

# Module 10 – Medicare and Medicaid Fraud, Waste, and Abuse Prevention

## *Section Objectives*

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

## **Lesson 1: Fraud and Abuse Overview**

### *Definition of Fraud and Abuse*

<b>Fraud</b>	<b>Waste</b>	<b>Abuse</b>
When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program.	The overutilization of services, or other practices that directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.	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, waste, and abuse is intention.**

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

### *Protecting Taxpayer Dollars*

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

The Medicare Hospital Insurance Trust Fund pays for Medicare Part A benefits such as inpatient hospital care, skilled nursing facility care, home health care, and hospice care. It's funded by payroll taxes, income taxes paid on Social Security benefits, interest earned on trust fund investments, and Part A premiums from people who aren't eligible for premium-free Part A.

The Supplementary Medical Insurance Trust Fund pays for Medicare Part B benefits including doctor services, outpatient hospital care, home health care not covered under Part A, durable medical equipment, certain preventive services, lab tests, Medicare Part D prescription drug benefits, and Medicare program administrative costs. Its funding is authorized by Congress from Part B premiums, Part D (Medicare prescription drug coverage) premiums, and interest earned on trust fund investments.

The federal government contributes to the annual Medicaid expenditure, and CMS must protect the public resources that fund the 50 state-run Medicaid programs operated by the states, the District of Columbia, and U.S. Territories.

CMS has to manage the careful balance between paying claims quickly and limiting provider burden, versus conducting reviews that prevent and detect fraud.

### *Examples of Fraud*

Examples of possible fraud include the following:

- Medicare or Medicaid is billed for services you never got, equipment you never got or that was returned
- Documents that are altered to gain a higher payment
- Misrepresentation of dates, descriptions of furnished services, or your identity
- Someone else uses your Medicare/Medicaid card with or without your permission
- A company uses false information to mislead you into joining a Medicare Plan
- For recent examples of Medicare fraud by region, visit CMS Outreach & Education Medic at [medic-outreach.rainmakersolutions.com/fraud-in-the-news](http://medic-outreach.rainmakersolutions.com/fraud-in-the-news) to view the U.S. Department of Justice's "Fraud in the News" press releases

### *Consequences of Sharing a Medicaid Card or Number*

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

- The Medicaid lock-in program limits you to certain doctors, drug stores, and hospitals. Lock-in may be used for people with Medicaid in these circumstances:
  - Visiting hospital emergency departments for non-emergency health concerns
  - Using 2 or more hospitals for emergency room services
  - Using 2 or more doctors resulting in duplicated medications and/or treatments
  - Exhibiting possible drug-seeking behavior
    - Requesting a specific scheduled medication (narcotics)
    - Requesting early refills of scheduled medications
    - Reporting frequent losses of scheduled medications

- Using multiple pharmacies to fill prescriptions
- Your medical records could be wrong—the next time you go to the doctor, you'll have to explain what happened so you don't get the wrong kind of care
- You may have to pay money back or be fined
- You could be arrested and spend time in jail if found guilty of fraud
- You might lose your Medicaid benefits

### *Who Commits Fraud?*

Most individuals and organizations that work with Medicare and Medicaid are honest, 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.

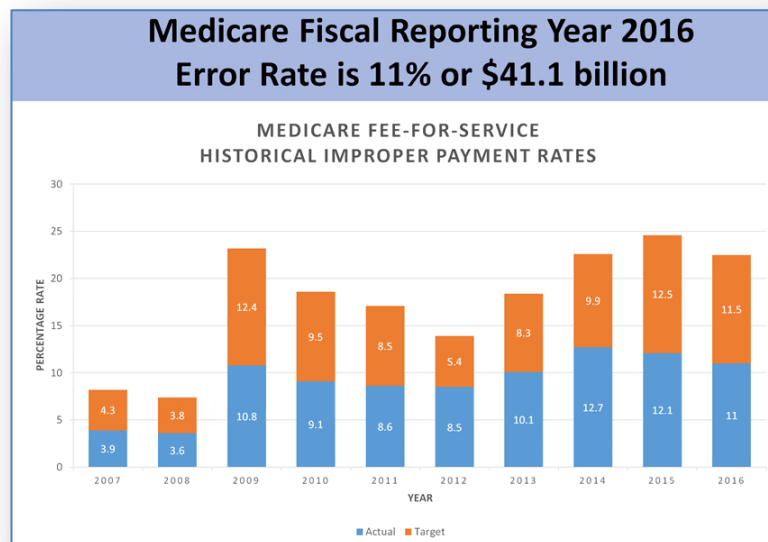
Any of the following may be involved in Medicare and Medicaid fraud, waste, and abuse:

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

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

### *Improper Payment Transparency – Medicare*

An improper payment, according to the Government Accountability Office, is “any payment that shouldn't 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 from this graph the goal of reduction in each fiscal year (FY). As part of the Accountable Government Initiative, Medicare and Medicaid are considered high-error programs. Medicare processes over 1 billion fee-for-service (FFS) claims per year, and pays over \$370 billion for more than 55 million beneficiaries. The FY 2016 improper payment rate was 11%, representing \$41.1 billion in improper payments.

The Medicare FFS improper payment rate decreased from 12.09 percent in Fiscal Year (FY) 2015 to 11.00 percent in FY 2016, meeting and exceeding the FY 2016 improper payment rate target of 11.50 percent. This decrease was driven by a reduction in improper payments for inpatient hospital claims. HHS' "Two Midnight" rule and corresponding educational efforts led to a reduction in improper inpatient hospitals claims, reducing the improper payment rate from 9.23 percent in 2014 to 6.18 percent in 2015 to 3.85 percent in 2016.

In FY 2016, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors. Insufficient documentation errors were prevalent for home health claims, despite the improper payment rate decrease from 58.95 percent in FY 2015 to 42.01 percent in FY2016. Medical necessity was the major error reason for Inpatient Rehabilitation Facility (IRF) claims. The improper payment rate for IRF claims increased from 45.50 percent in FY 2015 to 62.39 percent in FY 2016.

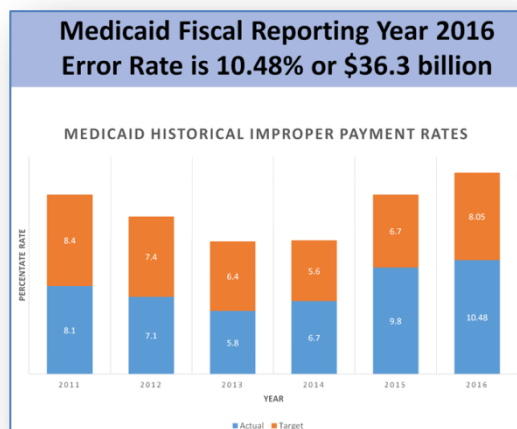
**NOTE:** Error rates can be viewed at [paymentaccuracy.gov](http://paymentaccuracy.gov).

### *Improper Payment Transparency – Medicaid*

Medicaid is the primary source of health coverage for over 68 million Americans and pays more than \$433 billion in benefit claims each year. The fiscal year (FY) 2016 improper payment rate was 10.348%, representing \$36.3 billion in improper payments.

The national Medicaid improper payment rate is calculated differently than for Medicare. It's a rolling improper payment rate that includes findings from the most recent 3 measurements (in this case, for FYs 2013, 2014, and 2015). Each time a group of 17 states is measured under Payment Error Rate Measurement, the previous findings for that group of states are dropped from the calculation and the newest findings are added. In general, the national rate is calculated by multiplying each state's most recently observed error rate by that state's expenditures and dividing by total expenditures. The 2016 Medicaid improper payment rate target is 11.5%.

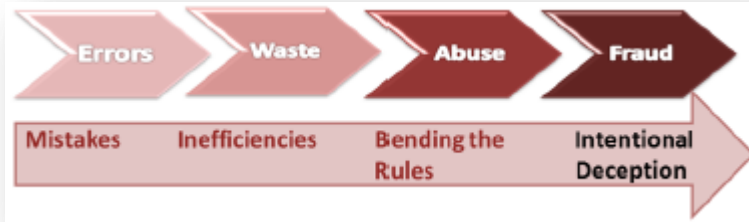
**NOTE:** Error rates can be viewed at [paymentaccuracy.gov/](http://paymentaccuracy.gov/).



## *Causes of Improper Payments*

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

The Centers for Medicare & Medicaid Services' (CMS's) 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 someone's eligibility for a benefit, or an eligible person gets a payment that is too high—or too low—due to a data entry mistake or inefficiencies.

Also, many of the overpayments are payments that may have been proper, but were labeled improper due to a lack of proper documentation. CMS believes that having proper documentation 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 to help avoid 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 people with Medicare and Medicaid.

## *Preventing Fraud in Medicare Parts C and D*

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 people with Medicare in responsible ways that protect them and the Medicare program from marketing practices that could result in fraud. This includes the plan's agents or brokers who represent them.

Some examples of activities Medicare Plans and people who represent them aren't allowed to do:

- Sending you unwanted emails or coming to your home uninvited to sell a Medicare Plan.

- Calling you unless you're already a member of the plan. If you're a member, the agent who helped you join can call you.
- Offering you cash to join their plan.
- Giving you free meals while trying to sell you a plan.
- Talking to you about their plan in areas where you get health care, like an exam room, hospital patient room, or at a pharmacy counter.

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

### *Telemarketing and Fraud – Durable Medical Equipment (DME)*

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

Potential DME scams include the following:

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

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

### *Quality of Care Concerns*

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

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

- Medication errors like being given the wrong medication; being given medication at the wrong time; being given a medication to which you're allergic; or being given medications that interact in a negative way. They can evaluate if it merits Medicare Drug Integrity Contractor intervention.
- Change in condition not treated, like not receiving treatment after abnormal test results or when you developed a complication.
- Discharged from the hospital too soon.

- Incomplete discharge instructions and/or arrangements.

Medicare BFCC-QIOs will help you with these issues. To get the address and phone number of the BFCC-QIO for your state or territory, visit [Medicare.gov/contacts](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: 1-877-486-2048.

## **Lesson 2: CMS Fraud and Abuse Strategies**

### *The Center for Program Integrity*

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

- Coordinates the work of anti-fraud contractors to investigate Medicare providers and conducts audits of Medicaid providers to identify for potential overpayments.
- 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 by:
  - Creating a rigorous screening process for providers and suppliers enrolling in Medicare, Medicaid, and CHIP.
  - Requiring cross-termination among federal and state health programs, so providers and suppliers whose Medicare billing privileges are revoked, or whose participation has been terminated by a Medicaid or CHIP program, are barred or terminated from all other Medicaid and CHIP programs.
  - Temporarily stopping enrollment of new providers and suppliers in high-risk areas. Medicare and state agencies are watching for trends that may indicate a significant potential for health care fraud, and can temporarily stop enrollment of a category of providers or suppliers, or enrollment of new providers or suppliers, in a geographic area that has been identified as high risk. CMS used this authority for the first time in July 2013 on new home health agencies in Miami and Chicago, and ambulance companies in Houston based on their risk of fraud to Medicare and Medicaid. Since the implementation of the Affordable Care Act, CMS have revoked the billing privileges of over 50,000 providers, thanks to the new screening requirements and other proactive initiatives.
  - Coordinating with private and public health payers and other stakeholders to detect and deter fraudulent behaviors within the health care system.
  - Providing outreach and education to key stakeholders to reach key program objectives.



## *Program Integrity Contractors*

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

- Zone Program Integrity Contractors (ZPIC)
- Medicare-Medicaid Data Match (Medi-Medi) Contractors
- Unified program Integrity Contractors (UPIC)
- Recovery Audit Program
- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
- Medicaid Integrity Contractors
- Outreach & Education MEDIC (O&E MEDIC)

**NOTE:** See also “Contractor Entities At-a-Glance” at [CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ContractorEntityGuide\\_ICN906983.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf).

## *Zone Program Integrity Contractors (ZPICs)*

Zone Program Integrity Contractors (ZPICs) were created to perform program integrity functions in zones for Medicare Part A and Part B; durable medical equipment, prosthetics, orthotics, and supplies; home health and hospice; and Medicare-Medicaid data matching.

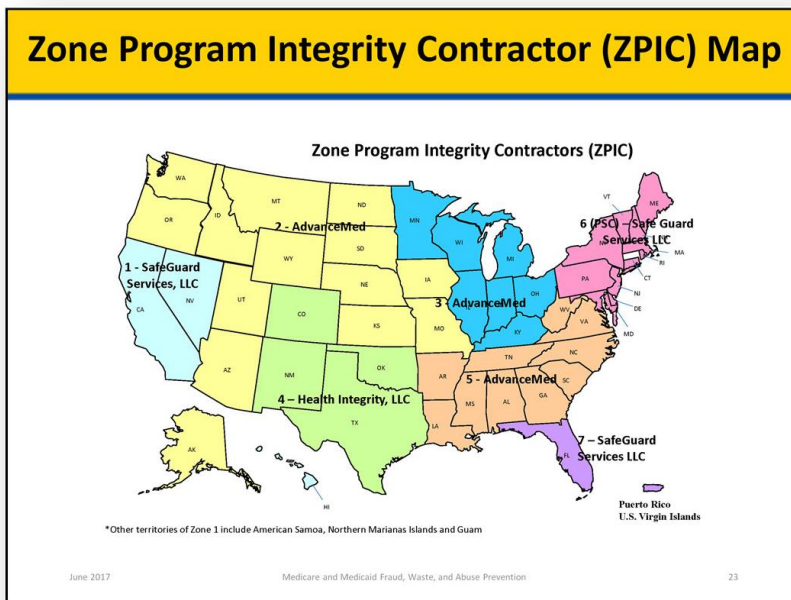
ZPIC’s main responsibilities include the following:

- Investigate leads generated by the new Fraud Prevention System (FPS) and a variety of other sources
- Provide feedback and support to CMS to improve the FPS
- Perform data analysis to identify and investigate cases of suspected fraud, waste, and abuse

Additional Zone Program Integrity Contractor (ZPIC) responsibilities are to

- Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars.
- Make referrals to law enforcement for potential prosecution.
- Provide support for ongoing law enforcement investigations. Identify improper payments to be recovered by Medicare Administrative Contractors (MACs). CMS relies on a network of MACs to process Medicare claims, and MACs serve as the primary operational contact between the Medicare fee-for-service program and approximately 1.5 million health care providers enrolled in the program.



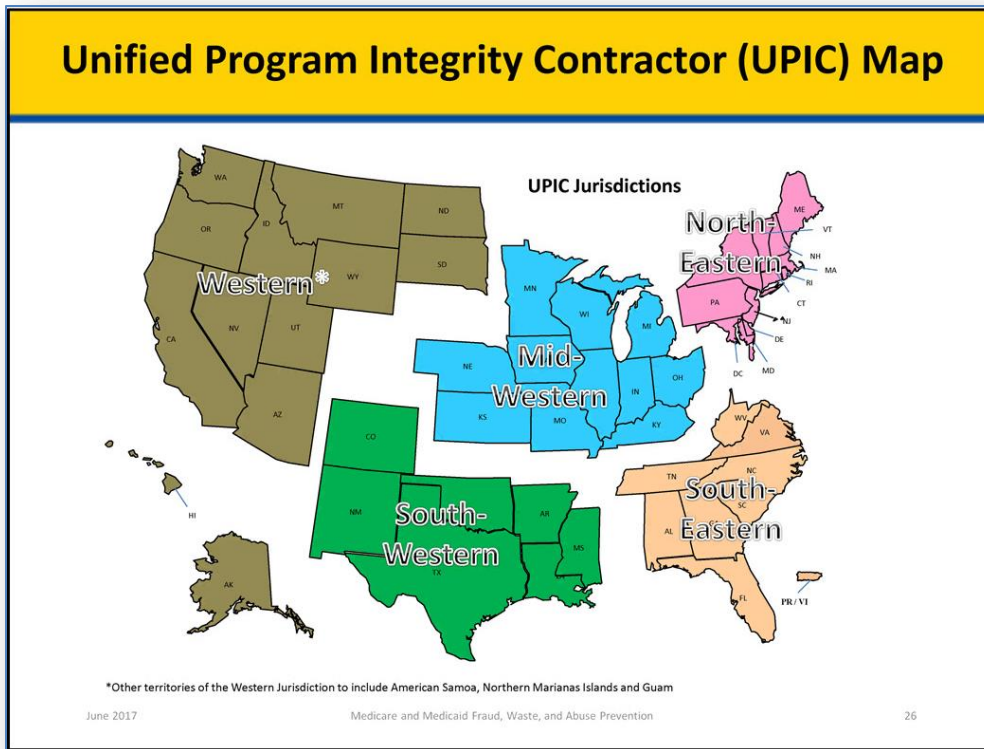


### *Medicare-Medicaid Data Match (Medi-Medi) Contractors*

Medi-Medi is coordination program with State Medicaid Agencies to match Medicare and Medicaid data to identify fraud, waste, and abuse across programs. State participation in Medi-Medi is voluntary and Medi-Medi activities are carried out as separate tasks under the ZPIC contracts. ZPICs use the matched data to identify fraud, waste, and abuse, and then conduct investigations alongside State Medicaid Agencies.

### *Unified Program Integrity Contractor (UPIC)*

The Unified Program Integrity Contractor (UPIC) operates in a geographical area or jurisdiction defined by individual task orders to maintain Medicare and Medicaid program integrity by detecting, preventing, and proactively deterring healthcare fraud, waste, and abuse. The UPIC combines and integrates the existing functions of Zone Program Integrity Contractors, Medicare-Medicaid Data Match Contractors, and the Medicaid Integrity Contractors into a single contractor to perform Medicare and Medicaid program integrity work on behalf of CMS. Such activities include, coordinating audits, conducting investigations with federal and state law enforcement, performs Medi-Medi claims data analysis, and recommends administrative actions.



### *Recovery Audit Program*

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

The Recovery Audit Contractor (RAC) program was permanently implemented for Medicare Part A and Part B on a nationwide basis.

States must establish Medicaid RAC programs and the programs must

- Identify and recover overpayments and identify underpayments.
- Coordinate their efforts with other auditing entities, including state and federal law enforcement agencies. CMS and states work to minimize the likelihood of overlapping audits. As of March 26, 2014, all except 2 states reported Medicaid RAC data.

**NOTE:** For more information, visit the Medicaid “RACs At-a-Glance” webpage at [Medicaidrac.com/medicaid-rac-activity](http://Medicaidrac.com/medicaid-rac-activity). For Medicare RAC information, visit [aha.org/advocacyissues/rac/index.shtml](http://aha.org/advocacyissues/rac/index.shtml).

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

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) monitors and investigates fraud, waste, and abuse in the Part C and Part D plans in all 50 states, the District of Columbia, and U.S. Territories. NBI has investigators throughout the country who work with federal, state, and local law enforcement authorities and other stakeholders.

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

- Investigate potential fraud, waste, and abuse
- Get complaints
- Investigate complaints alleging Medicare fraud
- Perform proactive data analyses
- Identify program vulnerabilities
- Refer potential fraud cases to law enforcement agencies

**NOTE:** For more information, visit [healthintegrity.org/contracts/nbi-medic](http://healthintegrity.org/contracts/nbi-medic).

## *Medicaid Integrity Contractors (MICs)*

Medicaid Integrity Contractors (MICs)

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

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

For more information, visit [CMS.gov/medicare-medicare-coordination/fraud-prevention/medicaidintegrityprogram](http://CMS.gov/medicare-medicare-coordination/fraud-prevention/medicaidintegrityprogram).

### *Outreach & Education Contractors*

To communicate efforts undertaken by the Center for Program Integrity to detect and reduce fraud, waste, and abuse

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

### *CMS Administrative Actions*

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

- Automatic denials are a “don’t pay claim” status for items or services ordered or prescribed by an excluded provider.
- Payment suspensions are a “hold on paying claims” status until an investigation or request for information is completed.
- Prepayment edits are coded system logic that either automatically pay all or part of a claim, automatically deny all or part of a claim, or suspend all or part of a claim so that a trained analyst can review the claim and associated documentation to make determinations about coverage and payment.
- Civil monetary penalties are a punitive fine imposed by a civil court on an entity that has profited from illegal or unethical activity. They may be imposed to punish individuals or organizations for violating a variety of laws or regulations. Visit [oig.hhs.gov/fraud/enforcement/cmp/](http://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.
- Payments are halted and providers are in limbo until the corrective action plan or request for reconsideration process is complete.
- Referrals are made to law enforcement.
- Post-payment reviews to determine if there were overpayments.

### *Law Enforcement Actions*

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

- Providers/companies are barred from the program. The U.S. Department of Health & Human Services (HHS), Office of the Inspector General (OIG) has the authority to exclude individuals and entities from participating in federally-funded health care programs.
- Providers/companies can’t bill Medicare, Medicaid, or Children’s Health Insurance Programs.
- Providers/companies are fined.
- Arrests and convictions occur.

- Corporate Integrity Agreements may be negotiated between 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*

The Health Care Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and associations to identify and reduce fraud, waste, and abuse across the health care sector.

The HFPP prevents fraud, waste, and abuse by:

- Sharing information and best practices.
- Improving detection of fraud, waste, and abuse.
- Preventing improper and fraudulent payments across public and private payers.
- Enabling the exchange of data and information among partners. The long-range goal of the partnership is to use sophisticated technology and analytics on industry-wide health care data to predict and detect health care fraud schemes (using techniques similar to credit card fraud analysis).

### *Health Care Fraud Prevention and Enforcement Action (HEAT) Team*

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

The mission of the HEAT team is to

- 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 people with Medicare and Medicaid

- Highlight best practices by providers and public sector employees who are dedicated to ending waste, fraud, and abuse in Medicare
- Build upon existing partnerships between HHS and DOJ to reduce fraud and recover taxpayer dollars

### *Medicare Fraud Strike Force Teams*

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

- Medicare Fraud Strike Force team locations are evidence of the geographic dispersion of Medicare fraud, with current operations in the identified fraud hot spots of Baton Rouge, Brooklyn, Chicago, Dallas, Detroit, Houston, Los Angeles, Miami-Dade, and Tampa Bay
- Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots
- Interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers

CMS is working collaboratively with federal and state law enforcement partners to increase the recovery of improper payments and fraud by providing data and other support during Health Care Fraud Prevention and Enforcement Action investigations and prosecutions, and suspending payments for providers subject to credible allegations of fraud. For Strike Force news and activities, visit [oig.hhs.gov/fraud/strike-force](http://oig.hhs.gov/fraud/strike-force).

### *Providers and Beneficiary Education*

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

- Provider education helps correct vulnerabilities so that they
  - Maintain proper documentation
  - Reduce inappropriate claims submissions by educating providers on common billing mistakes
  - Protect patient and provider identity information
  - Establish a broader culture of compliance
- Beneficiary education helps them join in the fight against fraud by learning to identify and report suspected fraud. For a copy of the “Program Integrity: Beneficiary Card Sharing Toolkit,” visit [CMS.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/beneficiary-education-toolkits/beneficiary-toolkit.html](http://CMS.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/beneficiary-education-toolkits/beneficiary-toolkit.html).
- “Protecting Yourself & Medicare from Fraud” is a free publication to help people with Medicare get information on how to detect and protect against fraud and identity theft. To read or download this pub, visit [Medicare.gov/Publications/PubID\\_10111](http://Medicare.gov/Publications/PubID_10111).

## Lesson 3: How You Can Fight Fraud

### *4Rs for Fighting Medicare Fraud*

- **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, 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](http://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](http://MyMedicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to review your Medicare claims. TTY: 1-877-486-2048. If you're in a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization) or Medicare Prescription Drug Plan, call your plan for more information about a claim. You can get help from your local SMP program with checking your MSNs for errors or suspected fraud.
- **Report** suspected Medicare fraud by calling 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. When using the automated phone system, have your Medicare card with you and clearly speak or enter your Medicare number and letter(s). If you identify errors or suspect fraud, the SMP can also help you make a report to Medicare.
- **Remember** to protect your Medicare number. Don't give it out, except to your doctor or other health care provider. Never give your Medicare number in exchange for a special offer. Medicare will never contact you and ask for personal information, like your Medicare or bank account numbers. Never let someone use your Medicare card, and never use another person's card.

The "4Rs for Fighting Fraud," (CMS Product No. 11610), is available at [Medicare.gov/Pubs/pdf/11610.pdf](http://Medicare.gov/Pubs/pdf/11610.pdf).

### *Medicare.gov/fraud*

You're the first line of defense against Medicare fraud. [Medicare.gov/fraud](http://Medicare.gov/fraud) is a good place for you to learn about resources available to protect yourself, your loved ones, and Medicare. You'll learn

- Tips to prevent fraud
- How to spot fraud
- How to report fraud
- What you need to know if you're in, or thinking about joining, a Medicare health or drug plan



## Medicare Summary Notice (MSN)

**How to Check This Notice**  
Do you recognize the name of each facility? Check the dates.  
Did you get the claims listed? Do they match those listed on your receipts and bills?  
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplemental insurance (Medigap) plan or other insurer that plan may pay your share.

**How to Report Fraud**  
If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227). Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.  
**You can make a difference!** Last year, Medicare saved taxpayers \$4.2 billion—the largest amount ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

**How to Get Help with Your Questions**  
1-800-MEDICARE (1-800-633-4227)  
Ask for "hospital services." Your customer service code is 05535.  
TTY 1-877-486-2048 (for hearing impaired)  
Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call 1-855-555-5555.

**Your Benefit Periods**  
Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.  
**Inpatient Hospital:** You have **56 out of 90 covered benefit days** remaining for the benefit period that began May 27, 2013.  
**Skilled Nursing Facility:** You have **63 out of 100 covered benefit days** remaining for the benefit period that began May 27, 2013.  
See your "Medicare & You" handbook for more information on benefit periods.

**Your Messages from Medicare**  
Get a **person-to-person shot**. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.  
**To report a change of address**, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.  
**Early detection is your best protection.** Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.  
**Want to see your claims right away?** ACCESS YOUR Original Medicare claims at [www.Medicare.gov](http://www.Medicare.gov), usually within 24 hours after Medicare processes the claim. You can use the "Blue Button" feature to help keep track of your personal health records.

There's a Part A, a Part B, and a durable medical equipment (DME) Medicare Summary Notice (MSN). The MSN shows all services and supplies that were billed to Medicare, what Medicare paid, and what you owe each provider. You should review your MSN carefully to ensure that you received the services and supplies for which Medicare was billed.

CMS redesigned the MSN to make it simpler for people with Medicare to understand, spot, and report fraud.

For more information or to view samples of the Part A, Part B, and/or DMS MSNs, visit [Medicare.gov/forms-help-and-resources/mail-about-medicare/medicare-summary-notice-msn.html](http://Medicare.gov/forms-help-and-resources/mail-about-medicare/medicare-summary-notice-msn.html).

Visit [Medicare.gov/pubs/pdf/summarynoticea.pdf](http://Medicare.gov/pubs/pdf/summarynoticea.pdf) to see how to read your Part A MSN.

Visit [Medicare.gov/pubs/pdf/summarynoticeb.pdf](http://Medicare.gov/pubs/pdf/summarynoticeb.pdf) to see how to read your Part B MSN.

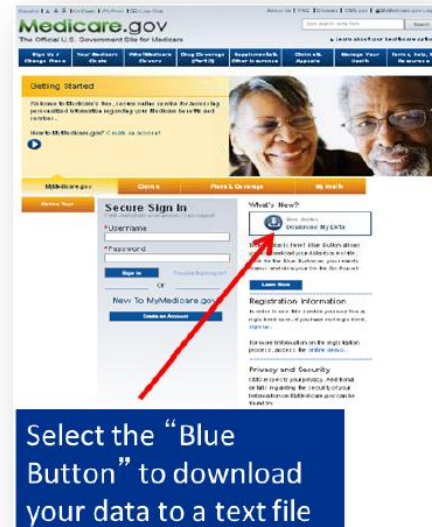
Visit [Medicare.gov/pubs/pdf/SummaryNoticeDME.pdf](http://Medicare.gov/pubs/pdf/SummaryNoticeDME.pdf) to see how to read your DME MSN.

**NOTE:** Medicare Advantage Plans provide an Explanation of Benefits that provides similar information. The Medicare Part C EOB is an ad hoc enrollee communication that provides MA enrollees with clear and timely information about their medical claims to support informed decisions about their health care options. Medicare Advantage organizations are required to issue EOBs that include the information reflected in the CMS-developed templates. For additional information, please see the final templates and instructions at: [CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketingModelsStandardDocumentsandEducationalMaterial.html](http://CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketingModelsStandardDocumentsandEducationalMaterial.html) Medicare Part D sponsors must ensure that enrollees who utilize their prescription drug benefits get their EOBs by the end of the month following the month in which they utilized their prescription drug benefits.

## MyMedicare.gov

[MyMedicare.gov](https://www.medicare.gov) is Medicare's free, secure online service for accessing personalized information regarding Medicare benefits and services. [MyMedicare.gov](https://www.medicare.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're 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 for Medicare Part A and Part B and identify fraudulent claims. You don't have to wait to get your Medicare Summary Notice (MSN) in the mail to view your Medicare claims. Visit [MyMedicare.gov](https://www.medicare.gov) to track your Medicare claims or view electronic MSNs. Your claims will generally be available within 24 hours after processing.
  - If there's a discrepancy, you should call your doctor or supplier. Call 1-800-MEDICARE if you suspect fraud. TTY: 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)

People with Medicare can call 1-800-MEDICARE (1-800-633-4227) to make a complaint and report fraud. TTY: 1-877-486-2048.

The Call Center has an Interactive Voice Response (IVR) system available for people who haven't registered or don't use [MyMedicare.gov](https://www.medicare.gov). The IVR can access 15 months of Original Medicare claims processed on their behalf, if it's available. The data gathered helps CMS

- Target providers or suppliers with multiple consumer complaints for further review.
- Track fraud complaints to show when fraud scams are heating up in new areas. Using existing data in this innovative way enables CMS to target providers and suppliers with multiple consumer complaints for further investigation.

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

- The provider's name and any identifying number you may have
- Information on the service or item you're questioning
- The date the service or item was supposedly given or delivered
- The payment amount approved and paid by Medicare
- The date on your Medicare Summary Notice
- Your name and Medicare number (as listed on your Medicare card)

### *Learning Activity*

John has concerns and wants to discuss his Medicare Summary Notice with you. What are some things that might indicate fraud?

### **What Might Indicate Fraud?**

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

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

### *Fighting Fraud Can Pay*

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

- You call either 1-800-HHS-TIPS (1-800-447-8477), or call 1-800-MEDICARE (1-800-633-4227) to report suspected fraud. TTY: 1-877-486-2048.
- The suspected Medicare fraud you report must be proven as potential fraud by the Zone Program Integrity Contractor (the Medicare contractors responsible for investigating potential fraud and abuse), and formally referred as part of a case by one of the contractors to the Office of Inspector General for further investigation.
- You aren't an "excluded individual." For example, you didn't participate in the fraud offense being reported. Or, there isn't another reward that you qualify for under another government program.
- The person or organization you're reporting isn't already under investigation by law enforcement.
- Your report leads directly to the recovery of at least \$100 of Medicare money.

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

To read the press release, visit [HHS.gov/news/press/2013pres/04/20130424a.html](https://www.hhs.gov/news/press/2013pres/04/20130424a.html) and the Code of Federal Regulations at CFR 420.405 “Rewards for information relating to Medicare fraud and abuse.”

### *The Senior Medicare Patrol (SMP)*

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



- **Conduct Outreach and Education.** SMPs give presentations to groups, exhibit at events, and work one-on-one with people with Medicare. Since 1997, more than 30 million people have been reached during community education events, more than 6.5 million people with Medicare have been educated and served, and more than 46,000 volunteers have been active.
- **Engage Volunteers.** Protecting older persons’ health, finances, and medical identity while saving precious Medicare dollars is a cause that attracts civic-minded Americans. The SMP program engages over 5,000 volunteers nationally who collectively contribute approximately 150,000 hours each year.
- **Get Complaints from People with Medicare.** When people with Medicare, caregivers, and family members bring their complaints to the SMP, the SMP makes a determination about whether or not fraud, errors, or abuse is suspected. When fraud or abuse is suspected, they make referrals to the appropriate state and federal agencies for further investigation.

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

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

### *Protecting Personal Information*

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

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

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

### *Identity Theft*

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

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

- Call your local police department.
- Call the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338. TTY: 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: 1-800-325-0778.

For more information about identity theft or to file a complaint online, visit [ftc.gov/idtheft](http://ftc.gov/idtheft).

You can also visit [stopmedicarefraud.gov/fightback\\_brochure\\_rev.pdf](http://stopmedicarefraud.gov/fightback_brochure_rev.pdf) to view "Medical Identity Theft & Medicare Fraud."

### *Reporting Suspected Medicaid Fraud*

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

- Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. 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](http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/contact-directors.pdf).
- The Office of Inspector General (OIG) certifies and annually re-certifies each MFCU. You can contact the U.S. Department of Health & Human Services OIG.
  - 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.
  - Call: 1-800-447-8477. TTY: 1-800-377-4950.
- You can also report suspected fraud and abuse to your State Medical Assistance (Medicaid) office. You may locate them at [CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Downloads/smafraudcontacts-oct2014.pdf](http://CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Downloads/smafraudcontacts-oct2014.pdf).

Learn more about Medicaid fraud at [Medicaid.gov/medicaid-chip-program-information/by-topics/program-integrity/program-integrity.html](http://Medicaid.gov/medicaid-chip-program-information/by-topics/program-integrity/program-integrity.html) .

## Key Points to Remember

- The difference between fraud, waste, and abuse is intention
- While there are many causes of improper payments, many are honest mistakes
- The Centers for Medicare & Medicaid Services (CMS) fights fraud, waste, 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, waste, and abuse with the 4Rs: record, review, report, and remember
- There are many sources of additional information

## Fraud Prevention Toolkit

The Centers for Medicare & Medicaid Services (CMS) provides a fraud prevention toolkit located on [CMS.gov](https://www.cms.gov) that includes

- The 4Rs brochure—(Record, Review, Report, and Remember)
- Fact sheets on preventing and detecting fraud
- Frequently Asked Questions

[CMS.gov](https://www.cms.gov) also has information about the Center for Program Integrity and fraud prevention efforts in Original Medicare (fee-for-service), Part C and Part D, and Medicaid.

**NOTE:** For more information on the fraud prevention toolkit, visit [CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html](https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html). For the latest news and information from the Center for Program Integrity, visit [CMS.gov/aboutcms/components/cpi/center-for-program-integrity.html](https://www.cms.gov/aboutcms/components/cpi/center-for-program-integrity.html).

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

June 2017 Medicare and Medicaid Fraud, Waste, and Abuse Prevention 56



# Medicare and Medicaid Fraud & Abuse Resource Guide

## Resources

### Centers for Medicare &

### Medicaid Services (CMS)

- Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

- [Medicare.gov](http://Medicare.gov)

### MyMedicare.gov

- [MyMedicare.gov/](http://MyMedicare.gov/)
- [Medicare.gov/fraud](http://Medicare.gov/fraud)

### Social Security

- Cal 1-800-772-1213. TTY: 1-800-325-0778
- [SSA.gov](http://SSA.gov)

### Senior Medicare Patrol Program

- [smpresource.org](http://smpresource.org)

### National Health Care Anti-Fraud Association

- [NHCAA.org](http://NHCAA.org)

### NBI Medic's Parts C&D Fraud Reporting Group

- Call 1-877-7SAFERX (1-877-772-3379).
- [healthintegrity.org/contracts/nbi-medic/reporting-a-complaint](http://healthintegrity.org/contracts/nbi-medic/reporting-a-complaint)



# Medicare and Medicaid Fraud & Abuse Resource Guide (continued)

## Medicare Products

1. **“Medicare Authorization to Disclose Personal Information”** form (CMS Product No. 10106)
2. **“Help Prevent Fraud: Check Your Medicare Claims Early!”** (CMS Product No. 11491 and No. 11492)
3. **“Protecting Yourself & Medicare From Fraud”** (CMS Product No. 10111)
4. **“Quick Facts About Medicare Plans and Protecting Your Personal Information”** (CMS Product No. 11147)
5. **“4Rs for Fighting Fraud”** (CMS Product No. 11610)
6. **“You Can Help Protect Yourself and Medicare From Fraud Committed by Dishonest Suppliers”** (CMS Product No. 11442)

**To access these products:**

- View and order single copies at [Medicare.gov/publications](http://Medicare.gov/publications).
- Order multiple copies (partners only) at [Productordering.cms.hhs.gov](http://Productordering.cms.hhs.gov).  
*You must register your organization.*

# Medicare and Medicaid Fraud & Abuse Resource Guide (continued)

## Resources

### CMS Outreach & Education MEDIC

- [medic-outreach.rainmakersolutions.com/](http://medic-outreach.rainmakersolutions.com/)

### 2015 HCFAC Report

- [OIG.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf](http://OIG.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf)

### Medicaid Beneficiary Education

- [CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html](http://CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html)

### Prevention Toolkit

- [CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html](http://CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html)

### CMS Program Integrity

- [CMS.gov/About-CMS/Components/CPI/Center-for-program-integrity.html](http://CMS.gov/About-CMS/Components/CPI/Center-for-program-integrity.html)

### Fraud Hotline

- Call 1-800-HHS-TIPS (1-800-447-8477)
- TTY: 1-800-337-4950
- Fax 1-800-223-8162