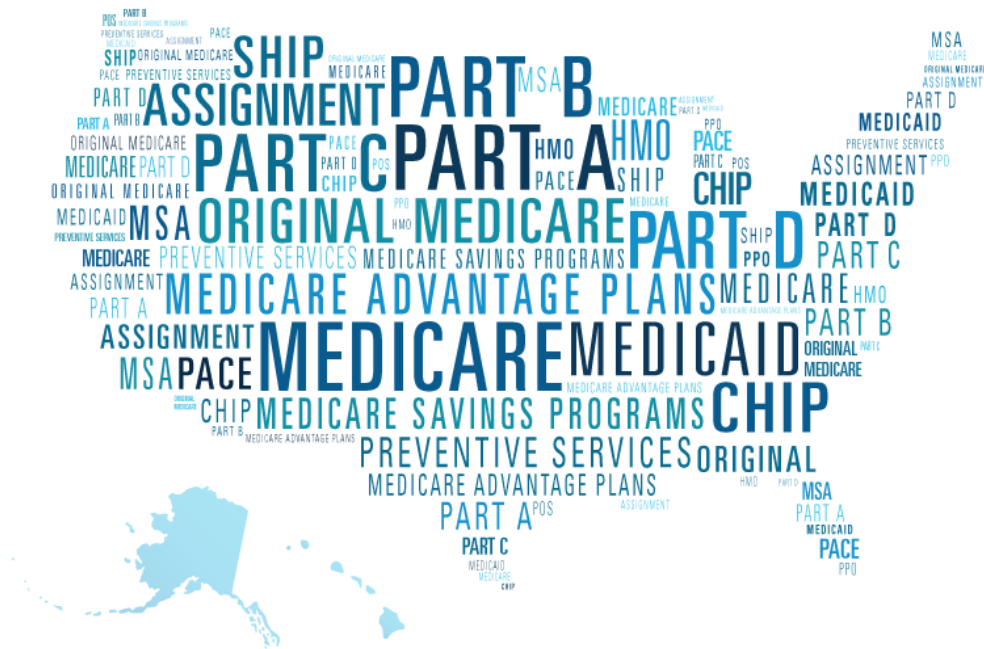


2014 National Training Program

Workbook

Module: 10

Medicare and Medicaid Fraud and Abuse Prevention



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

Module 10 - Medicare and Medicaid Fraud and Abuse Prevention

Module Description

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

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

Objectives

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

Target Audience

This module is designed for presentation to trainers and other information givers. Lessons one and three are suitable for presentation to groups of beneficiaries.

Time Considerations

The module consists of 56 PowerPoint slides with corresponding speaker's notes, suggested videos, knowledge checks, and learning activities. It can be presented in 50 minutes. Allow approximately 10 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities. It has a resource guide and NTP contact slide to reference. Appendix A provides a one-page view of Program Integrity Contractors from slide 34.

Course Materials

Most materials are self-contained within the module. YouTube links are provided in the slides, but we recommend having the actual downloaded video saved to your laptop. Slide 33 is a placeholder for region-specific findings on fraud and abuse. If you don't plan to provide this information, we recommend you hide the slide. This module contains the opportunity to apply the module concepts in a real-world setting.

- Suggest you have these videos ready to launch when you reach appropriate slide:
 - Slide 20 - Medicare Fraud – “Cracking Down” TV ad at youtube.com/watch?v=z1_mgvpkode
 - Slide 46 - Senior Medicare Patrol 60-Second Public Service Announcement at youtube.com/watch?feature=player_embedded&v=ybuioldq5cy

Module 10: Medicare and Medicaid Fraud and Abuse Prevention

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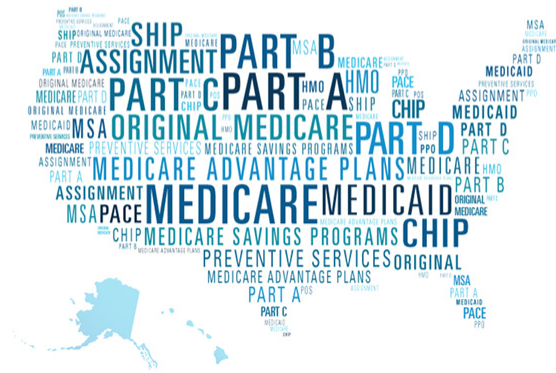
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2014 National Training Program



Module 10

Medicare and Medicaid Fraud and Abuse Prevention

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

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace. The information in this module was correct as of May 2014.

To check for an updated version of this training module, visit cms.hhs.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html.

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

Session Objectives

This session will help you

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

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

This session will help you to:

- Define fraud and abuse
- Recall causes of improper payments
- Discuss how the Centers for Medicare & Medicaid Services fights fraud and abuse
- Explain how you can fight fraud and abuse
- Identify sources of additional information

Lesson 1 - Fraud and Abuse Overview

- Definition of fraud and abuse
- Protecting the Medicare Trust Funds and other public resources
- Who can commit fraud?
- Causes of improper payments
- Examples of fraud in different parts of Medicare or Medicaid
- Quality of care concerns

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

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

- Definition of fraud and abuse
- Why we must protect the Medicare Trust Funds and other public resources
- Who can commit fraud?
- Causes of improper payments
- Examples of fraud in different parts of Medicare or Medicaid
- Quality of care concerns

Definition of Fraud and Abuse

Fraud

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

Abuse

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

The primary difference between fraud and abuse is intention.

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

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

Fraud occurs when someone intentionally executes or attempts to execute a scheme to obtain money or property of any health care benefit program. The primary difference between fraud and abuse is intention.

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

While some fraud schemes may involve legitimate care, some fraud schemes never involve real care, such as false storefronts pretending to operate a business.

- Each working day, Medicare processes over 4.6 million claims, of which 200,000 are for durable medical equipment, from a total of 1.5 million fee-for-service providers.
- Each year, Medicaid processes 3.9 billion claims, representing more than \$430 billion paid annually, for more than 57 million beneficiaries.

Need more information?

For more information, see 2013 data updates at cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicaremedicaidstatsupp/2013.html and CMS Fast Facts at cms.gov/fastfacts/ or CMS Data Navigator at dnnav.cms.gov/views/search.aspx.



Protecting Taxpayer Dollars

- CMS must protect Medicare Trust Funds
 - Medicare Hospital Insurance Trust Fund
 - Supplementary Medical Insurance Trust Fund
- CMS must also protect the public resources that fund the Medicaid programs
- CMS has to manage the careful balance between
 - Paying claims quickly and limiting burden on the provider community with conducting reviews that prevent and detect fraud

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

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

- The Medicare Hospital Insurance Trust Fund pays for 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 (Medical Insurance) benefits including doctor services, outpatient hospital care, home health care covered under Part A, durable medical equipment, certain preventive services and lab tests, Medicare Part D prescription drug benefits, and Medicare program administrative costs, including costs for paying benefits and combating fraud and abuse. It's funding is authorized by Congress from Part B premiums, Part D (Medicare Prescription Drug Coverage) premiums, and interest earned on trust fund investments.
- CMS must also protect the public resources that fund the 56 state-run Medicaid programs. In federal fiscal year 2012, the total amount spent was \$428.5 billion. The federal government contributed roughly 57 percent of this total, with the remainder coming from state and local contributions.
- CMS has to manage the careful balance between paying claims quickly and limiting provider burden versus conducting reviews that prevent and detect fraud.

Who Commits Fraud?

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

05/01/2014

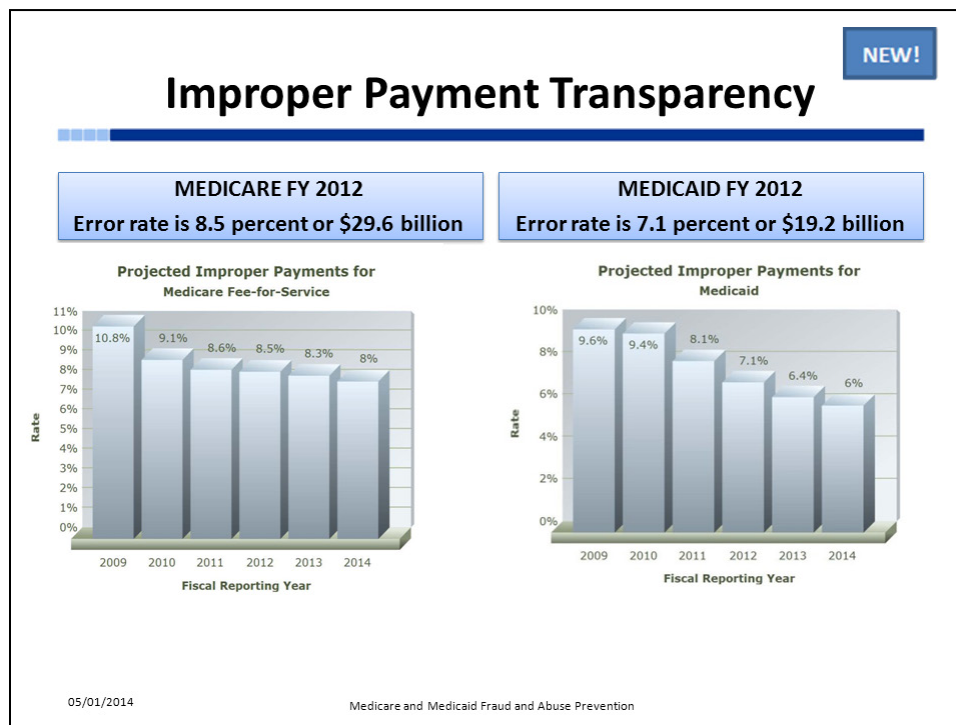
Medicare and Medicaid Fraud and Abuse Prevention

Most individuals and organizations that work with Medicare and Medicaid are honest—but there are some bad actors. The Centers for Medicare & Medicaid Services is continually taking the steps necessary to identify and prosecute these bad actors.

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

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

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



As part of its Accountable Government Initiative, Medicare and Medicaid are considered high-error programs. The president established a goal to reduce government-wide improper payments. An improper payment, according to the Government Accountability Office, is “any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements.” You can see by this graph the goal of reduction in each fiscal year.

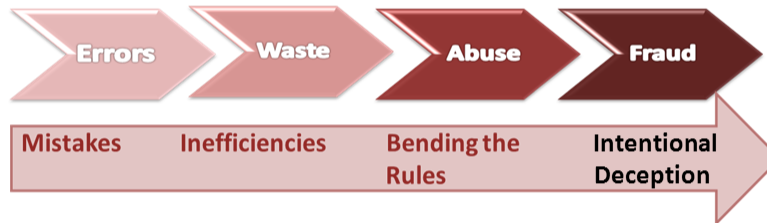
Medicare - Every year Medicare pays over \$566 billion for more than 52 million beneficiaries. (Both sets of these numbers include Medicare Advantage and other Medicare health plans. The FY 2012 improper payment rate was 8.5 percent, representing \$29.6 billion in improper payments. The primary cause of improper payments was administrative and documentation errors, which were mainly due to insufficient documentation. Other notable causes included authentication and medical necessity errors, caused by medically unnecessary services and, to the lesser extent, incorrect coding accounted for the remaining errors. Data show that many improper payments occur as a result of claims paid for services that would have been clinically appropriate if provided in less intensive settings.

Medicaid - Each year, Medicaid processes 3.9 billion claims, representing more than \$430 billion paid annually, for more than 57 million beneficiaries. Data are from FYs 2010, 2011, and 2012. The 3-year rolling error rate was 7.1 percent or \$19.2 billion. The weighted national error components rates are as follows: Medicaid FFS: 3.0 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 4.9 percent. The majority of the FY 2012 errors were a result of cases reviewed for eligibility that were either not eligible or their eligibility status could not be determined, thus they were considered errors. The most common cause of cases in error for the Medicaid FFS medical review was insufficient documentation.

NOTE: Real error rates can be viewed at paymentaccuracy.gov/. These 2013 numbers will be finalized/published in the late spring 2014. Medicaid processes 3.9 billion claims, representing more than \$430 billion paid annually, for more than 57 million beneficiaries.

Causes of Improper Payments

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



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

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

Causes of improper payments run from errors, to waste, to abuse, to fraud. Also shown as mistakes, inefficiencies, bending the rules, and intentional deception.

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

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

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

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

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

Examples of Fraud

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

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

Examples of possible fraud include the following

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

NOTE: Additional examples will be discussed in upcoming slides and lessons.

Preventing Fraud in Medicare Parts C and D

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

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

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

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

- Send you unwanted emails or come to your home uninvited to sell a Medicare plan.
- Call you unless you 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.
- Give you free meals while trying to sell you a plan.
- Talk to you about their plan in areas where you get health care, like an exam room, hospital patient room, or at a pharmacy counter.

NOTE: Call 1-800-MEDICARE to report any plans that ask for your personal information over the telephone or that call to enroll you in a plan. TTY users should call 1-877-486-2048.

NOTE: Although the Medicare Drug Integrity Contractor fights fraud, waste, and abuse in Medicare Advantage Plans (Part C) and Medicare Prescription Drug Coverage (Part D), they don't handle Parts C and D marketing fraud. You should refer those issues to 1-800-MEDICARE.

Telemarketing and Fraud

- Durable Medical Equipment (DME) telemarketing rules
 - DME suppliers can't make unsolicited sales calls
- Potential DME scams
 - Calls or visits from people saying they represent Medicare
 - Telephone or door-to-door selling techniques
 - Equipment or service is offered free and you 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

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

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

Potential DME scams include the following:

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

Quality of Care Concerns

- Patient quality of care concerns aren't fraud
 - Medication errors
 - Unnecessary or inappropriate surgery or treatment
 - Change in condition not treated
 - Discharged from the hospital too soon
 - Incomplete discharge instructions and/or arrangements
- Contact Quality Improvement Organizations (QIO)
 - Visit [medicare.gov/contacts](https://www.medicare.gov/contacts) and click on Find Helpful Contacts
 - Call 1-800-MEDICARE (1-800-633-4227)
 - TTY users should call 1-877-486-2048

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

Patient quality of care concerns aren't fraud. Examples of quality of care concerns that your Quality Improvement Organization (QIO) can address include the following:

- Medication errors, like being given the wrong medication, being given medication at the wrong time, being given a medication to which you are allergic, or being given medications that interact in a negative way. They can evaluate if it merits Medicare Drug Integrity Contractor intervention.
- 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 didn't need, or being given treatment that isn't recommended for patients with your specific medical condition.
- Change in condition not treated, like not receiving treatment after abnormal test results or when you developed a complication.
- Discharged from the hospital too soon, like while still having severe pain.
- Incomplete discharge instructions and/or arrangements, like being sent home without instructions for the changes that were made in your daily medications while you were in the hospital, or during an office visit, or you receive inadequate instructions about the follow-up care you need.

Medicare QIOs will help you with these issues. To get the address and phone number of the QIO for your state or territory, visit [medicare.gov/contacts](https://www.medicare.gov/contacts) and search for information on the topic of "Complaints about my care or services." Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Check Your Knowledge—Question 1



The primary difference between fraud and abuse is bending the rules.

- a. True
- b. False



Refer to page 57 to check your answers.

Check Your Knowledge—Question 2



Possible causes of improper payment include

- a. Insufficient documentation
- b. Not eligible or their eligibility status could not be determined
- c. Honest mistakes
- d. All of the above



Refer to page 57 to check your answers.

Lesson 2 - CMS Fraud and Abuse Strategies

- The Center for Program Integrity
 - Comprehensive Strategy
- CMS Program Integrity Contractors
- CMS Administrative Actions
- Law Enforcement Actions
- The Health Care Fraud Prevention Partnership
- The Fraud Prevention Toolkit at [cms.gov](https://www.cms.gov)
- Provider and Beneficiary Education
- Region-Specific Discussion

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

In this lesson we will discuss the following:

- The Center for Program Integrity
 - Comprehensive Strategy
- The Centers for Medicare & Medicaid Services (CMS) Program Integrity Contractors
- CMS Administrative Actions
- Law Enforcement Actions
- The Health Care Fraud Prevention Partnership
- The Fraud Prevention Toolkit at [cms.gov](https://www.cms.gov)
- Provider and Beneficiary Education
- Region-Specific Discussion (optional)

CMS Center for Program Integrity

- Consolidates CMS anti-fraud components
- New authorities from the Affordable Care Act
 - More rigorous screenings for health care providers
 - Reciprocal termination of providers from Medicare and Medicaid
 - May temporarily stop enrollment in high-risk areas
 - Used first in July 2013 and is extended into 2014
 - Temporarily stop payments in cases of suspected fraud

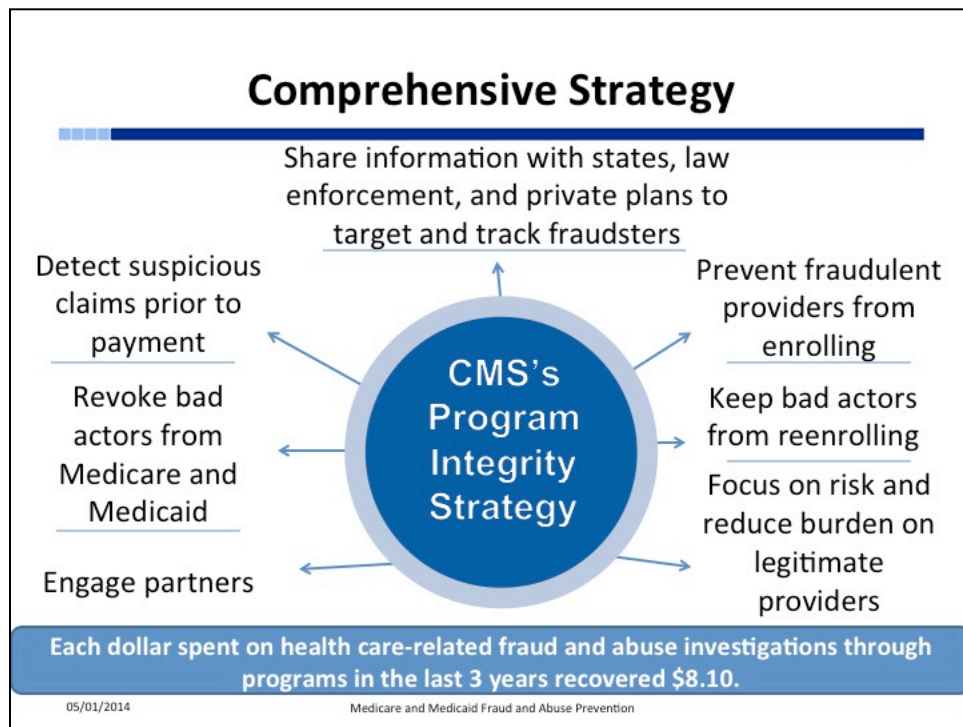
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Medicare and Medicaid Fraud and Abuse Prevention

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

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

- Creating a rigorous screening process for providers and suppliers enrolling in Medicare, Medicaid, and CHIP.
- Requiring a cross-termination among federal and state health programs, so providers and suppliers whose Medicare billing privileges are revoked, or whose participation has been terminated by a Medicaid or CHIP program, will be barred or terminated from all other Medicaid and CHIP programs.
- Temporarily stopping enrollment of new providers and suppliers in high-risk areas. Medicare and state agencies will be watching for trends that may indicate a significant potential for health care fraud, and can temporarily stop enrollment of a category of providers or suppliers, or enrollment of new providers or suppliers, in a geographic area that has been identified as high risk. The Centers for Medicare & Medicaid Services (CMS) used this authority for the first time in July 2013 on new home health agencies in Miami and Chicago, and new ambulances in Houston, based on their risk of fraud to Medicare and Medicaid.
- In the 2 years after the implementation of the Affordable Care Act, CMS doubled the number of providers who have had their billing privileges revoked compared to the 2 years prior, thanks to the new screening requirements and other proactive initiatives.



The Centers for Medicare & Medicaid Services (CMS) has a comprehensive strategy for a coordinated program integrity effort that is stronger and more efficient than any stand-alone effort. It focuses on enrollment and payment. By integrating predictive analytics in processing claims, and provider screening during enrollment, CMS can better ensure that it enrolls only qualified providers and pays only valid claims.

CMS is now using the Fraud Prevention System—similar to credit card technology—to screen every Medicare claim. Since the system was implemented in 2011 we have stopped, prevented, or identified an estimated \$115 million in fraudulent payments. This comes out to an estimated \$3 in savings for every \$1 spent.

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

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

Each dollar spent on health care–related fraud and abuse investigations through programs in the last 3 years, the government recovered \$8.10. This is the highest 3-year average return on investment in the 17-year history of the Health Care Fraud and Abuse Control Program.

Lesson 2 – Learning Activity 1

- Medicare Fraud - "Cracking Down" TV ad



05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

Lesson 2 – Learning Activity 1 – Video

Click picture in slideshow view to view “Cracking Down on Fraud” or enter URL to launch [youtube.com/watch?v=z1_mgvpkode](https://www.youtube.com/watch?v=z1_mgvpkode) (video).

CMS Program Integrity Contractors

- A nationally coordinated Medicare/Medicaid program integrity strategy that cuts across regions
 - HEAT Strike Force Teams
 - Zone Program Integrity Contractors (ZPIC)
 - National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
 - Recovery Audit Program
 - Medicaid Integrity Contractors

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

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

- Health Care Fraud Prevention and Enforcement Action(HEAT) Strike Force Teams
- Zone Program Integrity Contractors
- National Benefit Integrity (NBI) MEDIC
- Recovery Audit Program
- Medicaid Integrity Contractors

Need more information?

See also “Contractor Entities At-a-Glance” at cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/contractorentityguide_icn906983.pdf.



Health Care Fraud Prevention and Enforcement Action (HEAT) Team

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

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

The Health Care Fraud Prevention and Enforcement Action (HEAT) team is a joint initiative between the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Justice (DOJ) to combat fraud. HEAT task forces are interagency teams composed of top-level law enforcement and professional staff. The team builds on existing partnerships, including those with state and local law enforcement organizations to prevent fraud and enforce anti-fraud laws. Their goal is to improve interagency collaboration on reducing and preventing fraud in federal health care programs. By deploying law enforcement and trained agency personnel, HHS and DOJ increase coordination, data sharing, and training among investigators, agents, prosecutors, analysts, and policymakers. Project HEAT has been highly successful in bringing health care fraud cases and prosecuting them quickly and effectively.

A central feature of the HEAT initiative is the use of Strike Force teams. The first Fraud Strike Force team was launched in Miami in March 2007. In 2009, it expanded to seven cities and is currently in nine cities.

The mission of the HEAT team is as follows:

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

HEAT Strike Force Teams

- **Strike Force Teams**
 - Located in Fraud “Hot Spot” locations
 - Use advanced data analysis to identify high-billing levels in health care fraud hot spots
 - Coordinate national takedowns
- **CMS supports Strike Force takedowns**
 - Perform data analysis
 - Suspend Payment

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

The joint U.S. Department of Justice/U.S. Department of Health and Human Services Medicare Fraud Strike Force is a multi-agency team of federal, state, and local investigators designed to fight Medicare fraud.

- Medicare Fraud Strike Force team locations are evidence of the geographic dispersion of Medicare fraud, with current operations in the identified fraud hot spots of Baton Rouge, Brooklyn, Chicago, Dallas, Detroit, Houston, Los Angeles, Miami-Dade, and Tampa Bay.
- Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud spots.
- Interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers.
- The Centers for Medicare & Medicaid Services is working collaboratively with federal and state law enforcement partners to increase the recovery of improper payments and fraud by providing data and other support during Health Care Fraud Prevention and Enforcement Action investigations and prosecutions, and suspending payments for providers subject to credible allegations of fraud.

Need more information?

See also

[stopmedicarefraud.gov/aboutfraud/heattaskforce/
index.html](http://stopmedicarefraud.gov/aboutfraud/heattaskforce/index.html)



Zone Program Integrity Contractors (ZPICs)

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

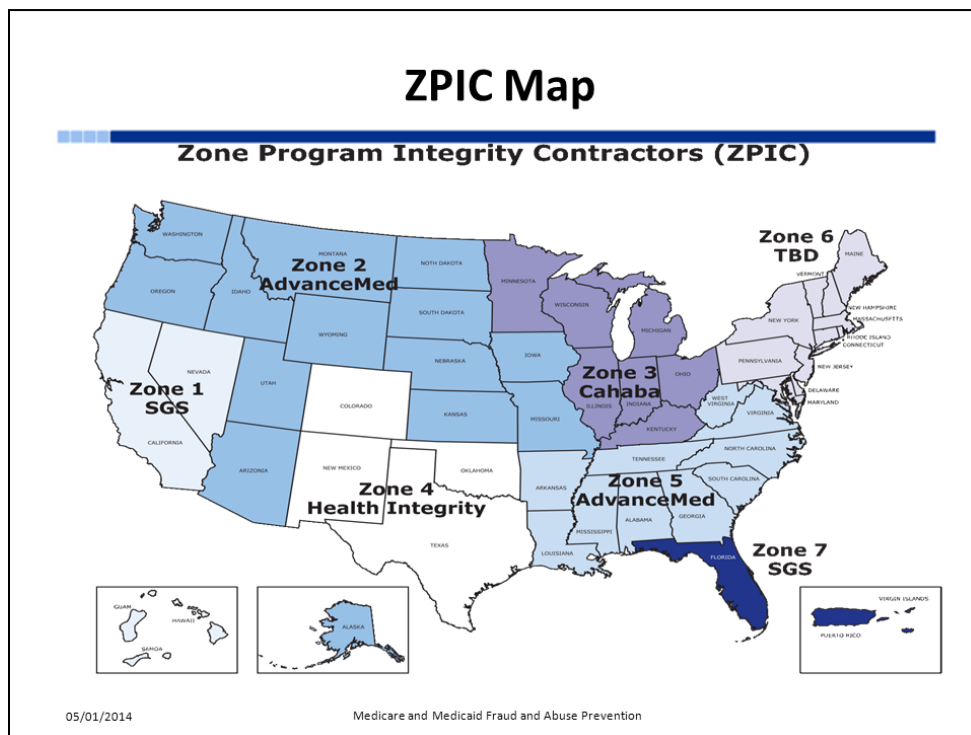
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Medicare and Medicaid Fraud and Abuse Prevention

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

ZPICs main responsibilities include the following:

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



The seven Zone Program Integrity Contractor zones align with Medicare Administrative Contractor jurisdictions.

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

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)

- Monitors fraud, waste, and abuse in the Part C and Part D programs in all 50 states, the District of Columbia, and U.S. Territories
- Works with law enforcement and other stakeholders
- Key responsibilities include
 - Receive complaints
 - Resolve beneficiary fraud complaints
 - Perform proactive data analyses
 - Identify program vulnerabilities
 - Refer potential fraud cases to law enforcement agencies
- There is also an Outreach and Education MEDIC (O&E MEDIC) that provides outreach tools



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Medicare and Medicaid Fraud and Abuse Prevention

National Benefit Integrity (NBI) Medicare Drug Integrity Counselor (MEDIC) supports the CMS Center for Program Integrity. NBI monitors and investigates fraud, waste, and abuse in the Part C and Part D programs in all 50 states, the District of Columbia, and U.S. Territories. NBI has investigators throughout the country that work with federal, state, and local law enforcement authorities and other stakeholders. For more information, visit healthintegrity.org/contracts/nbi-medic/referring-fraud-waste-or-abuse-cases.

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

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

There is also an Outreach and Education MEDIC (O&E MEDIC) that provides outreach tools. New fraud awareness inserts are offered for your use as part of CMS's continued commitment to provide Medicare Advantage Organizations and Prescription Drug Plans with outreach tools and educational products that will further efforts to detect and prevent fraud, waste, and abuse in Medicare Parts C and D.

Need more information?

To begin using these outreach tools, please go to the "Free Resources" page of the CMS O&E MEDIC website at medic-outreach.rainmakerssolutions.com/free-resources, and follow the instructions provided on the site.



Examples of Cases NBI MEDIC Handles

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

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Medicare and Medicaid Fraud and Abuse Prevention

You should refer suspected fraud to the National Benefit Integrity Medicare Drug Integrity Counselor. Examples of fraud include the following:

- 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, or money
- Someone asks you to sell your Medicare prescription drug card or Medicare Advantage (MA) Plan membership card
- Someone offers to pay you cash to visit specific providers, suppliers, or pharmacies
- You were billed for drugs or services that you didn't receive
- Your Medicare Summary Notice or explanation of medical benefits form lists products or services you didn't receive or doesn't accurately reflect the nature of the products or services you received
- Someone asks you to get drugs for them using your Medicare prescription drug card or MA Plan membership card
- Your pharmacy didn't give you all of your drugs
- You received a different drug than your doctor ordered
- You had your personal information stolen or suspect someone has stolen your personal information

Recovery Audit Program

- Recovery Audit Program's mission
 - Reduce improper Medicare payments by
 - Detecting and collecting overpayments
 - Identifying underpayments
 - Implementing actions to prevent future improper payments
- Establish Medicare Part C and D programs
- States and territories establish Medicaid Recovery Audit Contractors
 - Identify overpayments and underpayments
 - Coordinate efforts with federal and state auditors

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Medicare and Medicaid Fraud and Abuse Prevention

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

In May 2013, the Centers for Medicare & Medicaid Services (CMS) started the procurement process for the new Medicare Fee-for-Service (FFS) (Part A and B) Recovery Audit Program contracts. CMS plans to contract with four A/B Recovery Auditors and one national durable medical equipment and Home Health/Hospice Recovery Auditor.

CMS is expanding the Recovery Audit Programs to Medicare Parts C/D as required by the Affordable Care Act. CMS awarded a contract for a Medicare Part D Recovery Audit Contractors (RAC) in January 2011. The Part C contract is pending.

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

States and territories must establish Medicaid RAC programs.

- Medicaid RACs must identify and recover overpayments and identify underpayments.
- Medicaid RACs must coordinate their efforts with other auditing entities, including state and federal law enforcement agencies. CMS and states will work to minimize the likelihood of overlapping audits. As of January 11, 2013, 42 states have implemented Medicaid RAC programs.

NOTE: Federal agencies recaptured a record \$4.4 billion in overpayments to contractors over the last 3 years, due in large part to the success of the Medicare FFS RAC program.



Need more information?

For more information, visit the Medicaid RACs At-a-Glance webpage at w2.dehpg.net/RACSS/Map.aspx.

Medicaid Integrity Contractors (MICs)

- Support, not supplant, state Medicaid program integrity efforts
- Conduct post-payment audits of Medicaid providers under Generally Accepted Governmental Auditing (Yellow Book) Standards
- Identify overpayments, and refer to the state for collection of the overpayments
- Doesn't adjudicate appeals, but supports state adjudication process
- Three types of MICs – review, audit, and education

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Medicare and Medicaid Fraud and Abuse Prevention

Medicaid Integrity Contractors (MICs):

- Support, not supplant, state Medicaid program integrity efforts
- Conduct post-payment audits of Medicaid providers under Generally Accepted Governmental Auditing (Yellow Book) Standards*
- Identify overpayments, and refer to the state for collection of the overpayments
- Don't make an official decision about who is right in appeals, but support state adjudication process

There are three types of MICs: (1) review, (2) audit, and (3) education.

State Medicaid Offices have their own program integrity unit in addition to Medicaid Recovery Audit Contractors described on this slide, and sometimes states have additional program integrity contractors as well. The in-house program integrity staff in states performs many of the same functions as Medicare contractors, including data mining, case development, investigations, and provider audits.

* The Generally Accepted Government Auditing Standards, also known as the Yellow Book, provide a framework for conducting high-quality audits with competence, integrity, objectivity, and independence. The Yellow Book is for use by auditors of government entities, entities that receive government awards, and other audit organizations performing Yellow Book audits.

Need more information?

Please visit:

[cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaidintegrityprogram](https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaidintegrityprogram)

[cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/edmic-landing.html](https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/edmic-landing.html)



CMS Administrative Actions

- When CMS suspects fraud, administrative actions include the following
 - Automatic denials of payment
 - Payment suspensions
 - Prepayment edits
 - Civil monetary penalties
 - Revocation of billing privileges
 - Referral to law enforcement
 - Payments must be paid back

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Medicare and Medicaid Fraud and Abuse Prevention

When fraud is detected, the appropriate administrative action is imposed by the Centers for Medicare & Medicaid Services:

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

Law Enforcement Actions

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

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Medicare and Medicaid Fraud and Abuse Prevention

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

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

Health Care Fraud Prevention Partnership

- Launched in July 2012
- Shares information and best practices
- Improves detection
- Prevents payment of fraudulent health care billings across public and private payers
- Enables the exchange of data and information among the partners

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Medicare and Medicaid Fraud and Abuse Prevention

The Health Care Fraud Prevention Partnership was announced in July 2012. It is designed to reduce health care fraud by partnering with the private sector and using data analysis techniques to sort through claims data. The voluntary partnership, which includes the federal government, state officials, private health insurance organizations, and other health care anti-fraud groups, is designed to accomplish the following:

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

Fraud Prevention Toolkit

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

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Medicare and Medicaid Fraud and Abuse Prevention

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

Need more information?

Please visit:

cms.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit.html.

Cms.gov also has the latest news and information from the Center for Program Integrity at cms.gov/about-cms/components/cpi/center-for-program-integrity.html.



Educate Providers and Beneficiaries

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

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Medicare and Medicaid Fraud and Abuse Prevention

The Centers for Medicare & Medicaid Services is working to shift the focus to the prevention of improper payments and fraud while continuing to be vigilant in detecting and pursuing problems when they occur. Educating providers and beneficiaries applies to both the Medicare and Medicaid programs.

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

Need more information?

See also: [cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/beneficiary-education-toolkits/beneficiary-toolkit.html](https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/beneficiary-education-toolkits/beneficiary-toolkit.html).



Lesson 2 – Region-Specific Discussion

- To learn about real-life state-specific cases visit
 - [STOPMedicarefraud.gov/newsroom/your-state/index.html](http://stopmedicarefraud.gov/newsroom/your-state/index.html)
 - Justice News at <http://www.justice.gov/opa/pr/2014/January/14-crm-082.html>
 - Annual report on the Health Care Fraud and Abuse Program, available on the Office of Inspector General website

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Medicare and Medicaid Fraud and Abuse Prevention

To facilitate region-specific examples, you may insert and/or discuss findings and/or resources that are state-specific, real-life examples of fraud schemes, takedowns, recoveries, convictions, etc.

- stopmedicarefraud.gov/newsroom/your-state/index.html
- Justice News at [justice.gov/opa/pr/2014/January/14-crm-082.html](http://www.justice.gov/opa/pr/2014/January/14-crm-082.html)
- Annual report on the Health Care Fraud and Abuse Program is available on the Office of Inspector General website at oig.hhs.gov/publications/docs/hcfac/fy2013-hcfac.pdf
- To see the 2014 **enrollment moratoria** on home health agencies in four metropolitan areas (Fort Lauderdale, Detroit, Dallas, and Houston) and ground ambulance suppliers in the Greater Philadelphia area, download The Federal Register notice at: federalregister.gov/public-inspection or visit cms.gov/newsroom/mediareleasedatabase/press-releases/2014-press-releases-items/2014-01-30-2.html

Need more information?

To learn about additional fraud scam examples, you can visit the following websites:

- smpresource.org
- smpresource.org/am/template.cfm?section=scams1&template=/cm/htmldisplay.cfm&contentid=5912
- medic-outreach.rainmakerssolutions.com/free-resources/



Lesson 2 - Learning Activity 2	
Name the Program Integrity Contractor	Contractor
1. Who coordinates national takedowns based on evidence of the geographic dispersion of Medicare fraud?	
2. Who investigates leads that you report based on zones and from other sources?	
3. Who handles Medicare Part C and D complaints?	
4. Who handles post-payment audit for the states?	
5. Who conducts audits to reduce improper payments in both Medicare and Medicaid?	

Lesson 2 – Learning Activity 2

Here are the key responsibilities of the Program Integrity contractors:

1. Who coordinates national takedowns based on evidence of the geographic dispersion of Medicare fraud? (The Health Care Fraud Prevention and Enforcement Action Strike Force teams.)
2. Who investigates leads that you report based on zones and from other sources? (Zone Program Integrity Contractor)
3. Who handles Part C and D complaints? (National Benefit Integrity Medicare Drug Integrity Contractor)
4. Who conducts post-payment audits for the states? (Medicaid Integrity Contractors)
5. Who conducts audits to reduce improper payments in both Medicare and Medicaid? (Recovery Audit Contractor)

NOTE: Appendix A is a chart providing additional responsibility detail for the various Program Integrity Contractors as a one-page resource.

Lesson 3 - How You Can Fight Fraud

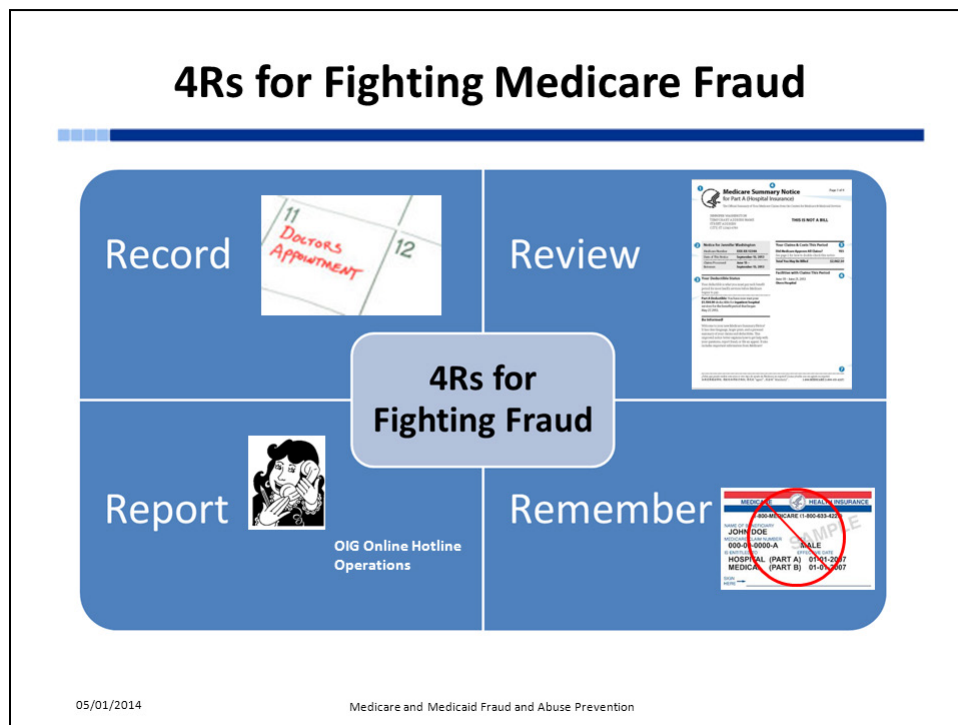
- 4Rs for Fighting Medicare Fraud
- stopmedicarefraud.gov
- Medicare Summary Notices
- mymedicare.gov
- 1-800-MEDICARE
- Senior Medicare Patrol
- Protecting Personal Information and ID Theft
- Reporting Medicaid Fraud
- Helpful Resources

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Medicare and Medicaid Fraud and Abuse Prevention

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

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



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



Need more information?

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

STOPMedicareFraud.gov

- Learn about fraud
- Find resources
- Report fraud online
- Access videos
- See recent HEAT Task Force results by state



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Medicare and Medicaid Fraud and Abuse Prevention

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

- Learn about fraud and ways to prevent it
- Find resources
- Report fraud online
- Access videos

Need more information?

See recent HEAT Task Force results by state available at stopmedicarefraud.gov/newsroom/your-state/index.html.



Medicare Summary Notice (MSN)

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



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Medicare and Medicaid Fraud and Abuse Prevention

There is a Part A, a Part B, and durable medical equipment Medicare Summary Notice (MSN). This isn't a bill. Medicare Advantage Plans provide an Explanation of Benefits that provides similar information. It was redesigned to make it easier for people with Medicare to spot fraud.

The MSN shows all services and supplies that were billed to Medicare, what Medicare paid, and what you owe each provider. You should review your MSN carefully to ensure that you received the services and supplies for which Medicare was billed.

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

Need more information?

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

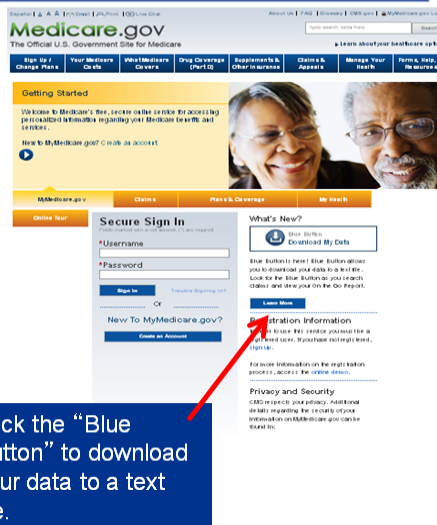
Visit medicare.gov/pubs/pdf/summarynoticea.pdf to see how to read your Part A MSN.

Visit cms.gov/apps/files/msn_changes.pdf to view a side-by-side comparison of the Part B MSN changes.



MyMedicare.gov

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



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Medicare and Medicaid Fraud and Abuse Prevention

[Mymedicare.gov](http://mymedicare.gov) is Medicare's free, secure online service for accessing personalized information regarding Medicare benefits and services. [Mymedicare.gov](http://mymedicare.gov) provides you with access to your personalized information at any time.

- View eligibility, entitlement, and preventive service information.
- Check personal Medicare information, including Medicare claims, as soon as they are processed.
- Check your health and prescription drug enrollment information as well as any applicable Part B deductible information.
- Manage your prescription drug list and personal health information.
- Review claims and identify fraudulent claims. You don't have to wait for your Medicare Summary Notice (MSN) in the mail to view your Medicare claims. Visit mymedicare.gov to track your Medicare claims or view electronic MSNs. Your claims will generally be available within 24 hours after processing.
- If there is a discrepancy, you should call your doctor or supplier. Call 1-800-MEDICARE if you suspect fraud. TTY users should call 1-877-486-2048.

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

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

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

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Medicare and Medicaid Fraud and Abuse Prevention

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

- Target providers or suppliers with multiple beneficiary complaints for further review.
- Track fraud complaints to show when fraud scams are heating up in new areas based on beneficiary calls to 1-800-MEDICARE that raise a question about possible fraud. Using existing data in this innovative way enables CMS to target providers and suppliers with multiple beneficiary complaints for further investigation.

CMS also has implemented an interactive voice response (IVR) system for beneficiaries who have not registered or don't use mymedicare.gov to identify and report fraud. IVR can access 15 months of claims processed on their behalf. IVR is available at 1-800-MEDICARE, or TTY users should call 1-877-486-2048.

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

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

Lesson 3 - Learning Activity 3



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

What are some things that might indicate fraud?

Medicare Summary Notice
for Part A (Hospital Insurance)

THIS IS NOT A BILL.

Notice for Jennifer Washington

Section	Amount
Part A Deductible	\$1,143.00
Part A Coinsurance	\$1,143.00
Part A Out-of-Pocket	\$1,143.00
Part A Total	\$3,429.00

Part A Summary

Section	Amount
Part A Deductible	\$1,143.00
Part A Coinsurance	\$1,143.00
Part A Out-of-Pocket	\$1,143.00
Part A Total	\$3,429.00

Part A Summary

Section	Amount
Part A Deductible	\$1,143.00
Part A Coinsurance	\$1,143.00
Part A Out-of-Pocket	\$1,143.00
Part A Total	\$3,429.00

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Medicare and Medicaid Fraud and Abuse Prevention

Lesson 3 - Learning Activity 3

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

Lesson 3 – Learning Activity 3

What Might Indicate Fraud?

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

What are the next steps?

Fight Back!
Deter, Detect, Defend

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Medicare and Medicaid Fraud and Abuse Prevention

Lesson 3 Medicare Summary Notice - Activity 3 - What questions should you ask?

- Were you charged for any medical services or equipment that you didn't get?
- Do the dates of services and charges look unfamiliar?
- Were you billed for the same thing twice?
- Does your credit report show any unpaid bills for medical services or equipment you didn't receive?
- Have you received any collection notices for medical services or equipment you didn't receive?
- What are the Next Steps? (Continued on next slide)

Lesson 3 – Learning Activity 3 Discussion

If John	Whom Should He Contact
Spots unusual or questionable charges	
Still hasn't resolved the issue	
Suspects Medicare fraud	
Thinks someone is misusing his personal information	

05/01/2014 Medicare and Medicaid Fraud and Abuse Prevention

Discuss Next Steps:

- If John spots unusual or questionable charges, he should contact his health care provider. It may just be a mistake.
- If his complaint isn't resolved by his provider, he should report the questionable charges to Medicare.
- If Medicare fraud is suspected, he should contact the U.S. Department of Health and Human Services Office of Inspector General.
 - Phone: 1-800-447-8477 (1-800-HHS-TIPS)
 - TTY: 1-800-377-4950 | FAX: 1-800-223-8164
 - Email: <mailto:hhstips@oig.hhs.gov>
 - Online: oig.hhs.gov/fraud/hotline
- If John thinks someone is misusing his personal information, he should contact his local police and/or the Federal Trade Commission.
 - Phone: 1-877-438-4338 (1-877-ID-THEFT)
 - TTY: 1-866-653-4261
 - Online: ftc.gov/idtheft

Fighting Fraud Can Pay

- You may get a reward if you meet **all** of these conditions
 - You call either 1-800-HHS-TIPS (1-800-447-8477) or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to report suspected fraud.
 - The suspected Medicare fraud you report must be investigated and validated by CMS's contractors.
 - The reported fraud must be formally referred to the Office of Inspector General for further investigation.
 - You aren't an excluded individual.
 - The person or organization you are reporting isn't already under investigation by law enforcement.
 - Your report leads directly to the recovery of at least \$100 of Medicare money.

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Medicare and Medicaid Fraud and Abuse Prevention

You may get a reward of up to \$1,000 if you meet **all** of 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 Office of Inspector General for further investigation.
- You aren't an "excluded individual." For example, you didn't participate in the fraud offense being reported. Or, there isn't another reward that you qualify for under another government program.
- The person or organization you're reporting isn't already under investigation by law enforcement.
- Your report leads directly to the recovery of at least \$100 of Medicare money.

Need more information?

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

Also, you may want to read the following press release: [hhs.gov/news/press/2013pres/04/20130424a.html](https://www.hhs.gov/news/press/2013pres/04/20130424a.html) and follow the Code of Federal Regulations at CFR 420.405 "Rewards for information relating to Medicare fraud and abuse."



The Senior Medicare Patrol

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



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Medicare and Medicaid Fraud and Abuse Prevention

The mission of the Senior Medicare Patrol (SMP) program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.

SMPs recruit and train retired professionals and other volunteers about how to recognize and report instances or patterns of health care fraud. Nationwide, SMPs recruit and teach nearly 5,700 volunteers every year to help in this effort. SMPs partner with community, faith-based, tribal, and health care organizations to educate and empower their peers to identify, prevent, and report health care fraud. SMPs teach you how to protect your identity, how to detect errors, and how to report fraud. SMPs receive training about how threats to financial independence and health status may occur when citizens are victimized by fraudulent schemes.

There are 54 SMP programs, including 1 in each state, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. SMP seeks volunteers to represent the program in their communities. In 2012, the 54 SMP projects had a total of 5,137 active volunteers.

The Centers for Medicare & Medicaid Services established SMP liaisons in each regional office to serve as the point of contact for compliance/marketing issues identified by SMPs, to proactively engage with SMPs, and to share relevant program information, changes, and Medicare updates.

NOTE: For an in-depth overview of the SMP program, and for information for your local area, please visit smpresource.org/ or call the nationwide toll-free number: 1-877-808-2468, available Monday through Friday, 9:00 a.m.–5:30 p.m. Eastern Time. Callers receive information about the SMP program and are connected to the SMP in their state for individualized assistance. This number is published in the Medicare & You handbook and other national Medicare and anti-fraud publications that reference the SMP program.

Senior Medicare Patrol Video

- Senior Medicare Patrol (SMP) Projects
- View Senior Medicare Patrol 60-Second Public Service Announcement



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Medicare and Medicaid Fraud and Abuse Prevention

Senior Medicare Patrol (SMP) projects reported conducting 188,199 media airings, which could be any distribution of media (e.g., print, radio, television, or electronic), to educate about fraud and the services of the project. It is expected that \$6M of Medicare and Medicaid funds recovered were attributable to the SMP projects. Savings to beneficiaries and others totaled \$133,977, and cost avoidance on behalf of Medicare, Medicaid, beneficiaries, and others was \$113,692.

One project provided information to federal prosecutors for a case that eventually resulted in a \$12.9 million settlement. For additional information, see the annual report on Performance Data for the Senior Medicare Patrol Projects: July 2013 Performance Report, OEI-02-13-00170 oig.hhs.gov/oei/reports/oei-02-13-00170.asp.

Sharing Information With Family/Caregiver

- If a caregiver wishes to speak to Medicare
 - Medicare requires written permission to protect personal information
 - You must designate an authorized person
 - Power of attorney isn't enough
 - Must submit "Medicare Authorization to Disclose Personal Information" CMS Form No. 10106

05/01/2014

Medicare and Medicaid Fraud and Abuse Prevention

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

- The beneficiary needs to designate the family member/caregiver as an authorized person to whom Medicare can disclose his/her personal information. Once Medicare has this authorization on file, the family member/caregiver will be able to discuss the beneficiary's Medicare issues directly with Medicare.
- Power of Attorney isn't enough. Family members/caregivers can contact Medicare at 1-800-MEDICARE (TTY users should call 1-877-486-2048) to request a "Medicare Authorization to Disclose Personal Information," Centers for Medicare & Medicaid Services Form No. 10106, or they can visit [medicare.gov/medicareonlineforms/authorizationform/onlineformstep.asp](https://www.medicare.gov/medicareonlineforms/authorizationform/onlineformstep.asp) to complete the process.

Protecting Personal Information

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

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Medicare and Medicaid Fraud and Abuse Prevention

Keep your personal information safe, such as your Medicare, Social Security, and credit card numbers. Share this information only with people you trust, i.e., your doctors and health care providers, your insurer, your State Health Insurance Assistance Program and Social Security, Medicaid, and Medicare.

Identity Theft

- Identity theft is a serious crime
 - Someone else uses your personal information, like your Social Security or Medicare number
- If you think someone is using your information
 - Call your local police department
 - Call the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338
- If your Medicare card is lost or stolen, report it right away
 - Call Social Security at 1-800-772-1213
 - TTY users should call 1-800-325-0778

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Medicare and Medicaid Fraud and Abuse Prevention

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

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

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

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

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

Need more information?

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

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

For more information on protecting yourself from identity theft view "Quick Facts About Medicare Prescription Drug Coverage and How to Protect Your Personal Information," CMS Product No. 11147 at medicare.gov/publications/pubs/pdf/11147.pdf.



Consequences of Sharing a Medicaid Card or Number

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

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Medicare and Medicaid Fraud and Abuse Prevention

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

The Medicaid lock-in program limits you to certain doctors, drugstores, and hospitals. Lock-in may be used for Medicaid beneficiaries in these circumstances:

- Visiting hospital emergency departments for non-emergency health concerns
- Using two or more hospitals for emergency room services
- Using two or more physicians resulting in duplicated medications and or treatments
- Exhibiting possible drug-seeking behavior
 - Requesting a specific scheduled medication
 - Requesting early refills of scheduled medications
 - Reporting frequent losses of scheduled medications (narcotics)
 - Using multiple pharmacies to fill prescriptions
- You could be arrested and spend time in jail if found guilty of fraud
- Your medical records could be wrong - the next time you go to the doctor, you will have to explain what happened so you don't get the wrong kind of care
- You can be required to pay a fine
- You might lose your Medicaid benefits

NOTE: A "Medicaid Card-Sharing Education Activity" can be found at [youtube.com/watch?feature=player_detailpage&v=k-iuapuwhp0&list=uuhhtpxz8awulgatmh3saka](https://www.youtube.com/watch?feature=player_detailpage&v=k-iuapuwhp0&list=uuhhtpxz8awulgatmh3saka).

Reporting Suspected Medicaid Fraud

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

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Medicare and Medicaid Fraud and Abuse Prevention

There are organizations where you may report suspected errors, fraud, or abuse:

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

Need more information?

Learn more about Medicaid fraud at medicaid.gov/medicaid-chip-program-information/by-topics/program-integrity/program-integrity.html.



Key Points to Remember

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

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Medicare and Medicaid Fraud and Abuse Prevention

Key points to remember:

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

Medicare Fraud & Abuse Resource Guide		
Resources	Medicare Products	
<p>Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) www.Medicare.gov</p> <p>MyMedicare.gov www.Medicare.gov</p> <p>CMS Program Integrity www.CMS.gov/About-CMS/Components/CPI/Center-for-program-integrity.html</p> <p>STOPMedicarefraud.gov Office of Inspector General OIG.hhs.gov U.S. Department of Health & Human Services ATTN: HOTLINE (https://forms.oig.hhs.gov/hotlineoperations/) P.O. Box 23489 Washington, DC 10026</p> <p>Fraud Hotline 1-800-HHS-TIPS (1-800-447-8477) TTY 1-800-337-4950 Fax 1-800-223-8162</p> <p>HealthCare.gov HealthCare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/</p> <p>Social Security Administration SSA.gov 1-800-772-1213 TTY 1-800-325-0778</p> <p>05/01/2014</p>	<p>Senior Medicare Patrol Program SMPresource.org Find the SMP resources in your state under Find Help - SMP locator</p> <p>Fraud Scams SMPresource.org/AM/Template.cfm?Section=Scams1&Template=/CM/HTMLDisplay.cfm&ContentID=5912</p> <p>NBI Medic's Parts C&D Fraud Reporting Group 1-877-7SAFERX (1-877-772-3379) http://www.healthintegrity.org/contracts/nbi-medic/reporting-a-complaint Fax a Complaint Form to 410-819-8698 Mail to: Health Integrity, LLC, 9240 Centreville Road, Easton, Maryland 21601 http://www.healthintegrity.org/contracts/nbi-medic</p> <p>National Health Care Anti-Fraud Assoc. www.NHCAA.org</p> <p>Medicaid Beneficiary Education CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html</p> <p>Prevention Toolkit http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html</p>	<p>"Medicare Authorization to Disclose Personal Information" form CMS Product No. 10106</p> <p>"Help Prevent Fraud: Check your Medicare Claims Early!" CMS Product No. 11491 and 11492</p> <p>"Protecting Medicare and You From Fraud" CMS Product No. 10111</p> <p>"Quick Facts About Medicare Plans and Protecting Your Personal Information" CMS Product No. 11147</p> <p>"4Rs for Fighting Fraud" CMS Product No. 11610</p> <p>"You Can Help Protect Yourself and Medicare From Fraud Committed by Dishonest Suppliers" CMS Product No 11442</p> <p>To access these products: View and order single copies: Medicare.gov/publications</p> <p>Order multiple copies (partners only): productordering.cms.hhs.gov (You must register your organization.)</p>

Medicare Fraud & Abuse Resource Guide

Additional Resources

Annual report on the Health Care Fraud and Abuse Program, available on the OIG website at oig.hhs.gov/reports-and-publications/hcfac/index.asp.

Civil Money Penalties oig.hhs.gov/fraud/enforcement/cmp/

CMS Outreach & Education MEDIC website medic-outreach.rainmakersolutions.com/free-resources

Data: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/2013.html and cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2013.html

HEAT Task Force results by state available at stopmedicarefraud.gov/newsroom/your-state/index.html

Medicaid RACs At-A-Glance webpage w2.dehpg.net/RACSS/Map.aspx

Payment errors www.paymentaccuracy.gov/

This training module is provided by the
CMS National Training Program (NTP)
For questions about training products email
training@cms.hhs.gov.

To view all available NTP materials,
or to subscribe to our email list, visit
[cms.gov/outreach-and-education/training/
cmsnationaltrainingprogram](https://cms.gov/outreach-and-education/training/cmsnationaltrainingprogram).

Medicare and Medicaid Fraud and Abuse Prevention

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To view all available CMS NTP materials or to subscribe to our email list, visit cms.gov/outreach-and-education/training/cmsnationaltrainingprogram.

Appendix A: Program Integrity Contractors

Program Integrity Contractor	Responsibilities
1. HEAT Strike Force Teams	<ul style="list-style-type: none"> Joint initiative between the U.S. Department of Health and Human Services and the U.S. Department of Justice to combat fraud Located in fraud “hot spots” Coordinate national takedowns based on evidence of the geographic dispersion of Medicare fraud
2. Zone Program Integrity Contractors (ZPIC)	<ul style="list-style-type: none"> Formerly known as Program Safeguard Contractors (PSC) Investigate leads in seven zones Medicare Parts A and B; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Home Health and Hospice; and Medicare-Medicaid data matching
3. National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)	<ul style="list-style-type: none"> Monitors fraud, waste, and abuse in Part C and Part D programs in all 50 states, the District of Columbia, and U.S. Territories Also, Outreach and Education MEDIC (O&E MEDIC) that provides outreach and education tools
4. Medicaid Integrity Contractors (MICs)	<ul style="list-style-type: none"> Three types: review, audit, and education Conducts post-payment audits of Medicaid providers Identifies overpayments and refers to state for collection
5. Recovery Audit Contractors (RACs)	<ul style="list-style-type: none"> Reduce improper payments through detection and collection of overpayments, identify underpayments, and implement action to prevent future improper payments

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Medicare and Medicaid Fraud and Abuse Prevention

Check Your Knowledge Answer Key



Question 1 (page 13)

The primary difference between fraud and abuse is bending the rules.

Answer: False

False. The primary difference between fraud and abuse is intention.

Question 2 (page 14)

Possible causes of improper payments include

- a. Insufficient documentation
- b. Not eligible or their eligibility status could not be determined
- c. Honest mistakes
- d. All of above

Answer: d

All of the above. The Centers for Medicare & Medicaid Services program integrity activities target all causes of improper payments, from honest mistakes to intentional deception. Contrary to common perception, not all improper payments are fraud (i.e., an intentional misuse of funds). In fact, the vast majority of improper payments are due to unintentional errors. For example, an error may occur because a program doesn't have documentation to support a beneficiary's eligibility for a benefit, or an eligible beneficiary receives a payment that is too high—or too low—due to a data entry mistake or inefficiencies.

Acronyms

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

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Website: cms.gov/outreach-and-education/training/cmsnationaltrainingprogram

Email: training@cms.hhs.gov

Centers for Medicare & Medicaid Services

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