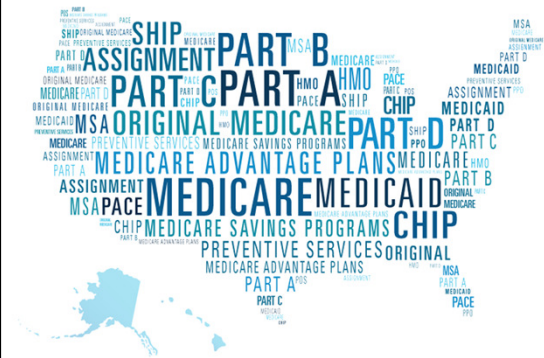




2017 National Training Program



Module 10

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

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

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 June 2017. To check for an updated version, visit [CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html).

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

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

The materials are designed for information givers/trainers who are familiar with the Medicare Program, and would like to have prepared information for their presentations.

The module consists of 57 PowerPoint slides with corresponding speaker’s notes, activities, and check-your-knowledge questions. It can be presented in about 45 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities.

Session Objectives

This session should help you

- 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

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Lesson 1—Fraud, Waste, and Abuse Overview

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

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

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

Definitions of Fraud, Waste, and Abuse

Fraud

When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program.

Waste

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.

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, waste, and abuse is intention.

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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.

Fraud occurs when someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program. Ultimately, fraud is determined by our judicial system.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program (e.g., medically unnecessary services or DME or prescription drugs, or more disposable DME or drugs than necessary [more syringes, diabetic test strips, disposable diapers or underpads than are really needed over a period of time]). Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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

The primary difference between fraud, waste, and abuse is intention.

Protecting Taxpayer Dollars

The Centers for Medicare & Medicaid Services must

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

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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

- Medicare or Medicaid is billed for
 - Services you never got
 - Equipment you never got or that was returned
- Documents are altered to gain a higher payment
- Misrepresentation of dates, descriptions of furnished services, or your identity
- Someone uses your Medicare or Medicaid card with or without your permission
- A company uses false information to mislead you into joining a Medicare Plan
- For recent examples of fraud by region visit, medic-outreach.rainmakersolutions.com/fraud-in-the-news/

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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/ to view the U.S. Department of Justice's "Fraud in the News" press releases

Consequences of Sharing a Medicaid Card or Number

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



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

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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.

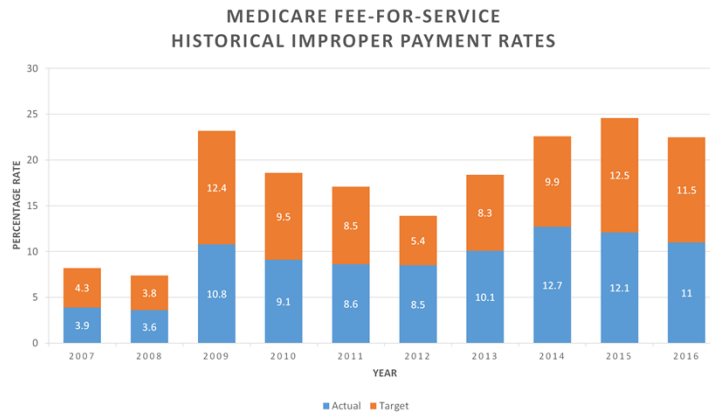
Any of the following may be involved in Medicare and Medicaid fraud, waste, and abuse:

- 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

Medicare Fiscal Reporting Year 2016 Error Rate is 11% or \$41.1 billion



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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.

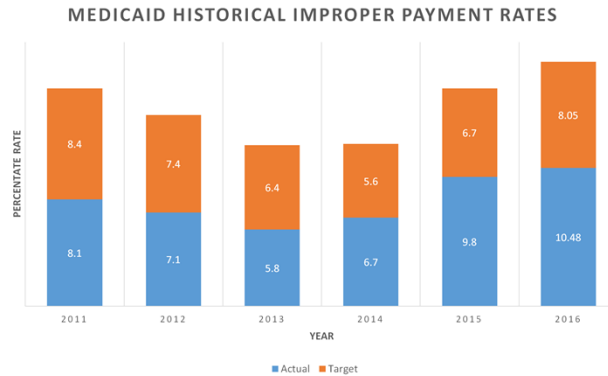
The Medicare FFS improper payment rate decreased from 12.09 percent in Fiscal Year (FY) 2015 to 11.00 percent in FY 2016, meeting and exceeding the FY 2016 improper payment rate target of 11.50 percent. This decrease was driven by a reduction in improper payments for inpatient hospital claims. HHS’ “Two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

Improper Payment Transparency—Medicaid

Medicaid Fiscal Reporting Year 2016
Error Rate is 10.48% or \$36.3 billion



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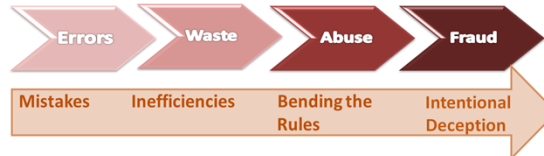
Medicaid is the primary source of health coverage for over 68 million Americans and pays more than \$433 billion in benefit claims each year. The fiscal year (FY) 2016 improper payment rate was 10.48%, representing \$36.3 billion in improper payments.

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.

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

Causes of Improper Payments

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



- The Centers for Medicare & Medicaid Services is targeting all causes of improper payments—from honest mistakes to intentional deception
- Most common error is insufficient documentation

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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 Part C and Part D

- Plan agents and brokers must follow CMS's Marketing Guidelines. Examples of what plans can't do include
 - Sending you unwanted emails
 - Coming to your home uninvited to get you to join
 - Calling you unless you're already a member
 - 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
- If you think an agent or broker broke Medicare Plan rules
 - Call 1-800-MEDICARE (1-800-633-4227)
 - TTY: 1-877-486-2048

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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)

- DME telemarketing rules
 - DME suppliers can't make unsolicited sales calls
- Potential DME scams
 - Calls or visits from people saying they represent Medicare
 - Telephone or door-to-door selling techniques
 - Equipment or service is offered free and you're then asked for your Medicare number for "record keeping purposes"
 - You're told that Medicare will pay for the item or service if you provide your Medicare number

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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

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

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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.

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.

Check Your Knowledge—Question 1

The definition of ____ is when someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program.

- a. Abuse
- b. Improper payment
- c. Fraud
- d. None of the above

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Check Your Knowledge—Question 1

The definition of ____ is when someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program.

- a. Abuse
- b. Improper payment
- c. Fraud
- d. None of the above

ANSWER: c. Fraud

Fraud occurs when someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program.

Check Your Knowledge—Question 2

Billing errors will always indicate a health care provider's or supplier's intent to commit fraud.

a. True

b. False

Check Your Knowledge—Question 2

Billing errors will always indicate a health care provider's or supplier's intent to commit fraud.

- a. True
- b. False

ANSWER: b. False

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.

Lesson 2—CMS Fraud and Abuse Strategies

- The Center for Program Integrity
- CMS Program Integrity Contractors
- CMS Administrative Actions
- Law Enforcement Actions
- The Health Care Fraud Prevention Partnership
- Health Care Fraud Prevention and Enforcement Action (HEAT) Team
- The Fraud Prevention Toolkit at [CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html](https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html)
- Provider and Beneficiary Education

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Lesson 2 discusses the following Centers for Medicare & Medicaid Services (CMS) fraud and abuse strategies:

- The Center for Program Integrity
- The CMS Program Integrity Contractors
- CMS Administrative Actions
- Law Enforcement Actions
- The Health Care Fraud Prevention Partnership
- Health Care Fraud Prevention and Enforcement Action (HEAT) Team
- The Fraud Prevention Toolkit at [CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html](https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html)
- Provider and Beneficiary Education

The Center for Program Integrity

- Consolidates CMS anti-fraud waste, and abuse components
- Coordinates the work of anti-fraud contractors to investigate Medicare providers and conducts audits of Medicaid providers to identify potential overpayments
- Authority comes from the Affordable Care Act
- More rigorous screenings for health care providers
- Revocation of Medicare providers based on for-cause terminations from Medicaid, and the Children's Health Insurance Program
- May temporarily stop enrollment in high-risk areas
 - Used first in July 2013 and extended into 2016
- Temporarily stop Medicare payments in cases of credible allegations of fraud
- Coordinates with private and public health payers and other stakeholders to detect and deter fraudulent behaviors within the health care system
- Provides outreach and education to key stakeholders to reach key program objectives

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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 has 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

- A nationally coordinated Medicare/Medicaid program integrity strategy that cuts across regions
 - 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 Contractors

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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 Contractors

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)

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

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

Zone Program Integrity Contractors (ZPICs) (continued)

- 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

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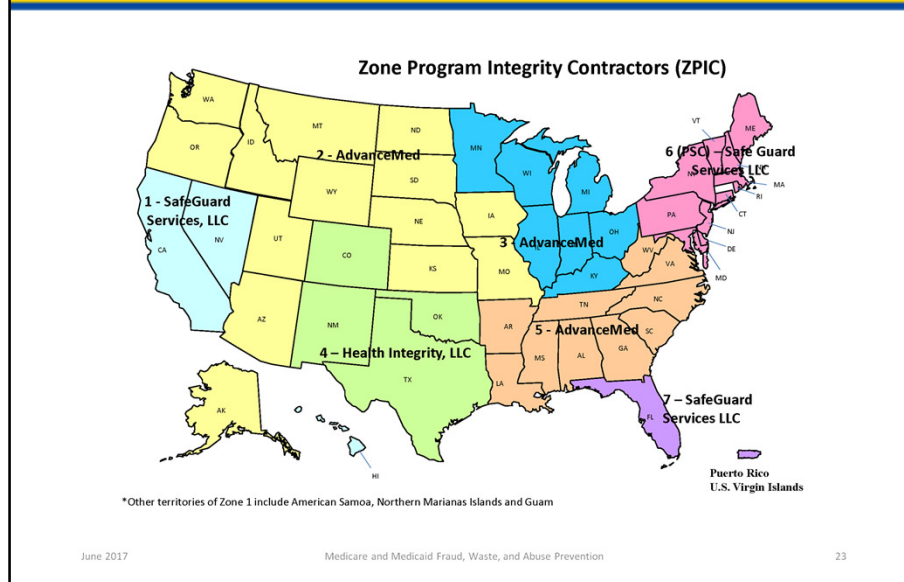
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Additional Zone Program Integrity Contractor (ZPIC) responsibilities are to

- 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.

Zone Program Integrity Contractor (ZPIC) Map



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

- Zone 1 is covered by SafeGuard Services, LLC (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 AdvanceMed and includes Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
- Zone 4 is covered by Health Integrity, LLC 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 PSC and Safe Guard Services, LLC and includes Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and the District of Columbia
- Zone 7 is covered by SGS and includes Florida and Puerto Rico

Medicare-Medicaid Data Match (Medi-Medi) Contractors

- Coordination program with State Medicaid Agencies to match Medicare and Medicaid data to identify fraud, waste, and abuse across programs
 - State participation is voluntary
 - Activities are separate tasks under the ZPIC contracts
 - ZPICs use the matched data to identify fraud, waste, and abuse to conduct investigations, with State Medicaid Agencies

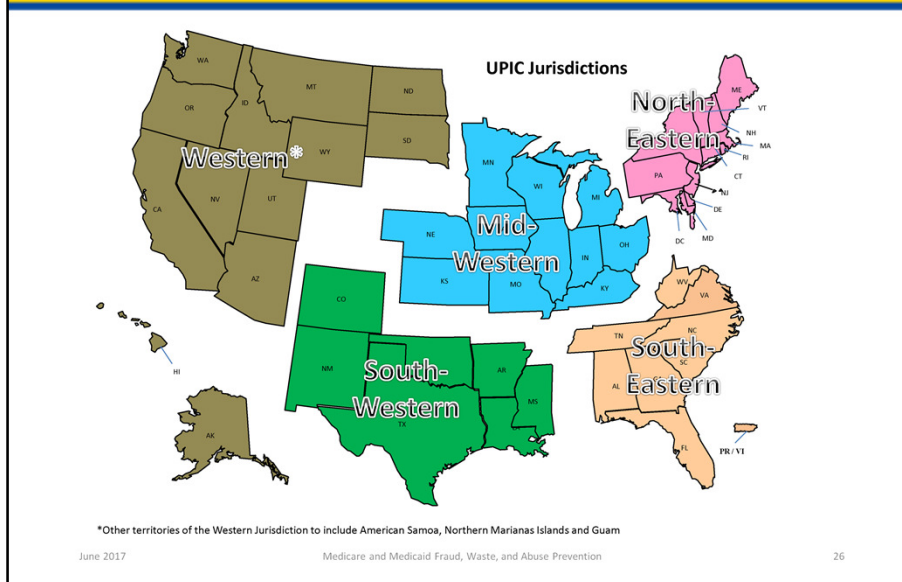
Medi-Medi is coordination program with State Medicaid Agencies to match Medicare and Medicaid data to identify fraud, waste, and abuse across programs. State participation in Medi-Medi is voluntary and Medi-Medi activities are carried out as separate tasks under the ZPIC contracts. ZPICs use the matched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

Unified Program Integrity Contractor (UPIC)

- Operates in a geographical area to maintain Medicare and Medicaid program integrity.
- Offers a coordinated approach to combating fraud, waste, and abuse
 - Combines the functions of Zone Program Integrity Contractors, Medicare-Medicaid Data Match (Medi-Medi) Contractors, and the Medicaid Integrity Contractors
- Coordinates audits, conducts investigations with federal and state law enforcement, performs Medi-Medi claims data analyses, and recommends administrative actions

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.

Unified Program Integrity Contractor (UPIIC) Map



The Unified Program Integrity Contractor operates in 5 jurisdictions. The American Samoa, Northern Marianas Islands, and Guam territories are part of the Western jurisdiction.

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
- States establish Medicaid Recovery Audit Contractor programs to
 - Identify overpayments and underpayments
 - Coordinate efforts with federal and state auditors

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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 Medicaid-rac.com/medicaid-rac-activity. For Medicare RAC information, visit aha.org/advocacy-issues/rac/index.shtml.

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)

- Monitors fraud, waste, and abuse in the Part C and Part D programs in all 50 states, the District of Columbia, and U.S. Territories
- Works with law enforcement and other stakeholders
- Key responsibilities include
 - Investigate potential fraud, waste, and abuse
 - Get complaints
 - Investigates complaints alleging Medicare fraud
 - Perform proactive data analyses
 - Identify program vulnerabilities
 - Refer potential fraud cases to law enforcement agencies



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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.

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 adjudicate appeals, but support state adjudication process

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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.

NOTE: For more information, visit [CMS.gov/medicare-medicare-coordination/fraud-prevention/medicaidintegrityprogram](https://www.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
- Examples:
 - Outreach and education materials
 - Professional education
 - Regulation and guidance
 - Fraud-fighting resources
 - General news

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

Examples:

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

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
 - Post-payment reviews for determinations

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

When law enforcement and the judicial system determines 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

- 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 healthcare sector.
- 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 the partners

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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

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

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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

- Multi-agency teams that
 - Are located in fraud “hot spot” areas
 - Use advanced data analysis to identify high-billing levels in health care fraud hot spots
 - Coordinate national takedowns
- CMS supports Strike Force takedowns
 - Performs data analysis
 - Suspends payment

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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.

Provider and Beneficiary Education

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

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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](https://www.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](https://www.Medicare.gov/Publications/PubID_10111).

Check Your Knowledge—Question 3

Which of the following provides authority for new rules, provider screening requirements, and other proactive initiatives to prevent and detect fraud, waste, and abuse?

- a. Center for Program Integrity
- b. The Affordable Care Act
- c. Medicaid Integrity Contractor
- d. Recovery Audit Program

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Check Your Knowledge—Question 3

Which of the following provides authority for new rules, provider screening requirements, and other proactive initiatives to prevent and detect fraud, waste, and abuse?

- a. Center for Program Integrity
- b. The Affordable Care Act
- c. Medicaid Program Integrity Contractor
- d. Recovery Audit Program

ANSWER: b. The Affordable Care Act

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.

Lesson 3—How You Can Fight Fraud

- “4Rs” for Fighting Medicare Fraud
- Medicare.gov/fraud
- Medicare Summary Notices
- MyMedicare.gov
- 1-800-MEDICARE
- Senior Medicare Patrol
- Protecting Personal Information and ID Theft
- Reporting Medicaid Fraud
- Helpful Resources
- Fraud Prevention Toolkit

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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 [Medicare.gov/fraud](https://www.medicare.gov/fraud)
- Review Medicare Summary Notices
- Highlight the advantages of using [MyMedicare.gov](https://www.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
- Fraud Prevention Toolkit

“4Rs” for Fighting Medicare Fraud

- Here are some ways you can protect yourself from fraud
 - Record appointments and services
 - Review services provided
 - Compare services actually obtained with services on your Medicare Summary Notice
 - Report suspected fraud
 - Remember to protect personal information, such as your Medicare card and bank account numbers



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- **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, 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: 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.

Medicare.gov/fraud

- Tips to prevent fraud
- Learn how to spot fraud
- Learn how to report fraud

The screenshot shows the Medicare.gov website with the following content:

- Header: "The Official U.S. Government Site for Medicare" with navigation tabs for "Sign Up / Change Plans", "Your Medicare Costs", "What Medicare Covers", "Drug Coverage (Part D)", "Supplements & Other Insurance", "Claims & Appeals", "Manage Your Health", and "Forms, Help, & Resources".
- Search bar: "Type search term here" with a "Search" button.
- Breadcrumbs: "Home > Forms, Help, & Resources > Help fight Medicare fraud".
- Main heading: "Help fight Medicare fraud".
- Text: "Medicare fraud wastes a lot of money each year and results in higher health care costs and taxes for everyone. Con artists commit Medicare fraud by getting people's Medicare number."
- Section: "You can help fight Medicare fraud in 2 simple steps:"
 1. Never give your Medicare number to get a free offer or gift.
 2. Always check your Medicare statement for errors, like equipment or services you never got.
- Text: "Protect your Medicare by protecting your Medicare number."
- Section: "More ways to protect yourself, your loved ones, and Medicare from fraud:"
 - Learn tips to prevent fraud
 - Learn how to spot fraud
- Right sidebar: "Related Resources" with links for "Don't Mess with My Medicare", "Look Out for Enrollment Fraud", and "Medicare Fraud Strike Force".
- Bottom right: "Find someone to talk to" with a dropdown menu for "Select your state..." and a "Go" button.

- Find out what you need to know if you're in, or thinking about joining, a Medicare health or drug plan

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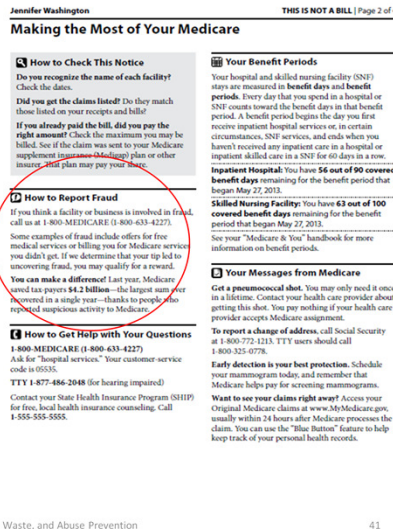
40

You're the first line of defense against Medicare fraud. [Medicare.gov/fraud](https://www.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)

- 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 a 3-month period
 - What Medicare paid
 - What you owe
- Read it carefully



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 got 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 DME MSNs, visit [Medicare.gov/forms-help-and-resources/mail-about-medicare/medicare-summary-notice-msn.html](https://www.Medicare.gov/forms-help-and-resources/mail-about-medicare/medicare-summary-notice-msn.html).

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

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

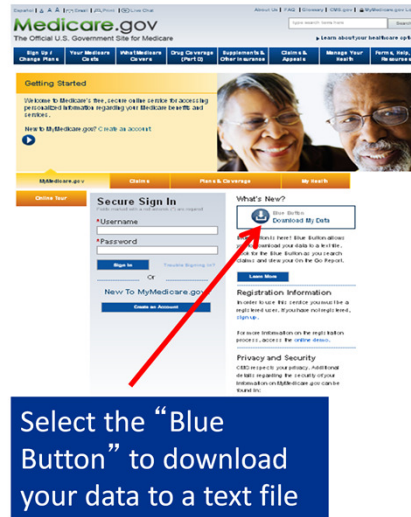
Visit [Medicare.gov/pubs/pdf/SummaryNoticeDME.pdf](https://www.Medicare.gov/pubs/pdf/SummaryNoticeDME.pdf) to see how to read your DME MSN.

NOTE: Medicare Advantage Plans provide an Explanation of Benefits (EOB) 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](https://www.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

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



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

- View eligibility, entitlement, and preventive service information.
- Check personal Medicare information, including Medicare claims, as soon as they'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.mymedicare.gov) to track your Medicare claims or view electronic MSNs. Your claims will generally be available within 24 hours after processing.
 - If there's a discrepancy, you should call your doctor or supplier. Call 1-800-MEDICARE if you suspect fraud. TTY: 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)

- Incoming fraud complaints
 - Help target certain providers/suppliers for review
 - Show where fraud scams are heating up
- Using the Interactive Voice Response System
 - Access up to 15 months of claims
 - Check for proper dates, services, and supplies obtained
 - If not checking claims on [MyMedicare.gov](https://www.mymedicare.gov)

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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.mymedicare.gov). The IVR can access 15 months of Original Medicare claims processed on their behalf, if they're available.

The data gathered helps CMS to

- 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?

1 **Medicare Summary Notice**
for Part A (Hospital Insurance)
The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

2 **Notice for Jennifer Washington**

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

3 **Your Deductible Status**

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

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

Be Informed!

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

4 **Your Claims & Costs This Period**

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

5 **Facilities with Claims This Period**

June 18 - June 21, 2013
Otero Hospital

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Table que puede recibir este servicio otros tipos de planes de Medicare en español. Llame y hable con un agente en español.
多項 Medicare 福利，包括其他类型的 Medicare 计划，均可提供此服务。请致电 Medicare 代理人 (408-432-2277)。

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Learning Activity

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

Learning Activity: What Might Indicate Fraud?

- Was he charged for any medical services he didn't get?
- Are the dates of services correct?
- 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?

Fight Back!
Deter, Detect, Defend

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

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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 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)

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



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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:

1. 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.
2. 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 5,200 volunteers nationally who collectively contribute more than 155,000 hours each year.
3. 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, or call the nationwide toll-free number at 1-877-808-2468. Callers get information about the SMP program and are connected to the SMP in their state for individualized assistance. This number can also be found in the "Medicare & You" handbook and other national Medicare and anti-fraud publications that reference the SMP program. You can also

email them at info@smpresource.org.

Protecting Personal Information

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

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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 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
 - 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

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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: 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: 1-800-325-0778.

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

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

Reporting Suspected Medicaid Fraud

- Medicaid Fraud Control Unit (MFCU) investigates and prosecutes
 - Medicaid fraud
 - Patient abuse and neglect in health care facilities
 - Call the Office of the Inspector General at 1-800-447-8477
 - TTY: 1-800-377-4950
 - They also certify and annually re-certify the MFCU
- State Medical Assistance (Medicaid) office
 - See state listing for Medicaid
 - Download contacts at [CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Downloads/smafraudcontacts-oct2014.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Downloads/smafraudcontacts-oct2014.pdf)

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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.
- 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/).
 - By 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](https://www.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](https://www.Medicaid.gov/medicaid-chip-program-information/by-topics/program-integrity/program-integrity.html).

Key Points to Remember

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

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Key points to remember include the following:

- 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

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

MyMedicare.gov

- MyMedicare.gov/
- Medicare.gov/fraud

Social Security

- Cal 1-800-772-1213. TTY: 1-800-325-0778
- SSA.gov

Senior Medicare Patrol Program

- smpresource.org

National Health Care Anti-Fraud Association

- 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

Medicare and Medicaid Fraud & Abuse Resource Guide (continued)

Resources	
CMS Outreach & Education MEDIC <ul style="list-style-type: none">• medic-outreach.rainmakersolutions.com/	Prevention Toolkit <ul style="list-style-type: none">• CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
2015 HCFAC Report <ul style="list-style-type: none">• OIG.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf	CMS Program Integrity <ul style="list-style-type: none">• CMS.gov/About-CMS/Components/CPI/Center-for-program-integrity.html
Medicaid Beneficiary Education <ul style="list-style-type: none">• CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html	Fraud Hotline <ul style="list-style-type: none">• Call 1-800-HHS-TIPS (1-800-447-8477)• TTY: 1-800-337-4950• Fax 1-800-223-8162

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](https://www.medicare.gov/publications).
- Order multiple copies (partners only) at [Productordering.cms.hhs.gov](https://productordering.cms.hhs.gov).
You must register your organization.

Fraud Prevention Toolkit

- Visit [CMS.gov](https://www.cms.gov) to access the Fraud Prevention Toolkit, which 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

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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/about-cms/components/cpi/center-for-program-integrity.html](https://www.cms.gov/about-cms/components/cpi/center-for-program-integrity.html).

Acronyms

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

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[CMS.gov/outreach-and-
education/training/CMSNationalTrainingProgram](https://www.cms.gov/outreach-and-education/training/CMSNationalTrainingProgram).

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