVIDES A RESOURCE ON HOW TO COMPLY WITH THE DOCUMENTATION REQUIREMENTS.**"

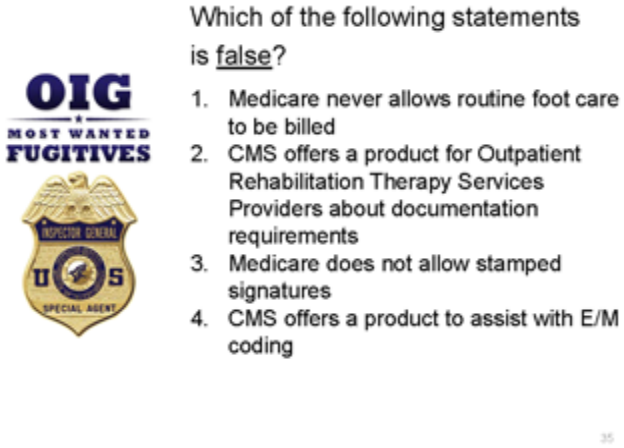
SLIDE 35
Read the question and answer choices.

Which of the following statements is false? 1. Medicare never allows routine foot care to be billed 2. CMS offers a product for Outpatient Rehabilitation Therapy Services Providers about documentation requirements 3. Medicare does not allow stamped signatures 4. CMS offers a product to assist with E/M coding

Question 5. Handout associated with the question

Give more time on this game question—they need to read through the handout to answer it.

Answer: **1. Foot Care**

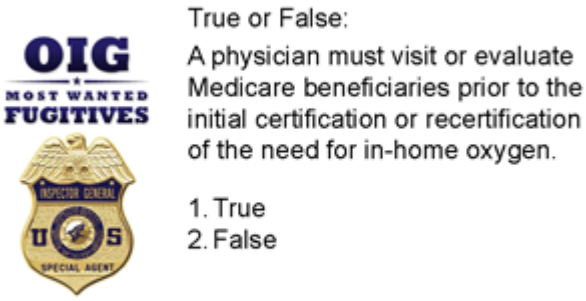


SLIDE 36
Read the question and answer choices.

True or False: A physician must visit or evaluate Medicare beneficiaries prior to the initial certification or recertification of the need for in-home oxygen. 1. True 2. False

Question 6.
Answer **1. True**

Again, give time to look through the handout.



SLIDE 37
Read the title

CMS Partners with State and Federal Law Enforcement Agencies

And then:
"Such as:
OIG – HHS Office of Inspector General
FBI – Federal Bureau of Investigation
DOJ – Department of Justice
MFCU – Medicaid Fraud Control Units"

SLIDE 38
Read the title

CMS Contracts with Other Entities

And then:
"Such as:

- **Program Safeguard Contractors (PSCs)/Zone Program Integrity Contractors (ZPICs)**
- **Medicare Drug Integrity Contractor (MEDIC)**
- **Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs)**
- **Recovery Audit Program Recovery Auditors**

Comprehensive Error Rate Testing (CERT) Contractors"

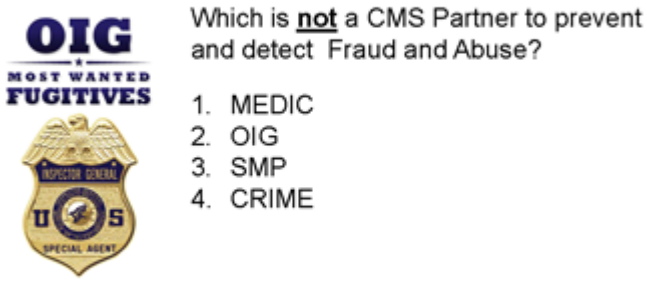
SLIDE 39
Read this slide.

Other CMS Partners
Medicare beneficiaries and caregivers Physicians, suppliers, and other providers Accreditation Organizations Senior Medicare Patrol (SMP)

SLIDE 40
Read the question and answer choices.

OIG Most Wanted Fugitives Slide - Which is not a CMS Partner to prevent and detect Fraud and Abuse? 1. MEDIC 2. OIG 3. SMP 4. CRIME

Question 7.
Answer **4. Crime**

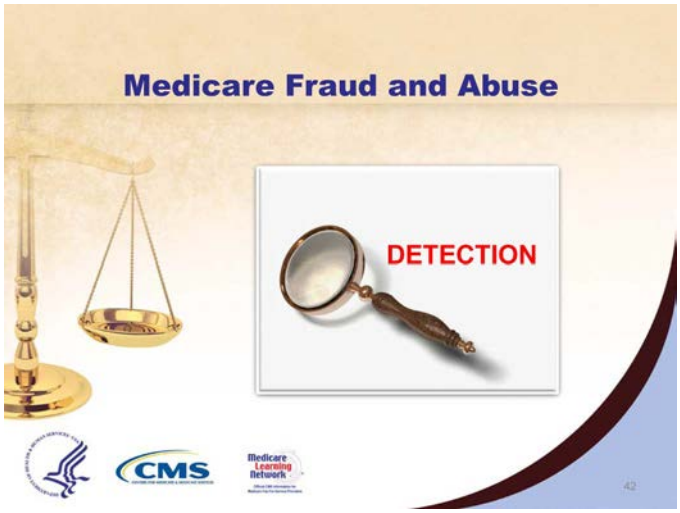


SLIDE 41

Half Time Team Results

SLIDE 42
Read this slide.

Medicare Fraud and Abuse Detection



SLIDE 43
Read first point and bullets.

The Role of Data

Target high-risk areas

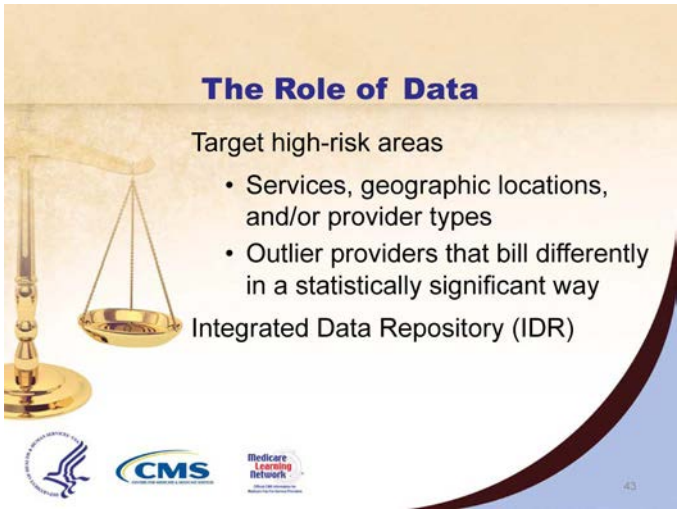
- Services, geographic locations, and/or provider types
- Outlier providers that bill differently in a statistically significant way

Integrated Data Repository (IDR)

And then for IDR: read**: "The new Integrated Data Repository (IDR) contains data from Medicare and Medicaid claims, beneficiaries, providers, and Medicare Advantage (MA) Plans."**

And then read:
"The IDR provides a greater information sharing, broader and easier access, enhanced data integration, increased security and privacy and strengthened query and analytic capability by building a unified data repository for reporting and analytics.
Data analysis guides much of the claim review of the prepayment and/or postpayment claim review entities that will be discussed next."

Source: Web-Based Training



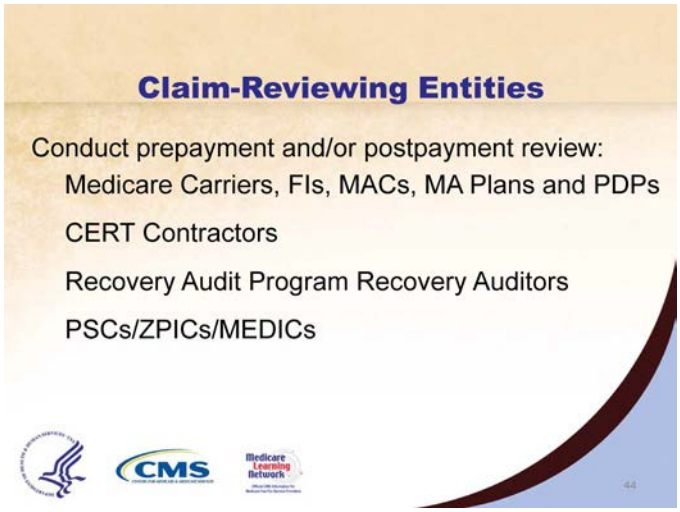
SLIDE 44
Read instead of title:

"Several different entities possess authority from CMS to conduct prepayment and/or postpayment review of claims including:"

Then read slide.

Conduct prepayment and/or postpayment review: Medicare Carriers, FIs, MACs, MA Plans and PDPs CERT Contractors Recovery Audit Program Recovery Auditors PSCs/ZPICs/MEDICs

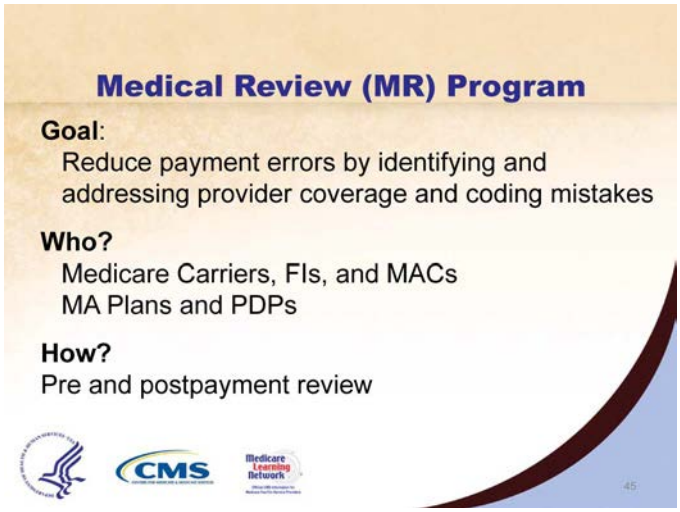
Then explain Carrier/FIs becoming MACs on Original Medicare side.



SLIDE 45
Before reading the slide say:
"Remember, we are still discussing claim-reviewing entities."

Then read slide.

Medical Review (MR) Program **Goal**: Reduce payment errors by identifying and addressing provider coverage and coding mistakes **Who?** Medicare Carriers, FIs, and MACs MA Plans and PDPs **How?** Pre and postpayment review

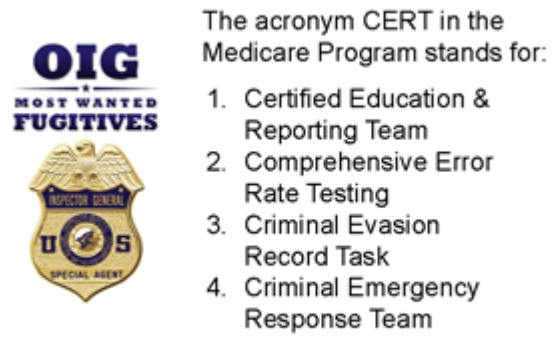


SLIDE 46
"Here's a question we didn't teach yet, but it's too easy after we teach the next slide."

Read the question and answer choices.

OIG Most Wanted Fugitives - The acronym CERT in the Medicare Program stands for: 1. Certified Education & Reporting Team 2. Comprehensive Error Rate Testing 3. Criminal Evasion Record Task 4. Criminal Emergency Response Team

Question 8.
Answer: **2. Comprehensive Error Rate Testing**



SLIDE 47
Read the slide.

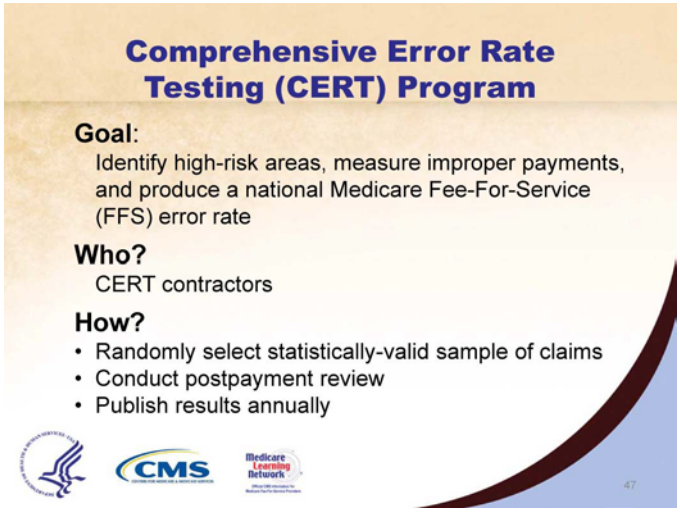
Comprehensive Error Rate Testing (CERT) Program
Goal:
Identify high-risk areas, measure improper payments, and produce a national Medicare Fee-For-Service (FFS) error rate

Who?
CERT contractors

How?
- Randomly select statistically-valid sample of claims
- Conduct postpayment review
- Publish results annually

After "Publish results annually" add: "**used to guide provider education efforts."**

"Remember, this is a claim-reviewing entity."



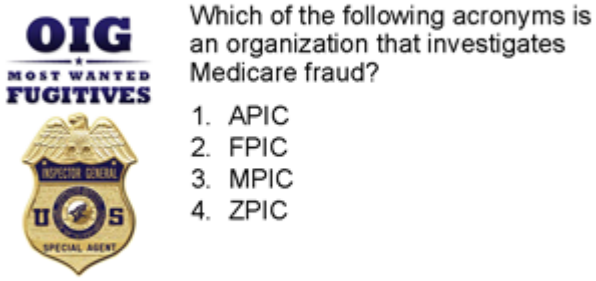
SLIDE 48
Read the slide.

Recovery Audit Program Goal: Detect improper underpayments and overpayments Who? Recovery Auditors How? • Postpayment claims review • May target reviews

SLIDE 49
Read the question and answer choices.

OIG Most Wanted Fugitives Slide - Which of the following acronyms is an organization that investigates Medicare fraud? 1. APIC 2. FPIC 3. MPIC 4. ZPIC

Question 9.
Answer: **4. ZPIC**



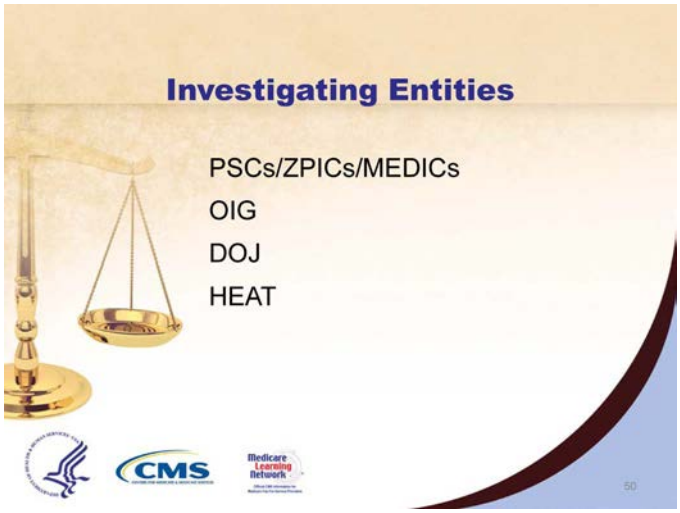
SLIDE 50

Do not read slide. Instead say:

"You'll recall one of the pre-assessment questions distinguished between claims reviewing only organization such as MACs and MA plans and those that do extensive investigations. The following entities review claims, but also conduct more extensive investigations of specific health care providers:"

Then read what the acronyms stand for:

"PSCs – Program Safeguard Contractors….. "will all become.."
ZPICs - Zone Program Integrity Contractors
DOJ – Department of Justice
HEAT-Health Care Fraud Prevention and Enforcement Action Team"



SLIDE 51
Read slide, and at appropriate places read:

Appropriate Medicare Contractor-**"for re-education"**

May take concurrent action to "**minimize the potential loss to the Medicare Trust Fund"**
And then "**Appropriate action varies from case to case"**

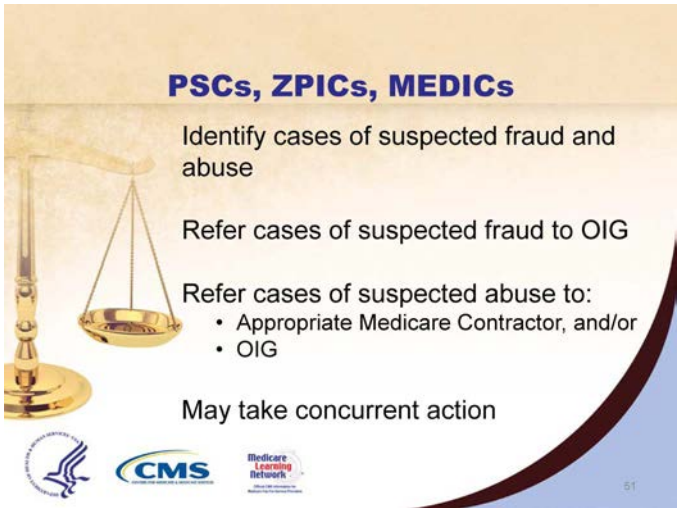
PSCs, ZPICs, MEDICs Slide - Identify cases of suspected fraud and abuse

Refer cases of suspected fraud to OIG

Refer cases of suspected abuse to:
- Appropriate Medicare Contractor, and/or
- OIG

May take concurrent action

Source materials: (FYI only-don't read)
PSCs/ZPICs do not have authority with MA Plans. MA Plans address any fraud and abuse issues with their providers.
Please refer to the Internet-Only Manual, Publication 100-16, Medicare Managed Care Manual, on the CMS website for more information
http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=48425bf8-4c57-4b95-b2e7-83ff1f4fb694 investigate potential fraud and abuse in Medicare's FFS program. CMS is in the process of transitioning the PSC benefit integrity activities to zone program integrity contractors (ZPICs).38
Once fully operational, ZPICs are expected to perform benefit integrity activities for Medicare Parts A, B, C, and D



SLIDE 52
Read this, not slide:

- "**Protects the integrity of HHS programs, including Medicare**
- **Carries out its duties thru a nationwide network of audits, investigations, inspections and other related functions**
- **Possesses the authority to exclude individuals and entities and impose penalties."**

And at end of the slide read: "**The OIG provides education, compliance guidelines, advisory opinions, and training at http://oig.hhs.gov/compliance on the Internet."**

Source: Web-Based Training

FYI; don't read:
http://oig.hhs.gov/publications/docs/semiannual/2010/semiannual_spring2010.pdf
Our health care oversight activities also continue to review Medicare and Medicaid contractors, prescription drug fraud, and Medicare Advantage

SLIDE 53
Read slide.

DOJ Investigates fraud and abuse in Federal Government programs Partners with the OIG through HEAT

Make sure to emphasize Federal government programs—(not just health care)

Transition to HEAT on next page.

SLIDE 54

Start with the following:

"**The DOJ and HHS established HEAT to build and strengthen existing programs to combat Medicare fraud while investing new resources and technology to prevent fraud and abuse. HEAT efforts have included expansion of the DOJ-HHS Medicare Fraud Strike Force that has been successful in fighting fraud."**

Read slide

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

- Gathers Government resources to
  - Help prevent waste, fraud, and abuse in the Medicare and Medicaid Programs, and
  - Crack down on fraud perpetrators who abuse the system
- Reduces health care costs and improves the quality of care
- Highlights best practices by providers and public sector employees
- Builds upon existing partnerships between the DOJ and OIG
- Maintains the Stop Medicare Fraud website

But instead of the last bullet, read "**HEAT created the Stop Medicare Fraud website, which provides information about how to identify and protect against Medicare fraud and how to report it. For more information, visit http://www.stopmedicarefraud.gov/heattaskforce on the Internet."**

Source: Web-Based Training

SLIDE 55
Read slide.

Medicare Fraud and Abuse - Reporting

SLIDE 56
Read this instead of slide:

"**The OIG maintains a hotline that accepts and reviews tips from all sources."**

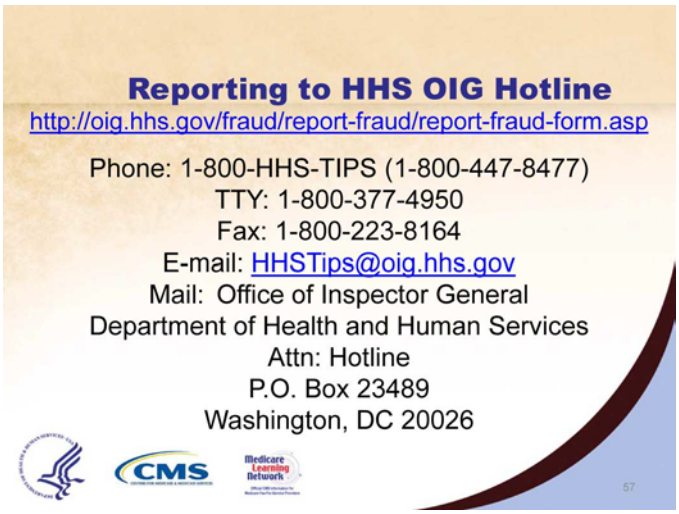
"No information is entered in OIG records that could trace the complaint. In many cases, however, the lack of contact information for the source prevents a comprehensive review of the complaint."

Transition to next page by saying: "**And now let's review the numerous ways one can report suspected fraud and abuse to the OIG."**

SLIDE 57
Say: "**AND THE THIRD PRE-ASSESSMENT QUESTION WAS HOW TO CONTACT THE OIG. LET'S REVIEW HOW…."**

Then read the slide.

Reporting to HHS OIG Hotline http://oig.hhs.gov/fraud/report-fraud/report-fraud-form.asp Phone: 1-800-HHS-TIPS (1-800-447-8477) TTY: 1-800-377-4950 Fax: 1-800-223-8164 E-mail: HHSTips@oig.hhs.gov Mail: Office of Inspector General Department of Health and Human Services Attn: Hotline P.O. Box 23489 Washington, DC 20026



SLIDE 58
Say: **"In addition to the OIG, there are other ways to report fraud complaints."**

Read slide.

Other Ways to Report Fraud and Abuse Medicare MA Plan or PDP complaints MEDIC 1-877-7SafeRx (1-877-772-3379) Medicare FFS complaints Carrier/FI or MAC Beneficiaries Only (any complaints) 1-800-MEDICARE (1-800-633-4227) TTY 1-800-486-2048

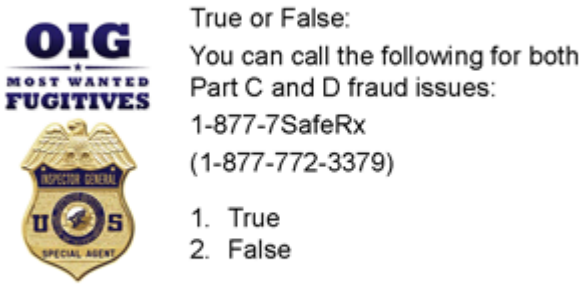
And explain that for Carrier, MAC, etc, must look up the number of the appropriate contractor.

SLIDE 59
Read the question and answer choices.

OIG Most Wanted Fugitives Slide - True or False: You can call the following for both Part C and D fraud issues: 1-877-7SafeRx (1-877-772-3379) 1. True 2. False

Question 10.
Answer **1. True**

Source: http://www.healthintegrity.org/html/contracts/medic/index.html



SLIDE 60

OIG Provider Self-Disclosure Protocol (SDP) Avoid costs and disruptions

Read 1st point, and then say "**associated with a Government-directed investigation."**

OIG works cooperatively

For 2nd point read: "**The OIG will work cooperatively with providers who are forthcoming, thorough, and transparent in their disclosures in resolving these matters."**

Then say:
"**While the OIG does not speak for the Department of Justice (DOJ) or other agencies, the OIG consults with these agencies, as appropriate, regarding the resolution of SDP issues. For more information, refer to** http://oig.hhs.gov/compliance/self-disclosure-info **on the OIG website**."

Source: Web-Based Training

SLIDE 61
Point out: Although this might look the same as previous slide, it's not. That was OIG and this is CMS form.

CMS Self-Referral Disclosure Protocol (SRDP) Slide - Actual or potential violations of Physician Self-Referral Law (Stark Law) Not used to obtain a CMS determination Submit with intent to resolve overpayment

For 1st point read: "**The CMS Self-Referral Disclosure Protocol enables health care providers and suppliers to self-disclose actual or potential violations of the Physician Self-Referral Law (Stark Law)-Referral Disclosure Protocol (SRDP).**"

For 2nd point read: "**The SRDP cannot be used to obtain a CMS determination as to whether an actual or potential violation of the Physician Self-Referral Law (Stark Law) occurred.**"

For 3rd point read: "**A disclosing party should make a submission to the SRDP with the intention of resolving its overpayment liability exposure for the conduct it identified.**"

From Web-Based Training: Under certain circumstances, CMS has the discretion to reduce the amount due. For more information, visit http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html on the CMS website. http://oig.hhs.gov/compliance/self-disclosure-info/index.asp uses the word UNDER but http://oig.hhs.gov/fraud/docs/openletters/OpenLetter3-24-09.pdf says providers into the SDP (self-disclosure protocol.)

SLIDE 62

Read: **"The Medicare Incentive Reward Program (IRP) encourages reporting of suspected fraud and abuse. It pays rewards for information on Medicare fraud and abuse or other punishable activities. The information must lead to a minimum recovery of $100 in Medicare funds from individuals and entities determined by CMS to have committed fraud."**

Then say:

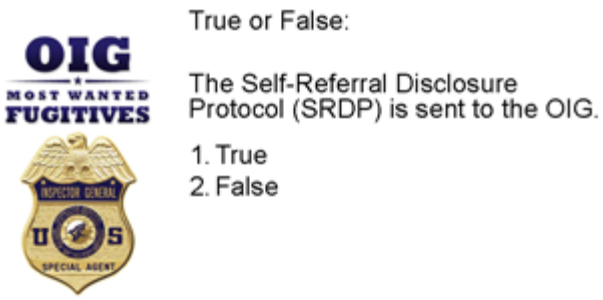
"**For more information, refer to the CMS Internet-Only Manual (IOM), "Medicare Program Integrity Manual" (Publication 100-08), Chapter 4, Section 4.9 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf on the CMS website."**

Source: Web-Based Training

SLIDE 63
Read the question and answer choices.

OIG Most Wanted Fugitives True or False: The Self-Referral Disclosure Protocol (SRDP) is sent to the OIG. 1. True 2. False

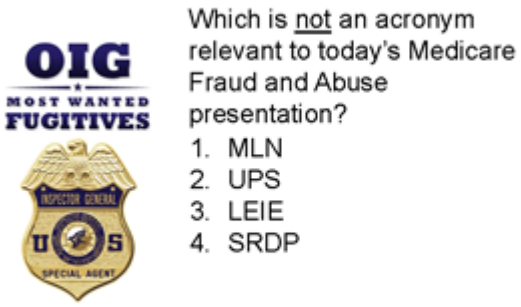
Question 11.
Answer: **2. False**



SLIDE 64
Read the question and answer choices.

OIG Most Wanted Fugitives Which is not an acronym relevant to today's Medicare Fraud and Abuse presentation? 1. MLN 2. UPS 3. LEIE 4. SRDP

Question 12.
Answer: **2. UPS**



SLIDE 65
If you have Internet access, the audience appreciates if you visit a few of these sites, showing them areas of interest.

Resources Slide
Centers for Medicare & Medicaid Services (CMS) Home Page
http://www.cms.gov

Civil Monetary Penalties (CMP) Law
http://oig.hhs.gov/fraud/enforcement/cmp

CMS Self-Referral Disclosure Protocol (SRDP)
http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Self_Referral_Disclosure_Protocol.html

Department of Health & Human Services (HHS)
http://www.hhs.gov

General Services Administration (GSA) Excluded Parties Listing System (EPLS)
http://www.epls.gov

SLIDE 66
Highlight HEAT, OIG, and MLN sites.

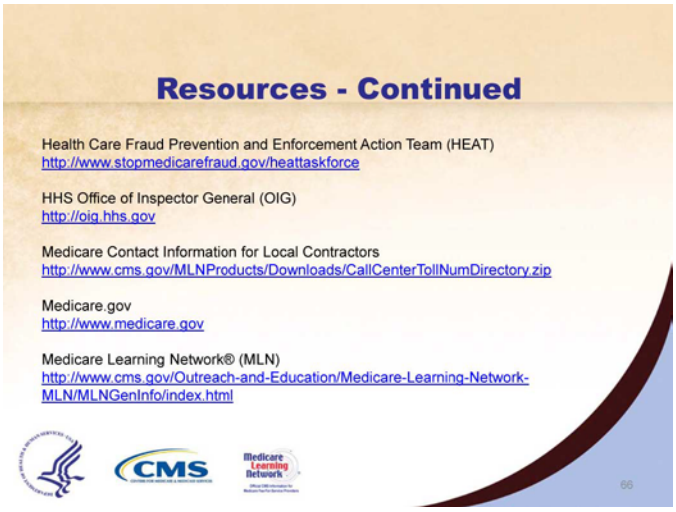
Resources Slide Continued
Health Care Fraud Prevention and Enforcement Action Team (HEAT)
http://www.stopmedicarefraud.gov/heattaskforce

HHS Office of Inspector General (OIG)
http://oig.hhs.gov

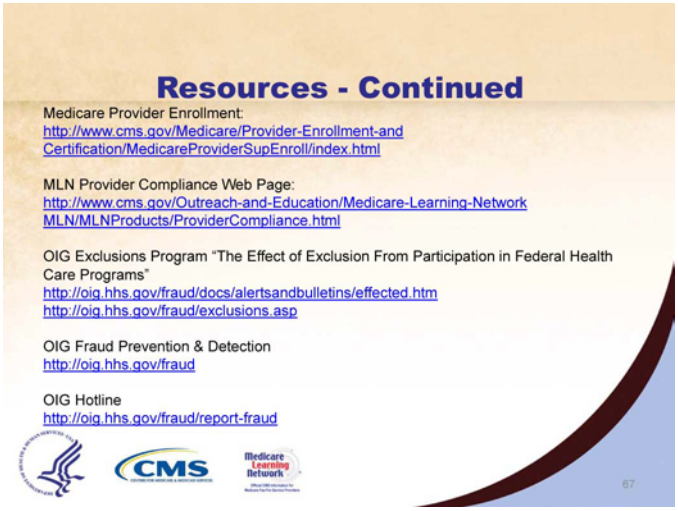
Medicare Contact Information for Local Contractors
http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Medicare.gov
http://www.medicare.gov

Medicare Learning Network® (MLN)
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html



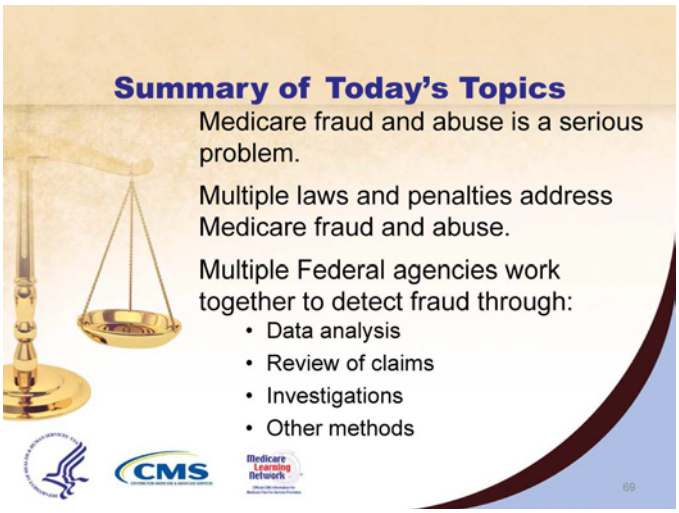
SLIDE 67
Read this instead of slide:
"The OIG provides education, compliance guidelines, advisory opinions, and training at http://oig.hhs.gov/compliance on the Internet."



SLIDE 68
Do not read slide. Visit a site of interest if desired.

SLIDE 69
Read slide.

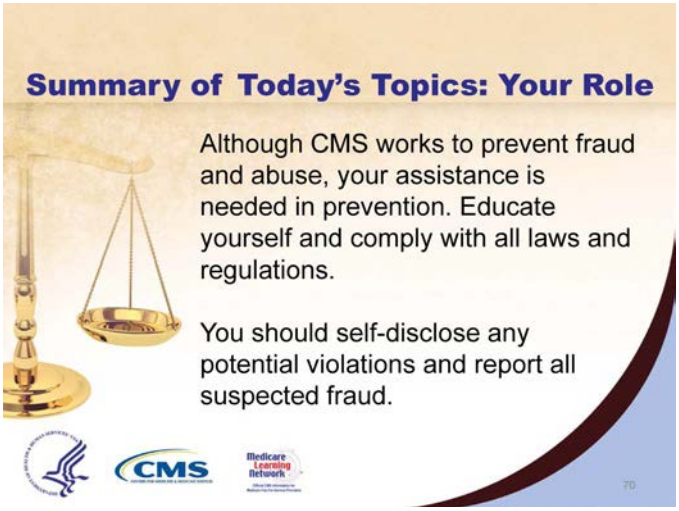
Summary of Today's Topics Medicare fraud and abuse is a serious problem. Multiple laws and penalties address Medicare fraud and abuse. Multiple Federal agencies work together to detect fraud through: • Data analysis • Review of claims • Investigations • Other methods



SLIDE 70
Read slide.

Summary of Today's Topics: Your Role Although CMS works to prevent fraud and abuse, your assistance is needed in prevention. Educate yourself and comply with all laws and regulations. You should self-disclose any potential violations and report all suspected fraud.

Distribute the post-assessment.



SLIDE 71
Remember the answer key document.

Please refer to the "Fraud & Abuse Facilitator Kit" document for distribution/collection of the forms.

Read the question and allow time for them to select the answer.

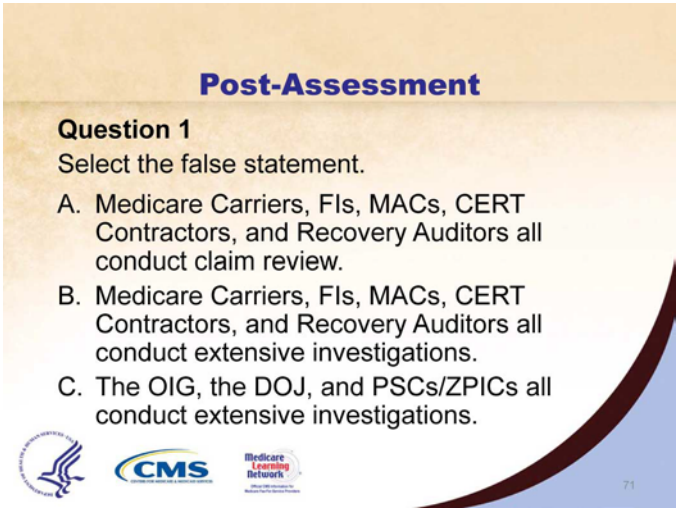
Post Assessment
Question 1
Select the false statement.

A. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Auditors all conduct claim review.

B. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Auditors all conduct extensive investigations.

C. The OIG, the DOJ, and PSCs/ZPICs all conduct extensive investigations.

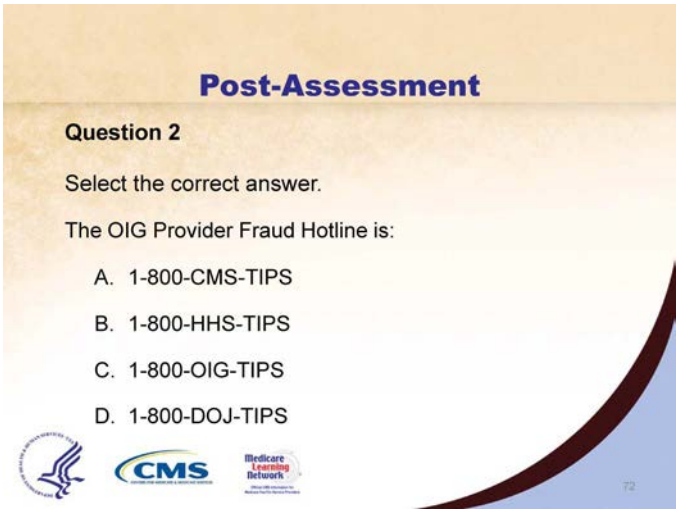
Correct Answer: B.



SLIDE 72
Read the question and allow time for them to select the answer.

Post Assessment Question 2 Select the correct answer. The OIG Provider Fraud Hotline is: A. 1-800-CMS-TIPS B. 1-800-HHS-TIPS C. 1-800-OIG-TIPS D. 1-800-DOJ-TIPS

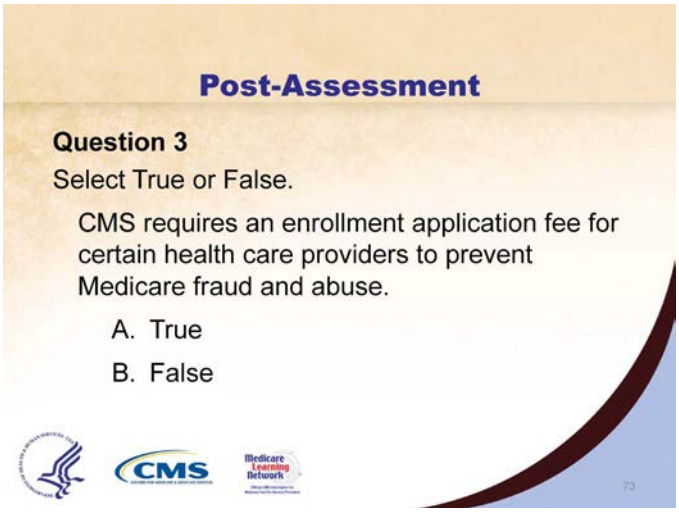
Correct Answer: B.



SLIDE 73
Read the question and allow time for them to select the answer.

Post-Assessment Question 3 Select True or False. CMS requires an enrollment application fee for certain health care providers to prevent Medicare fraud and abuse. A. True B. False

Correct Answer: A.



SLIDE 74
Use the Team Scoring Sheet to tabulate scores, and then announce the winner.

Are you smarter than an OIG Fugitive?

...and the winner is!

SLIDE 75
Ask the attendees to complete the Course Evaluation. Collect this and the Post-Assessments as they leave.

Thanks for playing!

Included Documents to Print

The documents included in this facilitator kit are for you to print. The first four documents are for the facilitator, while the last two are for the attendees. Be sure to only print the last two documents from this facilitator kit for the attendees.

Sign-in Sheet

Medicare Fraud & Abuse: Prevention, Detection, and Reporting Sign-in Sheet

Date:	Start Time:	Class Name: Medicare Fraud & Abuse: Prevention, Detection, and Reporting	Instructor(s):
Location:	End Time:		

To ensure you receive credit, print legibly in blue or black ink.

Organization	Attendee Name (Print Name)	Attendee Signature

Team Scoring Sheet

Team Scoring Sheet

	Team A	Team B	Team C	Team D	Team E
Question 1					
Question 2					
Question 3					
Question 4					
Question 5					
Question 6					
Question 7					
Question 8					
Question 9					
Question 10					
Question 11					
Question 12					
Totals:	0	0	0	0	0

Trainer Copy

Medicare Fraud & Abuse:
Prevention, Detection, and Reporting

Pre-Assessment Key

Question 1

Select True or False.

CMS requires enrollment application fee for certain health care providers to prevent Medicare fraud and abuse.

- **A. True**
- B. False

Answer: A.

Question 2

Select the false statement.

- A. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Auditors all conduct claim review.
- **B. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Auditors all conduct extensive investigations.**
- C. The OIG, the DOJ, and PSCs/ZPICs all conduct extensive investigations.

Answer: B.

Question 3

Select the correct answer.

The OIG Provider Fraud Hotline is:

- A. 1-800-CMS-TIPS
- **B. 1-800-HHS-TIPS**
- C. 1-800-OIG-TIPS
- D. 1-800-DOJ-TIPS

Answer: B.

Trainer Copy

Medicare Fraud & Abuse:
Prevention, Detection, and Reporting

Post-Assessment Key

Question 1

Select the false statement.

A. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Auditors all conduct claim review.
B. Medicare Carriers, FIs, MACs, CERT Contractors, and Recovery Auditors all conduct extensive investigations.
C. The OIG, the DOJ, and PSCs/ZPICs all conduct extensive investigations.

Answer: B.

Question 2

Select the correct answer.

The OIG Provider Fraud Hotline is:

A. 1-800-CMS-TIPS
B. 1-800-HHS-TIPS
C. 1-800-OIG-TIPS
D. 1-800-DOJ-TIPS

Answer: B.

Question 3

Select True or False.

CMS requires enrollment application fee for certain health care providers to prevent Medicare fraud and abuse.

A. True
B. False

Answer: A.

Medicare Fraud & Abuse:
Prevention, Detection, and Reporting

Pre-Assessment

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Medicare Fraud & Abuse:
Prevention, Detection, and Reporting

Post-Assessment

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