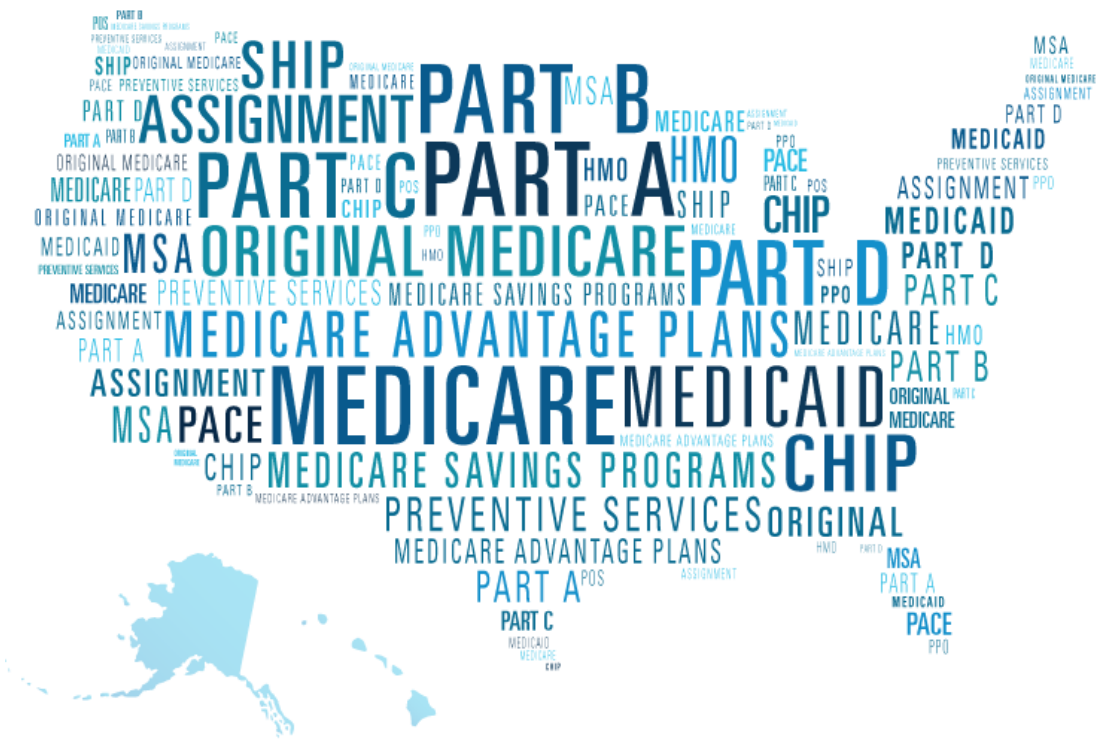
CENTERS FOR MEDICARE & MEDICAID SERVICES

2016 National Training Program



Module 10

Medicare and Medicaid Fraud and Abuse Prevention

Session Objectives

This session should help you

- Define fraud 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 health care fraud 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 and Abuse

Fraud

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

Abuse

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

The primary difference between fraud and abuse is intention.

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

Examples of Fraud

- Medicare or Medicaid is billed for
  - Services you never received
  - 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.rainmakerssolutions.com/fraud-in-the-news/

Consequences of Sharing a Medicaid Card or Number

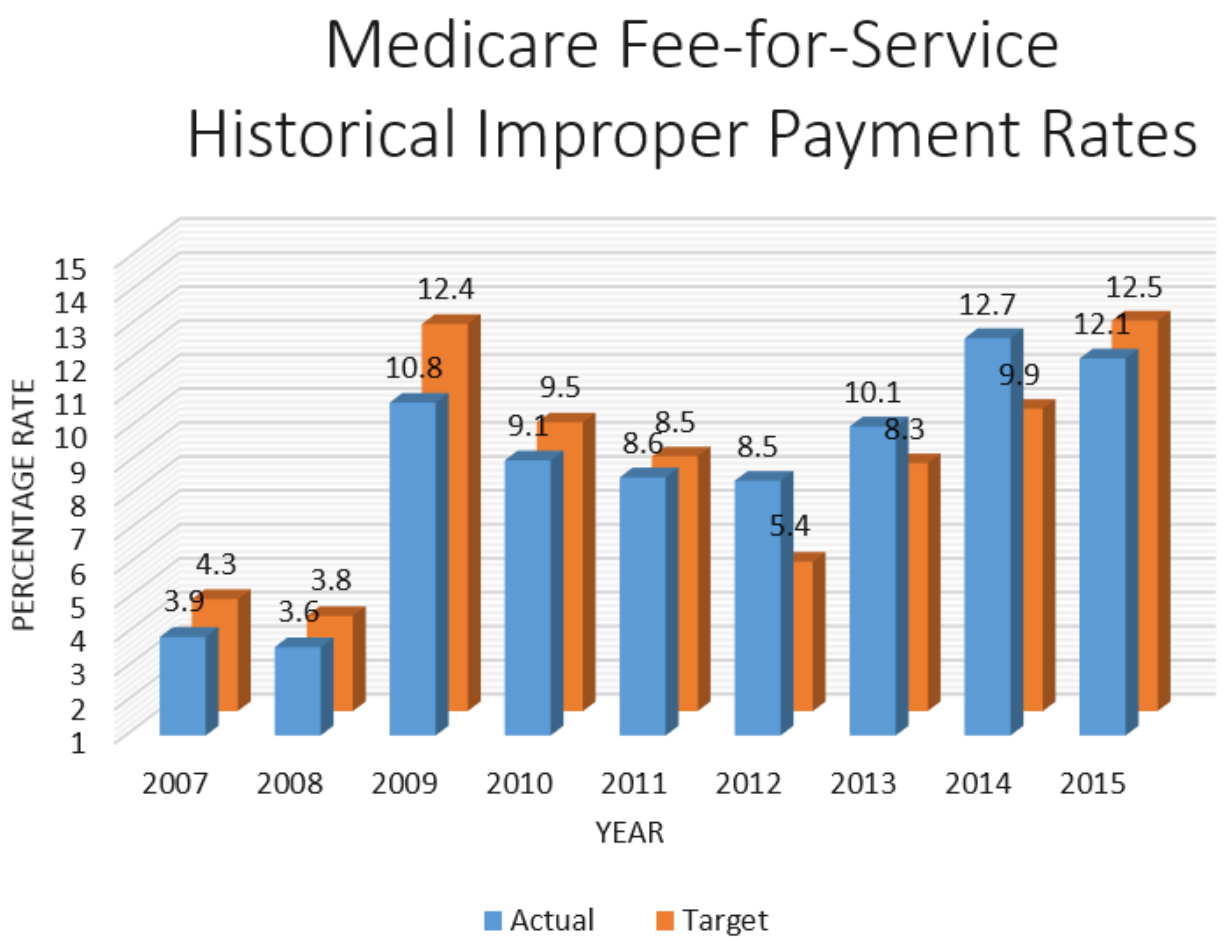
- Medicaid-specific lock-in program
  - Limits you to certain doctors/drug stores/hospitals
    - For activities like ER visits for non-emergency care and using multiple doctors that duplicate treatment/medication
- Your medical records could be wrong
- You may have to pay money back or be fined
- You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

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

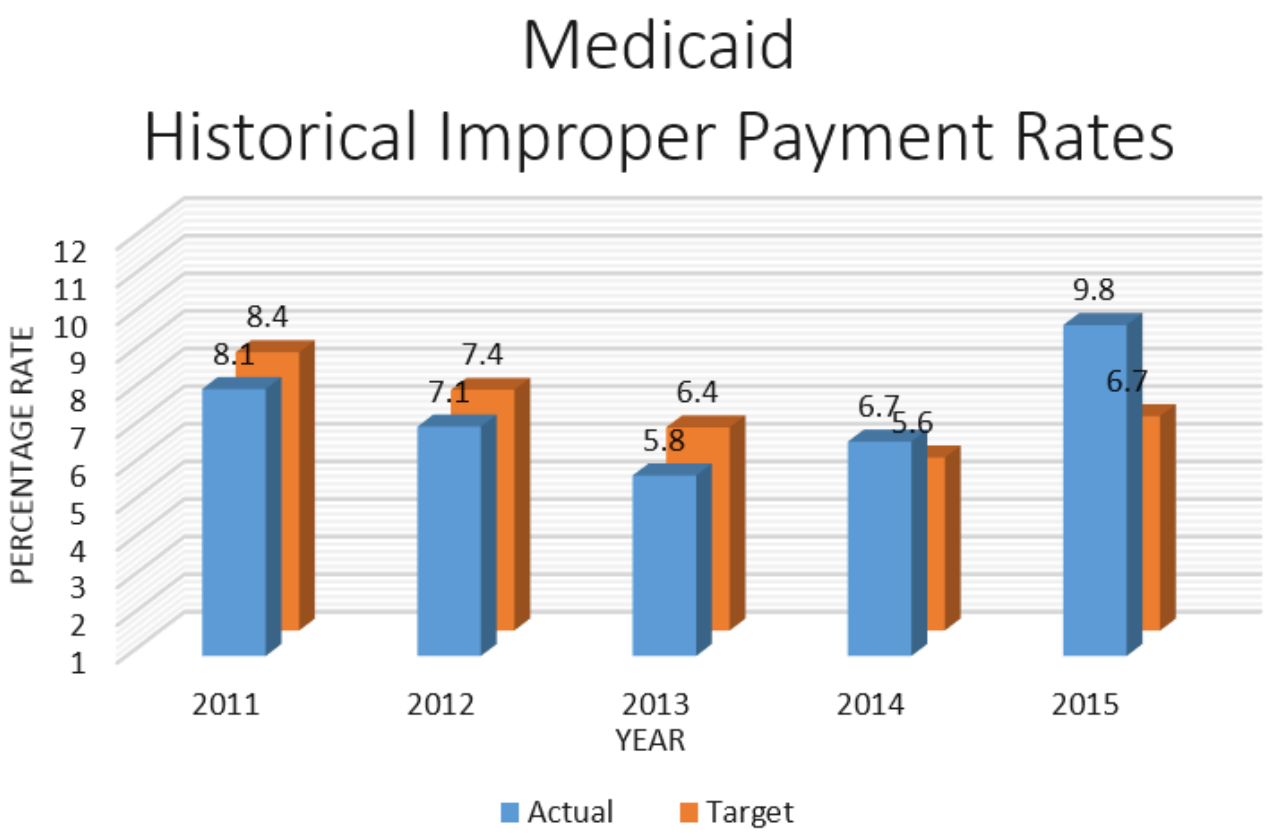
Improper Payment Transparency—Medicare

Medicare Fiscal Reporting Year 2015
Error Rate is 12.1% or $43.3 billion



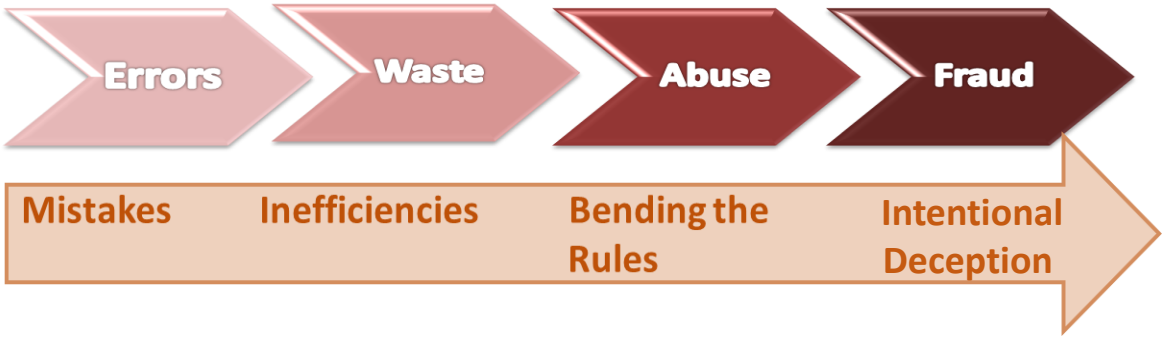
Improper Payment Transparency—Medicaid

Medicaid Fiscal Reporting Year 2015
Error Rate is 9.8% or $29.1 billion



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

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 a Medicare plan broke the rules
  - Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 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

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
  - Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 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

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

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
- Provider and Beneficiary Education

The Center for Program Integrity

- Consolidates CMS anti-fraud components
- Authority came from the Affordable Care Act
- More rigorous screenings for health care providers
- Reciprocal termination of providers from Medicare, 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 payments in cases of suspected fraud

Program Integrity Contractors

- A nationally coordinated Medicare/Medicaid program integrity strategy that cuts across regions
  - Zone Program Integrity Contractors (ZPIC)
  - Recovery Audit Program
  - National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
  - Outreach & Education MEDIC (O&E MEDIC)
  - Medicaid Integrity Contractors

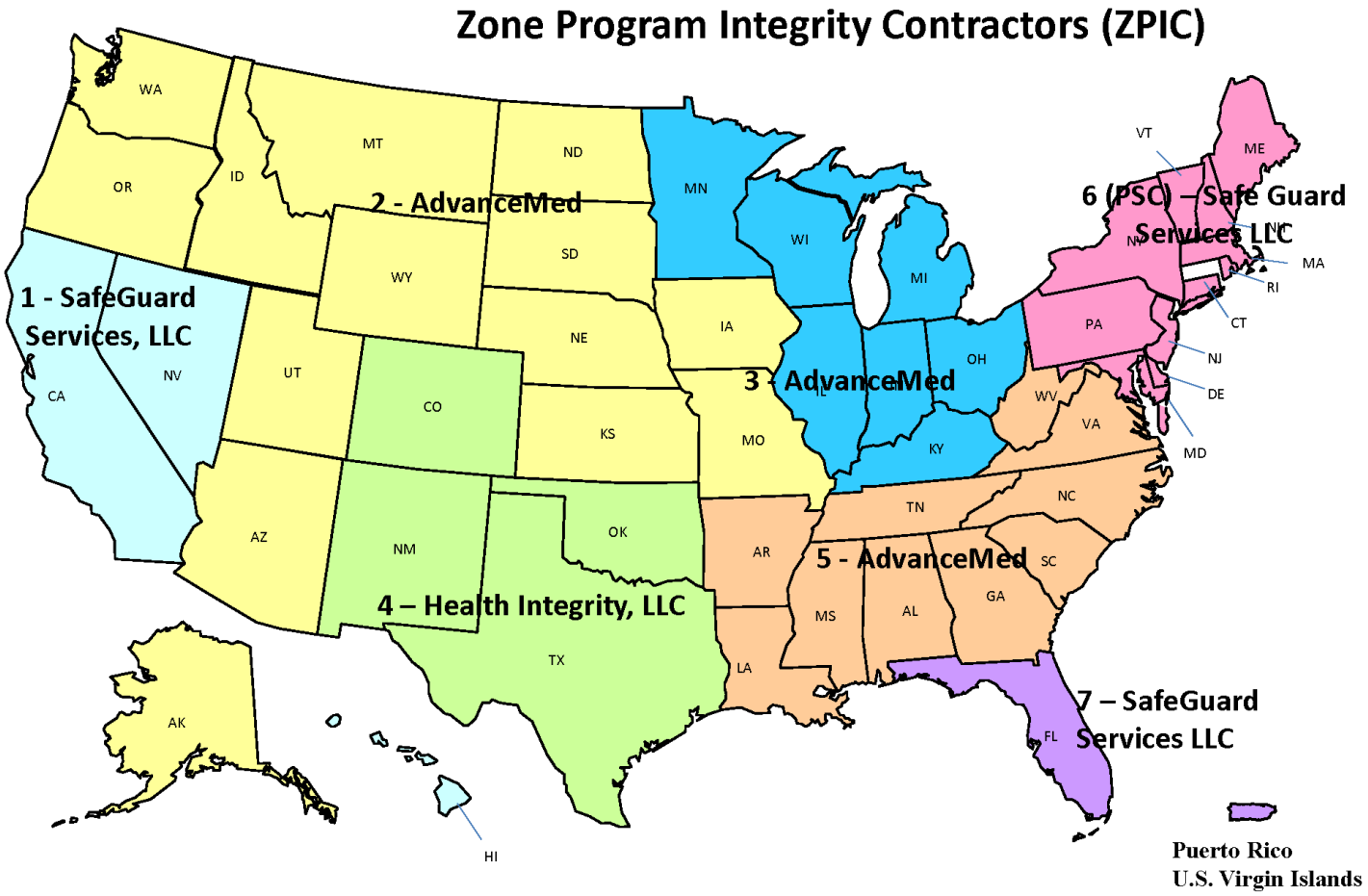
Zone Program Integrity Contractors (ZPICs)

- 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)—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

Zone Program Integrity Contractor (ZPIC) Map



*Other territories of Zone 1 include American Samoa, Northern Marianas Islands and Guam

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
  - Ensure that each Medicare Advantage Plan and Prescription Drug Plan has an anti-fraud plan in effect
- States and territories establish Medicaid Recovery Audit Contractors to
  - Identify overpayments and underpayments
  - Coordinate efforts with federal and state auditors

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
  - Receive complaints
  - Resolve fraud complaints from people with Medicare
  - Perform proactive data analyses
  - Identify program vulnerabilities
  - Refer potential fraud cases to law enforcement agencies

Outreach & Education MEDIC (O&E MEDIC)

- Created the CMS O&E MEDIC website on behalf of the CMS Center for Program Integrity
  - To help those committed to stopping Part C and Part D fraud, waste, and abuse, by providing
    - Outreach and education materials
    - Professional education
    - Regulation and guidance
    - Fraud-fighting resources
    - General news

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
- Three types of MICs: review, audit, and education

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

Law Enforcement Actions

- When law enforcement finds 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

Health Care Fraud Prevention Partnership

- Is designed to reduce health care fraud and includes the federal government, state officials, private health insurance organizations, and other health care anti-fraud groups
  - Shares information and best practices
  - Improves detection
  - Prevents payment of fraudulent health care billings across public and private payers
  - Enables the exchange of data and information among the partners

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

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

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

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

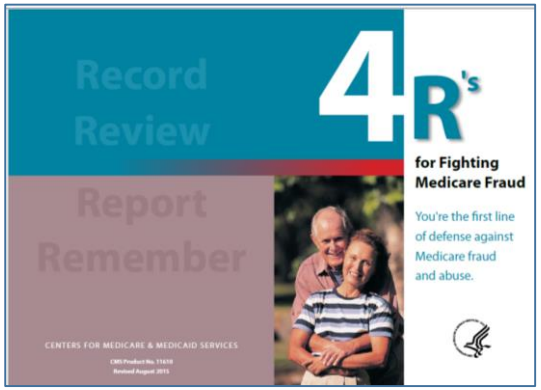
d. Recovery Audit Program

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

“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 received with services on your Medicare Summary Notice
  - Report suspected fraud
  - Remember to protect personal information, such as your Medicare card and bank account numbers



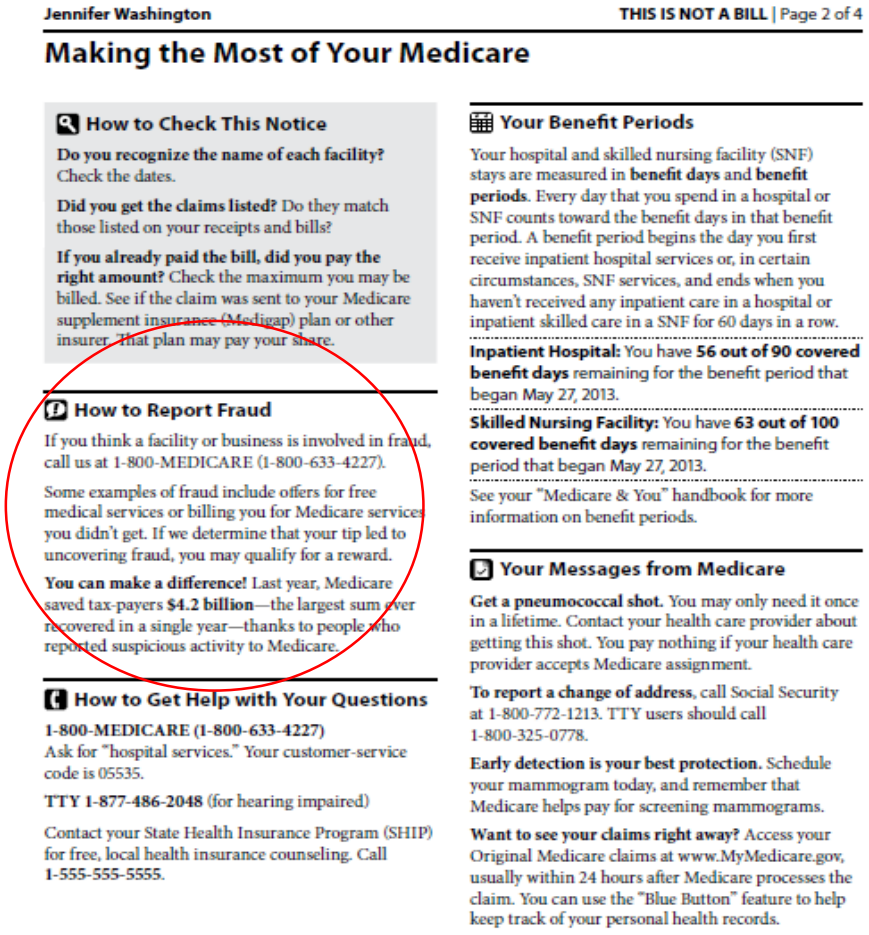
Medicare.gov/fraud

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

- Find out 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



Jennifer Washington THIS IS NOT A BILL | Page 2 of 4

Making the Most of Your Medicare

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 supplement 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 tax-payers **$4.2 billion**—the largest sum 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 **1-555-555-5555**.

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 pneumococcal 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.MyMedicare.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.

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

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

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

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

Learning Activity

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

- What are some things that might indicate fraud?

Medicare Summary Notice
for Part A (Hospital Insurance)

The Official Summary of Your Medicare Claims from the Centers for Medica

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

THIS IS NOT A BILL

Notice for Jennifer Washington

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

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 27, 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 better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

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

Facilities with Claims This Period

June 18 – June 21, 2013
Otero Hospital

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
1-800-MEDICARE (1-800-633-4227)

Learning Activity: What Might Indicate Fraud?

- 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 you didn't receive?
- Has he received any collection notices for medical services or equipment he didn't receive?

Fighting Fraud Can Pay

- You may get a reward if you meet all of these conditions:
  - You call either 1-800-HHS-TIPS (1-800-447-8477) or call 1-800-MEDICARE (1-800-633-4227) to report suspected fraud. TTY users should call 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.

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

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 users should call 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 users should call 1-866-653-4261.
- If your Medicare card is lost or stolen, report it right away
  - Call Social Security at 1-800-772-1213
  - TTY users should call 1-800-325-0778

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

Key Points to Remember

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

Resources

Resources

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

MyMedicare.gov - MyMedicare.gov/ Medicare.gov/fraud

Social Security
1-800-772-1213
TTY users should call
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
1-877-7SAFERX (1-877-772-3379)
healthintegrity.org/contracts/nbi-medic/reporting-a-complaint

NBI MEDIC at 1-877-7SafeRx (1-877-772-3379)
CMS Outreach & Education MEDIC
medic-outreach.rainmakerssolutions.com/

2015 HCFAC Report
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

Prevention Toolkit
CMS.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit

CMS Program Integrity CMS.gov/ About-CMS/Components/CPI/Center-for-program-integrity.html

Fraud Hotline
1-800-HHS-TIPS (1-800-447-8477)
TTY 1-800-337-4950
Fax 1-800-223-8162

Medicare Products

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

"Help Prevent Fraud: Check Your Medicare Claims Early!"
CMS Product No. 11491 and No. 11492

"Protecting Yourself & Medicare From Fraud"
CMS Product No. 10111

"Quick Facts About Medicare Plans and Protecting Your Personal Information"
CMS Product No. 11147

"4Rs for Fighting Fraud"
CMS Product No. 11610

"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/Search.
Order multiple copies (partners only) at productordering.cms.hhs.gov.
(You must register your organization.)

Fraud Prevention Toolkit

- Visit 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 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

This Training Provided by the

CMS National Training Program (NTP)

For questions about training products, email training@cms.hhs.gov.

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