# Module 10:
# Fraud and Abuse

National Medicare
TRAINING PROGRAM
...helping people with Medicare make informed health care decisions

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

**Module Description**

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

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

The following sections are included in this module:

| Slides | Topics |
|---|---|
| 2 | Session Objectives |
| 3-16 | Fraud & Abuse Overview |
| 17-40 | Medicare's Fraud & Abuse Strategies |
| 41-56 | How to Fight Fraud |
| 58 | Information Sources |

**Objectives**

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

**Target Audience**

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

**Learning Activities**

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

**Time Considerations**

The module consists of 59 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers.

**References**

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


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

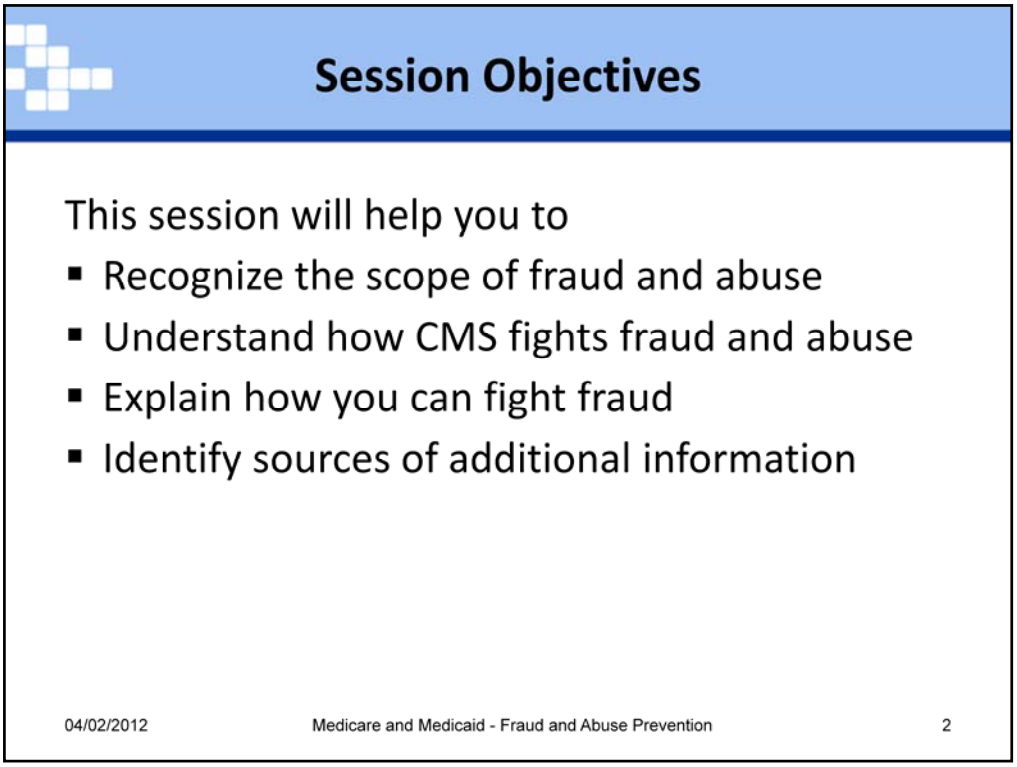
This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and Preexisting Condition Insurance Plans (PCIP). The information in this module was correct as of April 2012.

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

To check for an updated version of this training module, visit http://www.cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/Training-Library.html.

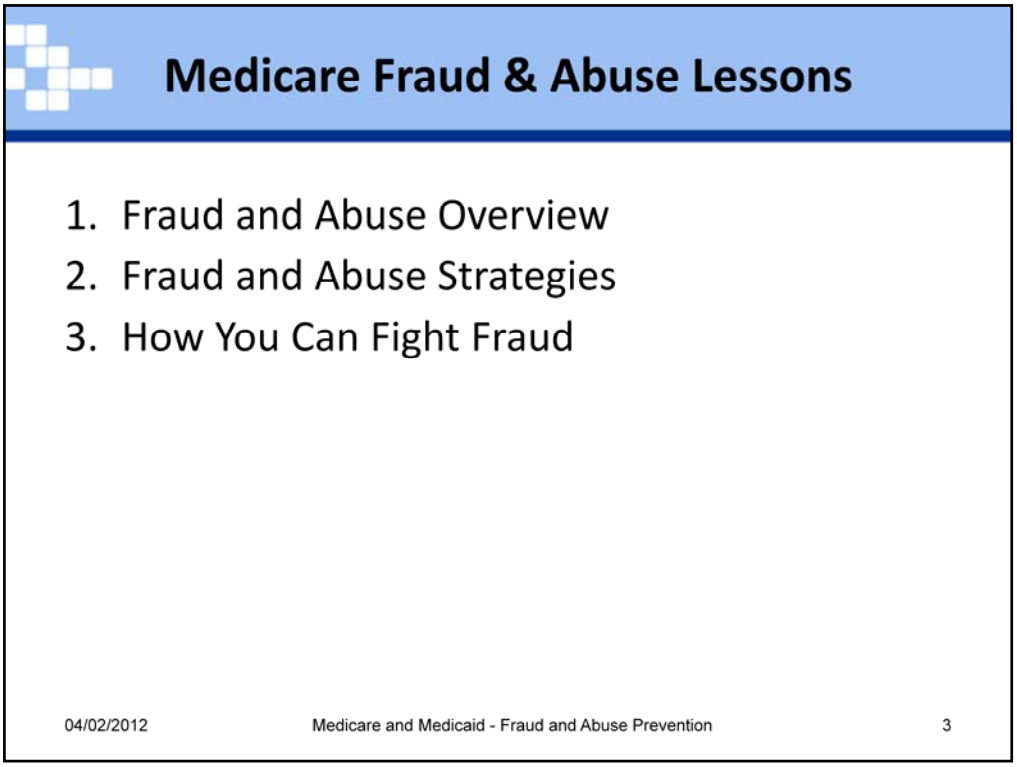
To learn more about CMS' fraud and abuse plans visit www.stopmedicarefraud.gov.

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



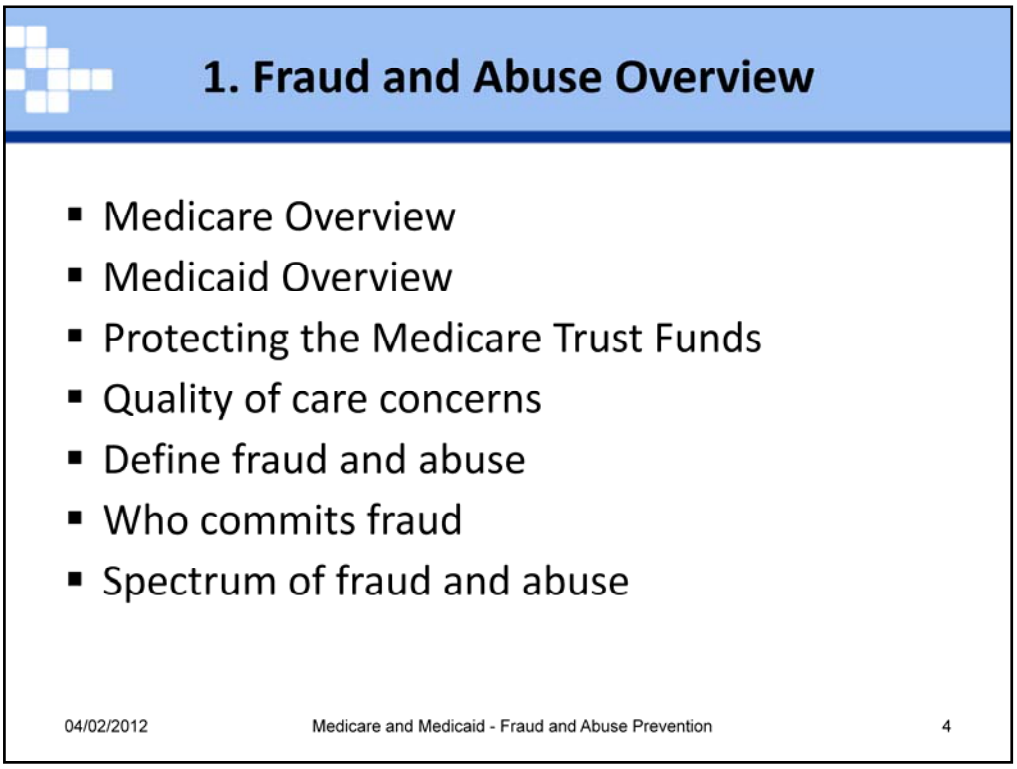

This session will help you to

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



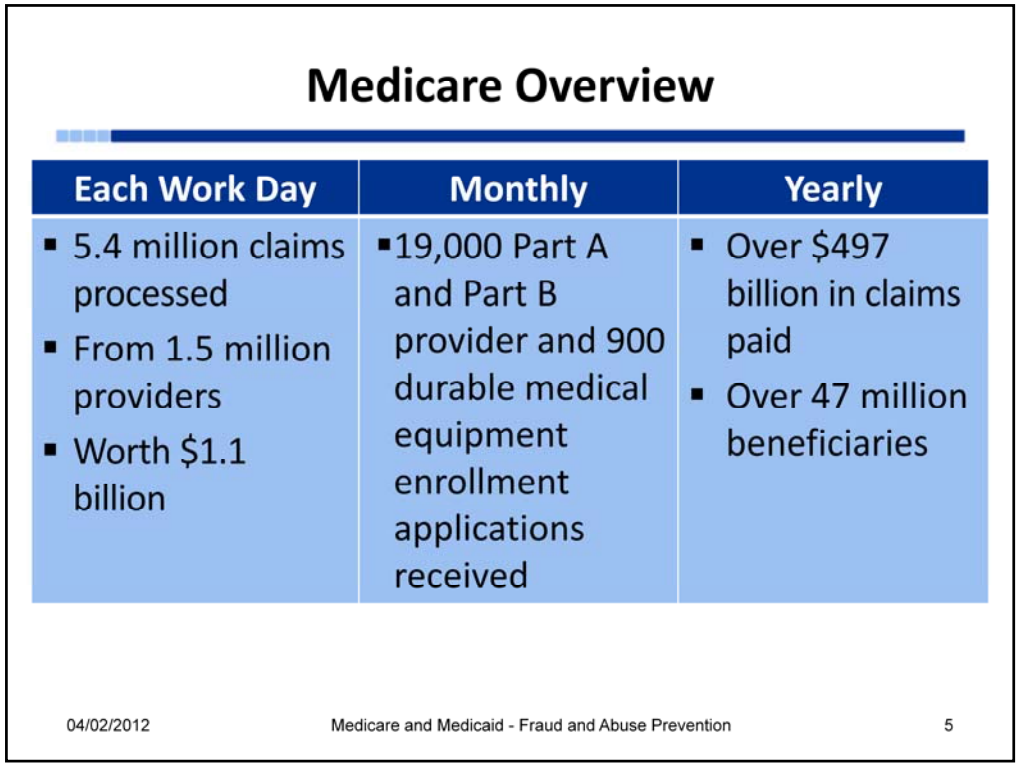

This module is divided into three lessons.

1. Fraud and Abuse Overview
2. Fraud and Abuse Strategies
3. How You Can Fight Fraud




Lesson 1 provides an overview of fraud and abuse.

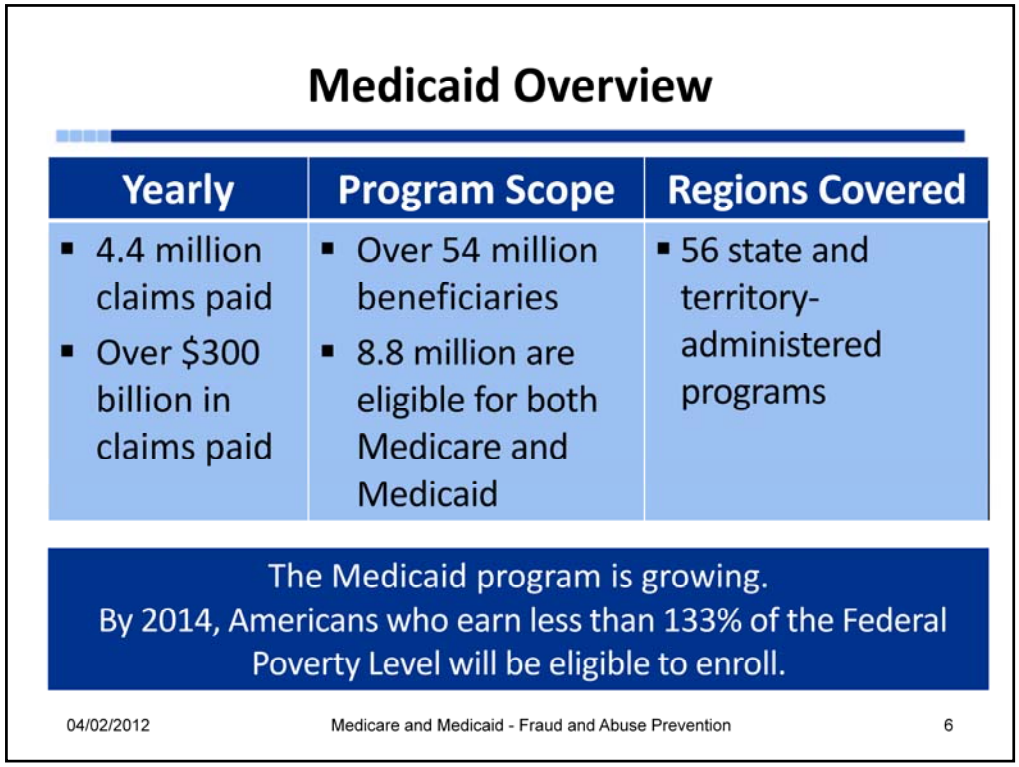
- Medicare Overview
- Medicaid Overview
- Protecting the Medicare Trust Funds
- Quality of care concerns
- Define fraud and abuse
- Who commits fraud
- Spectrum of fraud and abuse




Each working day Medicare processes over 5.4 million claims, to 1.5 million providers, worth $1.1 billion.

Each month, Medicare receives almost 19,000 Part A & B provider enrollment applications and 900 durable medical equipment applications.

Every year Medicare pays over $497 billion for more than 47 million beneficiaries.

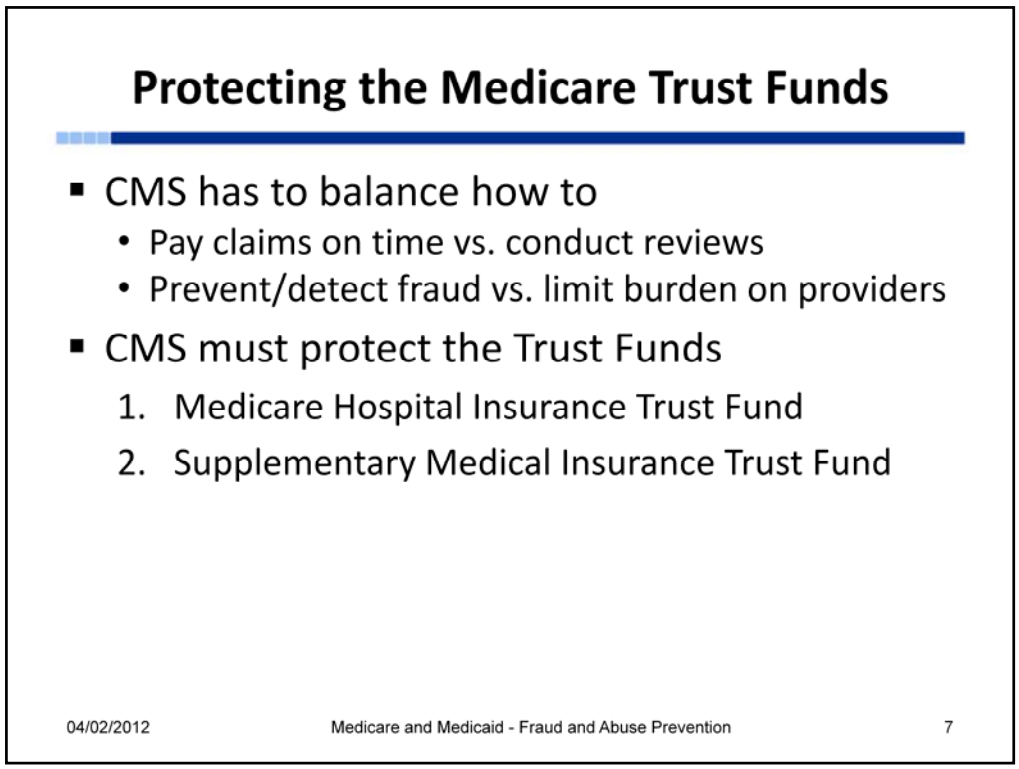



Each year, Medicaid pays 4.4 million claims, representing more than $300 billion, for more than 54 million beneficiaries.

8.8 million (18% ) of Medicaid beneficiaries qualify for both Medicare and Medicaid coverage.

There are 56 state and territory-administered programs.

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

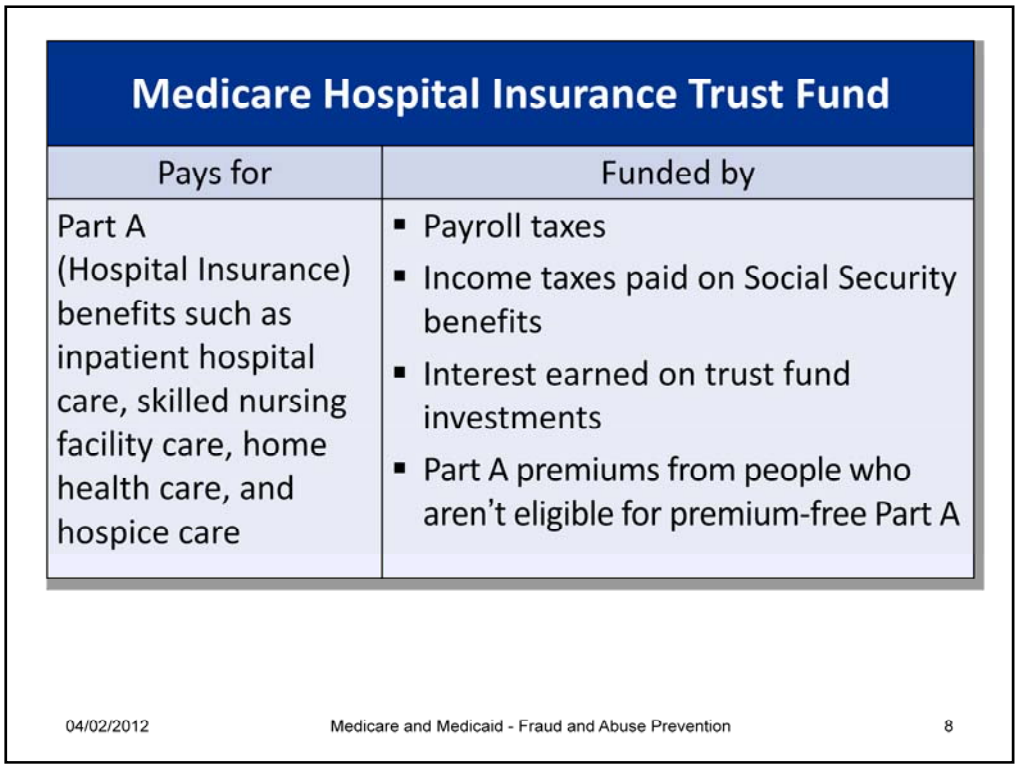



CMS has to manage the careful balance between

- Paying claims on time vs. conducting reviews and
- Preventing and detecting fraud and limit burden on provider community

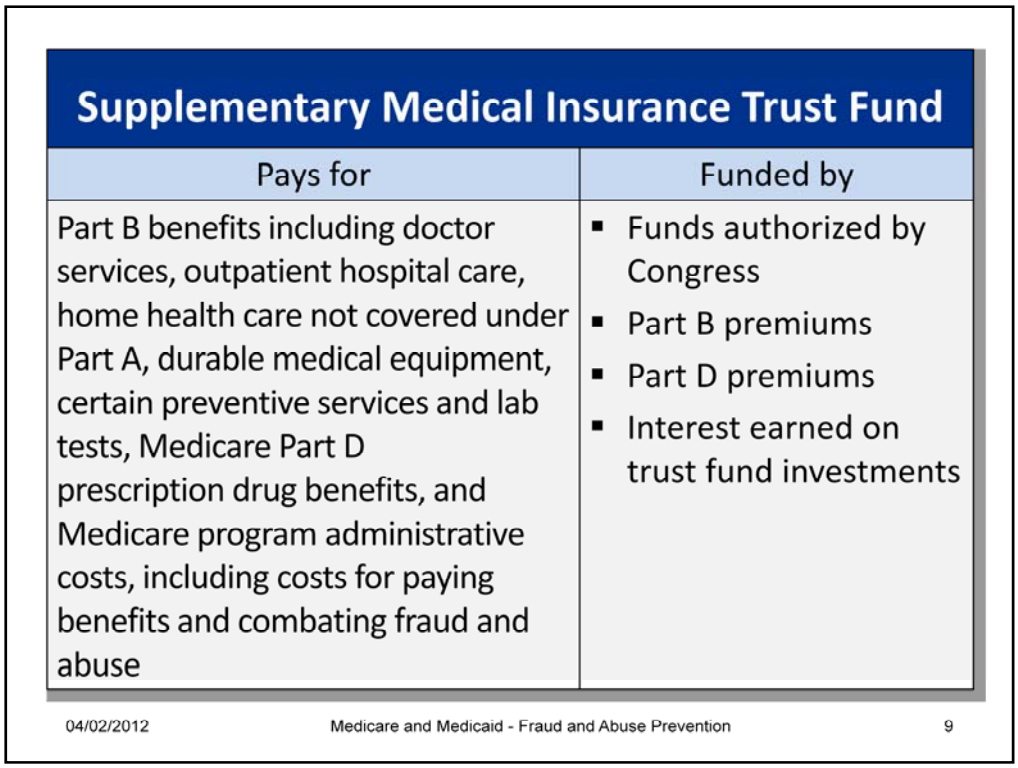
CMS must protect the Trust Funds

1. Medicare Hospital Insurance Trust Fund
2. Supplementary Medical Insurance Trust Fund



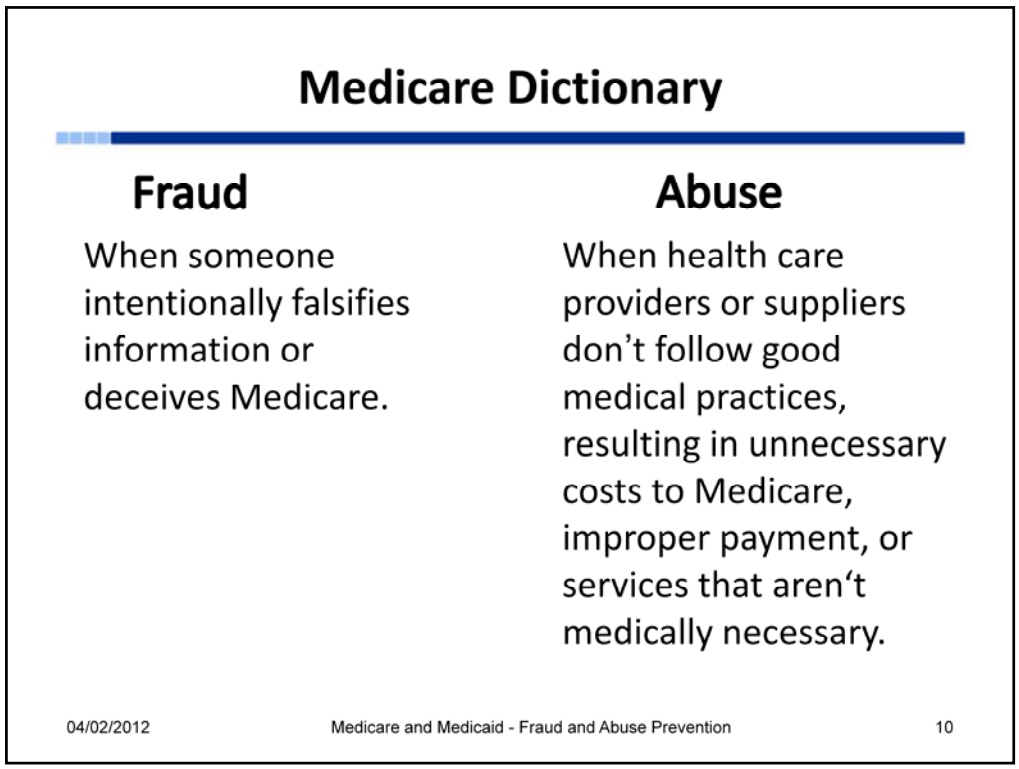

The Medicare Hospital Insurance Trust Fund pays for Part A (Hospital Insurance) benefits such as inpatient hospital care, skilled nursing facility care, home health care, and hospice care.

It is funded by payroll taxes, income taxes paid on Social Security benefits, interest earned on trust fund investments, and part A premiums from people who aren't eligible for premium-free Part A.




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

It is funded by funds authorized by Congress, Part B premiums, Part D premiums, and interest earned on trust fund investments.



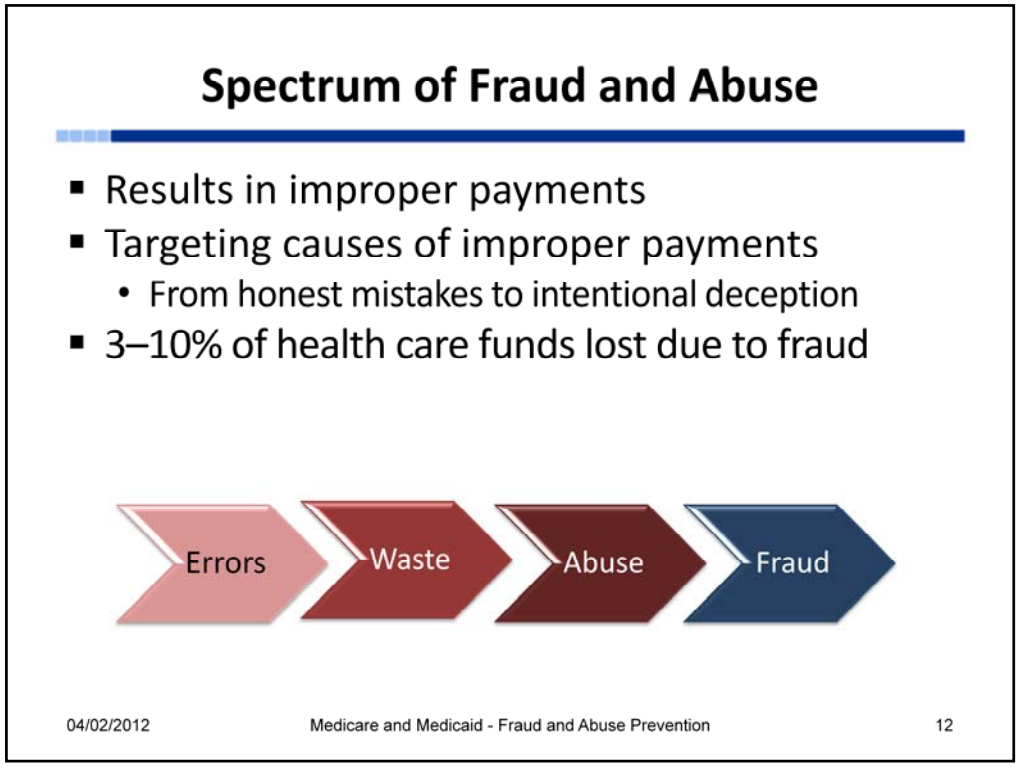

Fraud occurs when someone intentionally falsifies information or deceives Medicare.

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


Most individuals and organizations that work with Medicare and Medicaid are honest. But there are some bad actors. CMS is continually taking the steps necessary to identify and prosecute these bad actors.

Who commits fraud?

- Business owners
- Health care providers and suppliers
- Medicare and Medicaid beneficiaries

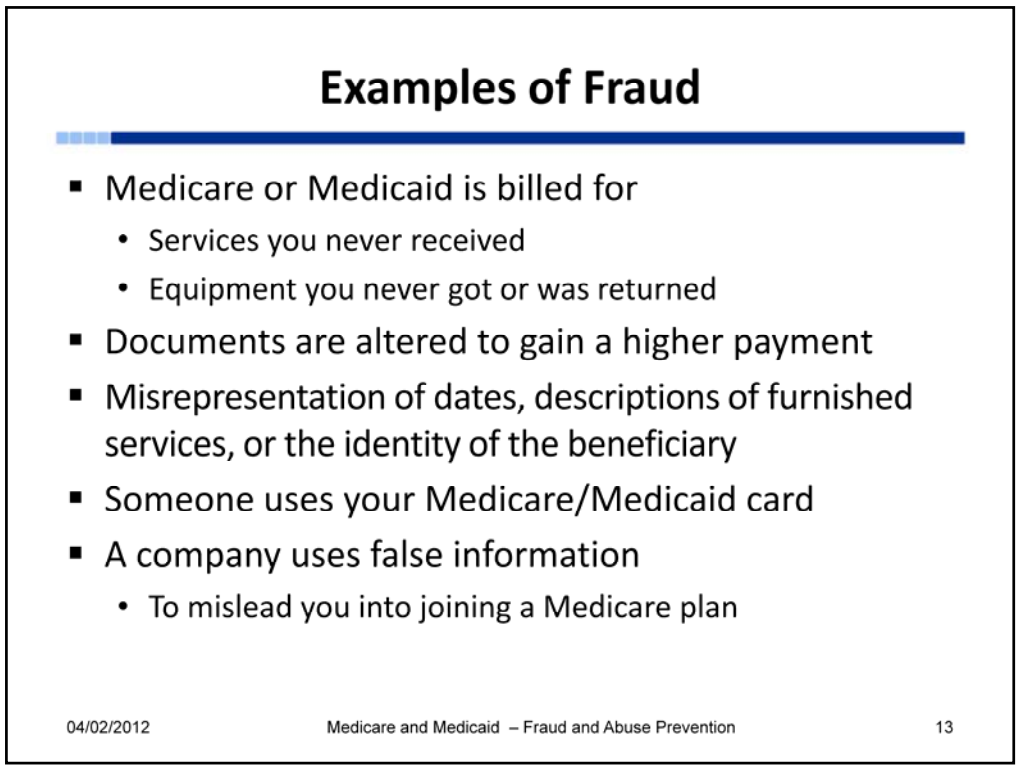



Spectrum of Fraud and Abuse

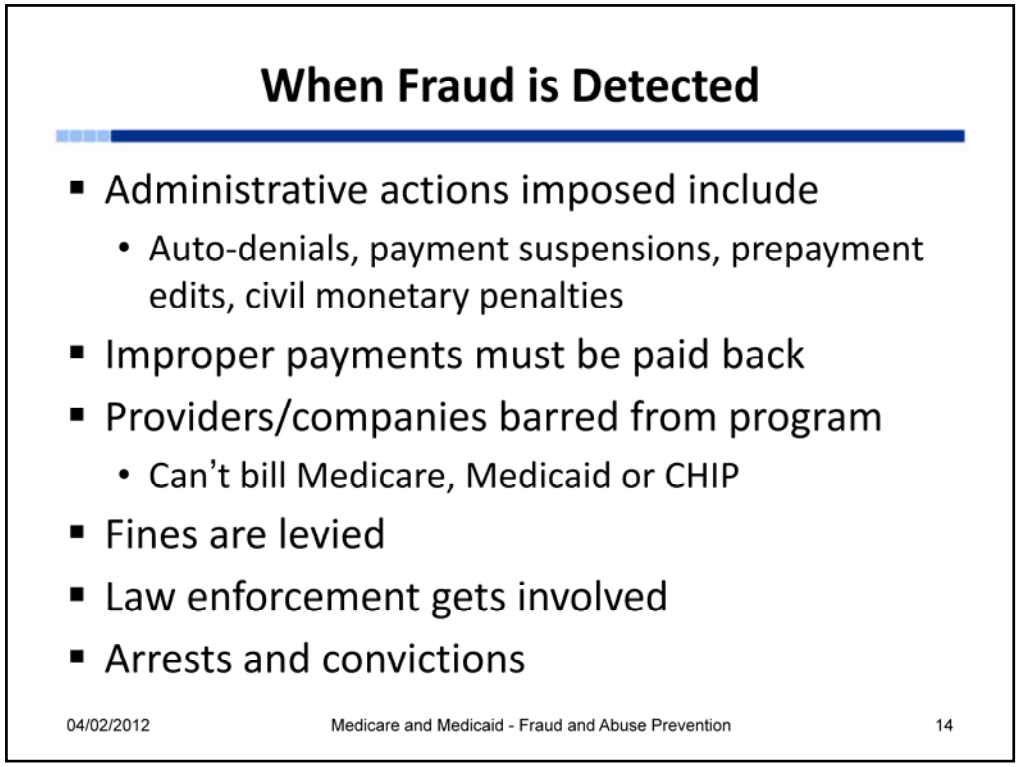
CMS enforcement activities target the causes of improper payments. They are designed to ensure that correct payments are made to legitimate providers and suppliers for appropriate and reasonable services and supplies for eligible beneficiaries.

The CMS spectrum of improper payments runs from error to waste to abuse to fraud.

It is estimated that 3-10% of health care funds are lost due to fraud.




Examples of possible Medicare fraud are Medicare or Medicaid is billed for services you never received, equipment you never got or was returned, documents that are altered to gain a higher payment, misrepresentation of dates, descriptions of furnished services, or the identity of the beneficiary. It is also considered fraud if someone uses your Medicare/Medicaid card, or if a company uses false information to mislead you into joining a Medicare plan.




When fraud is detected, the appropriate administrative action is imposed. Administrative actions include automatic denials, payment suspensions, prepayment edits, identification of overpayments, and civil monetary penalties.

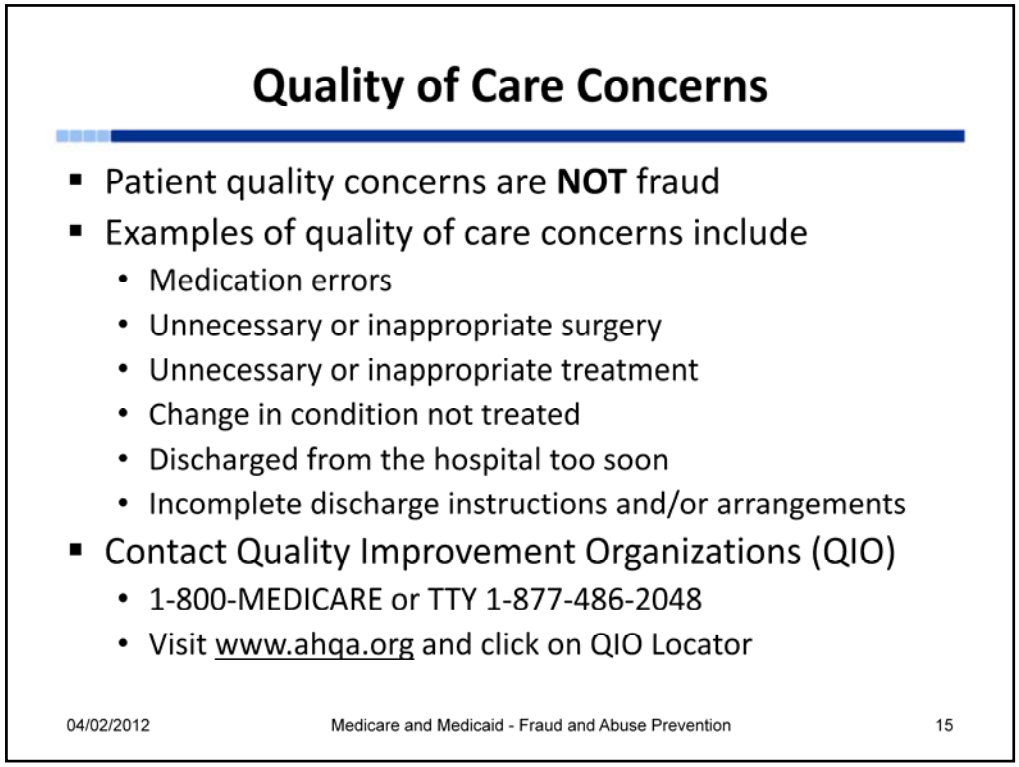
Prepayment edits are coded system logic that either automatically pays all or part of a claim, automatically denies all or part of a claim, or suspends all or part of a claim so that a trained analyst can review the claim and associated documentation in order to make determinations about coverage and payment.

Improper payments must be paid back.

Providers/companies are barred from doing business , and they can't bill Medicare, Medicaid or CHIP.

Fines are levied.

Law enforcement gets involved, which may lead to arrests and convictions.

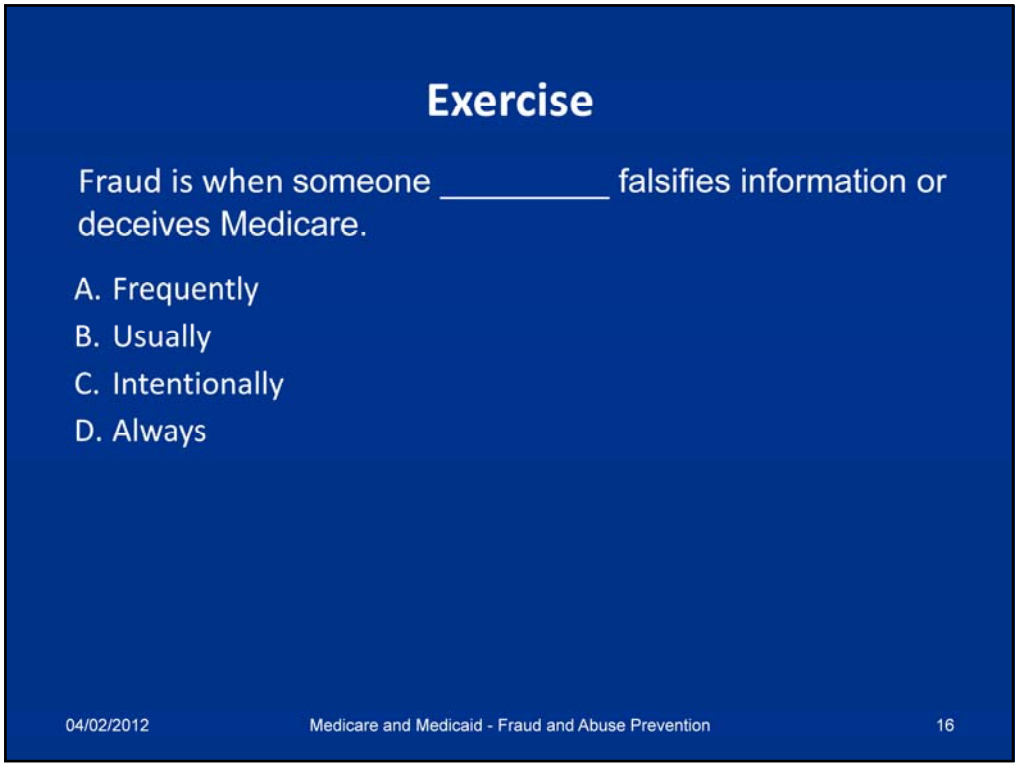



Patient quality of care concerns are not fraud. They should be handled by the appropriate Quality Improvement Organization.

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

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

Medicare Quality Improvement Organizations will help you with these issues. To get the address and phone number of the QIO for your state or territory, visit www.ahqa.org on the web and click on "QIO Locator." Or, you can call 1-800-MEDICARE (1-800- 633-4227) for help contacting your QIO. TTY users should call 1-877-486-2048.




**Exercise**

Fraud is when someone _____ falsifies information or deceives Medicare.

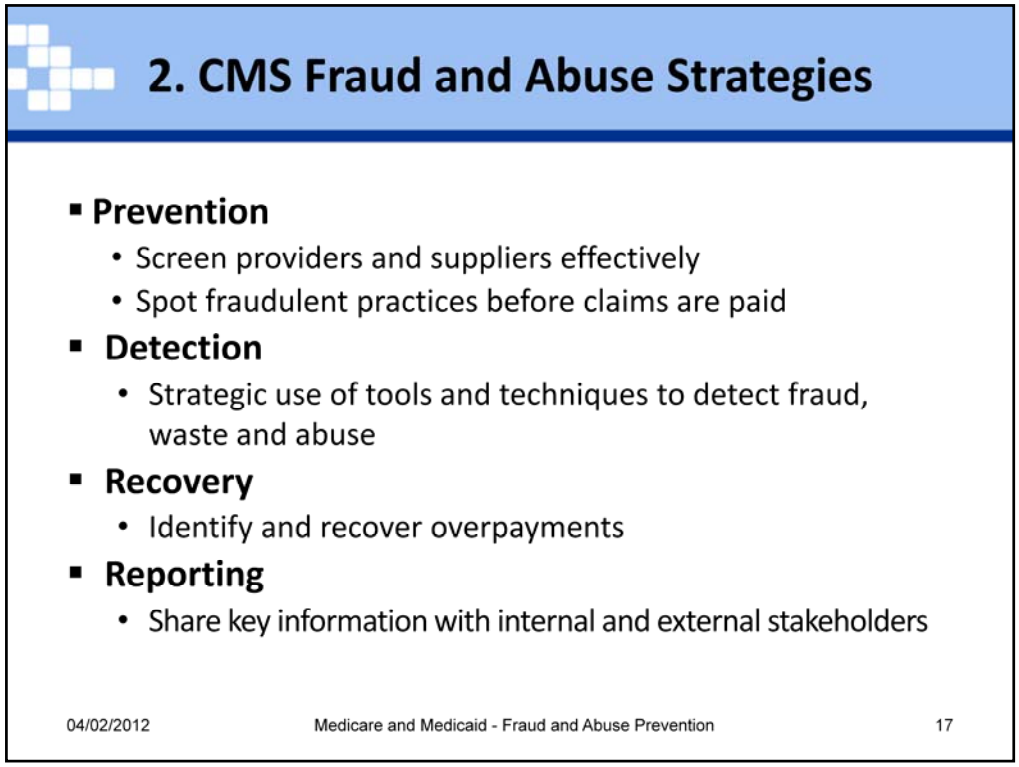
A. Frequently

B. Usually

C. Intentionally

D. Always

**Answer:** C. Intentionally



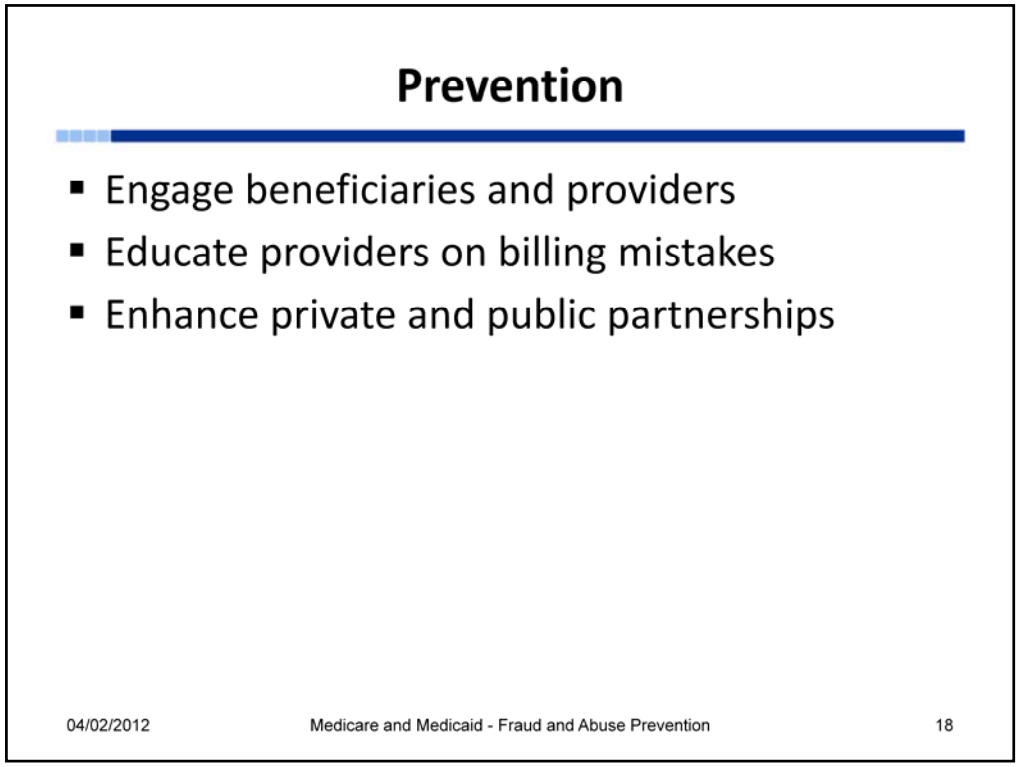

CMS uses four strategies to fight program fraud and abuse:

**Prevention -** Screen providers and suppliers effectively and spot fraudulent practices before claims are paid

**Detection -** Strategic use of tools and techniques to detect fraud, waste and abuse

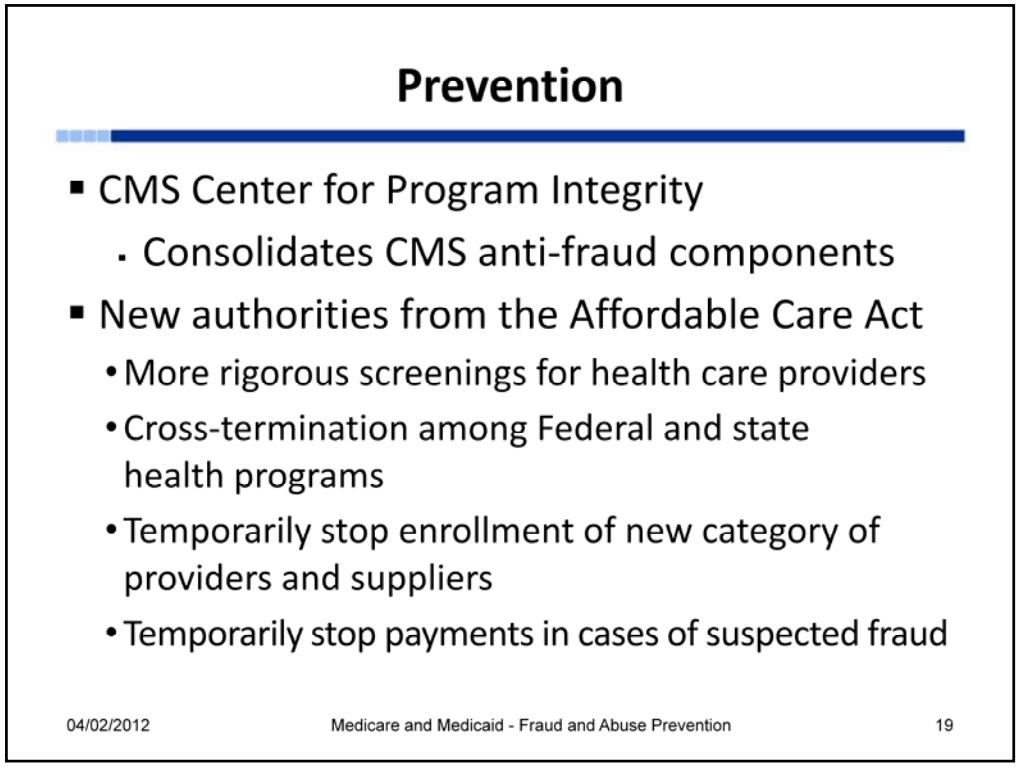
**Recovery -** Identify and recover overpayments

**Reporting -** Share key information with internal and external stakeholders




CMS is working to shift the focus to the prevention of improper payments and fraud while continuing to be vigilant in detecting and pursuing problems when the occur by

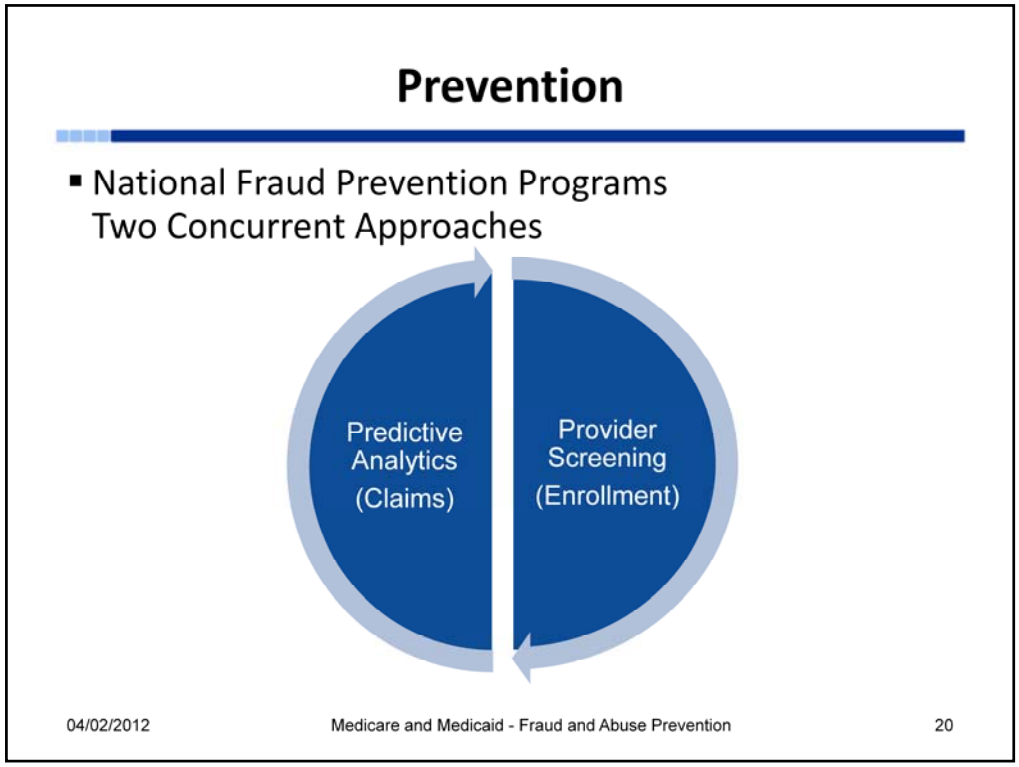
- Educating providers on common billing mistakes.
- Engaging beneficiaries and health care providers to join in the fight against fraud.
- Enhancing partnerships with the private sector.




CMS formed the Center for Program Integrity, pulling together existing CMS anti-fraud components and forming new ones. This centralized approach has enabled CMS to pursue a more strategic and coordinated set of policies, as well as enhanced collaboration on anti-fraud initiatives with law enforcement partners.

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

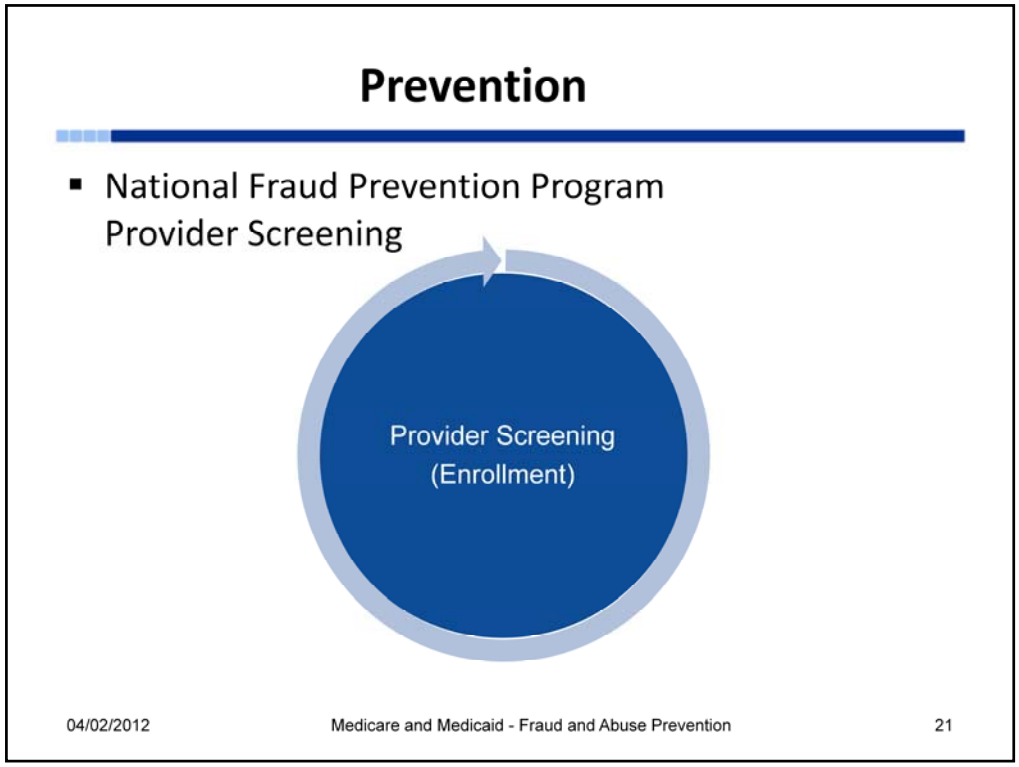
- Creating a rigorous screening process for providers and suppliers enrolling in Medicare, Medicaid and CHIP.
- Require a cross-termination among Federal and state health programs, so providers and suppliers that have had their Medicare billing privileges revoked or whose participation has been terminated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



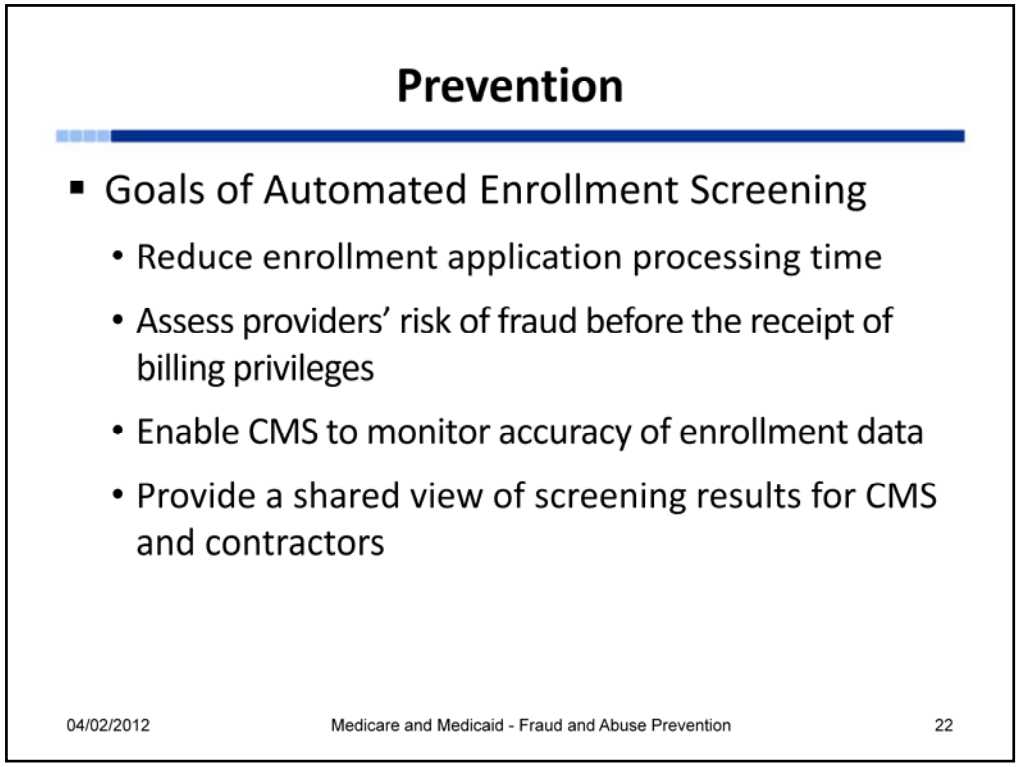

The National Fraud Prevention Program streamlines the Agency's strategic projects into one coordinated program that is stronger and more efficient than any stand-alone effort.

By integrating these predictive analytics in processing claims, and provider screening during enrollment, CMS can better ensure that it enrolls only qualified providers and pays only valid claims.

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

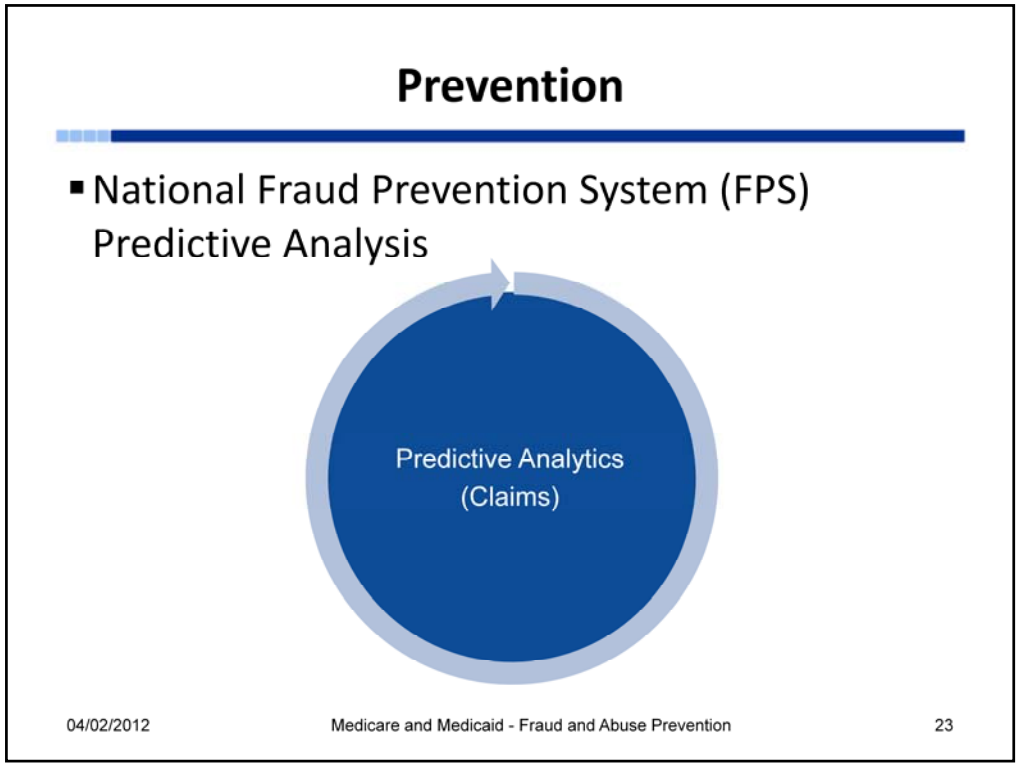



One of the two key program integrity gateways is the process through which providers enroll to the Medicare and Medicaid programs.



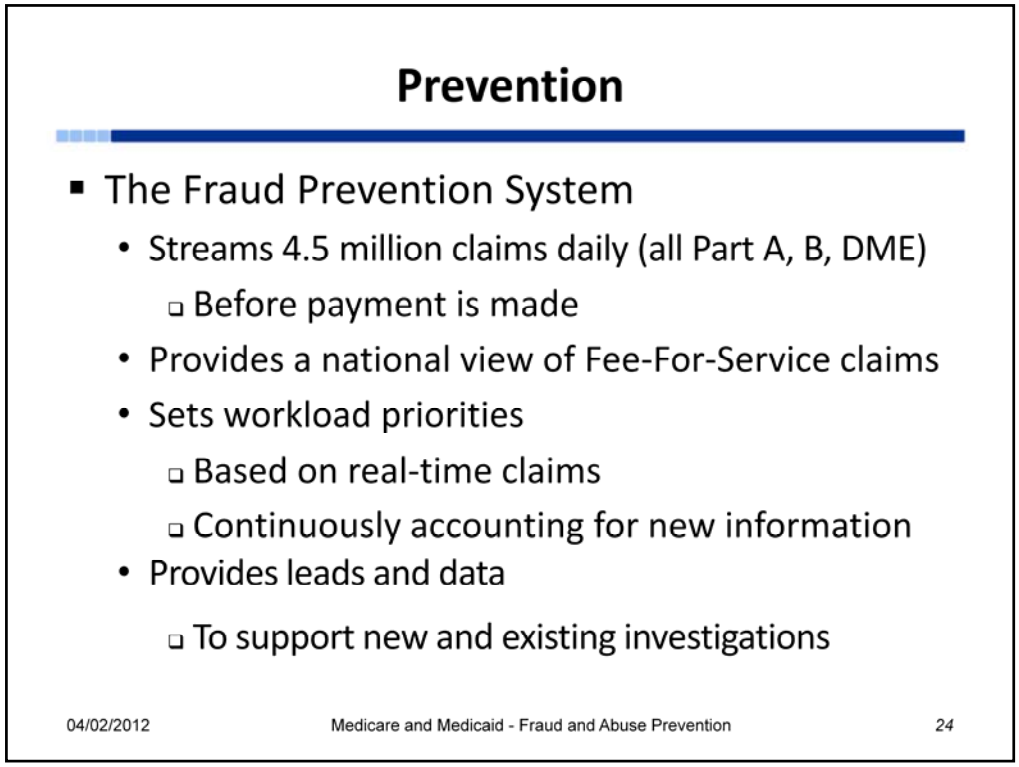

CMS' automated provider screening technology, to be fully implemented in early 2012, will

- Reduce provider and supplier enrollment application processing time,
- Assess individual risk of provider pre-enrollment before giving billing privileges,
- Monitor the accuracy of all provider and supplier enrollment data, and
- Provide a shared view of screening results where CMS and Medicare contractors can verify, update, and act on relevant information found during the enrollment process.



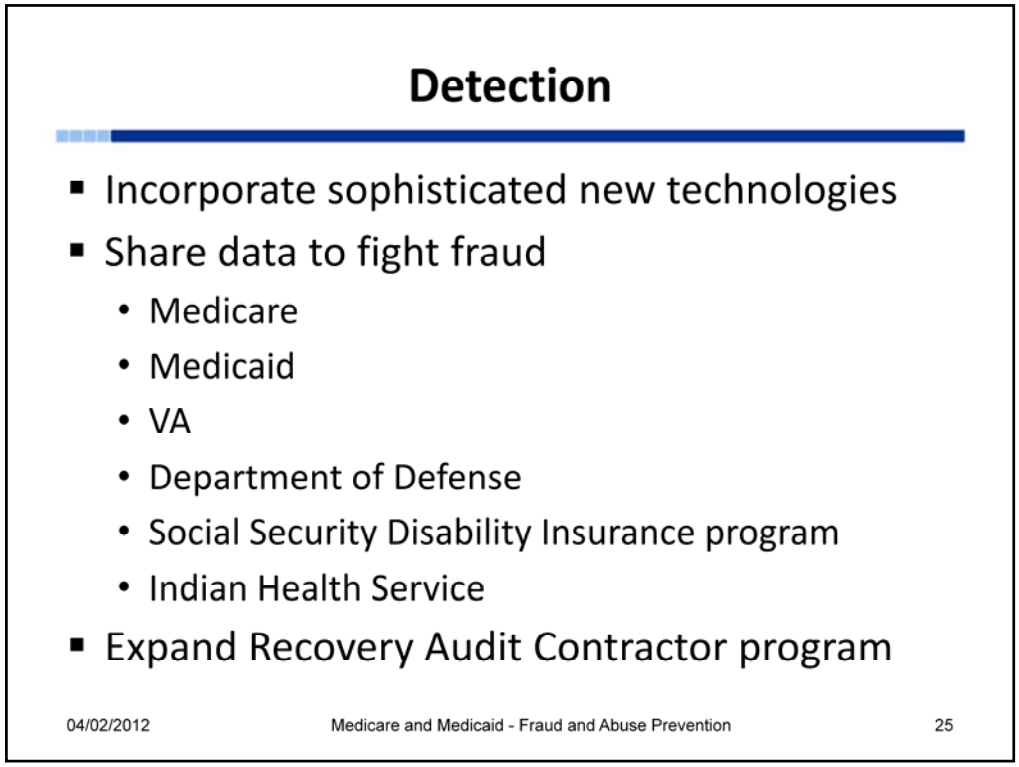

CMS is now streaming every Medicare fee-for-service claim in real-time through its predictive modeling technology, known as the Fraud Prevention System (FPS).

Much like the predictive modeling systems used in the financial industry, the FPS uses a series of algorithms to identify potentially fraudulent claims and prioritize the most egregious situations.



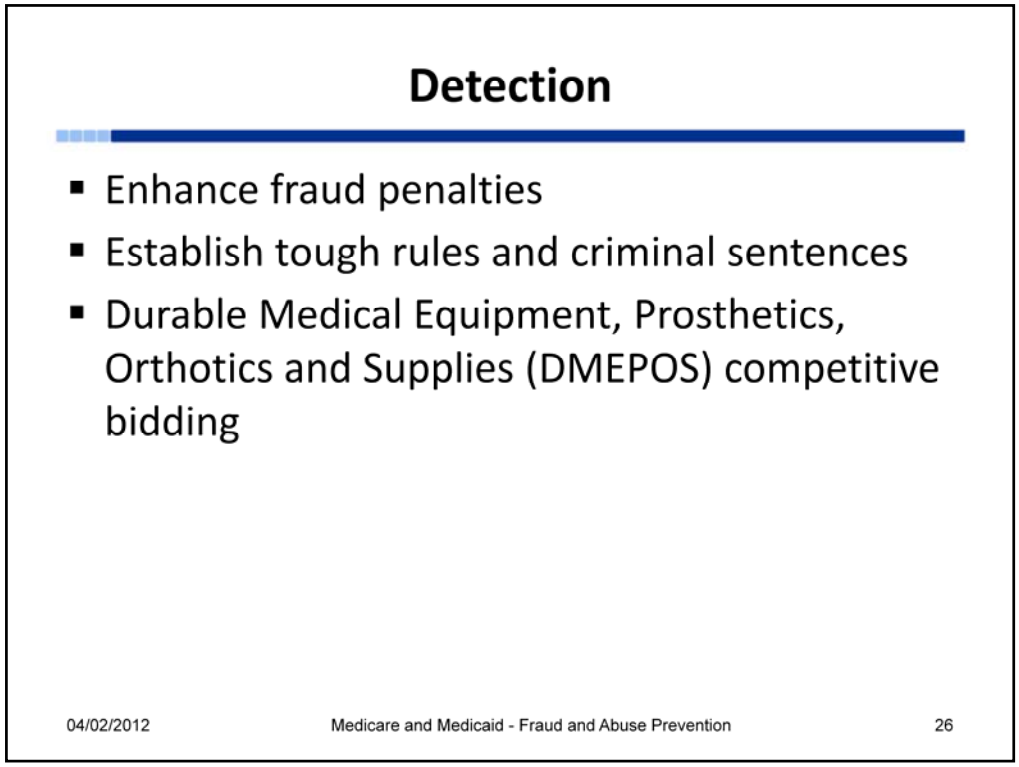

As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, and billing patterns. Using these profiles, CMS estimates a claim's likelihood of fraud and prioritizes providers with billing behavior that seem to pose an elevated risk to Medicare for a closer review. Some key facts

- The FPS streams 4.5 million claims (all Part A, B, DME) each day, before payment is made.
- The FPS has provided CMS with a national view of Fee-For-Service claims for the first time.
- The FPS uses historical data and external databases to build robust profiles for beneficiaries, providers and suppliers.
- The FPS sets workload priorities based on real-time claims, continuously accounting for new information.
- The FPS is providing successful new leads and additional data to support current and new investigations for CMS' program integrity contractors and law enforcement.



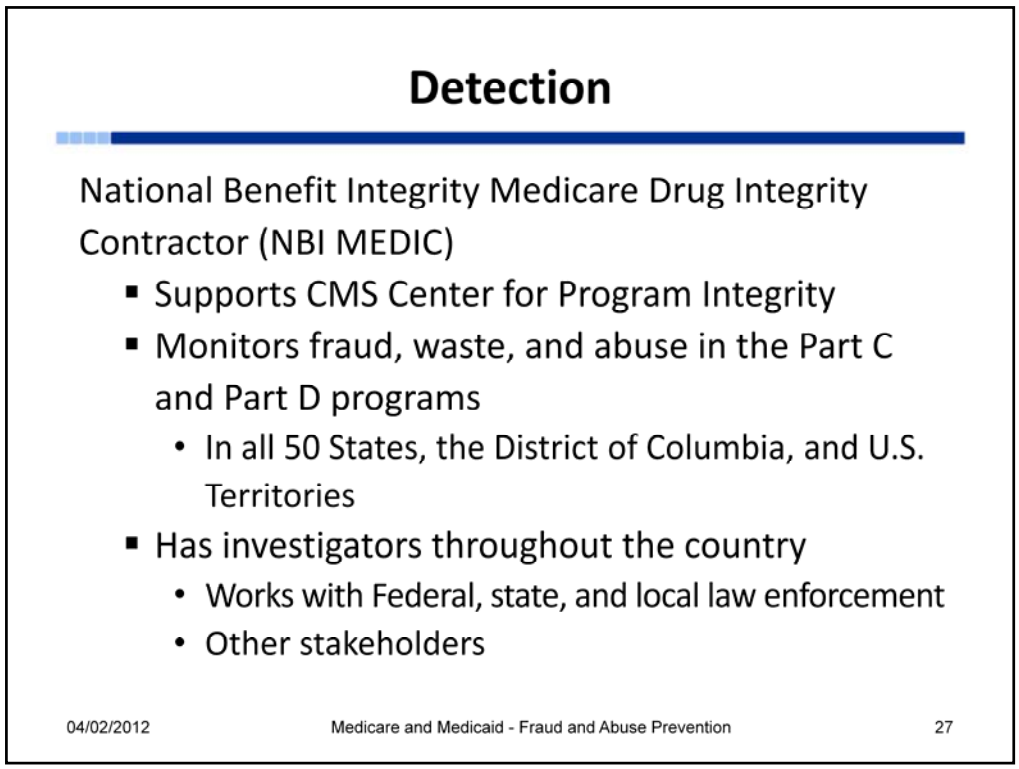

Fraud detection strategies include

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



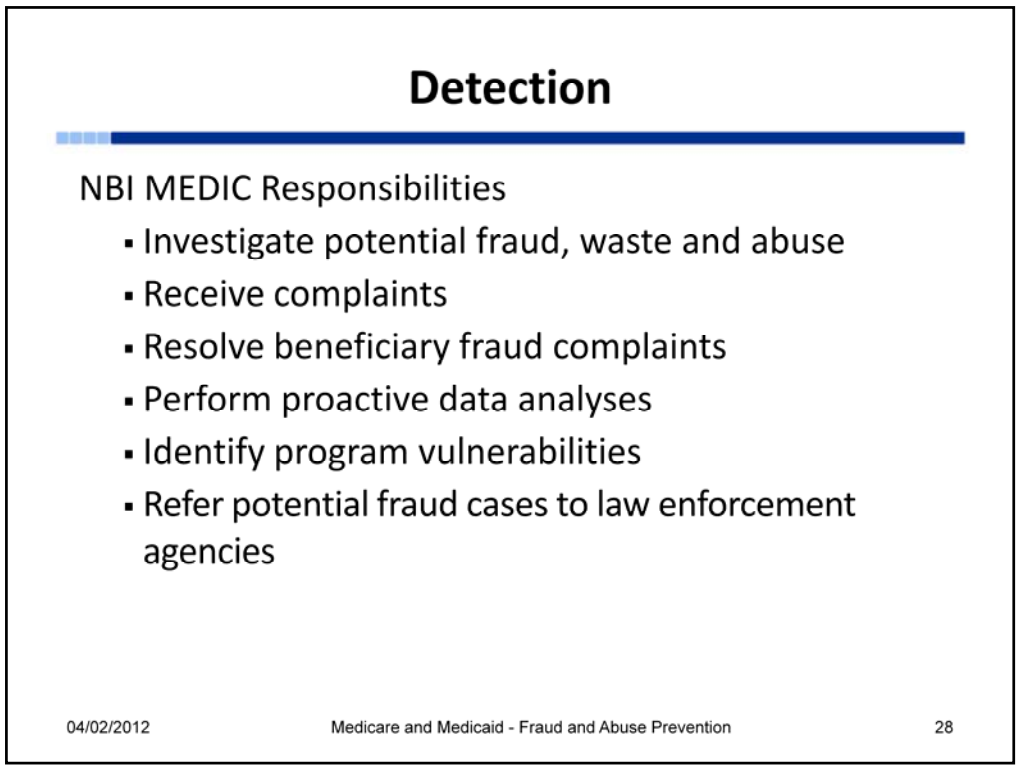

Fraud detection strategies include

- Enhance penalties to deter fraud and abuse. The Affordable Care Act provides the Office of the Inspector General with the authority to impose stronger civil and monetary penalties against those found to have committed fraud.
- Establishing tough new rules and sentences for criminals. The Federal sentencing guidelines have increased for health care fraud offenses involving $1M or more in losses to federal health care programs.
- The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) competitive bidding program aims to reduce Medicare's excessive payment amounts for certain DME items, which makes these items less attractive targets for fraud and abuse. Through supplier competition, the program sets new, lower payment rates for certain medical equipment and supplies, such as oxygen equipment, certain power wheelchairs, and mail order diabetic supplies.



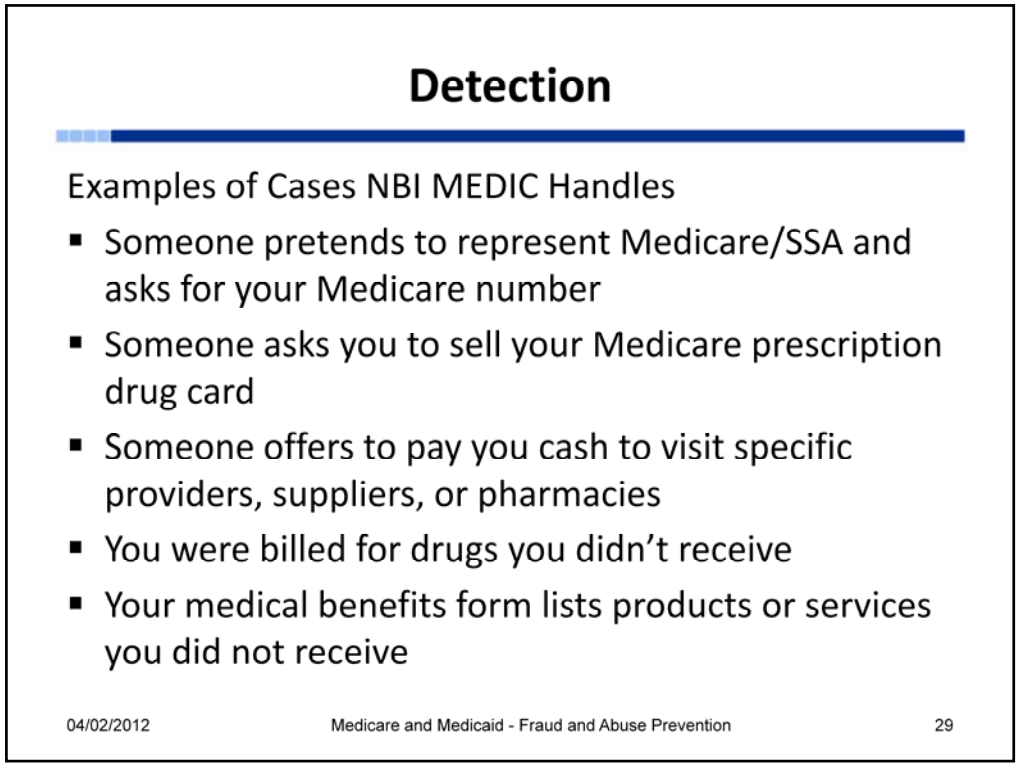

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) supports the CMS Center for Program Integrity

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




NBI Medic has a number of key responsibilities, including

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

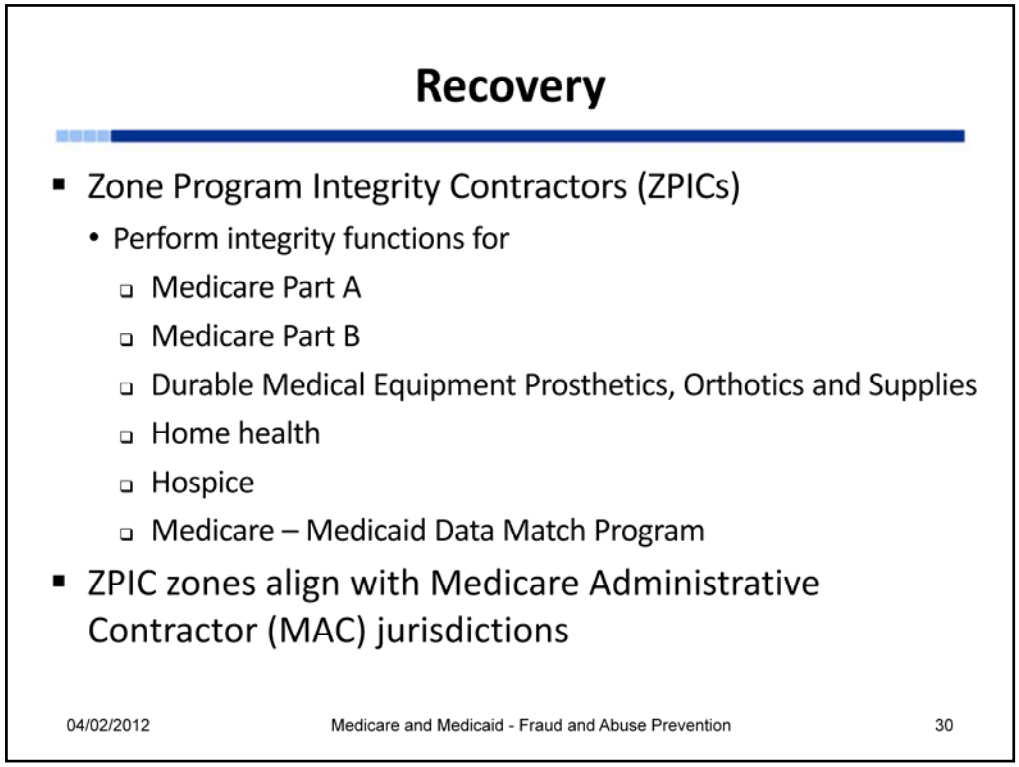



The NBI MEDIC monitors and performs analysis of various types of data for the purpose of detecting fraud, waste, and abuse activity and developing candidates among plans, providers and beneficiaries for further investigation.

The NBI MEDIC works with law enforcement, Medicare Advantage organizations, prescription drug plans, consumer groups and other key partners to protect consumers and enforce Medicare's rules.

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

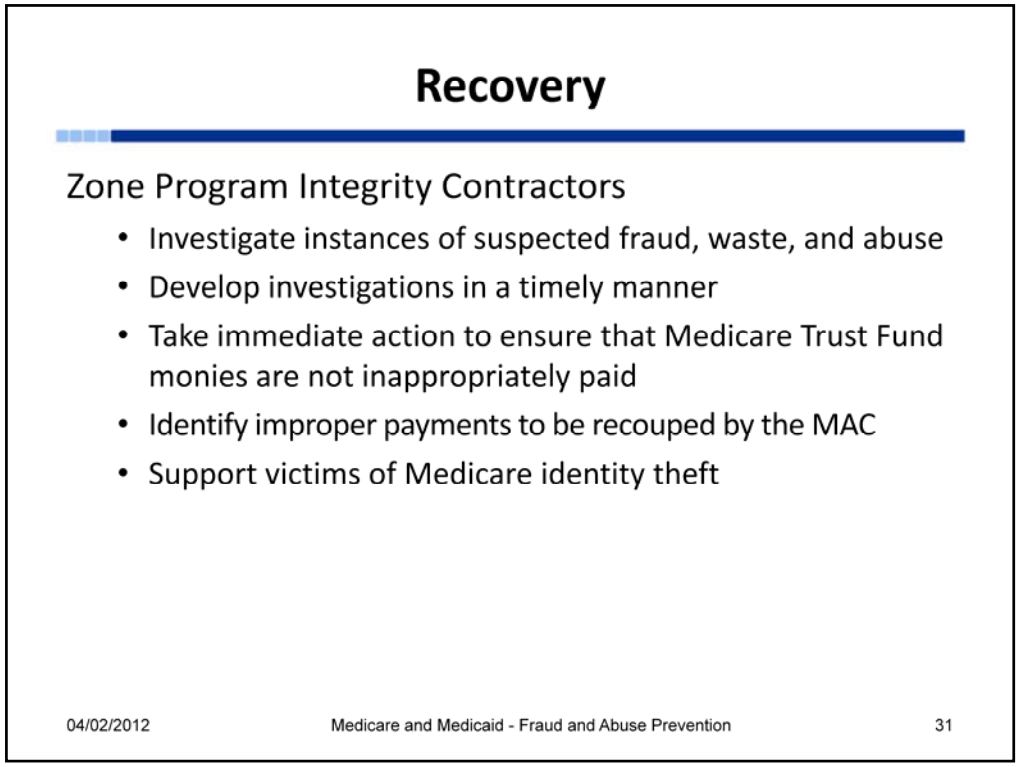
- An individual or organization pretends to represent Medicare and/or Social Security, and asks you for your Medicare or Social Security number, bank account number, credit card number, money, etc.
- You had your personal information stolen or suspect someone has stolen your personal information.
- Someone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




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

MACs

- Administer Medicare Parts A and B fee-for-service benefits for Medicare beneficiaries
- Manage provider and beneficiary enrollment
- Process claims
- Claims processing, including paying providers/suppliers;
- Provider outreach and education;
- Recouping monies lost to the Trust Fund (the ZPICs identify these situations and refer them to the MACs for the recoupment);
- Medical review not for benefit integrity purposes;
- Complaint screening;
- Claims appeals of ZPIC decisions;
- Claim payment determination;
- Claims pricing; and
- Auditing provider cost reports.

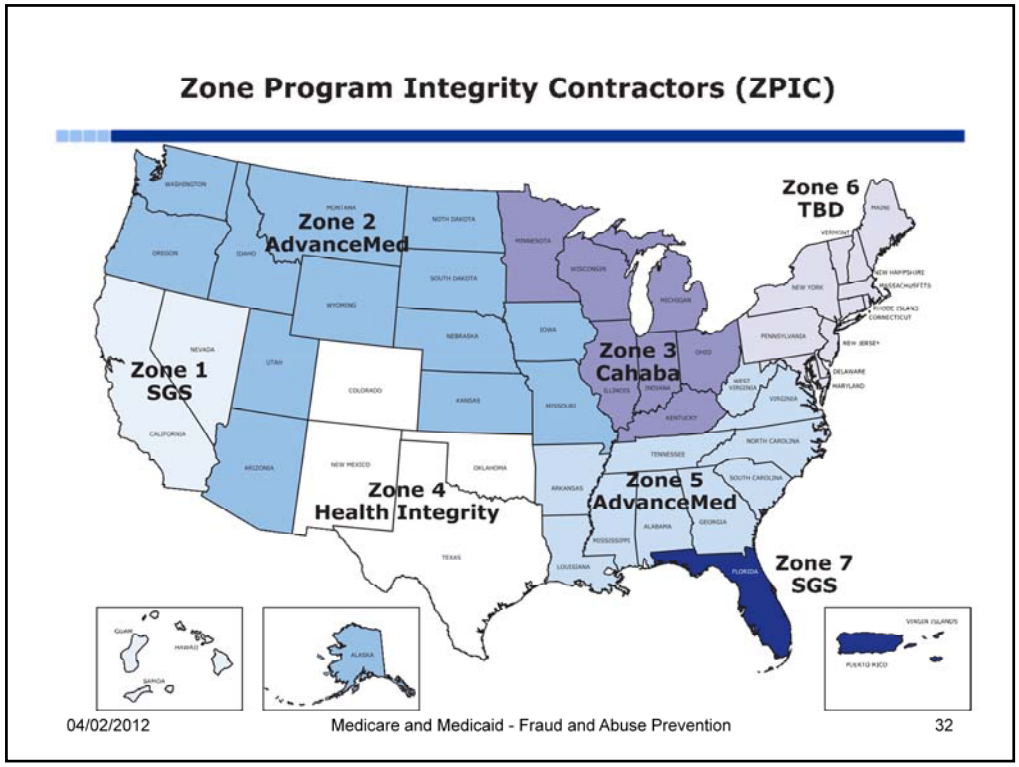



**Zone Program Integrity Contractor (ZPIC) Functions**

The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid.

ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider.

Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf




There are seven Zone Program Integrity Contractors.

Zone 1 is covered by SGS and includes California, Hawaii, and Nevada.

Zone 2 is covered by AdvanceMed and includes Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

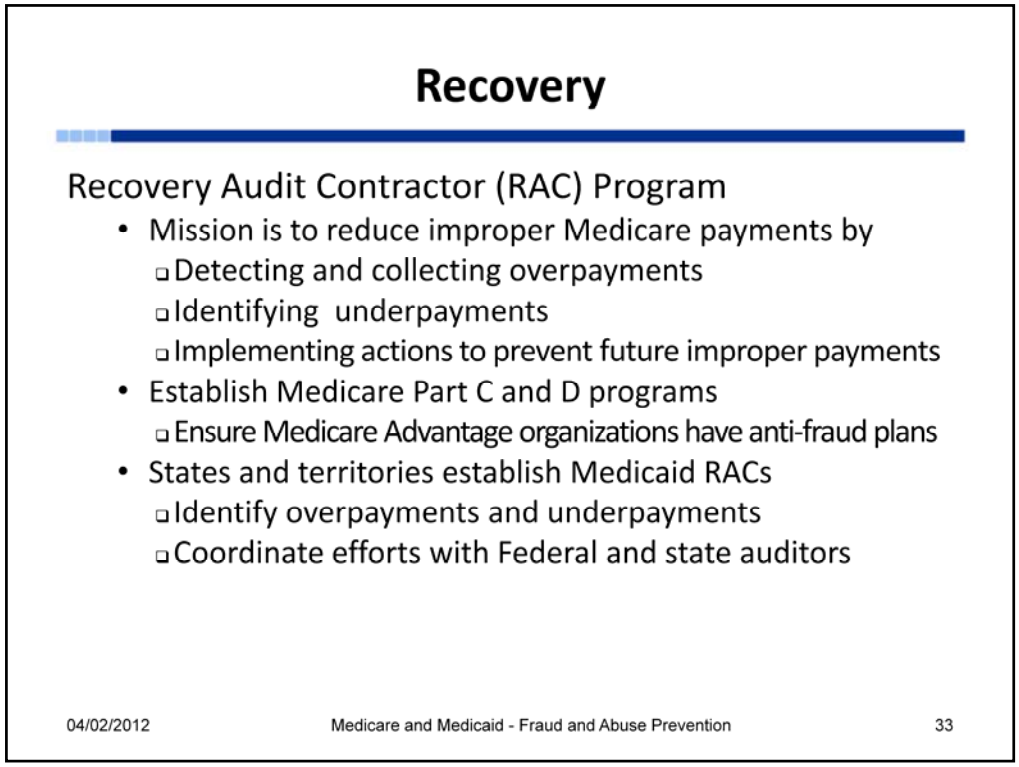
Zone 3 is covered by Cahaba and includes Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

Zone 4 is covered by Health Integrity and includes Colorado, Oklahoma, New Mexico and Texas.

Zone 5 is covered by AdvanceMed and includes Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Zone 6 is covered by TBD and covers Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington, DC.

Zone 7 is covered by SGS and includes Florida and Puerto Rico.




The Recovery Audit Contractor Program's mission is to reduce Medicare improper payments through

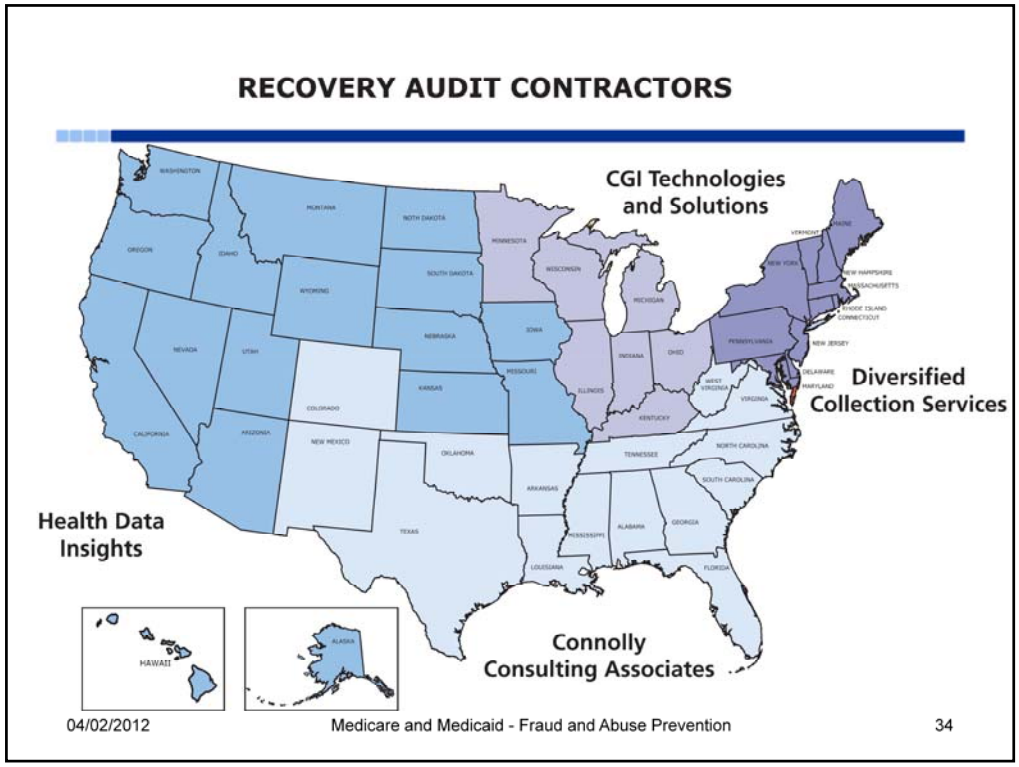
- the efficient detection and collection of overpayments,
- the identification of underpayments,
- and the implementation of actions that will prevent future payments.

CMS is establishing Medicare parts C/D Recovery Audit Contractor (RAC) programs in accordance with the requirements specified in the Affordable Care Act.

- Medicare parts C/D RACs must ensure that each Medicare Advantage and drug plan has an anti-fraud plan in effect, and to review the effectiveness of each plan.
- RACs will retroactively examine claims for reinsurance to determine if drug plan sponsors submitted claims exceeding allowable costs.
- RACs will review estimates submitted by plans for high cost beneficiaries and compare to numbers of beneficiaries actually enrolled in such plans.
- RACs collect overpayments.
- RACs are paid on a contingency fee basis.

States and territories must establish Medicaid RAC programs

- Medicaid RACs must identify and recover overpayments and identify underpayments.
- States must pay Medicaid RACs on a contingency fee basis for identification and recovery of overpayments and will determine the fee paid to Medicaid RACs to identify underpayments.
- Medicaid RACs must coordinate their efforts with other auditing entities, including State and Federal law enforcement agencies. CMS and States will work to minimize the likelihood of overlapping audits.

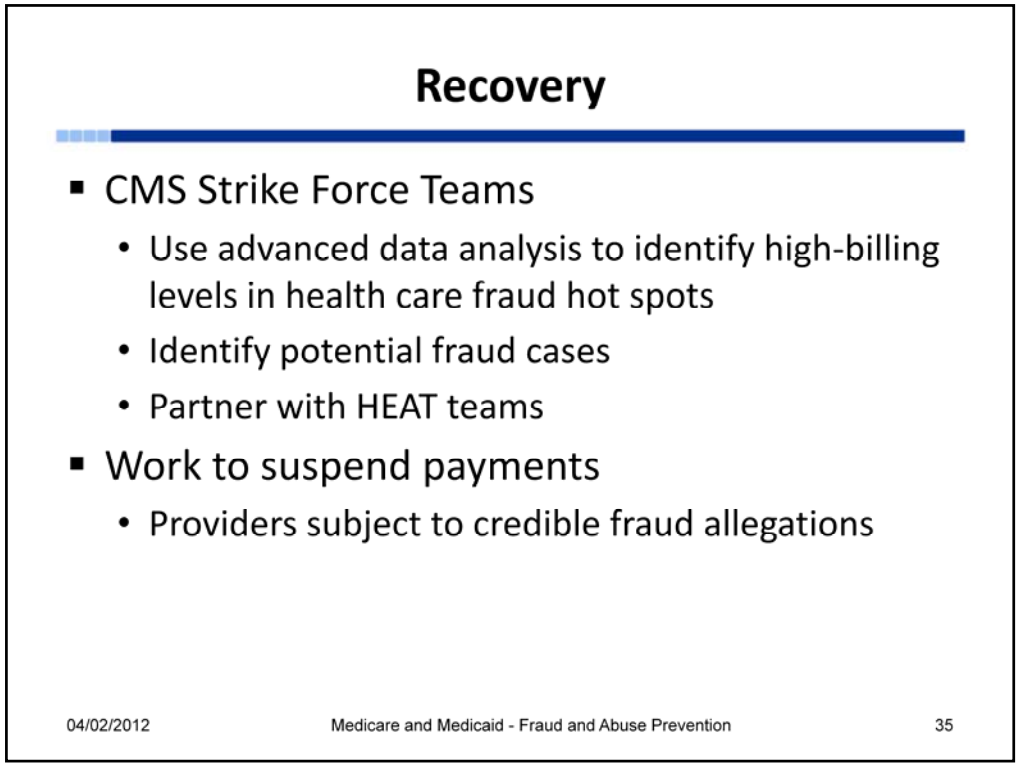



Expanded Overpayment Recovery Efforts via Recovery Audit Contractors

There are four RACs

- Diversified Collection Services
- CGI Technologies and Solutions
- Connolly Consulting Associates
- HealthDataInsights

This map is specific to Part A and Part B Recovery Audit Contractors.



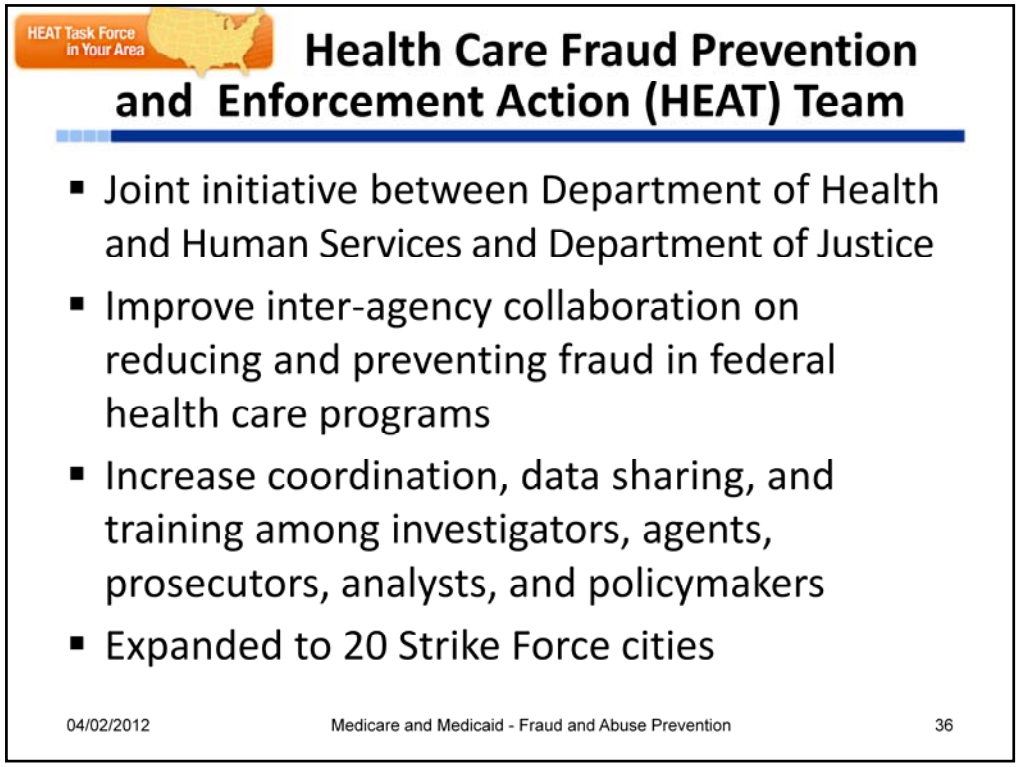

CMS Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers.

CMS is working collaboratively with Federal and law enforcement partners to increase the recovery of improper payments and fraud by working toward suspending payments for providers subject to credible allegations of fraud.

Partnering in expansion of the Healthcare Fraud Prevention & Enforcement Action Team (HEAT) task forces to additional cities throughout the country.

HEAT task forces are inter-agency teams composed of top-level law enforcement and professional staff. The team builds on existing partnerships, including those with state and local law enforcement organizations to prevent fraud and enforce anti-fraud laws.

More than $2.5 billion stolen from federal health care programs was identified for return to the Medicare Health Insurance Trust Fund, the Treasury, and others in FY 2010. This is an unprecedented achievement for the Health Care Fraud and Abuse Control Program (HCFAC), a joint effort of the two departments to coordinate Federal, state, and local law enforcement activities to fight health care fraud and abuse.



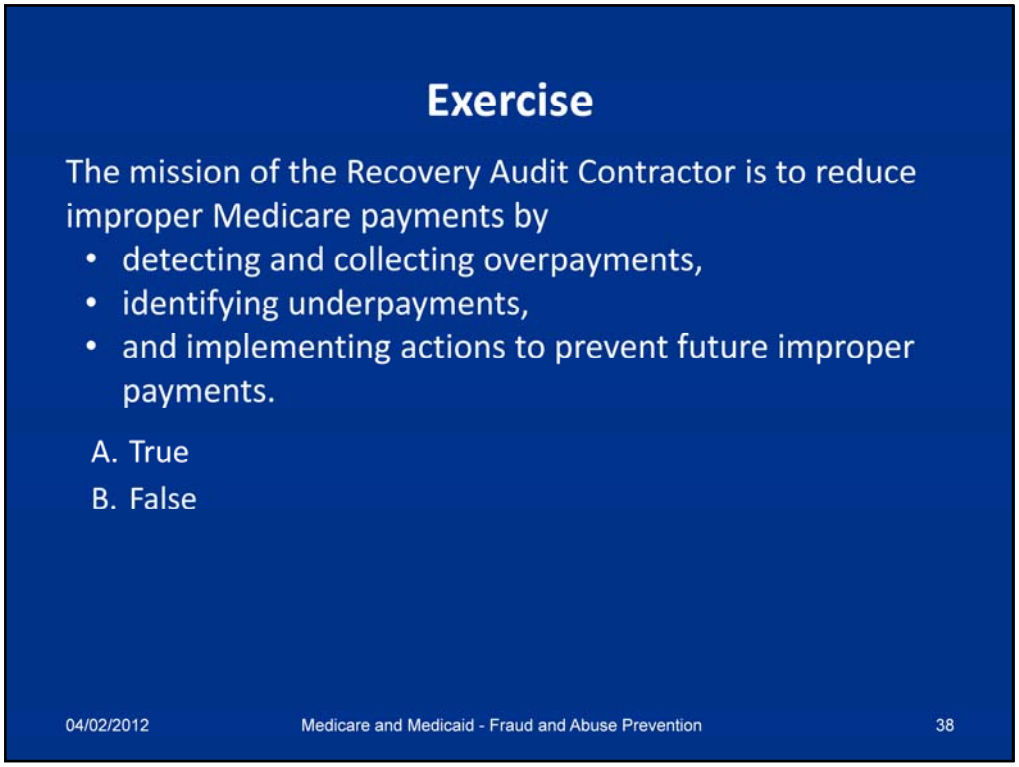

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is a joint initiative between the Department of Health & Human Services and the Department of Justice(DOJ) to combat fraud.

Their goal is to improve inter-agency collaboration on reducing and preventing fraud in federal health care programs. By deploying law enforcement and trained agency personnel HHS and DOJ to increase coordination, data sharing, and training among investigators, agents, prosecutors, analysts, and policymakers, Project HEAT has been highly successful in bringing health care fraud cases and prosecuting them quickly and effectively.

HEAT Team is chaired by the Department of Health & Human Services Deputy Secretary and the Deputy Attorney General.


Mission of HEAT Team is to

- To gather resources across government to help prevent waste, fraud and abuse in the Medicare and Medicaid programs, and crack down on the fraud perpetrators who are abusing the system and costing us all billions of dollars.
- To 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.
- To highlight best practices by providers and public sector employees who are dedicated to ending waste, fraud and abuse in Medicare.
- To build upon existing partnerships between the Department of Justice and the Department of Health and Human Services such as our Medicare Fraud Strike Forces to reduce fraud and recover taxpayer dollars.




**Exercise**

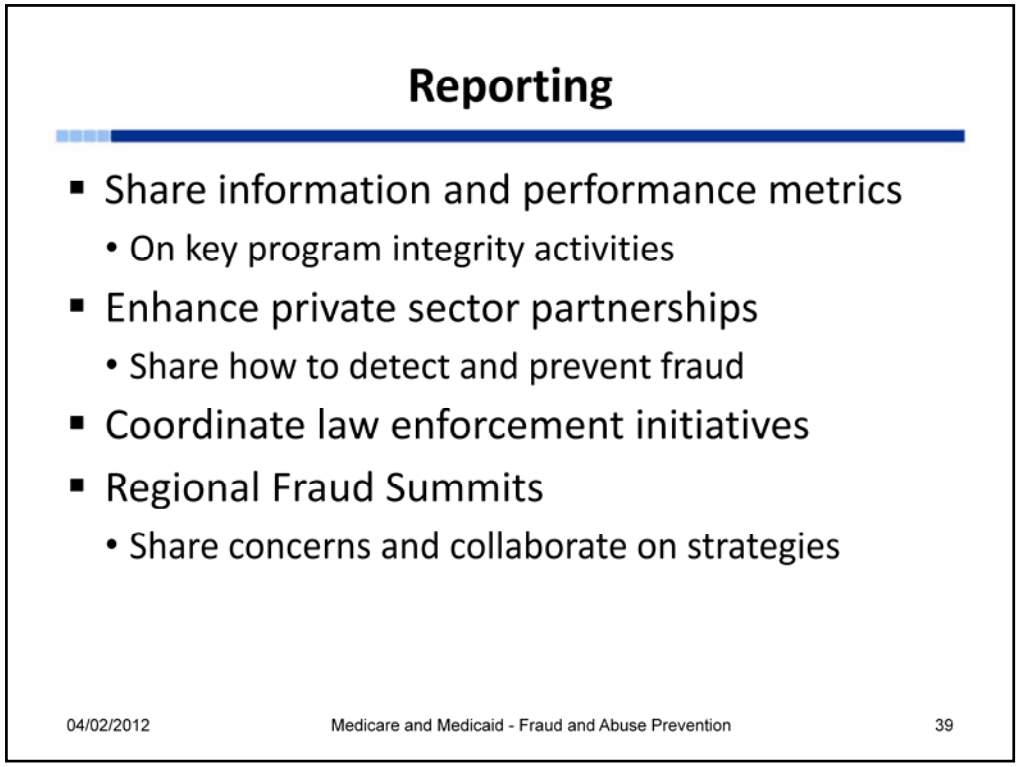
The mission of the Recovery Audit Contractor is to reduce improper Medicare payments by

- detecting and collecting overpayments,
- identifying underpayments,
- and implementing actions to prevent future improper payments.

A. True

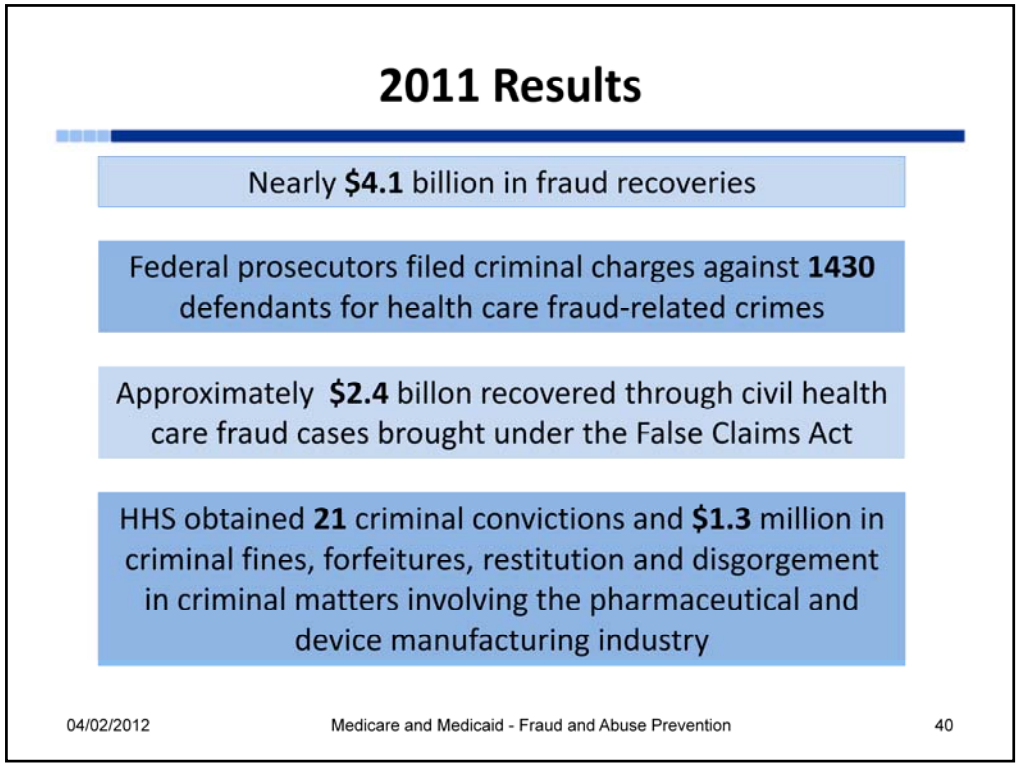
B. False

**Answer:** A. True




CMS is working to increase the reporting of improper payments and fraud through the following.

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

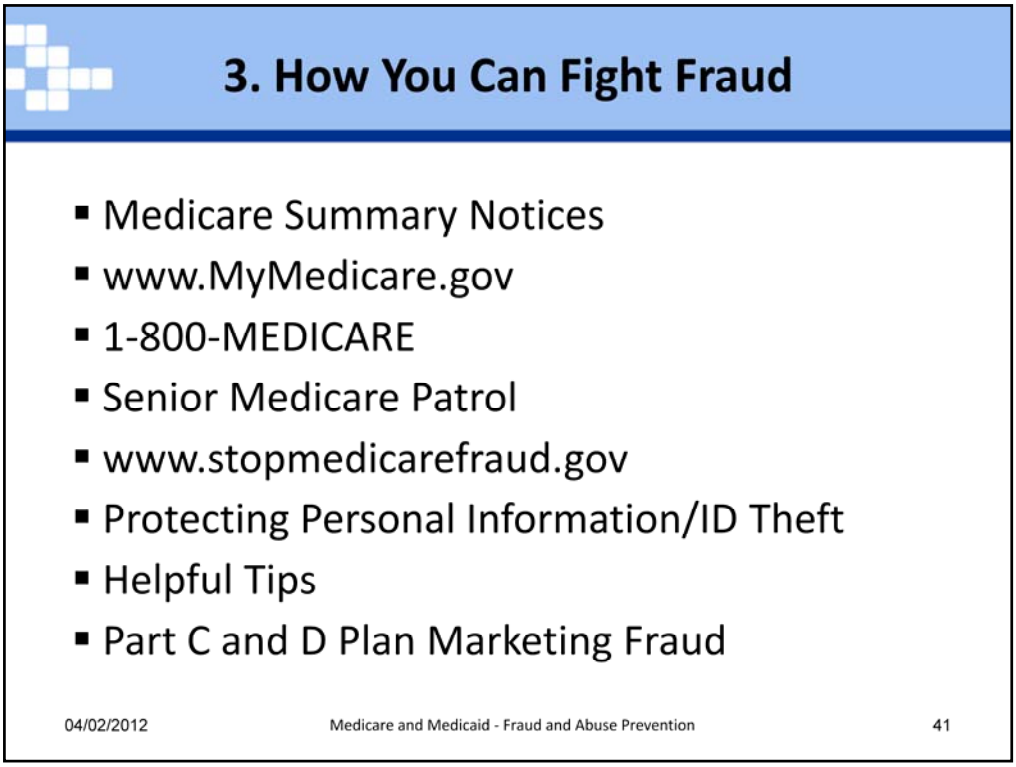



Nearly $4.1 billion in fraud recoveries.

Federal prosecutors filed criminal charges against 1430 defendants for health care fraud-related crimes.

HHS obtained 21 criminal convictions and $1.3 million in criminal fines, forfeitures, restitution and disgorgement in criminal matters involving the pharmaceutical and device manufacturing industries. (Disgorgement is when an entity is forced to give up profits obtained by illegal or unethical acts. The entity may be ordered by a court to pay back illegal profits, with interest.)

Approximately $2.4 billon was recovered through civil health care fraud cases brought under the False Claims Act.

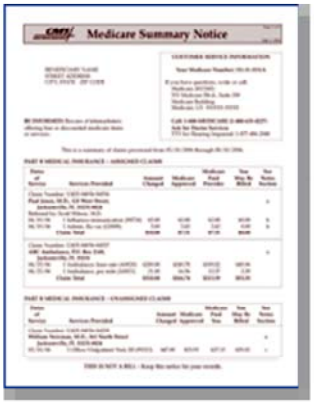



In lesson three we will learn about how people with Medicare can fight fraud. We will

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

## Medicare Summary Notice (MSN)

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




Newly designed MSN will be online in 2012. Mailed in 2013.



There is a Part A and a Part B Medicare Summary Notice (MSN). 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 the beneficiary owes each provider.

You should review your MSN carefully, to ensure that you received the services and supplies that Medicare was billed for.

CMS is currently redesigning the MSN to make them simpler to understand and spot fraud. The new MSN will be ready in 2013. It will be easier to understand and read. It will provide additional information, like a quarterly summary of claims.

There is a pilot program in some higher fraud areas to send MSNs monthly.

If there is a discrepancy, you should call your doctor or supplier.

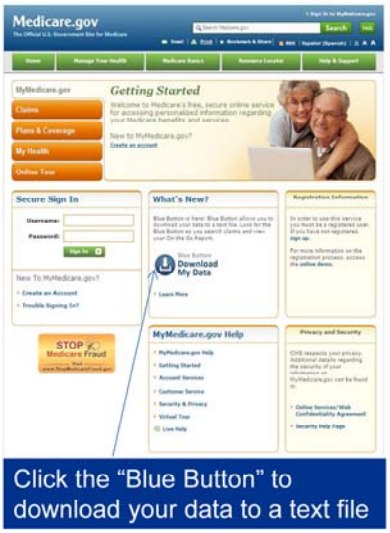
Note: The Medicare Summary Notice is being updated, and a new MSN will be delivered to people with Medicare in 2013.

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

Call 1-800-MEDICARE if you suspect fraud.

## MyMedicare.gov

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




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

04/02/2012 Medicare and Medicaid - Fraud and Abuse Prevention 43

Medicare's free, secure online service for accessing personalized information regarding Medicare benefits and services.

www.MyMedicare.gov provides you with access to your personalized information at any time.

View eligibility, entitlement and preventive service information.

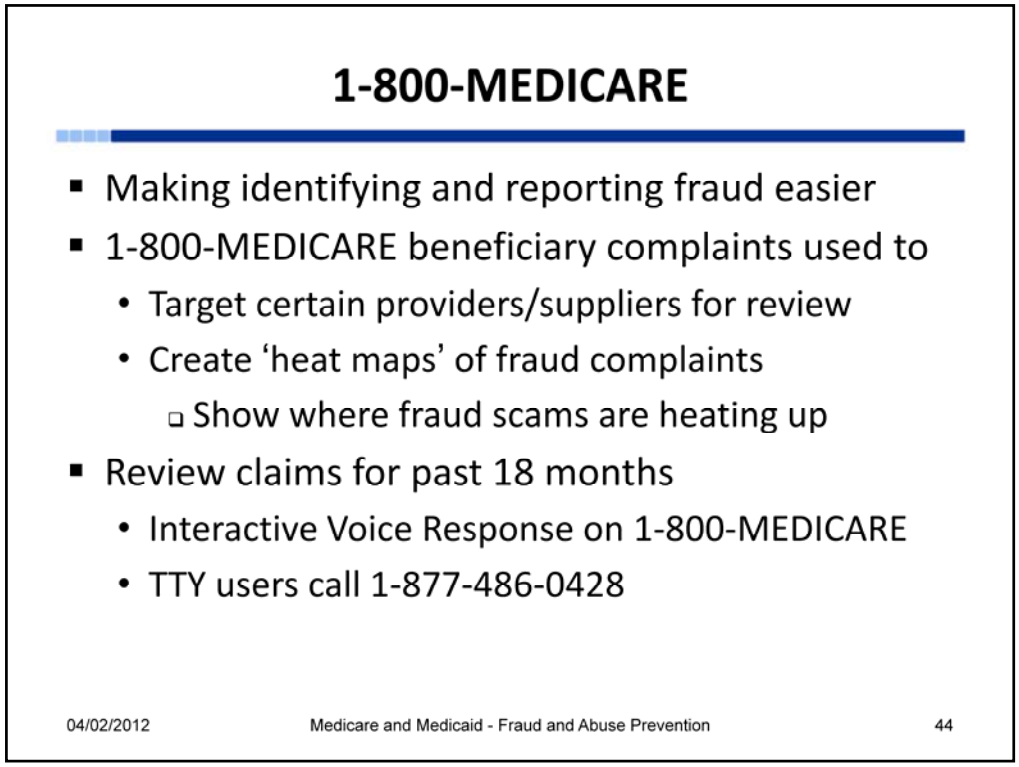
Check personal Medicare information, including Medicare claims as soon as they are processed.

Check your health prescription drug enrollment information your Part B deductible information.

Manage your prescription drug list personal health information.

Review claims – identify fraudulent claims. You don't have to wait for your Medicare Summary Notice to view your Medicare claims. Visit www.MyMedicare.gov to track your Medicare claims or view electronic MSNs. Your claims will generally be available within 24 hours after processing.

In order to use this service you must register on the site.

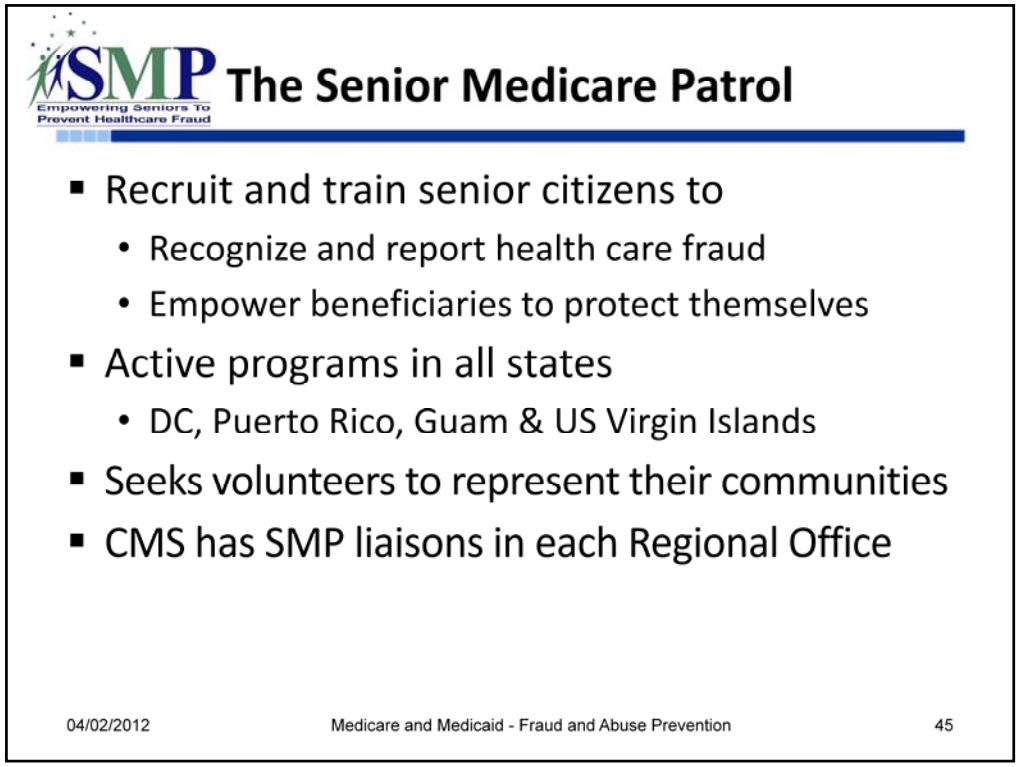



CMS has implemented an interactive voice response system for beneficiaries to identify and report fraud.

Interactive Voice Response on 1-800-Medicare allows beneficiaries that have not registered or do not use www.MyMedicare.gov to listen to the most recent five claims processed on their behalf for any month in the last year.

CMS is now using 1-800-Medicare beneficiary complaints to

- Target providers or suppliers with multiple beneficiary complaints for further review
- Create 'heat maps' of fraud complaints that will show when fraud scams are heating up in new areas.



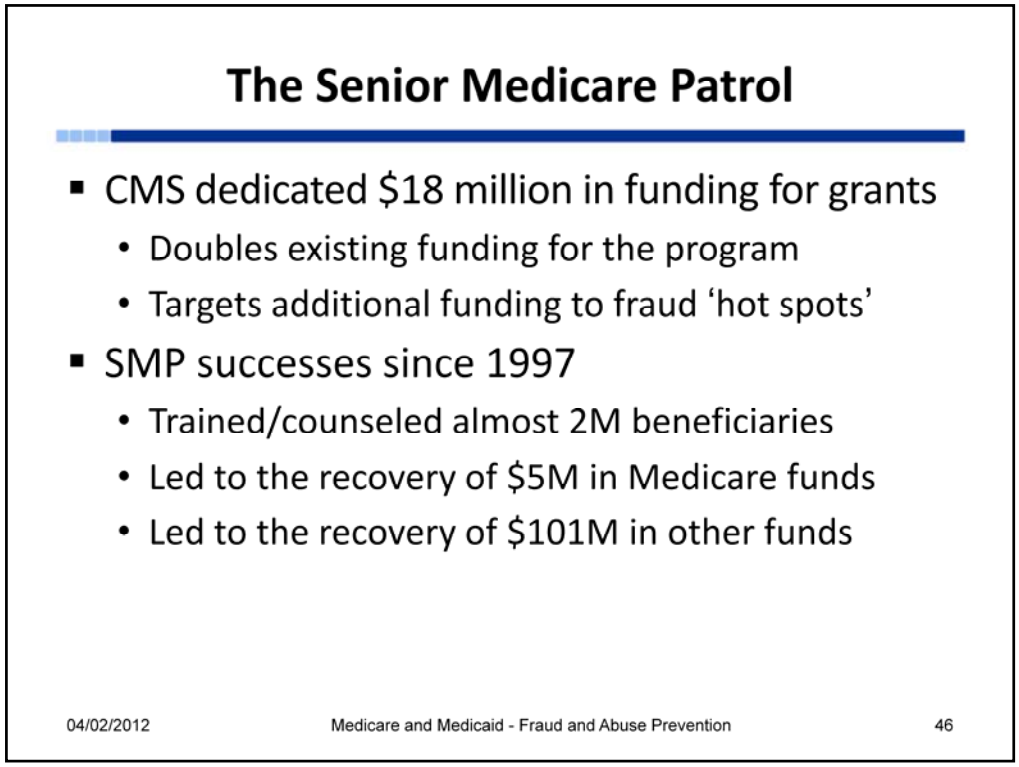

Senior Medicare Patrols (SMPs) recruit and train retired professionals and other senior citizens about how to recognize and report instances or patterns of health care fraud. They empower Medicare beneficiaries to protect themselves against fraud.

SMPs partner with community, faith-based, tribal, and health care organizations to educate and empower their peers to identify, prevent and report health care fraud. SMP's teach you how to protect your identity, how to detect errors, and how to report fraud. SMPs receive training about how threats to financial independence and health status may occur when citizens are victimized by fraudulent schemes.

There are SMP programs in all states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. The SMP seeks new volunteers to represent the SMP in their communities.

The SMP program empowers seniors through increased awareness and understanding of healthcare programs. This knowledge helps seniors to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error and abuse. SMP projects also work to resolve beneficiary complaints of potential fraud in partnership with state and national fraud control/consumer protection entities, including Medicare contractors, state Medicaid fraud control units, state attorneys general, the OIG and CMS.

CMS established SMP liaisons in each Regional Office to serve as the point of contact for compliance/marketing issues identified by SMPs, to proactively engage with SMPs and to share relevant program information, changes, and Medicare updates.




Since 1997 AoA has funded SMP projects to recruit and train retired professionals and other senior citizens about how to recognize and report instances or patterns of health care fraud. CMS has dedicated $18 million in funding for grants to expand state-based Senior Medicare Patrol programs.

The grants will

- Double existing funding for the program
- Target additional funding to current 'h t spots' for fraud

Since 1997, the Senior Medicare Patrol has

- Provided group training sessions to 75,000; and individual counseling to over 1 million beneficiaries
- Led to the recovery of $5 million dollars of Medicare funds
- Led to the recovery of $101 million dollars of Medicaid, beneficiary, and other payers funds

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

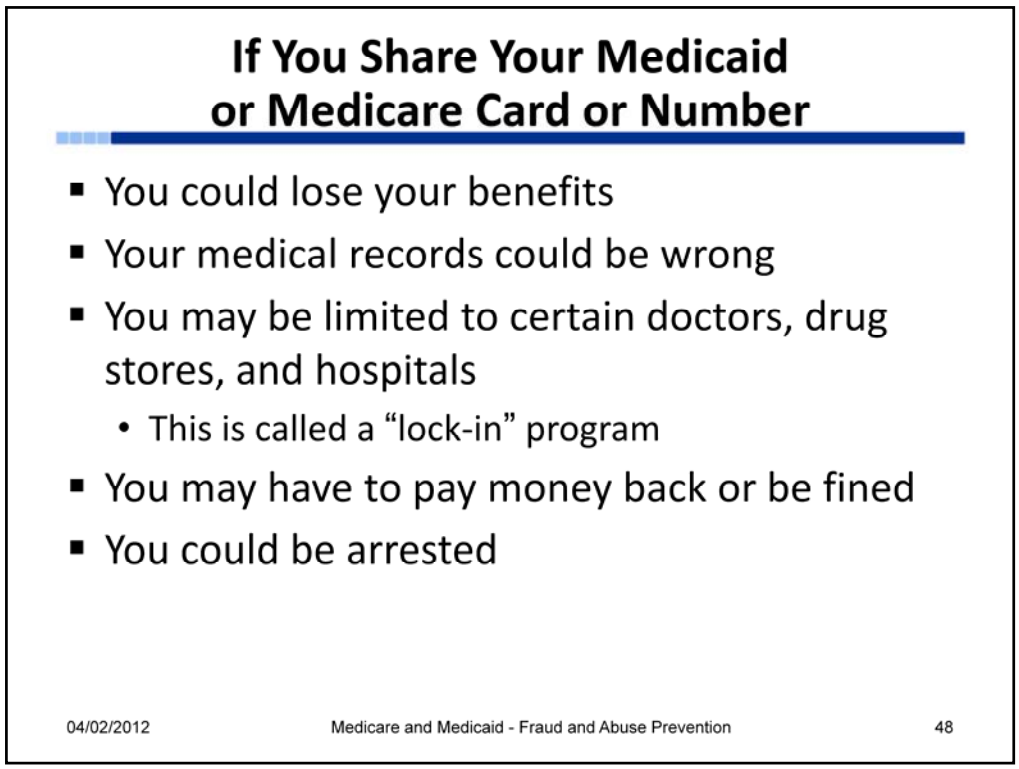
## www.stopmedicarefraud.gov

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


04/02/2012 Medicare and Medicaid - Fraud and Abuse Prevention 47

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

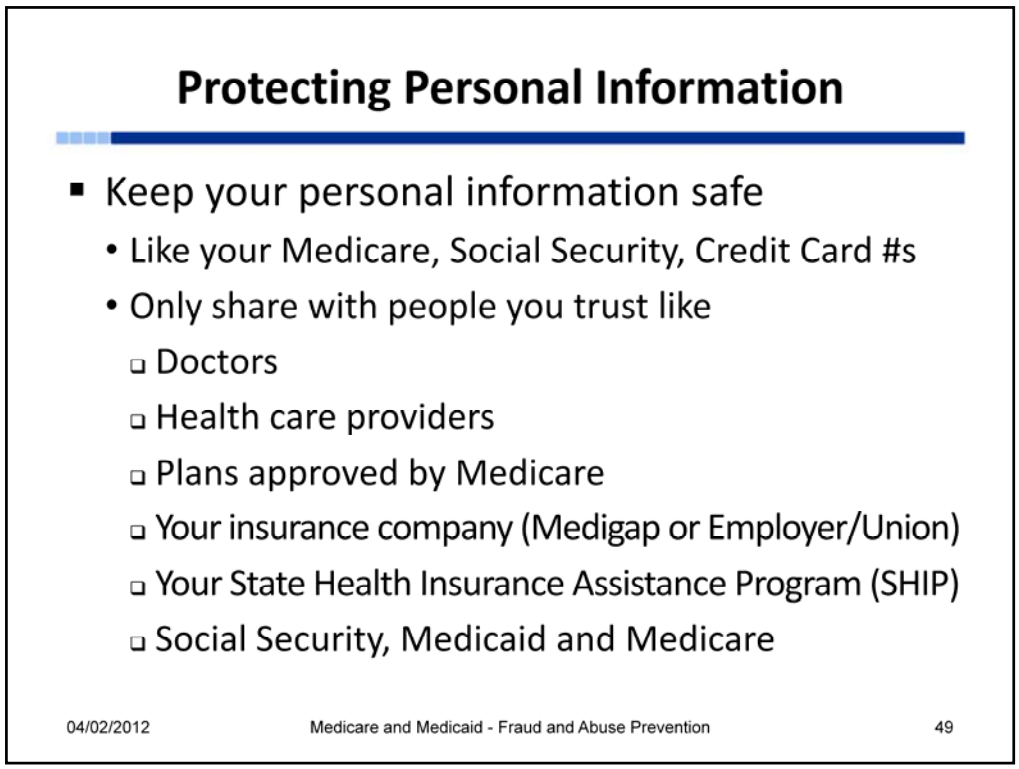
- Medicare fraud
- Resources available for beneficiaries and providers
- Ways you can prevent fraud
- Recent Health Care Fraud Prevention and Enforcement Action Team (HEAT) operations and results listed by state




If you share your Medicaid or Medicare card you could have serious problems.
If you share you Medicaid card you might lose your Medicaid benefits.
The next time you go to the doctor, you will have to explain what happened so you don't get the wrong kind of care.
Lock-in may be used for Medicaid beneficiaries who

- Visit hospital emergency departments for non-emergency health concerns
- Utilize two or more hospitals for emergency room services
- Utilize two or more physicians resulting in duplicated medications and or treatments
- Exhibit possible drug-seeking behavior by
  - •Requesting a specific scheduled medication
  - •Requesting early refills of scheduled medications
  - •Reporting frequent losses of scheduled medications (narcotics)
  - •Using multiple pharmacies to fill prescriptions

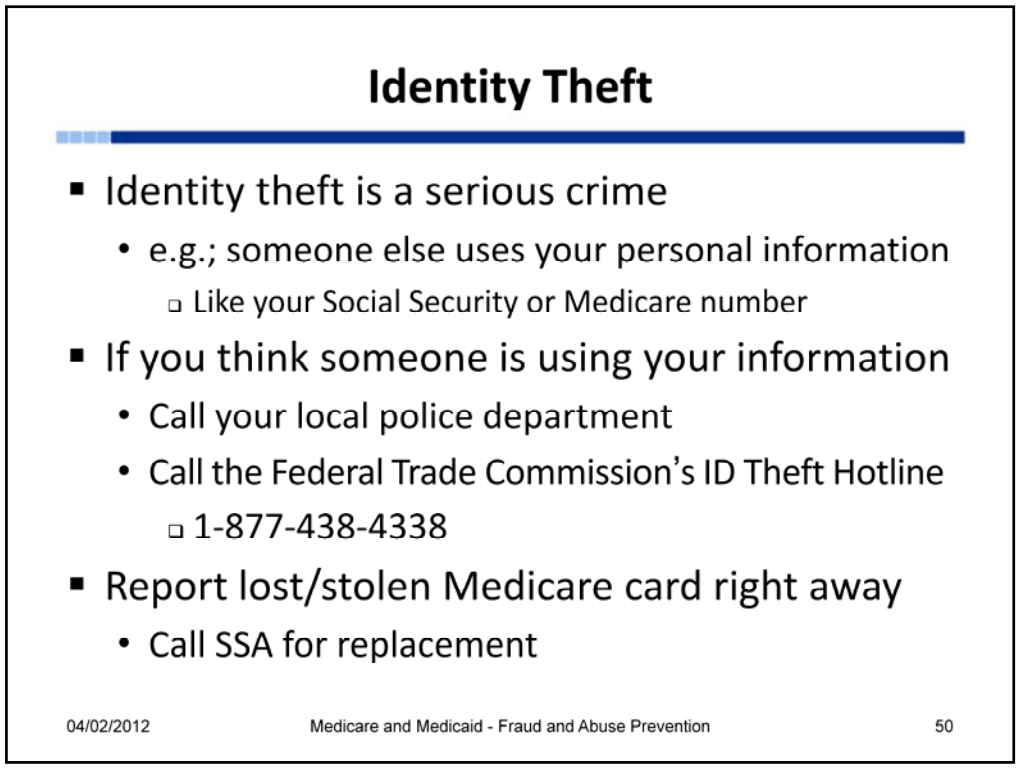
You can be required to pay a fine or spend time in jail if found guilty of fraud.




Sometimes beneficiaries need to share their medical information with family members or caregivers. By law, Medicare must have written permission to use or give our beneficiary medical information.

The beneficiary needs to designate the family member/caregiver as an authorized person to whom Medicare can disclose their personal information. Once Medicare has this authorization on file, the family member/caregiver will be able to discuss the beneficiaries Medicare issues directly with Medicare.

Family members/caregivers can contact Medicare at 1-800-MEDICARE to request a Medicare Authorization to Disclose Personal Information form 10106. Or they can visit www.medicare.gov/MedicareOnlineForms/AuthorizationForm/online to complete the process online.

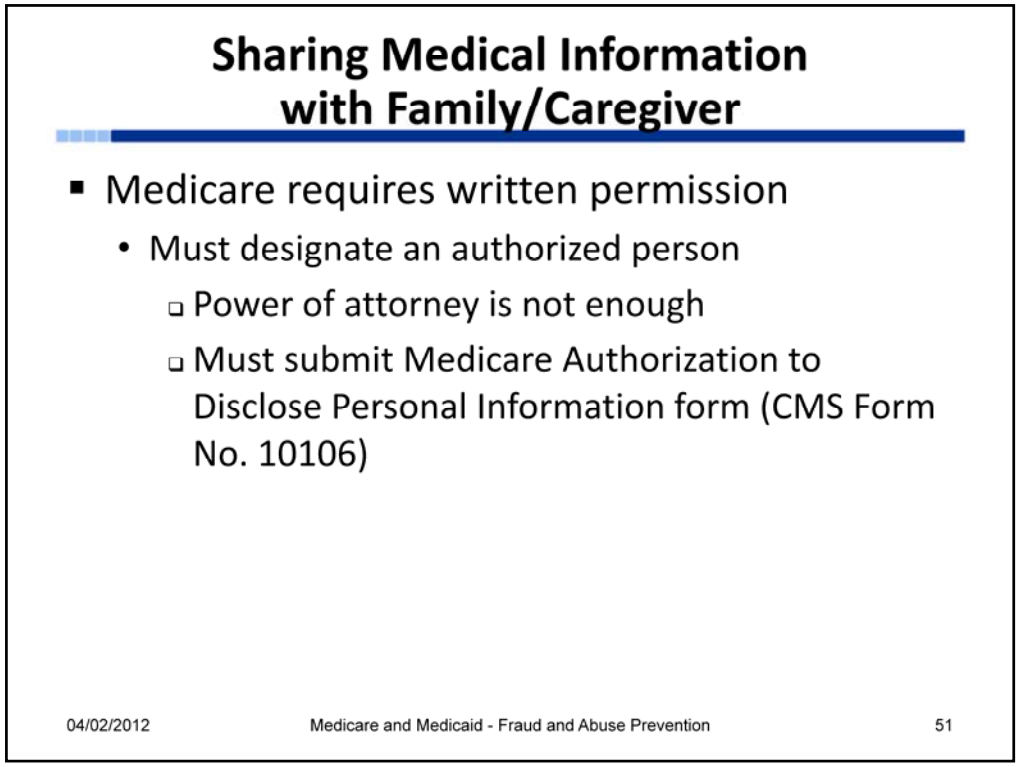



Identity theft is a serious crime

- Someone else uses your personal information
- Like your Social Security or Medicare number

If you think someone is using your information

- Call your local police department. Call the Federal Trade Commission's ID Theft Hotline – 1-877-438-4338. TTY users should call 1-866-653-4261.
- For more information about identity theft or to file a complaint online, visit www.ftc.gov/idtheft .
- You can also visit www.stopmedicarefraud.gov/fightback_brochure_rev.pdf to view the brochure, "Medical Identity Theft & Medicare Fraud."

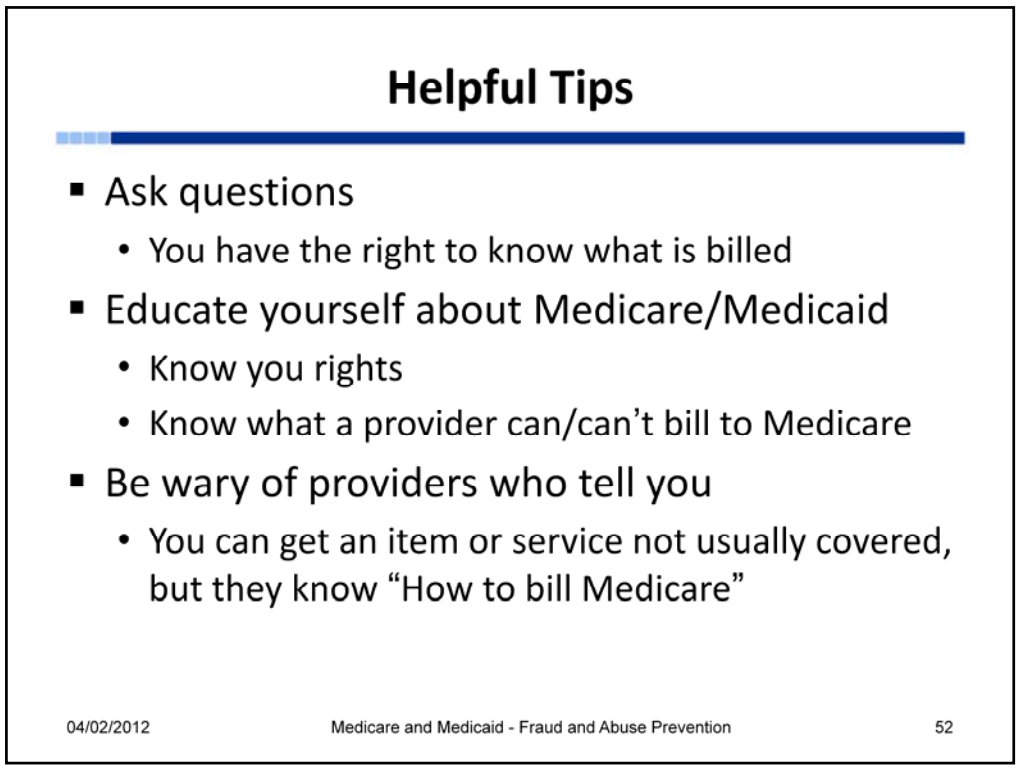



Sometimes beneficiaries need to share their medical information with family members or caregivers.

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

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

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

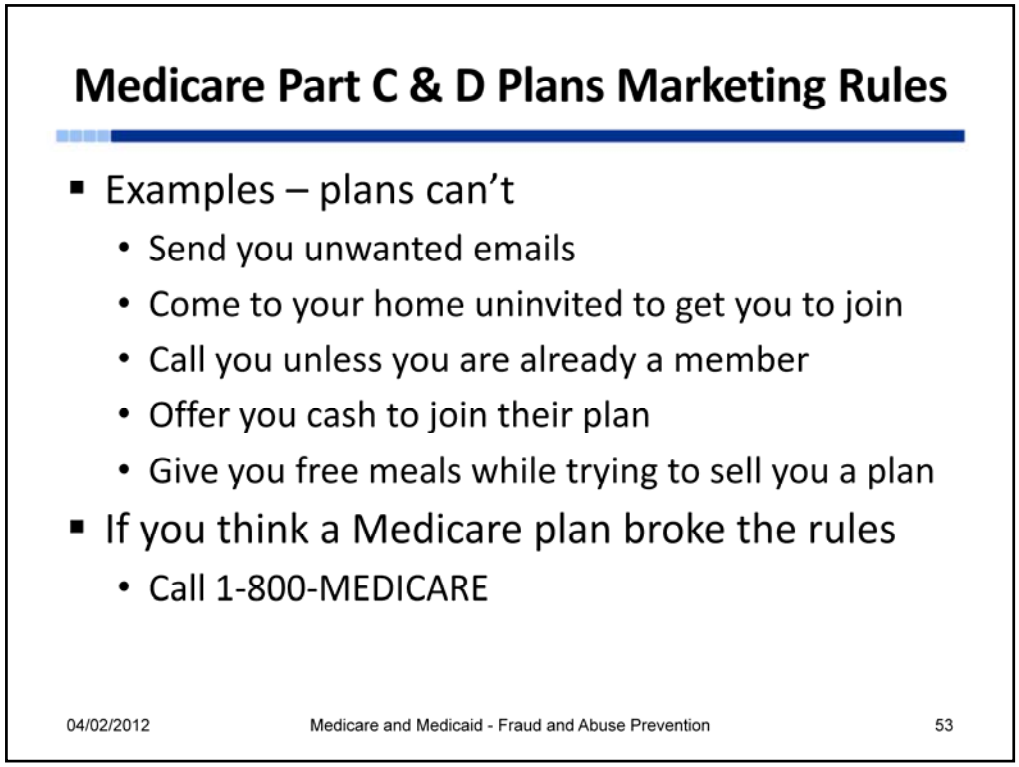



These are helpful tips that can help people with Medicare protect themselves from fraud.

Ask questions. You have the right to know what is billed to Medicare

Educate yourself about Medicare and know you rights and what a provider can and can't bill to Medicare.

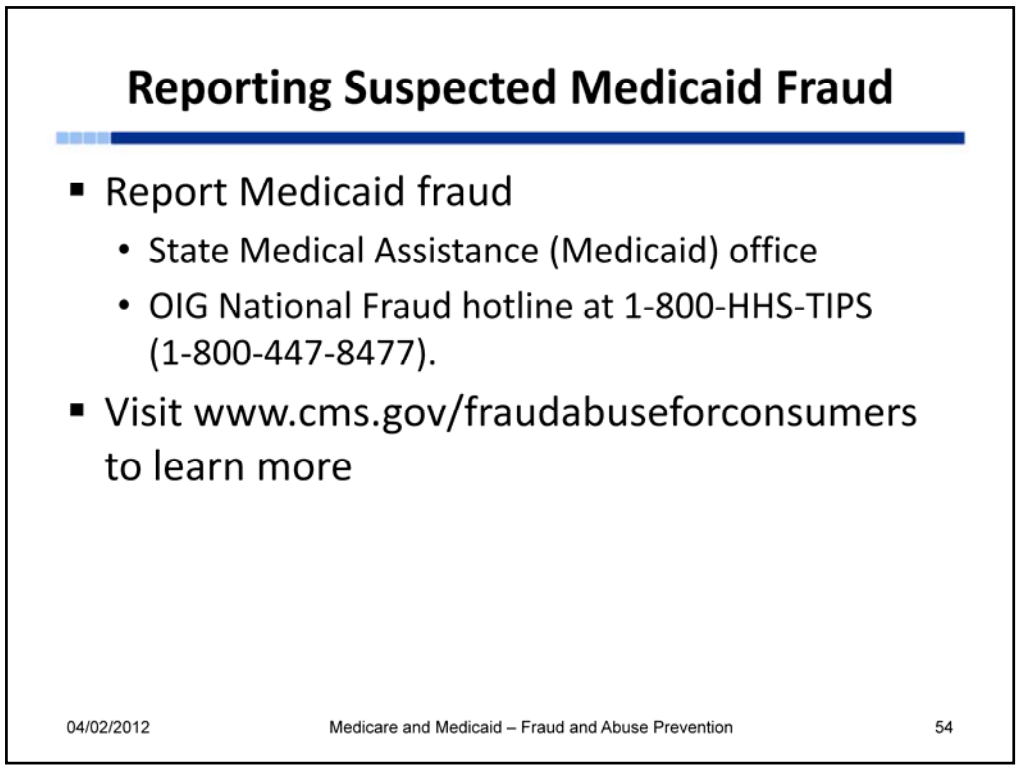
Be wary of providers who tell you that you can get an item or service that is not usually covered by Medicare, but they know "how to bill Medicare."



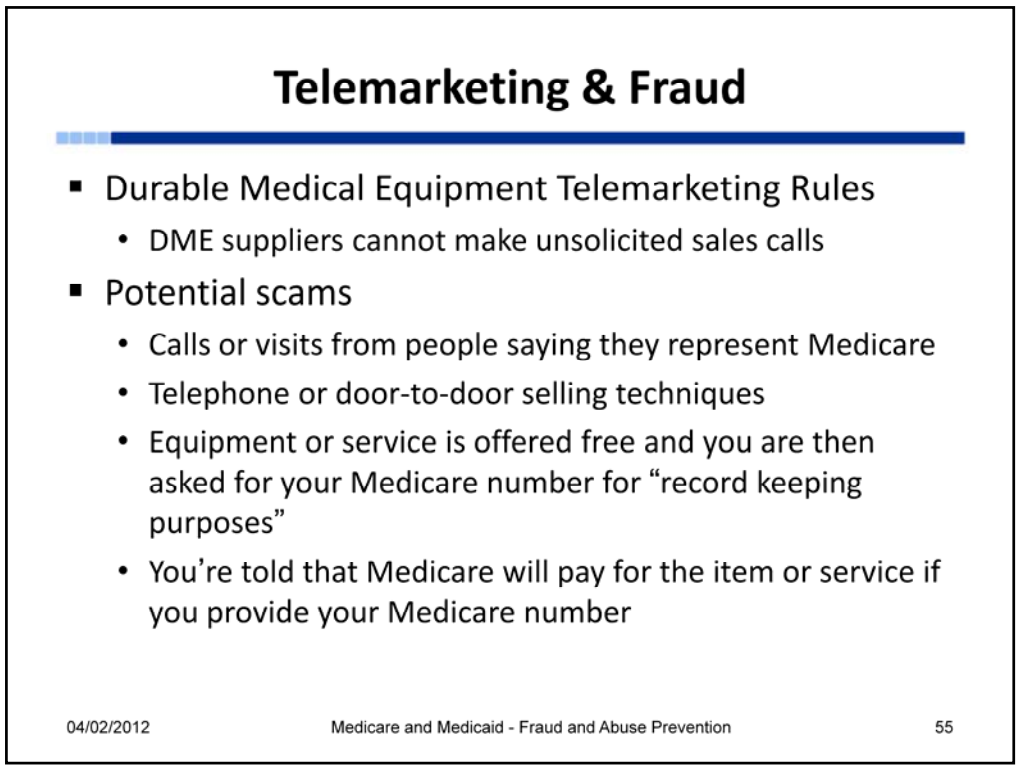

Below are some examples of activities Medicare plans and people who represent them are not allowed to do.

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

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




You can report suspected Medicaid fraud to your State Medical Assistance (Medicaid) office. Visit www.cms.gov/fraudabuseforconsumers to learn more. Medicaid fraud can also be reported to the OIG National Fraud hotline at 1-800-HHS-TIPS (1-800-447-8477).

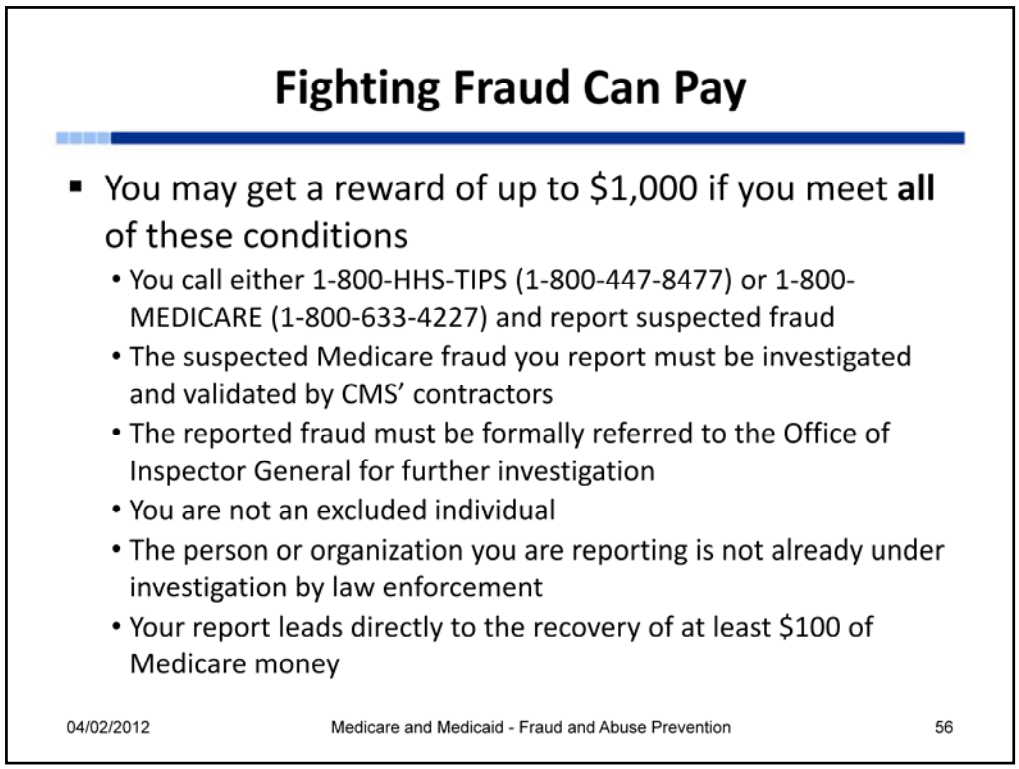



There are Durable Medical Equipment (DME) rules for telemarketing.

DME suppliers (people who sell equipment such as diabetic supplies and power wheelchairs) are prohibited by law from making unsolicited telephone calls to sell their products.

Potential scams

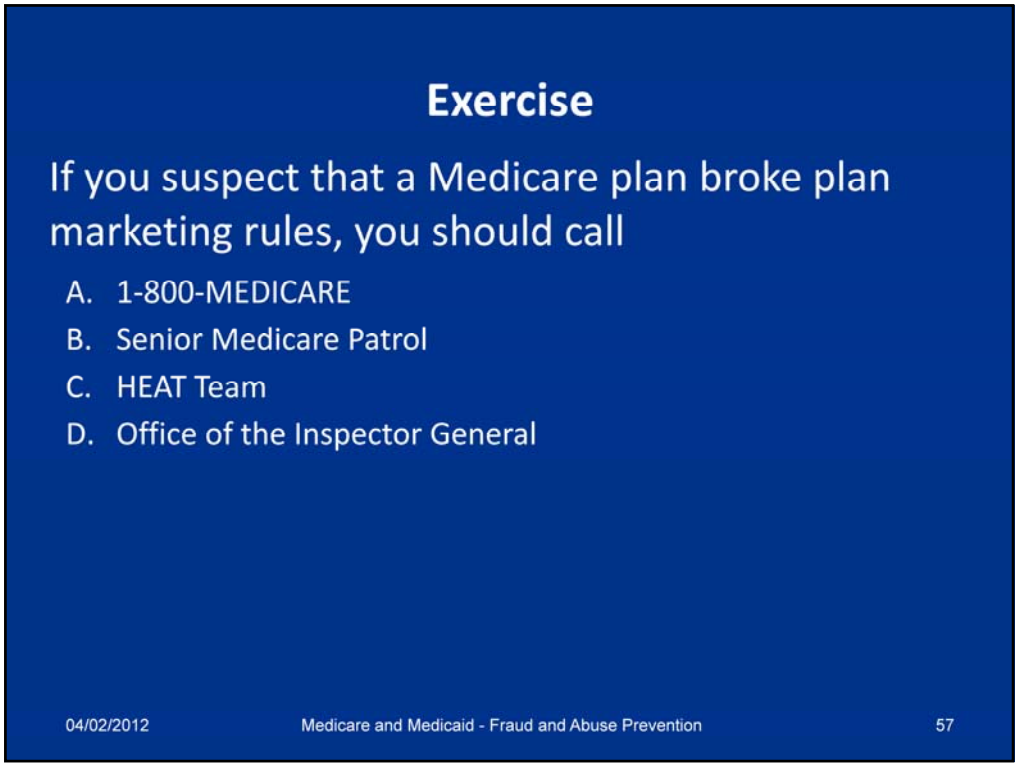
- Calls or visits from people saying they represent Medicare.
- Telephone or door-to-door selling techniques.
- Equipment or service is offered free and you are then asked for your Medicare number for "record keeping purposes."
- You're told that Medicare will pay for the item or service if you provide your Medicare number.




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

- You report suspected Medicare fraud.
- The suspected Medicare fraud you report must be proven as potential fraud by the program Safeguard Contractor or the Zone Program Integrity Contractor (the Medicare contractors responsible for investigating potential fraud and abuse) and formally referred as part of a case by one of the contractors to the Office of Inspector General for further investigation.
- You aren‘t an “excluded individual.” For example, you didn‘t participate in the fraud offense being reported. Or, there isn't’t another reward that you qualify for under another government program.
- The person or organization you’re reporting isn't’t already under investigation by law enforcement.
- Your report leads directly to the recovery of at least $100 of Medicare money.

For more information, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048.




**Exercise**

2. If you suspect that a Medicare plan broke plan marketing rules, you should call:
   A. 1-800-MEDICARE
   B. Senior Medicare Patrol
   C. HEAT Team
   D. Office of the Inspector General

2. Answer: A. 1-800-MEDICARE

# Medicare Fraud & Abuse Resource Guide

## Resources

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

**www.stopmedicarefraud.gov**

**www.healthcare.gov**

**NBI MEDIC**
877-7SAFERX (877-772-3379)
Fax a Complaint Form to 410-819-8698
Mailing to:
Health Integrity, LLC, 9240 Centreville Road,
Easton, Maryland 21601
**http://www.healthintegrity.org/html/contracts/medic/index.html**
**MyMedicare.gov**

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

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

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

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

**NBI Medic's Parts C&D Fraud Reporting Group**
1-877-7SAFERX (1-877-772-3379)
**http://www.healthintegrity.org/html/contracts/medic/index.html**

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

## Medicare Products

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

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

***Protecting Medicare and You from Fraud*** CMS Product No. 10111

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

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

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

This training module is provided by the

**National Medicare**
**TRAINING PROGRAM**

For questions about training products, e-mail
NMTP@cms.hhs.gov

To view all available NMTP materials
or to subscribe to our listserv, visit
www.cms.gov/NationalMedicareTrainingProgram


E-mail: NMTP@cms.hhs.gov
Website:cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244