SMP Foundations Training Manual

SMP Resource Center

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Acknowledgements

This manual is a product of the Senior Medicare Patrol (SMP) National Resource Center. It was supported in part by a grant (No. 90NP0001) from the Administration on Aging (AoA), Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official AoA, ACL, or DHHS policy.

Principal authors for this edition were Ginny Paulson, former SMP Resource Center Director; Heather Flory, SMP Resource Center Training Manager; and Mike Klug, Medicare subject matter expert and consultant to the SMP Resource Center.

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About this Edition

This *SMP Foundations Training Manual* is an October 2017 reprint of the August 2014 edition. Printing of this edition is supported by a grant (No. 90NP0003) from the Administration for Community Living (ACL). Its contents are solely the responsibility of the SMP National Resource Center and do not necessarily represent the official views of ACL. Light edits made since the August 2014 edition are outlined on pages iii - iv of this manual. Previous editions of this manual were published in 2009 and 2011.

About the SMP Resource Center

The Senior Medicare Patrol National Resource Center, more commonly known as "The SMP Resource Center," is funded by the U.S. Administration for Community Living (ACL), Department of Health & Human Services, and has existed since 2003. The SMP Resource Center serves as a central source of information, expertise, and technical assistance for the Senior Medicare Patrol (SMP) projects.

National SMP Website: www.smpresource.org

This website provides education to the public on health care fraud and how to contact their state SMP. It also contains a "Resources for SMPs" portal with resources, training, and technical assistance for the SMP projects nationwide.

Nationwide Toll-free Number: 877-808-2468

Available Monday through Friday, 9:00 a.m. – 5:30 p.m. Eastern Time.

E-mail: info@smpresource.org

Mailing Address:

SMP Resource Center, Northeast Iowa Area Agency on Aging, 2101 Kimball Ave., Ste. 320, P.O. Box 388, Waterloo, Iowa 50704-0388

Training Overview

Training Goal

The goal of SMP Foundations Training is to provide you with a foundation of knowledge in three main content areas:

1) The SMP Program
2) Medicare Basics
3) Medicare Fraud, Errors, and Abuse

About This Manual

This training manual provides detailed information on the following topics:

Chapter 1: SMP Program describes the SMP mission, SMP as a national program, the importance of volunteers, and how the public finds their SMP.

Chapter 2: Medicare Basics provides an overview of Medicare and explains how to read Medicare Summary Notices (MSNs).

> ***Note:*** The Medicare program undergoes changes to benefits, costs, and more every year. See the current version of the Medicare & You handbook for the latest information.

Chapter 3: Medicare Fraud, Errors, and Abuse Basics defines Medicare fraud, errors, and abuse and the national partners involved in addressing these problems.

Chapter 4: *Common Scams and Fraud Within Specific Medicare Services* highlights common scams that target Medicare beneficiaries and discusses coverage issues and fraud schemes within specific Medicare-covered health care services.

The ***Appendix*** provides related information as referenced in the manual.

Additional Training

After completing SMP Foundations Training, additional training may be provided by your SMP depending on your volunteer role, as described in Chapter 1. Additional training opportunities may include: SMP Group Education Training, SMP Counselor Training, or SMP Complex Interactions Training. Please talk with your local SMP for more information about the training opportunities available in your area.

Updates Since August 2014

As stated on page i, this edition is an October 2017 reprint of the August 2014 edition. Light edits made since August 2014 are outlined below.

Update 1: Sample MSN – Part B (Page 43)

Date: December 2014

The sample MSN (Medicare Summary Notice) for Medicare Part B, which was provided at www.Medicare.gov by CMS, the Centers for Medicare & Medicaid Services, is internally inconsistent. In this sample, the Your Deductible Status (shown on page 43) is not consistent with the Maximum You May Be Billed (shown on page 46). An explanatory note has been added to page 43.

Update 2: SMP Funding Source (Page 6)

Date: May 2016

As of June 1, 2016, SMP grants are fully funded by the Health Care Fraud and Abuse Control Program (HCFAC).

Update 3: SMP performance measures (Pages ii, 8, 10, and 122)

Date: May 2016

The SMP performance measures have changed effective January 1, 2016.

- Simple inquiries and one-on-one counseling sessions are now called basic interactions.
- Complex issues are now called complex interactions.
- Performance measures related to active volunteers and volunteer time now track active team members (including volunteers, partners, and staff) and team member time.

Update 4: Number of SMP programs (Page 6)

Date: May 2016

The number of SMP grantees has changed from 54 to 53. An SMP grantee now serves every state, as well as Puerto Rico, Guam, and Washington DC, for a total of 53 SMP programs nationwide.

Update 5: Annual allowable gifts (Page 90)

Date: January 2017

As of December 7, 2016 the allowable annual aggregate value of nominal gifts that a Medicare health plan may provide to a prospective or existing Medicare beneficiary increased from $50 to $75 per year.

Update 6: www.stopmedicarefraud.gov (Pages 64, 100, 105, and 129)

Date: October 2017

The website www.stopmedicarefraud.gov is no longer available. All references to this site have been removed, except on page 105 where an editor's note was added.

Update 7: New Medicare Cards (update to this memo only)

Date: October 2017

As you use this manual, consider the information below from CMS. For more information about the new Medicare cards, see www.cms.gov/newcard and the *Medicare & You* handbook, or contact your SMP.

NEW MEDICARE CARDS ARE COMING!

As you help people with Medicare, here are some key messages to share about the new Medicare card:

- Medicare will mail new cards between April 2018 – April 2019.
- To help prevent identity theft, new cards won't include Social Security numbers. Instead, each person will get a new unique Medicare Number.
- You don't need to do anything to get a new card, but you should make sure your mailing address is up to date. Visit **ssa.gov/myaccount** or call **1-800-772-1213** (TTY: 1-800-325-0778) to correct your mailing address, if updates are needed.
- Medicare will never call and ask for personal information before sending new cards, so don't share your Medicare Number or other personal information if someone calls and asks for it.
- Medicare will mail more information with the new cards – check **Medicare.gov** for the latest updates.

CMS

CMS Product No. 12003-P
August 2017

SMP Foundations Training Manual

CHAPTER 1: SMP Program

Objectives

This chapter provides an overview of the Senior Medicare Patrol (SMP) program.

Upon completion of Chapter 1: SMP Program, you will be able to:

1. Know the SMP mission
2. Understand that SMP is a national program
3. Understand SMP program accountability
4. Know the importance of volunteers to the SMP program

The SMP Mission

Medicare loses billions of dollars each year due to fraud, errors, and abuse. Estimates place these losses at approximately 60 billion annually, though the exact figure is impossible to measure. In addition, approximately 250,000 beneficiaries are listed as having had their medical identity compromised through stolen or misused Medicare numbers. Medicare numbers cannot be changed, so once a number has been compromised, that beneficiary's future benefits and health care may be forever at risk.

This problem is being addressed at many levels of government, as will be discussed in depth throughout this manual. The SMP program's unique role, however, is to work at the grassroots level with the people directly affected by Medicare fraud, errors, and abuse. SMPs increase public awareness about both the economic and health-related consequences associated with Medicare fraud, errors, and abuse. Education and prevention are at the core of the Senior Medicare Patrol program, as demonstrated by its mission:

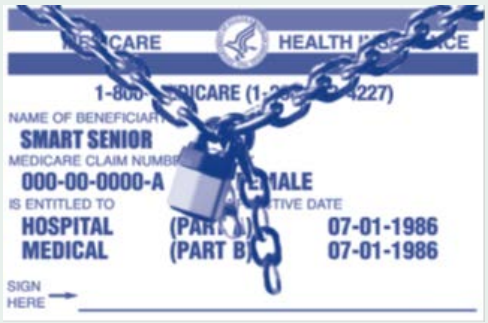
The SMP mission is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.

Prevent

SMPs prevent health care fraud through education. They present to groups, exhibit at community events, provide one-on-one counseling, and answer questions from people who call the SMP toll-free number. SMPs educate Medicare beneficiaries, their families, and caregivers to prevent health care fraud by protecting their medical identification cards and numbers, and cautioning beneficiaries to:

- Treat your Medicare card and number like you would a credit card. Medicare cards and numbers contain Social Security numbers, making them valuable to thieves interested in both medical identity theft and financial identity theft.
- Only share Medicare and other health care identification cards and numbers with trusted sources who need that information to serve you, such as your health care providers.
    - This information should not be provided to a stranger who calls, visits, or approaches you in a public setting.
    - Medicare already has your Medicare number. They will not call you to ask for it, and they certainly don't need your bank account number. If **you** call 1-800-Medicare for assistance, they will ask for your Medicare number, however.
    - Treat any offer of free services in exchange for your Medicare or health care identification number with caution.

Medicare numbers contain Social Security numbers. Because of this, **a Medicare number is as valuable to identity thieves as a credit card.**



- Rely on your doctors for medical advice and prescriptions, not advice or offers of medical services from unknown persons who call, visit, or approach you in public.
- Never sign a blank medical or insurance form.
    - Always read and make sure you understand the content before you sign.
    - Request a copy of a form or document you sign for your own records.

Detect

Prevention alone cannot stop all fraud, errors, and abuse. SMPs teach beneficiaries, their family members, and their caregivers to detect potential problems by taking the following steps:

1. Keep records of health care visits, services or equipment received, test results, etc. The SMP Personal Health Care Journal is a good health care record-keeping tool.
2. File copies of bills received from your doctor, hospital, pharmacist, supplier, or other health care provider.

3. Save your Medicare Summary Notices (MSNs) and Explanations of Benefits (EOBs) and review them for accuracy.
    - Compare the dates, providers, and services received, shown on MSNs and EOBs, to what is documented in your personal health care records.
    - Beware of charges for services not received, duplicate charges, or services that were not ordered by your doctor.

Important SMP Tool:
Personal Health Care Journal

A Personal Health Care Journal is a resource commonly used by SMPs. These pocket-size guides help Medicare beneficiaries, their caregivers, or family members document important information about a beneficiary's doctor visits, medical diagnoses, equipment received, and more. Kept up-to-date, the journals can be used later to cross-check services outlined on MSNs and EOBs.

4. Ask questions of your provider, Medicare plan, or 1-800-Medicare when:
    - You don't **understand** the charges billed
    - You don't think you **received the service**
    - You feel the service was **unnecessary**
    - You were charged for the same thing **twice**

Report

In some cases, SMPs do more than educate. When Medicare beneficiaries are unable to act on their own behalf to address suspected Medicare fraud, errors, or abuse, the SMPs work with them, their family, caregivers, and others to address the problems, and, if necessary, make referrals to outside organizations to intervene. SMPs educate beneficiaries to report suspected fraud, errors, or abuse immediately!

Here are steps SMPs recommend beneficiaries take to report their concerns:

1. **Call the health care provider.** Call the provider or supplier first to question the charge. If it was a mistake, ask them to correct it.
2. **Call the company that paid the bill.** If the provider or supplier can't answer the question, contact the company that paid the bill. Their contact information can be found on your Medicare Summary Notice (MSN) or Explanation of Benefits (EOB).
3. **Contact the SMP.** If you are not satisfied with the response you get from a provider, supplier, or billing company, you can contact your local SMP. The SMP helps beneficiaries understand the difference between suspected fraud, errors, or abuse. SMPs also assist beneficiaries in addressing suspected errors. If fraud or abuse is suspected, SMPs refer cases to the proper authorities for further investigation.

SMP is a National Program

The Senior Medicare Patrols (SMPs) are grant-funded projects of the federal U.S. Department of Health and Human Services (HHS), U.S. Administration for Community Living (ACL). All SMP grantees have a shared national identity through a national program name and logo.

History

The seeds of the SMP program we know today can be traced back to 1995, when the U.S. Administration on Aging (AoA) funded five small initiatives to address Medicare fraud. Through the 1997 Omnibus Consolidated Appropriations Act – legislation that formally supported enlisting seniors in the fight against Medicare fraud – the SMP program we know today was born.

Since its inception in 1997, the SMP program has evolved from 12 regional demonstration projects into a nationwide program. The number of grantees increased over time. Since 2003, the SMP program scope has been national. Currently, an SMP grantee serves every state, as well as Puerto Rico, Guam, and Washington DC, for a total of 53 SMP programs nationwide.

Funding Source

Every three years, ACL issues a new request for proposals for the SMP program and then competitively awards grants to a selected project in each of the 50 states, the District of Columbia, Guam, and Puerto Rico. As of June 1, 2016, SMP grants are funded by the **Health Care Fraud and Abuse Control Program (HCFAC)** as discretionary projects. This means funding is provided at the discretion of HHS operating divisions. ACL is an operating division headed by the Assistant Secretary on Aging, who is appointed by the president and serves under the U.S. Secretary for Health and Human Services.

KEY TERMS

U.S. Department of Health and Human Services (HHS): The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

U.S. Administration for Community Living (ACL): Created in 2012, this HHS agency brought together the Administration on Aging, the Office on Disability and the Administration on Developmental Disabilities and focuses attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.

Through several administration changes, leaders at HHS have continued to use their discretion to fund SMPs. Former Health and Human Services (HHS) Secretary Kathleen Sebelius spoke to SMPs at the August 2011 national SMP conference and she had this to say about the role of the SMP program, including its volunteers:

> "…We know that one of the most effective and direct steps we can take to improve Medicare's long-term health is ridding the program of waste, fraud, and abuse. And for the last 14 years, the Senior Medicare Patrol has been on the front lines of that fight. No one feels more strongly about keeping criminals out of Medicare than seniors themselves. When someone defrauds Medicare, it means higher premiums and co-pays for beneficiaries. It also threatens the program that they have worked so hard for – and that they want to make sure is there for their children and grandchildren."

The Administration for Community Living also uses Health Care Fraud and Abuse Control Program (HCFAC) funds to support the SMP program nationally. HCFAC funds are used to administer the program, maintain a national SMP data reporting system, and provide supportive services to SMPs nationally. Through HCFAC, ACL funds a national SMP Resource Center and occasionally funds other nationally beneficial initiatives, as funding allows. Some examples include media campaigns, demonstration projects to reach non-English-speaking and other harder-to-reach populations of beneficiaries, and program evaluations.

Program Accountability

As a government-funded program, the SMP program is accountable to the federal government and ultimately to taxpayers. SMPs must meet ACL requirements for reporting their activities and outcomes. SMP is unique in that annual SMP program outcomes are analyzed and published by the Office of Inspector General (OIG) Office of Evaluation and Inspections. The OIG usually performs this activity for federal agencies, not federal grantees. The OIG's annual report of SMP performance outcomes is the result of the 1997 Omnibus Consolidated Appropriations Act and a formal agreement with ACL.

KEY TERM

Office of Inspector General (OIG) Office of Evaluation and Inspections: The HHS (Department of Health and Human Services) agency that is responsible for performing audits and inspections of HHS programs.

This annual OIG report of SMP performance outcomes data is presented to ACL and is made available to the general public through the OIG's website. The results may be cited by HHS and the federal agencies within HHS, such as ACL and the Centers for Medicare & Medicaid Services (CMS), by organizations interested in SMP, and also by the media.

The OIG Report includes data about SMP activity in three major areas:

1. **Team member time and effort:** Includes the number of active team members as well as the number of team member work and training hours. Team members include SMP volunteers, partners, and staff. The SMP program engages over 5,000 volunteers who contribute approximately 150,000 hours each year.

2. **Outreach and education activities:** Includes such things as the number of group presentations, community events, and individual interactions, as well as the number of people served through these activities. Each year, approximately 2 million people are served nationally by the SMP program's outreach and education efforts.
3. **Complaints of suspected health care fraud, errors, or abuse:** When Medicare beneficiaries, caregivers, and family members bring their complaints to the SMP; the SMP makes a determination about whether or not fraud, errors, or abuse are suspected. These are called "complex interactions" by SMPs. The SMP helps resolve the errors by working with beneficiaries and providers. Suspected fraud and abuse are referred to the appropriate state and federal agencies for further investigation. Each year, SMPs handle approximately 2,000 complex interactions.

> "Since the inception of the program, SMP project efforts have resulted in savings to Medicare, Medicaid, beneficiaries, and other payers…. However, we know that the real value of your work with the program cannot be measured only through savings achieved. It is impossible to quantify the amount of fraud that has been prevented because of your work to teach Medicare beneficiaries how to scrutinize their statements and report suspicious billings."
>
> Kathy Greenlee, Administrator,
> U.S. Administration for Community Living, and
> Assistant Secretary for Aging, Administration on Aging,
> 2011 SMP National Conference

The Importance of SMP Volunteers

Engaging volunteers to fulfill the SMP mission is at the core of ACL's request of SMP program grantees. As a grassroots education program, SMP work requires significant face-to-face contact with Medicare beneficiaries, their caregivers, and family members to be effective. Reaching approximately two million beneficiaries each year would not be possible without the 5,000 volunteers engaged with the SMP program.

The SMP program mission is a compelling one and offers volunteers and other team members an opportunity to make an important difference in their communities. Protecting older persons' health, finances, and medical identity while saving precious Medicare dollars is a cause that attracts civic-minded Americans. Many SMP volunteers are also Medicare beneficiaries and thus well-positioned to assist their peers. Even volunteers who aren't Medicare beneficiaries take pride in working to ensure that the Medicare program will be protected for future generations.

> "The beauty…is [that] the volunteer receives so much. When I'm helping a senior with a problem and then see the relief on their face when we resolve the issue - that is all the payment one needs."
>
> *Ray Jones,*
> *SMP Volunteer, California*

What SMP Volunteers Do

SMP programs work with individual volunteers and other team members to match that volunteer's skills and interests to the needs of the SMP program. As a result, SMP team members may serve Medicare beneficiaries, their families, and caregivers in many creative ways. However, there are six types of activities most commonly conducted by SMP volunteers nationwide, called "volunteer roles":

- **Assisting with administration:** Help with work such as copying, filing, data entry, and placing outbound phone calls in support of SMP activity.
- **Distributing information:** Help with transporting and disseminating SMP information materials to sites and events; may include presenting prepared copy or performing scripted activities for small groups.
- **Staffing exhibits:** Help by staffing information kiosks or exhibits at events such as health fairs; also may provide general information about SMP to the public and answer simple questions.
- **Making group presentations:** Help by giving presentations on SMP topics to small and large groups; may interact with the audience by answering questions and through discussion.
- **Counseling:** Help by having direct conversations with beneficiaries about their individual situations; may include review of personal information such as Medicare Summary Notices, billing statements, and other related financial and health documents.

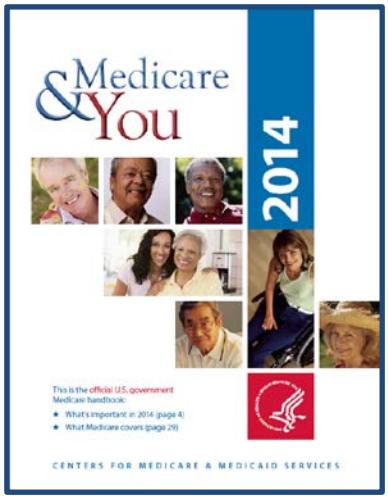
- **Handling complex interactions:** Help with in-depth interactions with beneficiaries who are reporting specific instances of health care fraud, errors, and abuse; may act on behalf of a beneficiary to correct an error or refer suspected fraud and abuse to the appropriate authorities.
- **Other roles:** State and local programs may create other roles not outlined above, or they may ask a volunteer to fill more than one of the standard SMP roles. Additionally, at the state and local levels, many SMPs rely on partnerships with other nationwide organizations that also serve the Medicare population, such as Area Agencies on Aging (AAAs) and State Health Insurance Assistance Programs (SHIPs). These key partners help SMPs achieve their mission and may even have an agreement with the SMP to help recruit, train, or house SMP volunteers. Because of this, some SMP volunteers may wear both an SMP hat and an AAA or SHIP hat, depending upon their interests.

> "I had enough billing problems with health care providers to get me interested in learning how to drill down and get the errors corrected."
>
> *Richard Hotinski,*
>
> *SMP Volunteer, Texas*

How Does the Public Find Their SMP?

Information about the SMP program is shared with Medicare beneficiaries, their families, caregivers, and the general public in several ways:

- **SMP Outreach:** Most members of the public learn about how to find the SMP in their area through their SMP's outreach and education efforts.
- **ACL's Website:** The Administration for Community Living provides information about the national SMP program on their website: www.acl.gov.
- **The *Medicare & You* Handbook:** The Centers for Medicare & Medicaid Services (CMS) provides information about the SMP program in the *Medicare & You* handbook. This official U.S. government handbook is provided to Medicare beneficiaries by CMS each year and is available online at www.Medicare.gov. The *Medicare & You* handbook directs readers seeking their SMP program to the national SMP Resource Center.



- **SMP Resource Center:** The SMP Resource Center operates a toll-free number (877-808-2468) and also has a national SMP website: www.smpresource.org. The SMP Resource Center's website and toll-free number provide individuals with contact information for the SMP program serving their geographic area.

SMP Foundations Training Manual

CHAPTER 2: Medicare Basics

Objectives

This chapter provides an overview of the Medicare program.

Upon completion of Chapter 2: Medicare Basics, you will be able to:

1. Explain basic information about Medicare and related programs
2. Describe the parts of Medicare and the coverage provided by each part
3. Know the difference between Original Medicare and Medicare Advantage
4. Read sample Medicare Summary Notices (MSNs)
5. Suggest resources to beneficiaries to help answer detailed Medicare questions

Medicare Overview

Congress created the Medicare program. It began in 1965.

Medicare is the federal health insurance program for:

- ✓ People 65 and older
- ✓ Some people with disabilities under 65
- ✓ Those with End-Stage Renal Disease (ESRD)
- ✓ Certain people with ALS (Lou Gehrig's disease or amyotrophic lateral sclerosis)

How many people are covered by Medicare? In 2013, according to the Medicare Trustees report, Medicare covered over fifty-two million people: 43.5 million people age 65 and older and 8.8 million people with disabilities.

The Centers for Medicare & Medicaid Services (CMS) administers Medicare. The program was **NOT designed to pay 100 percent** of all medical bills.

Eligibility

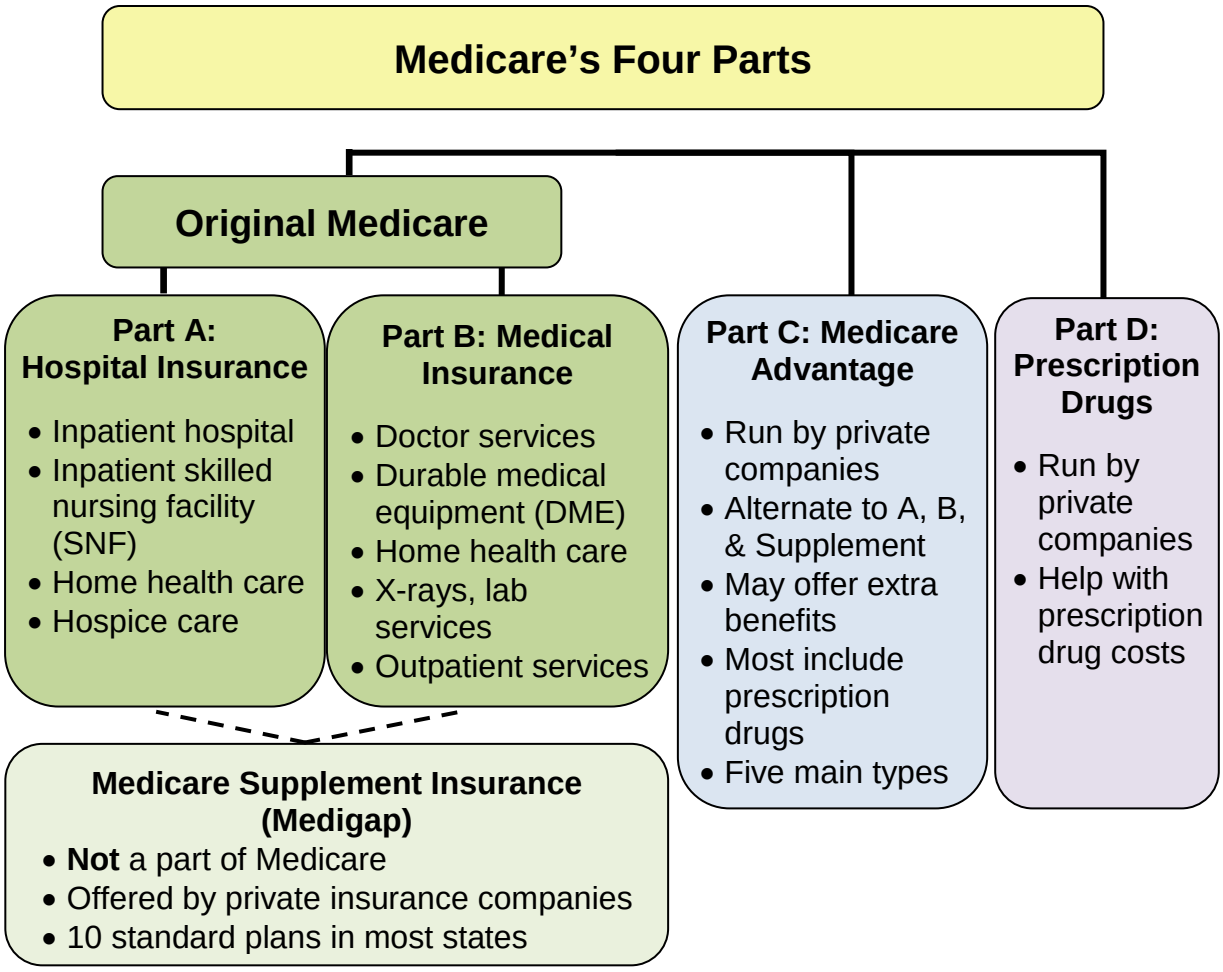
In order to be eligible for Medicare, a person must:

1		2
Be a U.S. citizen **OR** • Be a permanent resident and have lived in the U.S. continuously for five consecutive years	**AND**	**Be 65 or older** **OR** • Be under 65 but over 18 and receiving Social Security Disability Insurance (SSDI) for at least 24 months • Be under 65 but over 18 and get Social Security Disability Insurance (SSDI) because of a diagnosis of ALS (Lou Gehrig's disease) • At any age, with End-Stage Renal Disease (ESRD)

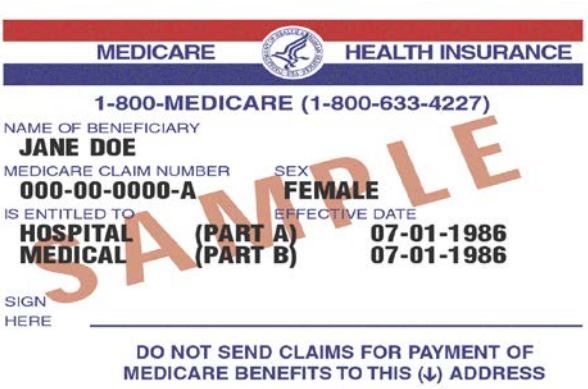
The A, B, C, & D of Medicare

Medicare consists of four parts called Part A, Part B, Part C, and Part D. Medicare Part A and Part B together are known as "Original Medicare." Beneficiaries in Original Medicare have the option of purchasing supplemental insurance to cover gaps in coverage. Medicare Part C offers an alternate system for delivering the same services as Original Medicare through private insurance plans, called Medicare Advantage Plans. In 2014, nearly 30 percent of beneficiaries were enrolled in Medicare Advantage and just over 70 percent in Original Medicare. Lastly, Medicare Part D delivers prescription drug coverage through certain Medicare Advantage Plans or through stand-alone Medicare Prescription Drug Plans.

The four parts of Medicare, along with Medicare Supplement Insurance, are illustrated below.



Medicare Numbers and Cards



Medicare beneficiaries are issued a Medicare number upon enrollment. In most cases, Medicare numbers contain a Social Security number – usually the beneficiary's own Social Security number, but not always. The Social Security number is followed by a letter or in some cases a combination of letters or a letter and number, to comprise the full Medicare number. If the Social Security number belongs to the beneficiary, who earned his or her benefits through his or her own work history, that letter will be an "A." When a beneficiary receives benefits based on someone else's work history, such as a spouse, the Social Security number will be the spouse's, followed by the letter "B." There are over one hundred possible letter combinations used in Medicare numbers, with "A" being the most common.

The use of Social Security numbers within Medicare numbers is controversial. Changing this system periodically comes under review by Congress. Until a change is made, Medicare beneficiaries need to be particularly careful with their Medicare numbers and their Medicare cards, due to the presence of a Social Security number. Though medical identity theft is a risk for anyone who receives medical services, Medicare beneficiaries are also at risk for financial identity theft, should their card or number fall into the wrong hands.

Everyone enrolled in Medicare is also issued a Medicare card. It is then used like any other insurance card. To replace a lost or stolen Medicare card, most beneficiaries need to contact the Social Security Administration. Beneficiaries who are railroad retirees should contact the Railroad Retirement Board. See Appendix A: Medicare Resources for Beneficiaries.

Medicare numbers currently contain Social Security numbers. Because of this, **a Medicare number is as valuable to identity thieves as a credit card.**

Original Medicare

Original Medicare – Parts A and B – is one of the health coverage choices offered as part of Medicare. It is run by the Centers for Medicare & Medicaid Services (CMS), a federal agency. People who are new to Medicare receive their benefits through Original Medicare unless they decide to join a Medicare Advantage Plan (Part C). People with Original Medicare can also join a Medicare Prescription Drug Plan (Part D) to add drug coverage and they can buy a Medigap (Medicare Supplement Insurance) policy (sold by private insurance companies) to help fill gaps in Part A and Part B coverage.

Medicare Part A: Hospital Insurance

Part A

Medicare Part A is also known as hospital insurance.
Part A provides coverage for the following health care benefits:

- Inpatient Hospital Care
- Skilled Nursing Facility (SNF) Care
- Home Health Care
- Hospice Care

Note: See Chapter 4 for details of these services.

Excluded Services

The following services are NOT covered under Medicare Part A:

- Most long-term care services, such as assisted living or non-SNF nursing home stays
- Custodial care, such as help with bathing, dressing, or eating when the patient is not also receiving skilled nursing or rehabilitation services
- Medically unnecessary stays
- Private hospital rooms unless they are medically necessary
- Private-duty nurses

Patient Rights

If a patient feels that a provider is discharging her too soon,
it is important to get that discharge in writing so that she can appeal the decision through the Quality Improvement Organization (QIO) for her state.

Part A Costs

Most people enrolled in Part A receive Part A benefits without paying a premium. Part A can be purchased if an individual (or his or her spouse) has not paid enough Medicare taxes to be eligible. For example, a low-wage seasonal worker or a person who immigrates to the United States late in life.

Beneficiaries with Part A can incur the following out-of-pocket costs:

- $ **Inpatient Hospital Stays.** Beneficiaries owe an inpatient hospital deductible at the start of each benefit period. The benefit period typically starts with a new hospital admission and ends when you haven't received any inpatient hospital (or skilled care in a SNF) for 60 days in a row. Benefit periods are not tied to a calendar year timeframe. Deductibles apply at the start of the benefit period. Daily coinsurance charges may apply for some stays.
- $ **Skilled Nursing Facility Stays.** Days one to 20 are free. Days 21 to 100 have a daily coinsurance charge.
- $ **Home Health Care**. No deductibles or coinsurance charges apply.
- $ **Hospice Care.** No deductibles apply. No coinsurance charges apply, except to respite services. A 5% coinsurance charge applies for some palliative medications, not to exceed $5 per prescription.

KEY TERMS

Coinsurance: An amount beneficiaries may have to pay as their share of the cost for services, after any deductibles. Coinsurance generally refers to a percentage of an approved payment amount, as opposed to a copayment, which is a fixed dollar amount. Coinsurance is the term most often used to describe beneficiary cost-sharing in Original Medicare.

Deductible: A fixed amount beneficiaries owe before Original Mediare, their prescription drug plan, or other insurance begins to pay. Original Medicare has separate deductibles for Parts A and B.

Premium: A beneficiary's periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Medicare Part B: Medical Insurance

Part B

Medicare Part B is also known as medical insurance. Part B provides health care benefits that help cover the following products and services and more:

- Doctor services
- Durable medical equipment
- Home health care
- X-rays, lab services
- Outpatient hospital services
- Mental health services
- Most preventive health care services ("Welcome to Medicare" or yearly "Wellness" visits)

Excluded Services

The following services are **NOT** covered under Medicare Part B:

- Routine foot care
- Hearing aids or examinations for fitting a hearing aid
- Examinations for eyeglasses unless required by cataract surgery
- Routine dental care or false teeth
- Acupuncture
- Cosmetic surgery
- Experimental medical procedures
- Custodial care

Part B Costs

Beneficiaries with Part B incur the following out-of-pocket costs:

$ **Part B premium.** Usually taken out of the monthly Social Security, Railroad Retirement, or Civil Service Retirement check sent to a beneficiary. If a beneficiary does not receive any of these monthly payments, a bill is sent every three months. For individuals with annual incomes exceeding $85,000, the Medicare Part B premium is tied to income.

$ **Deductible.** Beneficiaries enrolled in Part B are responsible for the Part B deductible each calendar year. This amount is adjusted annually in line with Medicare spending increases.

$ **Part B Coinsurance.** After meeting the deductible, in most cases Medicare Part B pays 80 percent of the Medicare-approved amount. The beneficiary is responsible for 20 percent of the Medicare-approved amount.

$ **Excess Charges.** Beneficiaries incur excess charges over and above Medicare's approved amount for services if they choose a provider who does not participate in Medicare or who does not accept "assignment".

$ **Private Pay Agreements.** A small number of providers choose not to enroll in Medicare at all – they "opt out". These providers cannot file a claim with or receive any payment from Medicare. Providers who opt out of Medicare must ask their patients to sign a "private pay agreement" which explains that beneficiaries must pay the full cost of the services themselves.

TIP: Beneficiaries in Original Medicare should ask before selecting doctors and suppliers if they accept payment from Medicare AND if they accept **assignment**.

Part B "Assignment"

"Assignment" means a doctor, supplier, or other service provider agrees to accept the Medicare-approved amount as full payment. The maximum payment allowed for these services is set by Medicare. Selecting providers who "accept assignment" limits out-of-pocket costs for beneficiaries in Original Medicare to the deductible and coinsurance amount. Some providers do not accept assignment and can charge beneficiaries higher prices, resulting in excess charges to beneficiaries.

The following facts about assignment and its impact on out-of-pocket costs to beneficiaries are important to keep in mind:

- With assignment, the provider must accept Medicare's approved amount as payment in full, even if this amount is less than the provider's actual charge.
- Most physicians accept assignment, but it's still important to ask. Physicians who don't accept assignment can bill no more than 15 percent above Medicare's approved amount. This is called "the limiting charge."
- Some providers and suppliers, particularly durable medical equipment (DME) suppliers, are not bound by the limiting charge. As a result, they can bill more than 15 percent of Medicare's approved amount.
- With assigned claims, Medicare pays the provider directly, whereas with unassigned claims Medicare sends its payment to the beneficiary who might have been asked to pay in full at the time of service.

KEY TERMS

Assignment: An agreement by a doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill for any more than the Medicare deductible and coinsurance.

Unassigned Claims: Claims to Medicare when a doctor, provider, or supplier does not agree to be paid directly by Medicare or to accept Medicare's approved amount as full payment for the service.

- Accepting assignment is sometimes required.
  - Some Part B providers, such as clinical diagnostic labs and ambulance companies, must accept assignment.
  - A few states actually **require** enrolled providers to accept the Medicare-approved amount as full payment. To find out if that applies in your state, contact your State Health Insurance Assistance Program (SHIP) (see Appendix A).
  - Beneficiaries who qualify for both Medicare and Medicaid (called "dual-eligibles") should not be billed for coinsurance or excess charges.

Case Example of Part B: "Total Owed by the Beneficiary"

The total amount owed by a beneficiary with Medicare Part B can vary, depending on the situation. The following example about an ultra-light manual wheelchair illustrates this point:

The DME provider or supplier bills: $2,300

Medicare approves: $2,000

Medicare pays: $1,600

	Provider or Supplier **Accepts Assignment**	Provider or Supplier **Does Not Accept Assignment**
Provider or Supplier Actual Charge	**$2,300**	**$2,300**
Medicare-approved Amount	**$2,000**	**$2,000**
Medicare's 80 Percent of Approved Amount	**$1,600**	**$1,600**
Beneficiary's 20 Percent Coinsurance	**$400**	**$400**
Excess Charge	**n/a**	**$300**
Total Owed by the Beneficiary	**$400**	**$700**

Medicare Supplement Insurance: Medigap

Medigap

Original Medicare covers most of the cost for medically necessary health care services and supplies, as mentioned previously. The out-of-pocket costs incurred by Medicare beneficiaries are called "gaps."

About one-third of Medicare beneficiaries cover Medicare's gaps through an employer-sponsored retiree health plan. Many other beneficiaries purchase a Medicare Supplement, or Medigap, insurance policy. State insurance departments regulate Medigap policies, which are sold by private insurance companies and are designed to fill Original Medicare's cost-sharing gaps by helping to pay the deductibles, coinsurance, copayments, and Part B excess charges. Some policies also offer coverage for services that Original Medicare doesn't cover, such as emergency care during international travel. Medigap policies eliminate most out-of-pocket costs for Medicare-covered services.

In most states, there are ten types of standardized Medigap policies, identified with letters ranging from A-N. In Massachusetts, Minnesota, and Wisconsin, however, Medigap policies are standardized in a different way. If you are in one of these three states, your SHIP program can explain the state-specific Medigap standardization rules. Elsewhere, Medigap insurance companies can decide which of the ten standardized Medigap policies they will sell, but there are conditions:

1. They can only sell these regulated (aka "standardized") Medigap policies.
2. Every Medigap policy must be clearly identified as Medicare Supplement Insurance.
3. They must offer a Medigap Plan A in order to offer any other Medigap plans.

Eligibility

To be eligible for Medigap insurance, a beneficiary must be in Original Medicare (enrolled in both Parts A and B).

There are also programs for low-income beneficiaries to help pay out-of-pocket costs (more information on this topic is provided later in this chapter); beneficiaries who qualify for one of these programs do **not** need a Medigap policy.

Beneficiaries who may benefit from a Medigap policy are encouraged to call their State Health Insurance Assistance Program (SHIP) for assistance in choosing a policy that is best for them.

Costs

- $ Each of the ten types of standardized Medigap policies offer the same benefits regardless of the company selling it, enabling “apples to apples” plan comparisons.
- $ Usually the only difference between Medigap policies of the same type, sold by different insurance companies, is the price of premiums.
- $ Each insurance company decides which Medigap policies it wants to sell and the price for each policy, though prices may be limited by state law.
- $ Medicare pays none of the costs for a Medigap policy.

Key Points on Medigap

- A Medigap policy stays in effect as long as the person continues to pay the premium.
- If a person has a Medigap policy, then leaves Original Medicare to join a Medicare Advantage Plan (Part C), the Medigap policy can’t be used to pay the Medicare Advantage plan copayments and deductibles.
- If a person drops a Medigap policy to join a Medicare Advantage plan, he may not be able to get that particular policy back if he returns to Original Medicare (unless he is within a 12 month trial period for those who have joined a Medicare Advantage plan for the first time).
- If a person already has a Medicare Advantage plan, it is illegal for anyone to sell her a Medigap policy unless she is switching back to Original Medicare.
- If a person joins when first eligible for Medicare at age 65, he can generally buy any Medigap policy during a 6-month Medigap Open Enrollment Period, regardless of pre-existing conditions. Policies available to Medicare beneficiaries under the age of 65, however, vary by state.
- Medigap policies will not cover Part D deductibles or copayments.
- If a person wants to change Medigap policies, she should contact her state SHIP to learn about options.

Medicare Part C: Medicare Advantage

Part C

Medicare Part C, more commonly called Medicare Advantage, is an alternative to Original Medicare when elected by a Medicare beneficiary. Medicare Advantage Plans are offered by private insurance companies that sign a contract with Medicare. Medicare Advantage Plans must provide all Medicare Part A and Part B benefits to plan members. Many offer benefits that Original Medicare doesn't cover, such as routine hearing, vision, and dental care and nonambulance medical transportation services. Most Medicare Advantage Plans also include Medicare Part D prescription drug coverage. A plan comparison tool is available on Medicare's website: www.Medicare.gov.

There are five main types of Medicare Advantage Plans:

1. **Health Maintenance Organization Plans (HMOs).** Members must see doctors in the plan's network. In most cases, a primary care doctor coordinates health care.
2. **Medicare Preferred Provider Organization Plans (PPOs).** Members may see any doctor, but it costs less to see health care providers in the plan's network.
3. **Private Fee-for-Service Plans (PFFS).** Members may see any Medicare-approved doctor or hospital if the provider agrees to the plan's terms and conditions of payment before treatment. Not all health care providers accept PFFS plan payment terms. The plan decides how much it will pay providers and how much it will charge beneficiaries. Some PFFS plans now have a provider network with doctors who agree to always treat plan members.
4. **Medicare Special Needs Plans.** These plans are not available everywhere. They provide all Medicare health care for beneficiaries with special needs, including those with chronic illness, people in institutions, and people with Medicaid.
5. **Medicare Medical Savings Account Plans.** These plans have two parts: a Medicare Advantage Plan with a high deductible and a Medical Savings Account into which Medicare deposits money that people can use to pay health care costs.

Eligibility

To be eligible to join a Medicare Advantage Plan, a person must:

- ✓ Be entitled to Medicare Part A and enrolled in Part B
- ✓ Live in the plan's service area
- ✓ Not have End-Stage Renal Disease at the time of enrollment

Medicare Advantage (Part C) Costs

Out-of-pocket costs vary among Medicare Advantage Plans.

- $ Plan members continue to pay the Part B premium
- $ Plans may charge an additional premium, though zero-premium plans are often available
- $ Copayments and coinsurance charges may apply
- $ Deductibles may apply
- $ Plans cannot charge members more than Original Medicare does for certain services such as chemotherapy, dialysis, and skilled nursing facility care.
- $ Plans have an annual cap on how much a beneficiary pays for Part A and Part B services. This maximum out-of-pocket amount can differ among plans.

Medicare Advantage Number and Card

Though all Medicare beneficiaries receive a Medicare card and number from the Social Security Administration, beneficiaries in Medicare Advantage Plans also receive a health plan identification (ID) card. This card contains a subscriber or member number that differs from the Medicare number and does not include a Social Security number. Plan members must use their health plan ID cards and numbers instead of the Medicare card and number for billing purposes. Plans typically inform new members to keep their Medicare cards in a safe place at home and to only use the health plan ID card when they go to the doctor or hospital. The health plan member ID card for Medicare Advantage Plans must comply with national standards for medical ID cards.

For example, Medicare Advantage health plan ID cards must include:

- ✓ The beneficiary's subscriber or member number with the plan
- ✓ The plan's website address
- ✓ The plan's customer service number
- ✓ The plan's Health Plan Identification Number (HPID), a CMS-issued number that identifies the plan
- ✓ The phrase "Medicare limiting charges apply" (on PPO and PFFS cards only)

Original Medicare vs. Medicare Advantage

It is important for SMPs to know the differences between Original Medicare and Medicare Advantage, because it affects SMP outreach and education and also the way beneficiary complaints are handled. See Appendix B for a summary of key differences.

Medicare Part D: Prescription Drug Coverage

Part D

Medicare Part D is also referred to as Medicare prescription drug coverage. The Centers for Medicare & Medicaid Services (CMS) contracts with private companies to offer Medicare Prescription Drug Plans to people with Medicare.

Beneficiaries are encouraged to compare plans prior to enrolling because coverage varies. The drugs covered, copayment amounts, deductibles, and gap coverage (see "coverage gap" description below) differ from plan to plan. A plan comparison tool is available on the Medicare website: www.Medicare.gov.

Eligibility

Beneficiaries with Original Medicare are eligible to enroll in a stand-alone Medicare Prescription Drug Plan if they live in the plan service area and are not incarcerated. Most beneficiaries enrolled in Medicare Advantage Plans receive their Part D benefit through the plan, but not all. Beneficiaries in some types of Medicare Advantage Plans *without* Part D coverage (e.g., certain private fee-for-service plans) may be eligible to enroll in a stand-alone Medicare Prescription Drug Plan. Eligibility is not based on income or health status.

Costs

The following out-of-pocket costs are associated with Medicare Part D:

- $ **Premium:** The monthly amount a beneficiary pays varies among plans and the type of coverage each plan offers.
- $ **Deductible:** The amount a beneficiary must pay out of pocket before the plan begins to pay. This amount may increase each year. Not all plans require that a deductible be met before coverage begins.
- $ **Copayments or Coinsurance:** Plans generally require the beneficiary to share in the monthly cost of medications. Copayments are lowest for generic drugs.
- $ **Coverage gap ("donut hole"):** Currently, most Part D plans have a coverage gap, which is also called a donut hole. This means there's a temporary limit on what the drug plan will cover for drugs. Not everyone will enter the coverage gap. The coverage gap begins after the beneficiary and the drug plan have spent a certain amount for covered drugs (see "catastrophic coverage," below). As a result of the Affordable Care Act, the coverage gap will be gradually eliminated by 2020.
- $ **Catastrophic coverage:** Once beneficiaries reach their plan's out-of-pocket limit, they automatically get "catastrophic coverage," which means that they only pay a small coinsurance or copayment amount for covered prescription drugs for the rest of the year.

Medicare Enrollment Periods

Medicare offers several different time frames for enrolling in the various parts of Medicare. Regardless of whether a beneficiary chooses to enroll in Original Medicare or elects a Medicare Advantage Plan, enrollment periods are the time frames in which people become Medicare beneficiaries. Default enrollment is into Original Medicare. Beneficiaries may *elect* to enroll in a Medicare Advantage Plan or a Medicare Prescription Drug Plan. The options and timeframes vary based on each beneficiary's situation or preferences.

Enrollment in Original Medicare (Parts A and B)

Eligible individuals can enroll in Medicare during one of three types of enrollment periods:

- Initial Enrollment Period
- General Enrollment Period
- Special Enrollment Period

Initial Enrollment Period

Individuals who are approaching their 65th birthday have an Initial Enrollment Period during which they can sign up for Medicare. The Initial Enrollment Period surrounds their 65th birthday.

The following points should be kept in mind regarding initial enrollment in Medicare:

- Individuals can enroll during a seven-month period that starts three months before their birthday month, includes their birthday month, and ends three months after their birthday month.
- To ensure coverage begins when they turn 65, they should enroll one to three months before their birthday month (unless they qualify for a special enrollment period, as described on the next page).
- They must enroll for Part A and Part B through the Social Security Administration, unless they qualify to be automatically enrolled.

In certain situations, beneficiaries are enrolled automatically in Original Medicare during the Initial Enrollment Period. Benefits begin without the beneficiary taking any action, as outlined below:

Individuals will be automatically enrolled in Original Medicare if:	Enrollment will take place and benefits will begin:
They have already been receiving retirement benefits from Social Security or the Railroad Retirement Board (RRB) before they turn 65	Starting the first day of the month they turn 65
They have a disability, are under age 65, and have been receiving Social Security Disability Insurance (SSDI) for at least 24 months	After they get SSDI or certain disability benefits from the RRB for 24 months

General Enrollment Period

Individuals who don't enroll in Medicare during the Initial Enrollment Period can sign up during a General Enrollment Period, which runs from January 1 to March 31 each year. Coverage starts on July 1. Late enrollment penalties may apply for those who wait a full year beyond their 65th birthday to enroll.

Special Enrollment Period

Individuals who continue to work past age 65 and are covered by employer-provided group health plans generally qualify for the Special Enrollment Period. The Special Enrollment Period is also available to:

- Spouses who are over 65 and covered by an employer group health plan due to current employment
- People with disabilities covered by an employer group plan through their own or a family member's current employment.

In these situations, individuals are not bound to the Initial Enrollment or General Enrollment Periods. However, they should enroll as soon as possible within the 8-month Special Enrollment Period to avoid a lapse in coverage. With special enrollment in Original Medicare, coverage starts the month after the beneficiary signs up for Medicare and usually no late premium penalty is assessed. The effective dates of coverage vary among Special Enrollment Periods.

$$ Premium penalties for delayed enrollment in Part B $$

Unless they qualify for a Special Enrollment Period, beneficiaries who choose Original Medicare need to enroll in Medicare Part B when they first become eligible, to avoid penalties. A 10 percent penalty applies for each full 12-month period they could have been enrolled in Part B but weren't. This late enrollment penalty continues as long as beneficiaries are enrolled in Medicare.

Note: There are some exceptions to this penalty. Beneficiaries who wish to be relieved of their penalty should contact the Social Security Administration for details.

Enrollment in Medicare Advantage and Prescription Drug Plans (Parts C and D)

Although the default enrollment is to Original Medicare, there are four types of election periods during which beneficiaries can instead enroll in or disenroll from a Medicare Advantage Plan (Part C) or a Medicare Prescription Drug Plan (Part D).

- Initial Coverage Election Period
- Annual Election Period, commonly known as "Medicare Open Enrollment"
- Special Election Periods
- Medicare Advantage Disenrollment Period

Initial Coverage Election Period

To enroll in a Medicare Advantage Plan (Part C), a beneficiary must be entitled to Part A and enrolled in Part B. To enroll in a Medicare Prescription Drug Plan (Part D), a beneficiary must be enrolled in Part A and/or Part B. Most people who are newly eligible for Medicare can elect to receive their Medicare benefits through a Medicare Advantage Plan during a period that CMS calls an "Initial Coverage Election Period." This period begins up to three months before a beneficiary's Medicare eligibility begins and lasts for seven months. During this period, the beneficiary can contact a Part C plan to enroll. However, he or she must wait for the arrival of his or her Medicare card before making that contact. If a beneficiary elects to enroll in a Medicare Advantage Plan during this Initial Coverage Election Period, the coverage effective date will be the same as if he or she had enrolled in Original Medicare.

Annual Election Period (Medicare Open Enrollment)

The Annual Election Period is also commonly known as "Medicare Open Enrollment" and takes place from October 15 to December 7 each year. During the Annual Election Period, beneficiaries can:

- ✓ Change their Medicare coverage from Original Medicare to a Medicare Advantage Plan
- ✓ Leave a Medicare Advantage Plan and return to Original Medicare
- ✓ Switch from one Medicare Advantage Plan to another
- ✓ Switch from one Medicare Prescription Drug Plan (Part D) to another
- ✓ Join a Medicare Part D plan for the first time

Coverage changes made during the annual election period become effective the following January 1.

Selection Periods

In Original Medicare, there is a Special *Enrollment* Period; however, for Parts C and D, there are Special *Election* Periods (SEPs) for making plan changes. Beneficiaries usually must remain in their Part C and Part D plans until the end of the calendar year. However, in certain situations, they can join, switch, or drop plans during a Special Election Period. The table below illustrates the most common reasons for relying on SEPs. There are approximately 20 circumstances in which SEPs might apply, however. For more detailed information about Special Election Periods, contact your SHIP program.

SEPs apply when a beneficiary…	SEP time frame
Moves out of the plan's service area	Begins on either the date of the permanent move or on the date the individual provides notification and continues for two months
Qualifies for both Medicare and Medicaid	Begins the month the individual becomes dually eligible and exists as long as he or she receives Medicaid benefits
Involuntarily loses prescription drug coverage that is as good as or better than Medicare prescription drug coverage	Begins two months from notice of the loss, or the date of the loss, whichever is later
Qualifies for "Extra Help"	Begins the month the individual becomes eligible for "Extra Help" and exists as long as he or she receives benefits (see page 51 for more information about "Extra Help")
Wants to switch to a plan with the highest quality ratings ("5 Star" plan)	Allowed once each year, between December 8 and November 30

Medicare Advantage Disenrollment Period

From January 1 to February 14, known as the Medicare Advantage Disenrollment Period, beneficiaries in Medicare Advantage can leave their plan to join Original Medicare. If they switch to Original Medicare during this period they have until February 14 to join a Medicare Prescription Drug Plan (Part D). Their coverage will begin the first day of the month after the plan receives their enrollment form.

During this period, beneficiaries cannot:

- Switch from Original Medicare to a Medicare Advantage Plan
- Switch from one Medicare Advantage Plan to another
- Switch from one Medicare Prescription Drug Plan to another
- Join, switch, or drop a Medicare Medical Savings Account Plan

Exceptions to the Disenrollment Period

- Beneficiaries who have joined a Medicare Advantage Plan for the first time can return to Original Medicare without waiting for the next Annual Election Period, if desired. Beneficiaries interested in this option can contact their state SHIP program if they need assistance.
- If plans or their representatives violate CMS rules, such as those governing marketing and education, beneficiaries can seek recourse to disenroll from a plan outside of the usual election periods. SMPs help beneficiaries who think they have been a victim of such violations (discussed further in Chapter 4).

How to Enroll

The process to enroll in Medicare varies depending on the part of Medicare.

Original Medicare (Parts A and B)	To enroll in Medicare Part A and/or Part B, individuals can contact Social Security at 1-800-772-1213 or apply online at www.ssa.gov. Railroad employees can contact the Railroad Retirement Board.
Medigap	To find Medigap policies, individuals can visit www.Medicare.gov and search by keyword or use the menu. Several states also publish Medigap shopper guides with local price information. For **Medigap**, the best time to buy a policy is during the six-month period that begins on the first day of the month in which the individual is both age 65 or older and enrolled in Part B. After this Initial Enrollment Period, options to buy a Medigap policy may be limited.
Medicare Advantage (Part C)	Plan comparison tools for both Part C and Part D plans are available at www.Medicare.gov. If individuals decide to enroll in a Medicare Advantage Plan (Part C) and/or a Medicare Prescription Drug Plan (Part D), they can enroll themselves using www.Medicare.gov, contact their SHIP program for assistance, or contact the plan directly to learn how to join. They may be able to join by completing a paper application, calling the plan, or enrolling online. When they join a Part C or Part D plan, applicants must provide their Medicare number and the date their Part A and/or Part B coverage started. There are many rules governing the way plans educate beneficiaries and market their products. For more information, see Chapter 4 of this manual.
Medicare Prescription Drug Plans (Part D)	

Where to get more information on Medicare and Enrollment

SMPs are not expected to be experts in all aspects of Medicare, since the SMP focus is fraud, errors, and abuse. You may be able to answer basic Medicare questions using what you have learned in training; however, for more detailed questions you should be familiar with the Medicare resources that are available to beneficiaries and refer to them as needed.

- 1-800-MEDICARE and www.medicare.gov
- The *Medicare & You* handbook
- Social Security (1-800-772-1213, www.ssa.gov)
- Your local SHIP (State Health Insurance Assistance Program)

See Appendix A for more information on ***Medicare Resources for Beneficiaries***.

Medicare Statements and Claims Tracking

Medicare statements outline payments made on a beneficiary's behalf for Medicare covered services. Several types of Medicare statements are sent to beneficiaries depending on whether they are enrolled in Original Medicare, a Medicare Advantage Plan, or a Medicare Prescription Drug Plan.

- Original Medicare statements are called Medicare Summary Notices, or MSNs.
- Medicare Advantage Plans (Part C) are required to provide most enrollees an Explanation of Benefits (EOB). EOB timing varies from monthly to quarterly, depending upon the circumstances. Plans also issue written Organizational Determinations when they deny coverage for services.
    - Prior to 2014, Medicare Advantage Plans were not required to issue EOBs, though many did so as a courtesy.
    - Plans are not required to send EOBs to dually eligible members (members enrolled in Medicaid as well as Medicare).
- Medicare Prescription Drug Plans (Part D) are required to provide enrollees an Explanations of Benefits (EOB). EOBs must be provided by the end of the month following the month in which an enrollee fills a prescription.

MSNs and EOBs explain:

- What the health care provider or pharmacy billed for
- The amount approved by Medicare for payment
- How much Medicare paid
- What the beneficiary may be billed for

Reviewing and understanding such statements is crucial for beneficiaries and SMPs.

MSN Redesigned in 2013

Medicare introduced a redesigned MSN that is easier to read and explains how to check it for important facts and potential fraud. It also better explains the beneficiary's deductible status, lists the providers who submitted claims, and clarifies whether or not Medicare approved those claims.

Medicare Summary Notices (MSNs)

One of the key "tools" that the SMP program uses for catching fraud, errors, and abuse is the Medicare Summary Notice, which provides information on Original Medicare claims. SMP program presentations frequently include instructions on how to read MSNs, which can be complicated and difficult for beneficiaries to understand. MSNs are mailed to beneficiaries every three months if there is a Medicare claim filed during that time period. The MSN is a statement, not a bill. Because many beneficiary questions are related to how to read Medicare Summary Notices, we will review the MSN in detail later in this chapter.

- A sample Part A MSN is shown on pages 37 – 42 with descriptions in blue text.
- A sample Part B MSN is shown on pages 43 – 48 with descriptions in green text.

Frequency of Mailed MSNs

The majority of MSNs are mailed quarterly. For many years, MSNs were mailed monthly, but CMS began sending them quarterly in 2006 to reduce costs. One known exception is in south Florida. CMS has continued issuing monthly MSNs to certain beneficiaries there as part of a fraud prevention demonstration project.

Explanations of Benefits (EOBs)

The Explanation of Benefits, or EOB, is similar to the MSN in that it is a statement, not a bill. MSNs provide information on Part A and Part B claims made to Original Medicare, whereas EOBs provide information on Medicare Advantage (Part C) benefits and Medicare prescription drug (Part D) benefits. Though MSNs are sent each quarter in which a beneficiary received services, Medicare Advantage Plans may send EOBs for each month in which enrollees received benefits. EOB design varies from plan to plan, however CMS issues requirements about the type of information EOBs must include.

Medicare rules require all Medicare Advantage EOBs to include the following:

- Crucial details about the covered services, including all claims for Part A and Part B covered services and any supplemental benefits offered by the plan
- Names of providers who billed
- The billed amount
- The plan's payment
- The beneficiary's share of the approved amount
- Information about how to appeal, unless it is provided separately in order to meet the CMS guidelines about timeliness
- Other rules too numerous to mention here, such as EOB formatting guidelines

Medicare rules require the following information in Part D EOBs:

- A record of the person's total out-of-pocket costs, which must also include:
    - A record of the total drug costs transferred from previous plans if a person changed plans during the year
    - A summary of the person's year-to-date costs in the plan, including the deductible
- Information about the person's current coverage period, the initial coverage period, the coverage gap, and catastrophic coverage
- A summary of the claims processed since the last EOB
- Any updates to the drug plan's formulary, if applicable
- How to contact the plan with questions, such as what beneficiaries can do if they question the accuracy of the EOB or disagree with coverage decisions made by the plan

Claims Tracking

Reviewing Medicare Statements

Regardless of whether the statement is an MSN (Original Medicare) or an EOB (Medicare Advantage and Medicare Prescription Drug Plans), when statements are received, it is important for beneficiaries to review them immediately and check for mistakes.

The SMP program encourages beneficiaries to keep a personal record of doctor visits and other health care services or equipment they receive in a calendar or Personal Health Care Journal (described in Chapter 1). Each MSN or EOB should be reconciled with the beneficiary's own records, including any bills from providers or suppliers for out-of-pocket costs.

When mistakes or discrepancies are identified, it's important to address them as soon as possible. Beneficiaries in Original Medicare typically have 120 days from the date they receive the MSN to appeal a coverage denial; however, the process and timeframe for correcting any billing errors may be different depending upon the circumstances. Part C and Part D plans also have appeals processes. Enrolled beneficiaries can check with their plan or 1-800-MEDICARE for details.

MyMedicare.gov

Medicare's website www.MyMedicare.gov allows beneficiaries in Original Medicare to view their most recent MSNs, track claims made on their behalf, and check payment status. MyMedicare.gov can serve as a valuable tool in combating fraud, errors, and abuse, since beneficiaries won't have to wait up to three months to review their Original Medicare claims.

MyMedicare.gov allows registered users to access a variety of other Medicare information.

For example, they can also:

- ✓ Check Part B deductible status
- ✓ View eligibility information
- ✓ Track available preventive services
- ✓ Find Medicare health or prescription drug plans
- ✓ Access Part D plan claims information

Sample MSN – Part A

Sample MSNs provided by CMS at www.Medicare.gov

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

3

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 4

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 5

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 6

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.
如果需要国语帮助，请致电联邦医疗保险，请先说"agent"，然后说"Mandarin"。 **1-800-MEDICARE (1-800-633-4227)** 7

1 – MSN Title. The title is large and bold.

2 – DHHS Logo. The official U.S. Department of Health & Human Services (DHHS) logo.

3 – Beneficiary Information. Beneficiaries should check their names, the last four digits of their Medicare numbers, the date the Medicare contractor issued the MSN, and the dates of the claims listed. The MSN reports claims for a three-month period.

4 – (Part A) Deductible Status. Beneficiaries owe a deductible at the start of a benefit period before Medicare pays for Part A services. They can check their deductible information under "Your Deductible Status." Beneficiaries may face more than one Part A deductible in a calendar year; see the "Benefit Periods" section on Page 2 of the MSN.

5 – Claims & Costs This Period. This feature indicates if Medicare approved or denied claims within the three-month MSN claim period as well as **the total the provider(s) can bill the beneficiary**. The beneficiary's cost normally is the sum of the unmet deductible and coinsurance charges for inpatient hospital and SNF (Skilled Nursing Facility) stays.

6 – Facilities with Claims This Period. This section names the hospitals, SNFs, and hospice providers that submitted claims during the three-month MSN claim period. The beneficiary should verify the list of dates for services received during this claim period.

7 – Help in Other Languages. For help in a language other than English or Spanish, call 1-800-MEDICARE and say "Agent." Say the language needed for free translation services.

Making the Most of Your Medicare

1

How to Check This Notice

2

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

3

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

4

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.

1 – Section Title. This helps beneficiaries find where they are in the MSN with its many sections. Titles are on the top of each page.

2 – How to Check This Notice. Medicare offers helpful tips on what to check when reviewing the MSN. The questions are part of Medicare's effort to enlist beneficiaries' help in catching mistakes and spotting potential fraud.

3 – How to Report Fraud. Beneficiaries can help Medicare save money by reporting fraud! This section places Medicare's key fraud prevention messages prominently on the MSN. It directs beneficiaries to call 1-800-MEDICARE. SMPs typically encourage beneficiaries to contact their local SMP to report suspected fraud.

4 – How to Get Help with Questions. Beneficiaries should call 1-800-MEDICARE with questions or concerns about the claim. They should contact the SHIP for help with Medicare plan comparisons, Medigap information, and appeals.

Making the Most of Your Medicare

5 – Benefit Periods. This section explains how the Part A benefit period works. It also reports the number of covered inpatient hospital and SNF days that remain in the benefit period.

6 – Messages from Medicare. Medicare updates these messages regularly, so beneficiaries should check them on each MSN they receive. They will find information here about new preventive benefits and seasonal benefits such as the flu vaccine.

Your Benefit Periods

5

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

6

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.

Jennifer Washington — THIS IS NOT A BILL | Page 3 of 4

Your Inpatient Claims for Part A (Hospital Insurance) 1

Part A Inpatient Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Definitions of Columns 2

Benefit Days Used: The number of covered benefit days you used during each hospital and/or skilled nursing facility stay. (See page 2 for more information and a summary of your benefit periods.)

Claim Approved?: This column tells you if Medicare covered the inpatient stay.

Non-Covered Charges: This is the amount Medicare didn't pay.

Amount Medicare Paid: This is the amount Medicare paid your inpatient facility.

Maximum You May Be Billed: The amount you may be billed for Part A services can include a deductible, coinsurance based on your benefit days used, and other charges.

For more information about Medicare Part A coverage, see your "Medicare & You" handbook.

June 18 – June 21, 2013 3
Otero Hospital, (555) 555-1234
PO Box 1142, Manati, PR 00674
Referred by Jesus Sarmiento Forasti

	4 Benefit Days Used	5 Claim Approved?	Non-Covered Charges	Amount Medicare Paid	6 Maximum You May Be Billed	See Notes Below
Benefit Period starting May 27, 2013	4 days	Yes	$0.00	$4,886.98	**$0.00**	
Total for Claim #20905400034102			$0.00	$4,886.98	**$0.00**	**A,B**

1 – Type of Claim. Claims for inpatient hospital, skilled nursing facilities, home health, or hospice services.

Note: *Part B hospital outpatient claims are shown in a format similar to Part A inpatient claims. Both may appear in the same MSN.*

2 – Definitions. Terms Medicare uses to explain its coverage and payment decisions.

3 –Visit Info. Dates the beneficiary received services from the Part A provider. Beneficiaries should keep their bills and compare them to the MSN to ensure they received all the services listed.

4 – Benefit Period and Benefit Days Used. When the beneficiary's current benefit period began and how many covered inpatient hospital or SNF days were used.

5 – Claim Approved? Medicare's decision to approve or deny coverage is shown here.

6 – Max That May Be Billed. The total amount the facility can bill the beneficiary. It's highlighted and in bold for easy reading. The beneficiary or a supplemental insurance policy owes this to the provider.

7 – Notes. See the bottom of the page for explanations of the items and supplies the beneficiary received. This section explains reasons for coverage denials, crossover claims to supplemental insurance companies, and more.

Notes for Claims Above 7

A Days are being subtracted from your total inpatient hospital benefits for this benefit period. The "Your Benefit Periods" section on page 2 has more details.

B $2,062.50 was applied to your skilled nursing facility coinsurance.

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

How to Handle Denied Claims or File an Appeal

Get More Details

1

If a claim was denied, call or write the hospital or facility and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the facility to contact our claims office to correct the error. You can ask the facility for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

If You Disagree with a Coverage Decision, Payment Decision, or Payment Amount on this Notice, You Can Appeal

2

Appeals must be filed in writing. Use the form to the right. Our claims office must receive your appeal within 120 days from the date you get this notice.

We must receive your appeal by:

January 21, 2014

If You Need Help Filing Your Appeal

3

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your facility: Ask your facility for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Find Out More About Appeals

For more information about appeals, read your "Medicare & You" handbook or visit us online at www.medicare.gov/appeals.

1 – Get More Details. Beneficiaries can call 1-800-MEDICARE to learn what to do about denied claims. Note that providers can submit corrected claims when the original claim was mistaken.

2 – Beneficiaries Can File an Appeal. Beneficiaries have 120 days to appeal claim denials. The appeal deadline is shown in the text box. Note that Medicare can extend the appeal deadline for "good cause," including serious illness and death in the family.

3 – If a Beneficiary Needs Help Filing an Appeal. Beneficiaries should call 1-800-MEDICARE with questions or concerns about the claim. They should contact SHIP for help with Medicare plan comparisons, Medigap information, and appeals.

Customer service representatives at the Medicare Call Center will explain reasons for coverage denials and send copies upon request of the basis used to deny payment on the claim.

The Medicare Call Center provides general information about appeals. The SHIP program is also a resource on this topic. Health care providers may sometimes appeal denials themselves.

Note: If additional Medicare claims occur beyond what will fit on Page 3 of the MSN, the claim information is shown on additional pages following Page 3. The information shown on Page 4 of this sample MSN will always appear on the last page of the MSN, regardless of the number of pages needed for claims.

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

How to Handle Denied Claims or File an Appeal

4 – Appeals Form. Beneficiaries must file appeals of coverage denials in writing. This first step in the appeals process is called a "redetermination request." Beneficiaries should follow the step-by-step directions when filling out the form and take special note of numbers 5 and 6 about identifying and copying all documents sent with the redetermination request.

File an Appeal in Writing

4

Follow these steps:

1 Circle the service(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your facility for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o Contractor Name
Street Address
City, ST 12345-6789

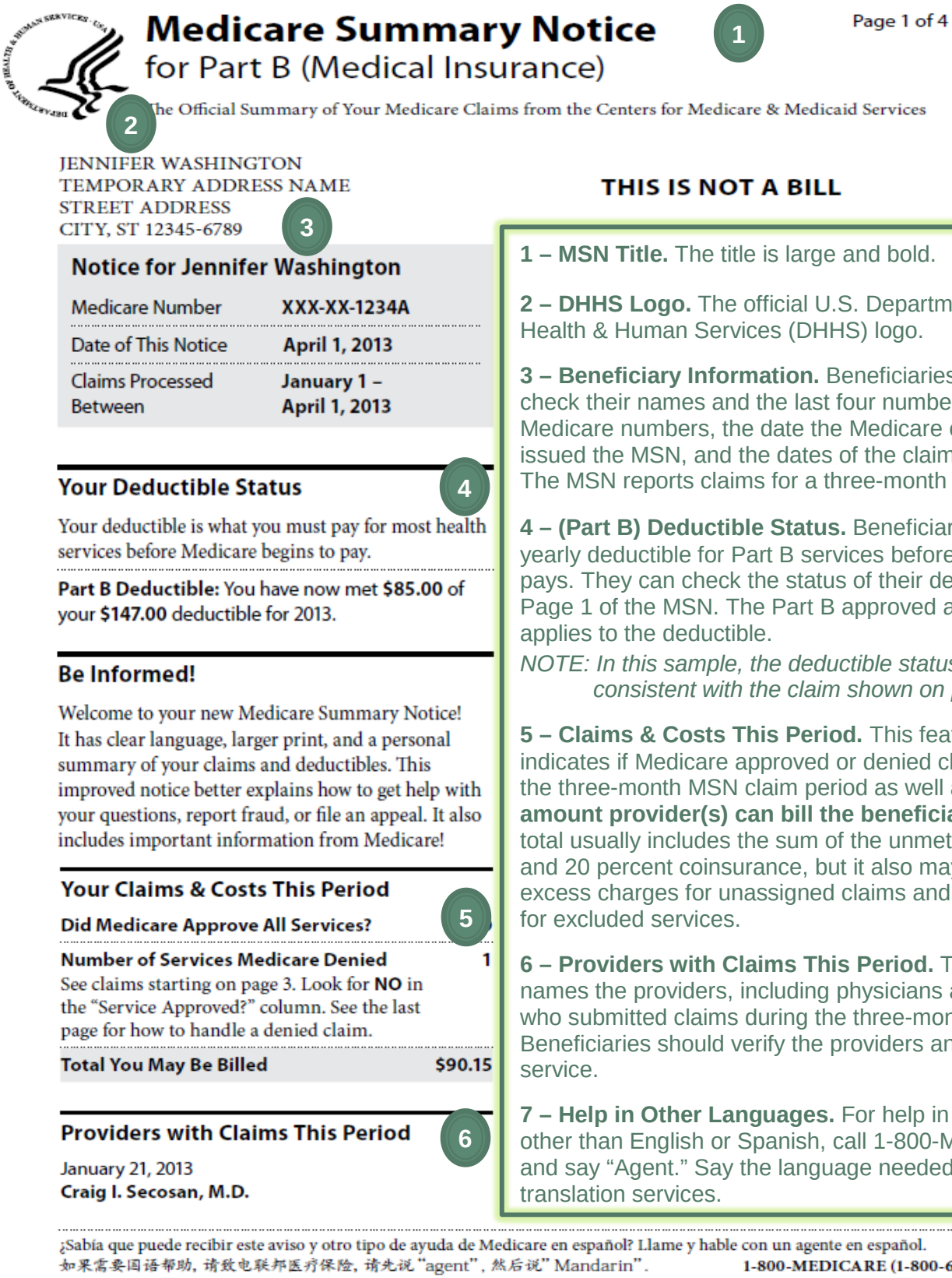
Note: This address may be different depending on the type of claim. Medicare works with a number of different payment contractors who receive appeal requests.

MSNs: Part A vs. Part B… What's the Difference?

	Part A	Part B
Coverage	Hospital insurance	Medical insurance
Page 1	"Facilities with Claims this Period"	"Providers with Claims this Period"
Page 2	"Your Benefit Periods"	"Medicare Preventive Services"
Page 3	"Benefit Period"	"Service Descriptions"
Last Page	N/A (no difference)	

Sample MSN – Part B

Sample MSNs provided by CMS at www.Medicare.gov



Medicare Summary Notice
for Part B (Medical Insurance)

1

Page 1 of 4

2 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

3

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	XXX-XX-1234A
Date of This Notice	April 1, 2013
Claims Processed Between	January 1 – April 1, 2013

Your Deductible Status 4

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

Part B Deductible: You have now met **$85.00** of your **$147.00** deductible for 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 5

Did Medicare Approve All Services?	
Number of Services Medicare Denied	1
See claims starting on page 3. Look for **NO** in the "Service Approved?" column. See the last page for how to handle a denied claim.	
Total You May Be Billed	$90.15

Providers with Claims This Period 6

January 21, 2013
Craig I. Secosan, M.D.

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要国语帮助，请致电联邦医疗保险，请先说"agent"，然后说"Mandarin"。 **1-800-MEDICARE (1-800-633-4227)** 7

1 – MSN Title. The title is large and bold.

2 – DHHS Logo. The official U.S. Department of Health & Human Services (DHHS) logo.

3 – Beneficiary Information. Beneficiaries should check their names and the last four numbers of their Medicare numbers, the date the Medicare contractor issued the MSN, and the dates of the claims listed. The MSN reports claims for a three-month period.

4 – (Part B) Deductible Status. Beneficiaries pay a yearly deductible for Part B services before Medicare pays. They can check the status of their deductible on Page 1 of the MSN. The Part B approved amount applies to the deductible.

NOTE: In this sample, the deductible status is not consistent with the claim shown on page 46.

5 – Claims & Costs This Period. This feature indicates if Medicare approved or denied claims within the three-month MSN claim period as well as **the total amount provider(s) can bill the beneficiary**. The total usually includes the sum of the unmet deductible and 20 percent coinsurance, but it also may include excess charges for unassigned claims and charges for excluded services.

6 – Providers with Claims This Period. This section names the providers, including physicians and labs, who submitted claims during the three-month period. Beneficiaries should verify the providers and dates of service.

7 – Help in Other Languages. For help in a language other than English or Spanish, call 1-800-MEDICARE and say "Agent." Say the language needed for free translation services.

Making the Most of Your Medicare

1

How to Check This Notice

2

Do you recognize the name of each doctor or provider? Check the dates. Did you have an appointment that day?

Did you get the services 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

3

If you think a provider 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

4

1-800-MEDICARE (1-800-633-4227)
Ask for "doctors 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.

1 – Section Title. This helps beneficiaries find where they are in the MSN, with its many sections. Titles are on the top of each page.

2 – How to Check This Notice. Medicare offers helpful tips on what to check when reviewing the MSN. The questions are part of Medicare's effort to enlist beneficiaries' help in catching mistakes and spotting potential fraud.

3 – How to Report Fraud. Beneficiaries can help Medicare save money by reporting fraud! This section places Medicare's key fraud prevention messages prominently on the MSN. It directs beneficiaries to call 1-800-MEDICARE. SMPs typically encourage beneficiaries to contact their local SMP to report suspected fraud.

4 – How to Get Help with Questions. Beneficiaries should call 1-800-MEDICARE with questions or concerns about the claim. They should contact the SHIP for help with Medicare plan comparisons, Medigap information, and appeals.

Making the Most of Your Medicare

5 – Preventive Services. Many Medicare beneficiaries are unaware of Medicare's preventive services and that the program covers many services at 100 percent of the approved amount. Look for the apple icon, indicating a preventive service, in the *Medicare & You* handbook.

6 – Messages from Medicare. Medicare updates these messages regularly, so beneficiaries should check them on each MSN they receive. They will find information here about new preventive benefits and seasonal benefits such as the flu vaccine.

Medicare Preventive Services 5

Medicare covers many free or low-cost exams and screenings to help you stay healthy. For more information about preventive services:

- Talk to your doctor.
- Look at your "Medicare & You" handbook for a complete list.
- Visit www.MyMedicare.gov for a personalized list.

Your Messages from Medicare 6

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.

Jennifer Washington — THIS IS NOT A BILL | Page 3 of 4

Your Claims for Part B (Medical Insurance) 1

Part B Medical Insurance helps pay for doctors' services, diagnostic tests, ambulance services, and other health care services.

Definitions of Columns 2

Service Approved?: This column tells you if Medicare covered this service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged.

Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid your provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

January 21, 2013 3

Craig I. Secosan, M.D., (555) 555-1234

Looking Glass Eye Center PA, 1888 Medical Park Dr, Suite C, Brevard, NC 28712-4187

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (92014) 4 5	Yes	$143.00	$107.97	$86.38	**$21.59** 6	
Destruction of skin growth (17000)	**NO**	68.56	0.00	0.00	**68.56**	**A**
Total for Claim #02-10195-592-390		$211.56	$107.97	$86.38	**$90.15**	**B**

1 – Type of Claim. Claims can either be assigned or unassigned.

Note: *Part B hospital outpatient claims are shown in a format similar to Part A inpatient claims. Both may appear in the same MSN.*

2 – Definitions. Terms Medicare uses to explain its coverage and payment decisions.

3 –Visit Info. Dates the provider delivered a service or item. Beneficiaries should keep their bills and compare them to the MSN to make sure they received all the services listed.

4 – Service Descriptions. This section describes the service(s) or item(s) the beneficiary received.

5 – Approved Column. Medicare's decision to approve or deny coverage is shown here.

6 – Max That May Be Billed. The total amount the provider can bill the beneficiary. It's highlighted and in bold for easy reading. A supplemental insurance policy may cover some, or all, of this amount.

7 – Notes. See the bottom of the page for explanations of the items and supplies the beneficiary received. This section explains reasons for coverage denials, crossover claims to supplemental insurance companies, and more.

Notes for Claims Above

A This service was denied. The information provided does not support the need for this service or item.

B Your claim was sent to your Medicare Supplement Insurance (Medigap policy), Wellmark BlueCross BlueShield of N. Carolina. Send any questions regarding your benefits to them. 7

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

How to Handle Denied Claims or File an Appeal

Get More Details

1

If a claim was denied, call or write the provider and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the provider to contact our claims office to correct the error. You can ask the provider for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

If You Disagree with a Coverage Decision, Payment Decision, or Payment Amount on this Notice, You Can Appeal

2

Appeals must be filed in writing. Use the form to the right. Our claims office must receive your appeal within 120 days from the date you get this notice.

We must receive your appeal by:

July 13, 2013

If You Need Help Filing Your Appeal

3

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your provider: Ask your provider for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Find Out More About Appeals

For more information about appeals, read your "Medicare & You" handbook or visit us online at www.medicare.gov/appeals.

1 – Get More Details. Beneficiaries can call 1-800-MEDICARE to learn what to do about denied claims. Note that facilities can submit corrected claims when the original claim was mistaken.

2 – Beneficiaries Can File an Appeal. Beneficiaries have 120 days to appeal claim denials. The appeal deadline is shown in the text box. Note that Medicare can extend the appeal deadline for "good cause," including serious illness and death in the family.

3 – If a Beneficiary Needs Help Filing an Appeal. Beneficiaries should call 1-800-MEDICARE with questions or concerns about the claim. They should contact the SHIP for help with Medicare plan comparisons, Medigap information, and appeals.

Customer service representatives at the Medicare Call Center will explain reasons for coverage denials and send copies upon request of the basis used to deny payment.

The Medicare Call Center provides general information about appeals. The SHIP may be able to help prepare the written appeal. Health care providers may sometimes appeal denials themselves.

Note: If additional Medicare claims occur beyond what will fit on Page 3 of the MSN, the claim information is shown on additional pages following Page 3. The information shown on Page 4 of this sample MSN will always appear on the last page of the MSN, regardless of the number of pages needed for claims.

How to Handle Denied Claims or File an Appeal

4 – Appeals Form. Beneficiaries must file appeals of coverage denials in writing. This first step in the appeals process is called a "redetermination request." Beneficiaries should follow the step-by-step directions when filling out the form and take special note of numbers 5 and 6 about identifying and copying all documents sent with the redetermination request.

File an Appeal in Writing

4

Follow these steps:

1 Circle the service(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your provider for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o Contractor Name
Street Address
City, ST 12345-6789

Note: This address may be different depending on the type of claim. Medicare works with a number of different payment contractors who receive appeal requests.

Assistance for People with Limited Income and Resources

People with limited income and resources may qualify for assistance programs offered by the federal government or through state-administered programs such as Medicaid.

Some common assistance programs that are available to beneficiaries who qualify include:

1. Medicaid
2. Medicare Savings Programs
3. Federal and state programs that help with prescription drug costs
4. Supplemental Security Income (SSI)

Note: For some of these programs, individual states may have different income and/or resource limits.

Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for some people with limited income and/or resources. Some people qualify for both Medicare and Medicaid. In Medicare terminology, they are referred to as "dual-eligibles."

- Most health care costs are covered if they have Medicare and Medicaid.
- Medicaid programs vary by state. They may also be called by different names, such as "Medical Assistance," "Title 19," or "Medi-Cal."
- People with Medicaid may receive coverage for services that aren't fully covered by Medicare, such as nursing home and in-home chore services.
- The income and resource limits for Medicaid (if a resource limit applies) may vary by state.
- The State Medical Assistance (Medicaid) office is responsible for determining eligibility and enrollment.

To find State Medical Assistance offices, visit www.Medicare.gov and search by keyword or use the menu.

Medicare Savings Programs

Medicare Savings Programs are state programs that help people with limited incomes and resources, pay their Medicare costs. The programs are available to those with limited income whose income and assets are high enough to make them ineligible for regular Medicaid benefits. Premiums, deductibles, and coinsurance charges may be covered, depending upon the program. Medicare Savings Programs help millions of people with Medicare save money each year.

The four Medicare Savings Programs are:

1. The Qualified Medicare Beneficiary (QMB) program
2. The Specified Low Income Medicare Beneficiary (SLMB) program
3. The Qualifying Individual (QI) program
4. The Qualified Disabled & Working Individuals (QDWI) program

Eligibility and Enrollment

The State Medical Assistance (Medicaid) office is responsible for determining eligibility and enrollment.

To qualify for a Medicare Savings Program, a person must meet these conditions:

- ✓ Have Medicare Part A
- ✓ Be an individual with limited resources (limits are set annually by Medicare)
  - o Resources include money in a checking or savings account, stocks, and bonds
  - o Resources don't include their home, car, furniture, other household items, or burial plot, or up to a set amount for burial expenses
- ✓ Be an individual or a married couple with a monthly income less than the threshold set by Medicare

Note: Some states have no asset test for the Medicare Savings Programs.

Federal and State Programs that Help with Prescription Drug Costs

The Medicare "Extra Help" program and the State Pharmacy Assistance Programs (SPAPs) provide help with prescription drug costs for those who qualify.

Medicare "Extra Help"

The "Extra Help" program (also known as "Low-Income Subsidy" or "LIS") helps beneficiaries who have limited income and resources with the premiums, deductibles, and copayments associated with a Medicare Prescription Drug Plan. The Social Security Administration determines eligibility for this benefit.

Those who qualify for Extra Help receive assistance with the monthly drug plan premium, yearly deductible, prescription coinsurance or copayments, and/or costs in the "coverage gap."

Most people who meet the following conditions automatically qualify for Extra Help:

- ✓ Receive full Medicaid benefits
- ✓ Get help from their state Medicaid program for paying Part B premiums (belong to a Medicare Savings Program)
- ✓ Receive Supplemental Security Income (SSI) benefits without Medicaid

Even people who don't automatically qualify may still be eligible for Extra Help and can apply for assistance.

State Pharmacy Assistance Programs (SPAPs)

Several states have State Pharmacy Assistance Programs (SPAPs) that help certain people pay for prescription drugs. Each SPAP makes its own rules about how to provide drug coverage to its members. Depending on the state, the SPAP will have different ways of helping pay prescription drug costs. To find out about the SPAPs in your state, call 1-800-MEDICARE (1-800-633-4227) or your local SHIP.

Supplemental Security Income (SSI) Benefits

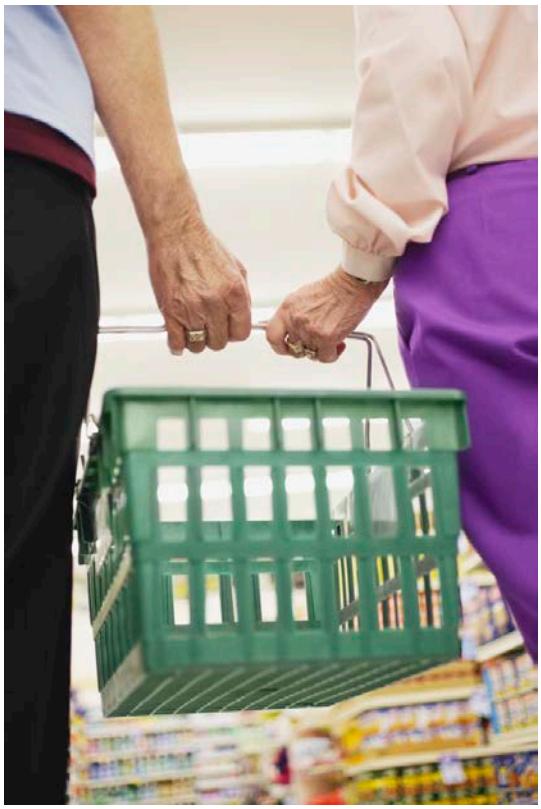
Supplemental Security Income, more commonly known as SSI, is a program administered by Social Security that pays a monthly amount to supplement the income of people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits provide cash to meet basic needs for food, clothing, and shelter. SSI benefits aren't the same as Social Security retirement or disability benefits and often supplement Social Security payments.

The Social Security Administration is responsible for determining eligibility and enrollment.

Note: People who receive SSI payments automatically qualify for Medicaid in many states.

In order to qualify for SSI, a person must also meet these conditions:

- ✓ Be a resident of the United States or the Northern Mariana Islands
- ✓ Not be absent from the country for more than 30 days
- ✓ Be either a U.S. citizen or national or in one of certain categories of eligible noncitizens
- ✓ Not live in Puerto Rico, the Virgin Islands, Guam, or American Samoa (these people generally can't get SSI)



Medicare Rights and Protections

Medicare has policies and procedures in place to ensure that a person's rights as a Medicare beneficiary and health care consumer are protected. For a full list of these rights and an explanation of additional protections, refer to the most current version of the *Medicare & You* handbook, and see the section entitled *Know Your Rights & How to Protect Yourself from Fraud*.

Some of the primary rights and protections explained in the *Medicare & You* handbook include:

- **Medicare Questions Answered.** Many basic rights to quality health care and health care coverage are included, such as the right to have questions about Medicare answered. The SMP program is one of the many available services that can help beneficiaries with this particular right.
- **Rights if a Beneficiary's Plan Stops Participating in Medicare.** Medicare health and prescription drug plans can decide not to participate in Medicare for the coming year. If this happens, the plan will send enrollees a letter about their options. Beneficiaries have the right to join another Medicare plan or return to Original Medicare.

- **Appeals.** An appeal is the action a person can take if he or she disagrees with a coverage or payment decision made by Medicare or a Medicare plan. The handbook covers details on what qualifies for an appeal and how to file an appeal.
- **Advance Beneficiary Notice of Noncoverage (ABN).** In Original Medicare, a health care provider or supplier may give a person a notice called an "Advance Beneficiary Notice" (ABN). This notice says Medicare probably (or certainly) won't pay for some services in certain situations. It allows the beneficiary to choose whether or not to get the services listed on the ABN. If the person accepts the items or services listed on the ABN, he or she might have to pay out of pocket. There are specific rules that govern how and when providers use ABNs, further described in the handbook. If a provider was required to use an ABN but didn't, the beneficiary usually must be reimbursed.
- **Privacy of Personal Information.** By law, Medicare is required to protect the privacy of personal medical information. Medicare is also required to notify beneficiaries how Medicare may use and give out ("disclose") their personal medical information held by Medicare.

SMP Foundations Training Manual

CHAPTER 3: Medicare Fraud, Errors, and Abuse Basics

Objectives

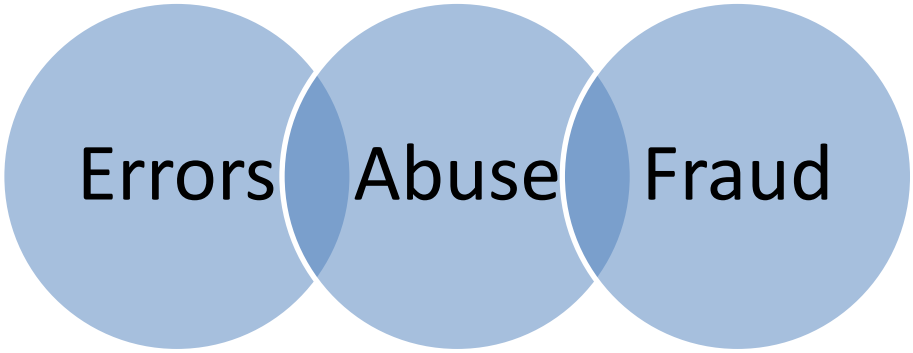
This chapter defines Medicare fraud, errors, and abuse and the national partners involved in addressing these problems.

Upon completion of Chapter 3: Medicare Fraud, Errors, and Abuse Basics, you will be able to:

1. Identify the differences between Medicare fraud, errors, and abuse
2. Describe the impact of Medicare fraud, errors, and abuse to both the Medicare program and Medicare beneficiaries
3. Identify national partnerships to stop Medicare fraud
4. Explain the SMP role in addressing Medicare fraud, errors, and abuse compared to other national partners

Waste in Medicare

Waste in the Medicare program involves the entire continuum of fraud, errors, and abuse.



First on the continuum is the possibility of a billing **error.** As you learned in Chapter 2, Medicare is complex. This complexity lends itself to innocent human errors that, if not caught, create losses to the Medicare program and to beneficiaries' own personal finances.

Next on the continuum is suspected **abuse**. Errors that become institutionally entrenched are one form of abuse in the Medicare program.

At the end of the continuum is Medicare **fraud**. Fraud is intentional and the types of fraud schemes are complex, sometimes even including the involvement of organized crime.

Former Senator Norm Coleman of Minnesota once said, “Scam artists have treated Medicare like an automated teller machine, drawing money out of the government’s account with little fear of getting caught.”

That is changing, however. Modern anti-fraud and abuse measures are being applied to the Medicare program. Former U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius said in February 2013:

> “The president’s health care law has allowed us to place a record number of boots on the ground to catch those seeking to game our health care system for personal gain. And through a combination of tougher criminal sentences and record civil recoveries, we have effectively deterred countless others from engaging in such conduct, saving taxpayers from immeasurable losses.”

Medicare Fraud and Abuse

The main difference between Medicare fraud and abuse is *intent.* Was the improper behavior *intentional* and conducted *knowingly*? Only the authorities will be able to make a final determination, not SMPs. It is still important to know the differences in the definitions of fraud and abuse. Both terms are commonly used. The actions authorities will take depend upon whether they suspect abuse or whether they suspect fraud.

Definition of Abuse

Medicare abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not **knowingly and intentionally** misrepresented the facts to obtain payment.

Medicare abuse is further defined as incidents or practices by providers that are inconsistent with accepted sound medical, business, or fiscal practices. These practices may directly or indirectly result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care or that are medically unnecessary. CMS includes in this definition “billing Medicare for services that are not covered or are not correctly coded.”

Definition of Fraud

Fraud assumes "criminal intent." Medicare fraud is defined as **knowingly** and **willfully** executing, or attempting to execute, a scheme or ploy to defraud the Medicare program or obtaining information by means of false pretenses, deception, or misrepresentation in order to receive inappropriate payment from the Medicare program.

The Centers for Medicare & Medicaid Services (CMS) further defines fraud as "the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true," and that is made "knowing that the deception could result in some unauthorized benefit to himself or herself or some other person."

Fraud vs. Abuse: Intent is Key

Inappropriate practices that start as abuse can evolve into fraud. A final determination can only be made after an investigation by the authorities.

Common Examples of Suspected Medicare Fraud or Abuse

- Billing for services or supplies that were not provided
- Providing unsolicited supplies to beneficiaries
- Misrepresenting a diagnosis, a beneficiary's identity, the service provided, or other facts to justify payment
- Prescribing or providing excessive or unnecessary tests and services
- Violating the participating provider agreement with Medicare by refusing to bill Medicare for covered services or items and billing the beneficiary instead
- Offering or receiving a kickback (bribe) in exchange for a beneficiary's Medicare number
- Requesting Medicare numbers at an educational presentation or in an unsolicited phone call
- *Routinely* waiving coinsurance or deductibles
    - Waivers are only allowed on a case-by-case basis where there is financial hardship, not as an incentive to attract business

Many more examples are provided in Chapter 4, which is dedicated to describing suspected fraud, errors, and abuse based upon specific types of Medicare-covered services.

KEY TERM

Anti-Kickback Statute: The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or generate federal health care program business.

Medicare Errors and Other Situations That May Not Be Fraud

The majority of health care providers are ethical, striving to provide quality care and to submit proper claims for payment. Billing Medicare for health care services involves following complicated rules and procedures, however, which can lead to human error in the billing process. It is important to not immediately jump to the conclusion of fraud if something doesn't look right on a Medicare Summary Notice (MSN) or Explanation of Benefits (EOB).

Because of Medicare's complexity, beneficiaries may have trouble understanding their Medicare statements and bills from providers or they may be suspicious of a charge or service that is actually legitimate. That's why SMPs encourage beneficiaries to contact their providers with questions as a typical first step in addressing suspected fraud, errors, and abuse.

Below are some common examples of suspected errors or misunderstandings:

Beneficiary Claims to Have Not Received a Service or Does Not Recognize a Provider Name

- A billing or processing error may have occurred. For example:
  - There may be two beneficiaries with the same name and the charge was assigned to the wrong person.
  - A coding mistake could have occurred, resulting in a charge for a different service than the one actually performed.
- The service could legitimately have been provided by a provider the beneficiary did not see in person or while conscious, such as an independent laboratory, pathologist, anesthesiologist, or radiologist.

High or Duplicate Charges on Hospital Inpatient Bill

- Medicare rules may allow for different charges in different settings. The hospital setting is a very common example. What may seem like high charges on a hospital bill compared to charges for a similar service in an outpatient setting may actually be legitimate, due to Medicare rules.
- Duplicate charges are often a billing or processing error.

Medicare Didn't Pay for Skilled Nursing Care

- The beneficiary may have entered the hospital as an outpatient under what's called "Observation Status" and was then transferred to skilled nursing without meeting Medicare's requirement for a three-day inpatient hospital admission. Though this is an area of concern for beneficiaries and their advocates, it is not fraud, error, or abuse.

If contacting the provider doesn't clarify whether or not an error occurred or whether the billing practice was consistent with Medicare rules, then Medicare fraud or abuse may be suspected. A pattern of error by a particular provider increases the likelihood of fraud or abuse and is considered a red flag.

The Impact of Medicare Fraud, Errors, and Abuse

The economic impact of Medicare fraud, errors, and abuse on taxpayers and the solvency of the Medicare Trust Fund are the most frequently touted reasons for addressing the problem. Less often discussed, but just as important to the SMP mission, is the economic and health impact to individual Medicare beneficiaries who are victims.

Medicare Trust Fund Losses

According to the Medicare Trustees report, total Medicare expenditures in 2012 were $574.2 billion. The prediction for Medicare expenses in 2022 is $1.0877 trillion, showing a near doubling in Medicare spending by the end of those 10 years. The projected dramatic increase in Medicare spending is due, in part, to a significant growth in the number of people eligible for Medicare – aging "baby boomers" – and inflation. With legitimate Medicare costs expected to rise, reducing loss due to fraud, errors, and abuse remains vital.

Improper Payments: Each year, CMS measures what is called "improper payments" out of the Medicare Trust Fund. For the most part, improper payments are known losses to Medicare, though improper payments also include instances when Medicare underpaid a provider. Improper payments are measurable and can result from a variety of errors, such as a claim paid based on an outdated fee schedule or payment for a duplicate claim. Improper payments due to known fraud and abuse are also counted. Some improper payments get corrected and the dollars returned to the trust fund whereas others are not recoverable. The HHS 2013 Agency Financial Report showed that there were $45.6 billion in Medicare overpayments in FY2013, which is about eight percent of total funding.

Fraud Estimates: Everyone agrees that money above and beyond what can be measured through improper payments is lost each year due to fraud, but that amount can only be estimated. In 2009, Daniel Levinson, inspector general of the U.S. Department of Health and Human Services Office of Inspector General, told the Senate Special Committee on Aging, "It is not possible to measure precisely the extent of fraud in Medicare." At the 2011 national SMP conference in Washington, D.C., Dr. Peter Budetti, then-director of CMS Program Integrity, said that the amount of Medicare funds lost due to fraud each year is not known; however, the more HHS spends to prevent and detect fraud the more it finds. What is clear is that the problem exists and efforts to address it through beneficiary and provider education, as well as law enforcement actions, produce results.

For years, the range for loss due to health care fraud has been estimated at three to 10 percent of expenditures. In a 2014 testimony to the Senate Special Committee on Aging, the National Health Care Anti-Fraud Association applied the 10 percent estimate to the nearly $600 billion in 2012 Medicare expenditures to estimate loss to the Medicare program at $60 billion.

> 2014 fraud estimates place annual Medicare losses in the 60 billion dollar range
>
> *–National Health Care Anti-Fraud Association testimony, 2014 Senate Special Committee on Aging*

Consequences to Beneficiaries

In addition to harming the Medicare program, Medicare fraud, errors, and abuse can result in serious personal consequences for Medicare beneficiaries, such as medical identity theft, negative health impacts, and personal financial losses.

Medical Identity Theft

Medical identity theft occurs when a beneficiary's Medicare number is misused, either by a provider, a supplier, or by someone posing as the real beneficiary in order to receive medical care. Such Medicare numbers are considered "compromised." Medicare numbers are for life, even if stolen or misused, so a beneficiary whose number is compromised may be affected forever by false claims against his or her Medicare number.

Health Impact

Receiving health care from a fraudulent provider can mean the quality of the care is poor, the intervention is not medically necessary, or worse: The intervention is actually harmful. A beneficiary may later receive improper medical treatment from legitimate providers as a result of inaccurate medical records that contain:

- False diagnoses
- Records showing treatments that never occurred
- Misinformation about allergies
- Incorrect lab results

Additionally, because of inaccurate or fraudulent claims to Medicare, beneficiaries may be denied needed Medicare benefits. For example, some services have limits. If Medicare thinks such services were already provided, they will deny payment.

Safeguarding Medicare numbers and reviewing MSNs and EOBs for accuracy are essential to protecting both the Medicare program and Medicare beneficiaries!

Personal Financial Losses

Medicare fraud, errors, and abuse can all result in higher out-of-pocket costs for beneficiaries, such as copayments for health care services that were never provided, were excessive, or were medically unnecessary. Beneficiaries may also find themselves stuck with bills for services from providers who should have billed Medicare but instead billed the beneficiary for the entire cost of that service. Finally, because Medicare numbers also contain Social Security numbers, financial fraud can be a side effect of having one's Medicare number compromised. Medicare numbers are as valuable as Social Security numbers to thieves who wish to set up credit card accounts with someone else's identity.

National Partnerships to Stop Medicare Fraud

The need for national partnerships to better address Medicare fraud has been a federal priority from at least 1997, when legislation established the **Health Care Fraud and Abuse Control Program (HCFAC)**, discussed in Chapter 1 as a funding source that supports SMP. HCFAC was made possible under the Health Insurance Portability and Accountability Act (HIPAA) and established a comprehensive national program with funding to combat fraud committed against all health plans, both public and private. The HCFAC program is designed to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse.

KEY TERMS

HCFAC: A comprehensive program to combat fraud committed against all health plans, both public and private, established under HIPAA. HCFAC is under the joint direction of the U.S. Attorney General and the U.S. Secretary of the Department of Health and Human Services (HHS) acting through the Office of Inspector General (OIG).

HIPAA: Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Established HCFAC and also other requirements important to Medicare, such as the MSNs and the CMS Medicare Integrity Program.

In 2009, thanks to HCFAC and also to the cabinet-level priority being placed on addressing Medicare fraud, HHS and the U.S. Department of Justice (DOJ) entered into a new partnership. Key HHS and DOJ players are involved:

- Federal Bureau of Investigation (FBI)
- Centers for Medicare & Medicaid Services (CMS)
- Office of Inspector General (OIG)
- Administration for Community Living (ACL)

A February 2014 HHS press release about the annual HCFAC program report outlined how the efforts of these national partnerships paid off. For every dollar spent on health care-related fraud and abuse investigations from 2010 through 2013, the government recovered $8.10. That was the highest three-year average return on investment in the 17-year history of the HCFAC program. This report is published by the OIG annually and is available at www.smpresource.org.

HEAT Task Force

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force was created through these national partnerships. HEAT is a multi-agency team of federal, state, and local investigators designed to fight Medicare and Medicaid fraud, particularly in cities deemed to have high rates of fraud. A Medicare Fraud Strike Force is part of HEAT, which uses Medicare data analysis techniques and an increased focus on community policing to combat fraud. Some highlights of HEAT Task Force accomplishments include:

- ✓ In 2011, HEAT coordinated the largest-ever federal health care fraud takedown involving $530 million in fraudulent billing.
- ✓ In May 2012, Medicare Fraud Strike Force teams charged 107 individuals, including doctors, nurses, and other licensed medical professionals, in seven cities for their alleged participation in Medicare fraud schemes involving more than $452 million in false billing.
- ✓ In October 2012, Medicare Fraud Strike Force operations in seven cities led to charges against 91 individuals – including doctors, nurses, and other licensed medical professionals – for their alleged participation in Medicare fraud schemes involving approximately $432 million in false billing.

The Medicare Fraud Strike Force had expanded to include nine cities by 2014:

- Baton Rouge, Louisiana
- Brooklyn, New York
- Chicago, Illinois
- Dallas, Texas
- Detroit, Michigan
- Houston, Texas
- Los Angeles, California
- Miami-Dade, Florida
- Tampa Bay, Florida

Public-Private Partnership

In 2012, a voluntary, collaborative partnership was created between government and private health insurers to prevent health care fraud on a national scale. Methods already long in use by the private sector are now being used by the government to prevent and detect Medicare fraud. One such method is called "predictive analytics," which analyzes Medicare claims to detect patterns that present a high risk of fraudulent activity. Public and private insurers can now share information on specific schemes, utilized billing codes, and geographical fraud hotspots so that action can be taken to prevent losses to both government and private health plans before they occur.

The Affordable Care Act: New Tools to Fight Fraud

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, contained many new tools to fight fraud that have enhanced these national partnerships. This act is most known for initiating the national Health Insurance Marketplace, also commonly referred to as "Obamacare." The lesser-known anti-fraud aspect of the ACA is of particular importance to SMPs.

Below is a summary of key ACA anti-fraud provisions:

Enhanced Oversight of Providers. The ACA provides new authorities for stepped-up oversight of providers and suppliers participating or enrolling in Medicare or Medicaid, such as:

- Mandatory licensure checks
- Mandatory use of national provider identification numbers on all claims
- Disclosure of financial relationships among providers and suppliers, including affiliations with anyone who has committed fraud

- Fingerprinting, site visits, and criminal background checks can be made a prerequisite to billing Medicare or Medicaid, based upon risk factors
- Provision of a detailed plan for fraud prevention rules as a condition of enrollment as a provider or supplier in Medicare or Medicaid
- Exclusion of providers who identify a Medicare overpayment and do not return it
- Withholding payment to any Medicare or Medicaid providers if an investigation is pending

Data Sharing. The ACA requires data sharing among CMS, Medicaid, the Department of Veterans Affairs, the Department of Defense, Social Security Administration, and the Indian Health Service. This sharing makes it easier to identify criminals who may be defrauding or abusing multiple programs.

Expanded Recovery Efforts. The ACA expanded overpayment recovery efforts in both Medicare and Medicaid. Also, if providers, suppliers, Part C plans, or Part D plans overcharge Medicare or Medicaid, they must now return funds within 60 days of when the problem is identified.

Tougher Rules, Investigations, and Sentencing. The ACA provides the authority to impose stronger civil and monetary penalties and also stronger sentences on those found to have committed fraud. It makes obstructing a fraud investigation a crime.

Responding to Complaints of Fraud, Errors, and Abuse

As you have learned, preventing and detecting potential Medicare fraud, errors, and abuse involves a cooperative effort among beneficiaries, SMPs, health care providers, federal agencies, and state agencies. Educational materials written for beneficiaries provide many options for reporting suspected fraud, errors, and abuse, primarily 1-800-Medicare (operated by CMS), private Medicare plans under contract with CMS, the OIG Hotline, and the SMP program.

How CMS Handles Complaints

CMS addresses fraud, errors, and abuse in the Medicare system. CMS becomes involved in errors because it is responsible for adjusting Medicare claims. When abuse is determined and administrative action is needed to address it, such as an order to return funds to Medicare, re-education, or a warning, CMS initiates that action. When CMS suspects fraud and criminal intent, it turns cases over to the OIG and other law enforcement entities.

CMS' handling of complaints varies based also upon whether a complaint involves Original Medicare, Medicare Advantage, or a Medicare Prescription Drug Plan. 1-800-Medicare triages complaints and refers them to the appropriate CMS contractor. CMS contractors may choose to refer some complaints to the OIG. Beneficiaries in private Medicare plans may be directed to contact their plan or CMS contractor directly.

The grid and text box below outline who handles the various types of complaints to CMS.

Type of Complaint	In Original Medicare	In Part C and Part D
Suspected error	*Claims Processing Contractor	The Medicare plan
Suspected fraud or abuse	**Program Integrity Contractor	**Program Integrity Contractor

CMS Contractors Defined

***Claims Processing Contractor**

MAC: Medicare Administrative Contractor. Reviews all standard Medicare billing claims for beneficiaries in Original Medicare.

****Program Integrity Contractors**

ZPIC: Zone Program Integrity Contractor. Investigates potentially abusive or fraudulent claims for beneficiaries in Original Medicare.

MEDIC: National Medicare Drug Program Integrity Contractor. Investigates potentially abusive or fraudulent claims for beneficiaries with Medicare Part D, as the name implies, but also Part C.

Addressing Errors: If a complaint is determined to be a billing error, processing error, or other misunderstanding, appropriate action is taken:

- Corrections are reflected on the beneficiary's MSN or EOB.
- Any improper payment to the provider is suspended.
- The Medicare claims processing contractor or private Medicare plan adjusts claims to reflect the correct information.

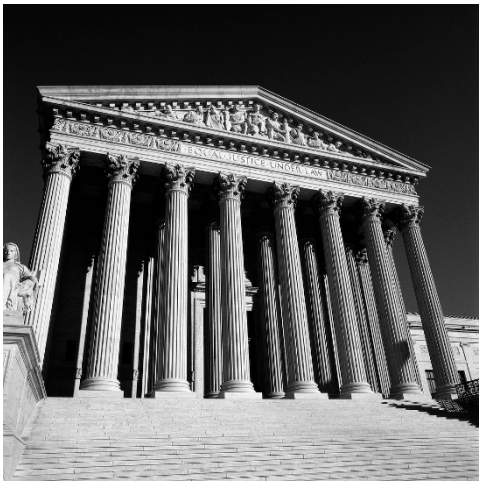
Addressing Abuse: When abuse is discovered, health care providers and suppliers will be asked to repay Medicare for overpayments. They are also provided with education or warnings. If patterns emerge, future claims by that provider may be subjected to a review before payment is authorized. If Medicare had overpaid a provider or supplier due to faulty claims, the overpayment can be deducted from current or future claims. Finally, providers and suppliers can be suspended or expelled from the Medicare program.

Addressing Suspected Fraud: If patterns of abuse continue, despite warnings, or if criminal intent is suspected or identified, CMS refers cases to the OIG and other federal law enforcement partners. CMS also keeps a database of compromised Medicare numbers. Claims by providers that involve numbers in this database may be subjected to greater scrutiny prior to authorizing payment.

The OIG and Medicare Fraud Complaints

The OIG is concerned primarily with fraud and criminal activity in the Medicare system. When legal action involving the justice system is needed, the OIG will become involved, working with other law enforcement entities, as needed. The OIG may take any of the following actions:

- Conduct an investigation
- Involve other state and federal law enforcement agencies, such as the FBI or Medicaid fraud control units (MFCUs)
- Seek criminal or civil prosecution
- Seek administrative sanctions (termination, agreements, etc.)
- Assess penalties
- Impose sanctions or exclusion from the Medicare program



- Impose civil monetary penalties (CMPs) up to $10,000 for repeated limiting charge violations

When the OIG receives complaints, it may send the complaint to CMS for further research and review before determining whether or not to investigate. Because the OIG and CMS collaborate to address complaints of health care fraud, there are mechanisms in place for referring cases to each other.

SMPs and Complaints of Fraud and Abuse

SMPs play a unique role in the fight against fraud and abuse. SMP volunteers and staff serve as "eyes and ears" in their communities, educating beneficiaries to be the first line of defense against Medicare fraud and abuse.

In Chapter 1, we learned how SMPs educate beneficiaries on how to prevent, detect, and report health care fraud. Prevention and detection efforts include educating beneficiaries, their family members, and caregivers on the importance of protecting personal information, safeguarding Medicare numbers, and reviewing MSNs and EOBs for accuracy (as shown in Chapter 2). When suspicious behaviors or charges are detected, SMPs educate beneficiaries about how to report their complaint.

Beneficiaries have many avenues to choose from when they wish to report potential health care fraud, errors, or abuse: their health care provider, 1-800-Medicare, their private Medicare plan, the OIG Hotline, or the SMP. Many beneficiaries choose to first turn to the SMP program for assistance because the SMP is a trusted and expert source of information about Medicare fraud, errors, and abuse. After all, part of the SMP mission is to *report* health care fraud, errors, and abuse. When errors are suspected, SMPs guide beneficiaries in the process of correcting them. When fraud or abuse is suspected, SMPs *refer* complaints to the proper authority; SMPs do not *investigate* suspected fraud and abuse. That is the role of CMS, the OIG, and law enforcement.

National referral protocols have been established for SMPs by ACL for use when suspected fraud or abuse is brought to the SMP's attention. There is a separate SMP training manual and policies for that process. This manual is not intended to prepare you to make referrals of suspected fraud and abuse on behalf of the SMP. Instead, this manual should prepare you to better *recognize* potential fraud, errors, and abuse.

Tip: Be sure you know who is responsible for handling complaints of suspected fraud and abuse at your SMP.

SMP Foundations Training Manual

CHAPTER 4: Common Scams and Fraud within Specific Medicare Services

Objectives

This chapter highlights common scams that target Medicare beneficiaries and discusses relevant coverage issues and fraud schemes within specific Medicare-covered health care services. Services addressed in this chapter are either at a known high risk of fraud or represent those most commonly brought to the attention of SMPs by beneficiaries suspecting fraud.

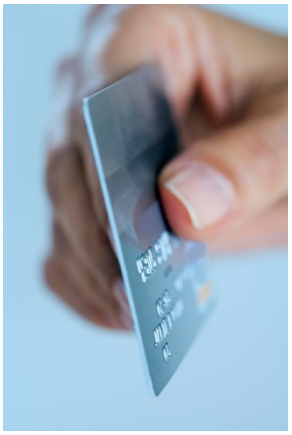
Upon completion of Chapter 4, you will be able to:

1. Identify consumer scams that target Medicare beneficiaries
2. Identify relevant Medicare coverage issues that are important to know before determining whether or not fraud can be suspected within specific health care services
3. Identify fraud schemes within specific Medicare-covered services
4. Identify legitimate and prohibited plan marketing practices

As you learned in Chapter 3, preventing and detecting Medicare fraud, errors, and abuse takes a coordinated effort by all of the national partners, with significant involvement by law enforcement. Some Medicare fraud, errors, and abuse can only be prevented and detected by CMS, the OIG, the DOJ and their private health insurance industry partners. In this chapter, we will focus on types of Medicare fraud, errors, and abuse that are detectable, at least in part, by beneficiaries and the SMP program. Because Medicare is complex, being able to first understand *legitimate* charges and practices within these targeted services is important to then being able to detect *suspicious* charges and practices.

Consumer Scams Targeting Medicare Beneficiaries

It is unfortunately common for Medicare beneficiaries to be targeted by telephone calls, mailings, or visits from scam artists who use Medicare as a ruse to obtain their sensitive personal identifying information, such as Medicare numbers, Social Security numbers, and bank account numbers. The Medicare program is complex; scam artists prey on beneficiaries' confusion about Medicare and also their fear of losing their health insurance. When Medicare numbers, Social Security numbers, or bank account numbers are obtained fraudulently, criminals may falsely bill Medicare, set up a credit card account in the beneficiary's name, or withdraw money from the beneficiary's bank account. Identity theft, medical identity theft, and financial fraud are the result.



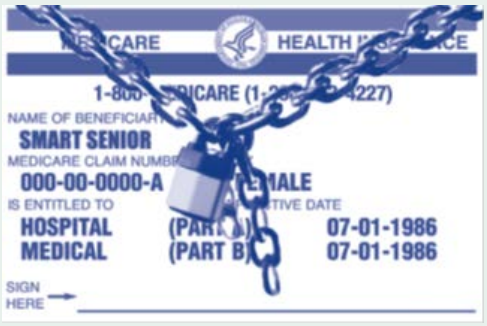
Medicare Card Scam

In this scam, individuals contact beneficiaries claiming to represent Medicare and saying the beneficiary needs a new Medicare card. They may threaten beneficiaries with the loss of Medicare benefits if the beneficiaries don't comply. Beneficiaries are asked to provide sensitive personal identifying information, particularly their Medicare number and bank account number, sometimes even being offered gifts or money. In other variations of this scam, beneficiaries are told that they have to pay for the new Medicare card.

It is important to remember that:

- Medicare beneficiaries receive a Medicare number and card automatically upon enrollment (as you learned in Chapter 2)
- Medicare cards do not expire
- Medicare will not call beneficiaries to offer a new card or request information in order to issue a new card
- Beneficiaries who lose their Medicare card can request a new one from the Social Security Administration

Medicare numbers contain Social Security numbers. Because of this, **a Medicare number is as valuable to identity thieves as a credit card.**



Obamacare Scam

In this scam, which was prevalent in the months after the passing of the Affordable Care Act (ACA) but still occurs, individuals may call or visit beneficiaries, claiming beneficiaries need to provide their Medicare number, Social Security number, bank account number, or other sensitive personal identifying information to retain Medicare benefits "because of Obamacare." Some scam artists even claim beneficiaries need to enroll in Obamacare as a justification for requesting sensitive personal identifying information.

It is important to remember that:

- The ACA was not originally referred to as "Obamacare," but the term has become a popular and accepted nickname for the ACA and for the resulting Health Insurance Marketplace
- The ACA did not affect Medicare for the most part. It did initiate the gradual closing of the Part D donut hole by 2020; however, no action is needed by beneficiaries enrolled in Part D
- The vast majority of Medicare beneficiaries are otherwise not affected by the ACA and it is, in fact, illegal to try to sell a Marketplace plan to a Medicare beneficiary

Medicare "Changes" Scam

The Medicare program changes over time and when it does, scam artists recycle old strategies to fit the changing health care environment. In this scam, individuals call or visit to explain Medicare "changes," then proceed to request sensitive personal identifying information. It can occur in conjunction with the Medicare Card or Obamacare scam. Like the Medicare Card and Obamacare scams, this scam uses a trusted and valued program – Medicare – to gain unauthorized access to beneficiary information.

It is important to know that beneficiaries may be **legitimately** contacted by CMS or CMS representatives as part of occasional "Medicare Current Beneficiary Surveys." CMS may also call or otherwise contact beneficiaries to resolve beneficiary complaints or investigate suspected fraud.

Ambulance Services

Medicare's ambulance benefit is frequently misunderstood. SMPs receive complaints about ambulance services that cover the entire range of suspected fraud, errors, and abuse. Sometimes providers bill beneficiaries directly rather than billing Medicare and beneficiaries wonder why. Sometimes beneficiaries are seen being transported by ambulance when the trip doesn't seem medically necessary and bystanders suspect fraud or abuse. At other times, Medicare denies coverage of an ambulance ride and beneficiaries wonder why their trip wasn't covered.

Ambulance Coverage Issues

Here are some basic Medicare definitions and rules about ambulance services that can help answer common SMP questions:

- **Definition of an Ambulance.** Medicare rules say that "any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in non-emergency situations, be capable of transporting beneficiaries with acute medical conditions." The rules also require that an ambulance must at least have a stretcher, linens, emergency medical supplies, oxygen equipment, and warning devices. If a vehicle does not meet these criteria, Medicare will deny the claim (unless the claim misrepresents the nature of the vehicle, which would be fraud).
- **Medical Necessity.** Ambulance rides must be medically necessary for Medicare to cover them. The key in the ambulance context is to show that transport in a vehicle other than an ambulance was "contraindicated," meaning that a trip by car or taxi would have put the patient's health at risk. Lack of medical necessity is a common reason for Medicare to deny ambulance claims.

- **Emergency Transport.** This level of ambulance service is provided in immediate response to a 911 call or the equivalent and when basic or advanced life support is required. Here are some examples of situations where the need for emergency transport can be assumed:
    - Accident, traumatic injury, or acute or life-threatening illness
    - Restraint is needed to prevent injury to the beneficiary or others
    - Oxygen or other emergency treatment is required during transport

- **Non-emergency Transport**. In non-emergency situations where transport in another vehicle is contraindicated, Medicare will only cover ambulance trips if the beneficiary is "confined to bed." This means that the beneficiary is unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair. Patients who need dialysis receive Medicare-covered ambulance transports when they meet these coverage criteria.
- **Air Ambulance.** Medicare covers transport by airplane or helicopter to the nearest appropriate hospital when transport by ground ambulance is contraindicated. Transport by an air ambulance is medically necessary when the beneficiary's condition is such that the length of time or instability of a ground transport would threaten the beneficiary's survival or seriously endanger his or her health.
- **Transportation Between Hospitals.** Most ambulance trips are covered by Part B. With hospital to hospital trips, however, it may be Part A. Part A covers some ambulance trips as "patient transportation" where a beneficiary is an inpatient in a hospital or skilled nursing facility (SNF) and "it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider." If the patient is discharged prior to transport to another hospital, it should be covered by Part B.
- **Medicaid May Cover Rides that Medicare Does Not.** Federal law requires Medicaid programs to ensure that necessary transportation to and from health care providers is available. This rule results in coverage for non-emergency ambulance trips to a doctor's office in some states, usually with prior authorization. Along with ambulance services, most state Medicaid programs cover some type of nonambulance transportation service.

Ambulance Fraud Schemes

- Falsification of documentation to provide the appearance of medical necessity when medical necessity did not actually exist
- Billing for more miles than actually traveled
- Billing non-emergency trips as emergency trips
- Billing Medicare for transport in vehicles that do not meet the definition of an ambulance
- Billing the beneficiary instead of Medicare if the provider participates in Medicare and the trip met Medicare's coverage criteria

News Releases: Ambulance Fraud

For real-life examples of ambulance fraud, see the following news releases in Appendix C:

- In ***Ambulance Company Driver Sentenced to Prison,*** a driver altered documentation to falsely show medical necessity.
- In ***Owners of Los Angeles Ambulance Company Sentenced for Medicare Fraud Scheme***, the owners knowingly provided non-emergency ambulance transportation to Medicare beneficiaries whose medical condition at that time did not require ambulance transportation.

Equipment and Supplies

Medicare Part B covers a wide variety of **durable medical equipment (DME)**, prosthetics, orthotics, and supplies, which are at a high risk of fraud and abuse. The vulnerabilities of these services were recognized in the Affordable Care Act (ACA), which created tools to prevent and detect fraud as well as to take strong enforcement action against fraud in this area. CMS has also implemented improved standards for providers and suppliers of these items through the **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding system**. Though this system is not yet nationwide, it is expanding. The DMEPOS competitive bidding system is designed to make it more difficult for fraudulent providers to enter and remain in the Medicare system.

KEY TERM

DMEPOS Competitive Bidding Program: Mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), this program requires that Medicare replace the current fee schedule payment methodology for selected Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items with a competitive bid process.

Below are examples of Medicare-covered equipment and supplies:

- **DME** includes such things as oxygen equipment and supplies, wheelchairs (including power mobility devices such as "scooters"), walkers, hospital beds, infusion pumps, and canes
- **Prosthetics and orthotics** include devices such as artificial limbs, breast prosthesis, ostomy supplies, back braces, neck braces, shoe inserts, and therapeutic shoes for people with severe diabetic foot disease
- **Medical supplies** include such items as surgical dressings, diabetes test strips, parenteral and enteral nutrition (specially formulated liquid nutrition) supplies for tube feeding

Equipment and Supplies Coverage Issues

Durable medical equipment (DME), prosthetics, orthotics, and medical supplies must be **prescribed** and are for **use in the patient's home**. Some types might be carried with you away from home. A hospital or nursing facility providing skilled nursing or rehabilitative services is not considered a home. For Medicare to allow coverage for any equipment and supplies, the item must meet the following requirements:

- Be medically necessary and meet Medicare guidelines for coverage
- Be appropriate for use in the home
- Serve primarily a medical purpose – that is, it cannot serve as merely a comfort and convenience item or be of use to persons who are not sick or injured
- Be able to withstand repeated use (does not apply to medical supplies)
- Be furnished by a Medicare certified vendor

Power Mobility Devices (PMDs)

Power mobility devices (PMDs) consist of power-operated vehicles – often referred to as scooters – and power wheelchairs. This particular Medicare benefit warrants special attention for three major reasons: 1) PMDs are very expensive, 2) Medicare will only replace these items after they have had five years of continuous use, and 3) this benefit is frequently targeted for fraud and abuse. PMD manufacturers may advertise that their products are covered by Medicare, but Medicare coverage is not automatic and a PMD is not covered in every case.

The physician or treating practitioner must provide documentation establishing that:

- The patient has a mobility limitation that significantly impairs his or her ability to perform mobility-related activities of daily living such as toileting, dressing, grooming, bathing, and feeding
- The patient does not have sufficient upper extremity function necessary to operate a manual wheelchair during a typical day

- The patient's mobility limitation cannot be resolved by a walker or cane
- The patient's mental and physical abilities are sufficient to operate the vehicle safely within the home
- The patient's weight or home environment are not prohibitive to safe use of the vehicle
- The patient has not expressed an unwillingness to use the vehicle

The following additional guidelines apply to power wheelchairs:

- The patient does not qualify for a power-operated vehicle (scooter).
- If the patient's mental and physical abilities are not sufficient to operate the vehicle safely within the home, there is a caregiver able and willing to assist, though the caregiver must be unable to adequately propel a manual wheelchair.
- For power wheelchairs that require special drive controls beyond the standard joystick, additional criteria apply, such as specialized provider certifications.

Equipment and Supplies Marketing Guidelines

Guidelines are in place to limit the ability of providers and suppliers to market equipment and supplies directly to beneficiaries. These marketing guidelines prohibit unsolicited direct contact with beneficiaries.

Marketing of Medicare-covered items can only take place under one or more of the following three circumstances:

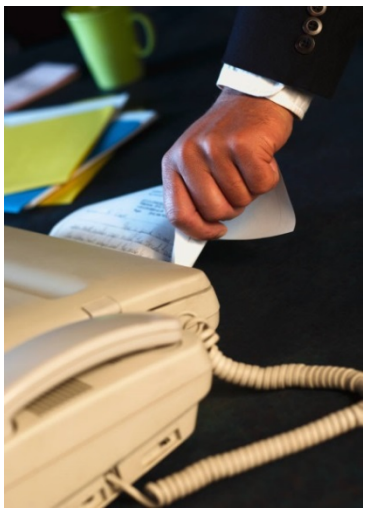
- The beneficiary has given written permission to be contacted
- The supplier is contacting the beneficiary about an item already provided
- The supplier has furnished one Medicare-covered item within the previous 15 months

Equipment and Supplies Fraud Schemes

The types of practices below are abusive or fraudulent:

- **Marketing Violations:**
  - Making unsolicited calls to beneficiaries to market items such as diabetes supplies or back braces
  - Requesting beneficiaries' health information, such as Medicare numbers and physician names, during unsolicited calls

- **Billing Practices**
  - Billing for rental equipment after date of return
  - Billing for equipment before it is delivered
  - Billing for equipment or supplies never provided
  - Billing that inappropriately overlaps with patients' hospital or skilled nursing facility stays
  - Refusing to pick up equipment after contact by recipient or physician and continuing to bill
  - Providing off-the-shelf items, such as shoe inserts, but billing Medicare for more expensive or custom made items, such as custom diabetic shoes
  - Billing for unnecessary or excessive repair or maintenance costs
- **Falsely Documenting Medical Necessity**
  - Completing documentation to show medical necessity for a patient not professionally known by the physician or treating practitioner
  - A supplier completing sections of necessary documentation reserved for the physician or treating practitioner
  - Falsifying documents to justify providing (or billing for) supplies to beneficiaries who do not otherwise meet the medical necessity requirement
  - Sending faxes to physicians requesting they sign off on equipment and supplies for individual patients is one way unethical suppliers attempt to obtain documentation regardless of true medical necessity
    - These faxes are sometimes the consequence of information gained through marketing violations



- **Dumping of Supplies**
  - Excessive amounts of supplies delivered to a recipient that cannot possibly be used within the prescribed time frame
  - Supplies delivered for equipment the recipient no longer uses
  - Supplies delivered when there is no prescribed equipment to justify the delivery of supplies
  - Delivery of supplies or equipment that the beneficiary does not need or did not ask for
    - Inappropriate provision of diabetes supplies is a common example

- **"Free" Offers**
  - Offering free supplies in exchange for Medicare numbers (and then billing Medicare, of course)
  - Offering free meals, food, or nutritional supplements, then billing Medicare for costly liquid nutritional supplies only given through tube feedings

News Release: Equipment and Supplies

For a real-life example of equipment and supplies fraud, see ***DME Owner Convicted on all Counts*** in Appendix C. In this case, a company billed Medicare thousands of dollars for tube feedings and supplies for beneficiaries who did not need or receive the feedings or supplies, using physician names and identifying numbers without the physicians' knowledge.

Home Health

Medicare's home health benefit has been frequently targeted for fraud and abuse. In fact, stopping home health fraud and abuse was stated as a top priority of the OIG in 2014. The vulnerability of this particular Medicare-covered service was also addressed by the Affordable Care Act (ACA), which put into law the following preventive measures:

- Requiring home health services to be ordered by a Medicare-enrolled physician or treating practitioner
- Requiring a physician or treating practitioner to have a face-to-face encounter (including via telehealth) with an individual, which must take place 90 days before the certification or 30 days after services start

Home Health Coverage Issues

If all of the required conditions are met, Medicare Part A covers the following services in the home, with one exception, as indicated:

- Skilled nursing care
- Physical therapy
- Speech therapy
- Occupational therapy
- Medical social services
- Home health aide services
- Medical supplies (other than drugs and biologicals)
- Durable medical equipment (provided under Part B)

The criteria for Medicare coverage of these home health services include the following:

- Home health services must be based on a plan of care **ordered** (or established and approved) by a **physician or treating practitioner**, who recertifies the need for home health care every 60 days.
- Patient must be **homebound**.
    - Because of illness or injury, the patient must need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave his or her place of residence; OR must have a condition such that leaving his or her home is medically contraindicated.
    - The patient must ALSO lack a normal ability to leave home AND leaving home must require a considerable and taxing effort.
- **Skilled care** services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury.
    - Skilled nursing services require the specialized judgment, knowledge, and skills of a registered nurse or, in some cases, a licensed practical nurse. Examples of skilled nursing services provided in the home setting include wound care, many injections, ostomy care, and tube feedings.
    - The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and effectively only by or under the general supervision of a skilled therapist. Some examples include therapeutic exercises, gait training, and range of motion exercises.
- Medicare beneficiaries should not be charged copayments, coinsurance, or deductibles for Medicare-covered home health care.
    - Equipment and supplies provided by a home health agency under Medicare Part B, however, may involve cost sharing.

Home Health Aide Services: Special Rules

There are special rules about the types of home health aide services for which Medicare will pay, primarily:

- A patient must also be receiving skilled nursing or rehab services.
- The aides must “provide hands-on personal care of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury.”

- If Medicare is paying for skilled home health care, it will also cover certain personal and custodial care commonly referred to as "home health aide care." Examples of covered home health aide services include assistance with:
    - Bathing
    - Dressing
    - Exercising
    - Getting in and out of bed
    - Toileting
- If personal care is the main purpose of the visit, aides can also provide services that are "incidental to personal care services" such as meal prep, taking out the trash, and "light housekeeping."
    - "Light housekeeping" includes changing bed linens, preparing meals, or doing laundry (but only for the patient).

Medicaid and Home Health

It is important to remember that Medicaid programs cover home and community-based services that aren't covered under Medicare. The coverage and eligibility criteria vary from state to state.

Home Health Fraud Schemes

- Billing for visits that are not provided
    - This can even result in a beneficiary being denied coverage for actual and legitimate home health care because Medicare thinks the services are already being provided
- Billing for more days of care than were provided
- Billing for skilled care services when no actual skilled care was provided or was not provided by the appropriate health care professional
- Billing for services to beneficiaries who do not meet the homebound criteria for Medicare coverage
    - For example, providing help with cooking, cleaning, shopping, and other household duties if the beneficiary is capable of performing his or her own chores and regularly leaves the residence for shopping, walking, or to visit friends and relatives
- Billing housekeeping or custodial services as skilled nursing or therapy services
    - For example, providing home health aides to patients in assisted living facilities and billing separately for these services, which should be provided by the assisted living facility

- Offering cash, gifts, or incentives such as free groceries or free transportation to beneficiaries in exchange for their Medicare number or for switching to their agency
- Offering to provide home-delivered meals, nonmedical transportation, housekeeping, or chore services when these are the only services needed and they aren't related to an approved plan of care
- Altering records to falsely indicate that a physician ordered or reordered the home health agency skilled care
- Paying "kickbacks" for patient referrals
    - Such as to a residential care facility operator who wants to provide "free" home health aide services in the facility when that facility should be providing those same services at no additional cost to Medicare

- Charging beneficiaries a copayment, coinsurance, or a deductible for home health services
- Asking beneficiaries to sign forms falsely verifying that Medicare home health services were provided

News Releases: Home Health

For a real-life example of a home health scam, see the press release ***Local In-Home Healthcare Provider Pleads Guilty to Fraud Charges*** in Appendix C. The agency provided care to patients who did not need it, billed Medicare for care that wasn't provided, falsified the diagnosis codes, and exaggerated patients' conditions to justify payment.

Hospice Care

Hospice care is provided under Medicare Part A for persons whose doctor has certified that they are terminally ill and expected to live six months or less if the disease runs its normal course. The hospice care benefit was considered at a high risk for fraud when the Affordable Care Act (ACA) was passed. One reason for this was a 2009 Medicare Payment Advisory Commission report noting that "Medicare's hospice payment system contains incentives that make very long stays in hospice profitable for the provider, which may have led to inappropriate utilization of the benefit among some hospices." To help reduce opportunities for fraud in hospice, the ACA requires documented face-to-face encounters with every hospice patient to determine continued eligibility.

Hospice Care Coverage Issues

Medicare's hospice benefit is available to beneficiaries who are certified by a physician as terminally ill and have a life expectancy of six months or less, if the illness runs its normal course. A Medicare beneficiary is entitled to two 90-day periods of hospice care, followed by an unlimited number of 60-day periods, which must also be certified. If a patient chooses the hospice benefit, the traditional cure-oriented Medicare-covered services are replaced with hospice care. However, if a patient is receiving hospice care and needs treatment for a condition unrelated to the terminal illness, Medicare will pay for medical care for the unrelated injury or illness. For example, if a person with terminal cancer has the hospice benefit and then breaks an arm, Medicare will still pay for treatment of the broken arm. Medicare will continue to cover the hospice care even if the patient does not actually die within six months, unless the beneficiary chooses to leave hospice care and return to cure-oriented Medicare-covered services.

Hospice Benefit's Unique Payment Structure

Medicare reimburses for different levels of hospice care. In the context of Medicare fraud detection, it is particularly important to understand the continuous home care level of care, which is also called "crisis care." It is available only for a patient who is experiencing acute medical symptoms resulting in a brief period of crisis and who requires the immediate, short-term provision of skilled nursing services in order to remain at home. The reimbursement rate for crisis care services is the highest daily rate a hospice can bill Medicare. Hospices are paid several hundred dollars more daily for each patient they certify as having received crisis care services rather than routine home hospice services.

Unlike most other Medicare-covered services, beneficiaries who elect hospice care have few out-of-pocket costs. Medicare will cover everything except for:

- A $5 copayment for outpatient prescription drugs for pain and symptom management
- Five percent of the Medicare-approved amount for inpatient respite care

When Beneficiaries are Enrolled in a Medicare Advantage Plan

Another unique aspect of the hospice benefit is that it is covered solely under Original Medicare. Medicare Advantage Plans may not newly enroll beneficiaries who are receiving the hospice benefit. Beneficiaries who are already enrolled in a Medicare Advantage Plan and later wish to receive hospice care will receive all Medicare-covered services through Original Medicare. Their Medicare Advantage Plan will continue to cover any extra services not covered under Original Medicare (such as vision and dental) while the beneficiary is in hospice care.

Hospice Care Fraud Schemes

- Falsely certifying that a patient is terminally ill
- Inflating the level of care beyond what the patient actually needs, such as falsely documenting the patient needs crisis care to receive the highest reimbursement rates
- Providing gifts to beneficiaries to encourage them to agree to a hospice level of care (even though they are also unlikely to be terminally ill)
- Billing for hospice services not provided

News Releases: Hospice Care

For real-life examples of hospice care fraud, see the following news releases in Appendix C:

- In ***Owner, Manager, and Hospice Company Indicted for Committing Medicare Fraud***, the company concealed the true medical condition of their patients and the true quality and quantity of health care services they were receiving in order to fraudulently obtain payment from Medicare.
- In ***U.S. Files Complaint against Philadelphia Hospice Provider and its Owners and Operators Alleging False Claims on Medicare***, the defendants knowingly submitted false claims and records (including fabricated records) to Medicare for purported hospice care for patients who were not terminally ill and thus not eligible for the Medicare hospice benefit. They also filed false claims for crisis care hospice services that were not necessary or not actually provided.

Medicare Advantage and Prescription Drug Plan Marketing

As explained in Chapter 2, Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D) are administered, marketed, and sold by private insurance companies. CMS has marketing guidelines that plans and plan representatives, including insurance agents, must follow. The purpose of these marketing guidelines is to protect Medicare beneficiaries from manipulative and deceptive sales and enrollment tactics.

Legitimate Contacts by Plans with Medicare Beneficiaries

Plans may contact beneficiaries who are already enrolled in their plan, unless the beneficiary has expressly refused certain contacts. Common legitimate contacts by plans include:

- ✓ A plan that offers Medigap insurance to beneficiaries enrolled in Original Medicare may send those beneficiaries information about the company's Part C and Part D plans, as long as the beneficiary has not refused mailings of materials.
- ✓ A plan contacts a beneficiary who has reviewed advertising or attended an educational event and gives permission to be contacted later by the plan.
- ✓ A plan that offers Medigap insurance has initiated a call with a current customer, who then asks about the plan's Part C and Part D products.
- ✓ An unsolicited outbound call may be made to beneficiaries currently enrolled in a Part C or Part D plan to conduct "normal business." For example:
  - o Calling a beneficiary on "Extra Help" who needs to be reassigned
  - o Initiating a phone call to confirm an appointment
  - o Contacting members to discuss educational events
  - o Contacting former members after the disenrollment date to conduct a disenrollment survey
  - o Returning beneficiary phone calls
- ✓ Home visits from a plan salesperson when a beneficiary has requested one (this includes visits in long-term care facilities).
- ✓ Agents and brokers who have a pre-scheduled appointment may leave plan information at a beneficiary's residence if the beneficiary is a "no show" for the scheduled appointment.

Beneficiaries who are already enrolled in Medicare Advantage plans may receive calls from plans or plan representatives about wellness benefits. Beneficiaries in Medicare Advantage who are also eligible for Medicaid (dual-eligibles) may receive calls from their plan or plan representatives related to coordination of the Medicare and Medicaid benefits. Legitimate contacts from Medicare Advantage plans of this nature will not entail requests for Medicare numbers or bank account numbers.

Legitimate Advertising by Plans

Because Part C and Part D plans are products that are sold, they are advertised. CMS divides these activities into the categories of "Marketing" (sales) and "Education" (informational only). Following are common rules for marketing and education:

- ✓ Advertising at events that are intended for marketing purposes must explain:
  - o "A sales person will be present with information and applications"

- "For accommodation of persons with special needs at sales meetings call <insert phone and TTY number>"

✓ Events that are purely educational and not for sales purposes are advertised as such.

✓ Providing a beneficiary with business cards at an educational event and responding to questions if asked is allowed, as long as business cards are free of marketing or benefit information.

✓ Plans can provide a meal valued at $15 or less at an event that is for general Medicare education purposes, not marketing.

✓ Plans can provide a light snack to prospective beneficiaries at events where plan benefits are discussed and plan materials are distributed.

✓ Offering promotional activities or items that are of "nominal" value is allowed

✓ Physicians can provide brochures or other educational materials about the plans in which they participate as long as they remain unbiased.

✓ Plan representatives can conducts sales presentations and distribute and accept enrollment applications in a common area of a health care setting, such as:

- Hospital or nursing home cafeterias
- Community, recreation, and conference rooms

✓ In long-term care facilities, plans can:

- Display posters
- Include materials in admission packets
- Provide to residents that meet Special Needs Plan criteria a brochure for each Special Needs Plan with which the facility contracts

Prohibited Contacts by Plans with Medicare Beneficiaries

As with legitimate contacts by plans, prohibited contacts often depend (though not always) upon whether or not the plan has a prior relationship with a beneficiary and whether or not the beneficiary has opted out of certain communications. The following are prohibited:

Ø Conducting unsolicited phone calls to beneficiaries with whom they have no prior relationship, including telemarketing

Ø Sending unsolicited emails to beneficiaries who have not agreed to receive emails

Ø Mailing or calling a beneficiary who has requested to opt out of receiving such communications

Ø Agents or brokers representing themselves as though they come from or were sent by Medicare, Social Security, or Medicaid

- Making an unsolicited home visit – i.e., "door-to-door cold call" sales
- Leaving information such as leaflets, flyers, and door hangers on someone's car or at their residence (unless the beneficiary is a "no show" for a pre-scheduled appointment)
- Initiating a discussion about other insurance products, such as life insurance annuities, during a visit or meeting about a Part C or Part D product
- Returning uninvited to a beneficiary's residence after an earlier "no show"

Prohibited Advertising by Plans

As with legitimate advertising by plans, prohibited behavior often depends (though not always) upon whether the purpose is for educational purposes (informational) or marketing purposes (sales). The following are prohibited:

- An advertisement for an event does not state its purpose – marketing or education
- Distributing communications that resemble government mailings
- Sending unsolicited emails, text messages, or voicemails to a beneficiary
- Providing a meal to prospective beneficiaries at any event or meeting at which plan benefits are being discussed or plan materials are being distributed
- Collecting beneficiary contact information at an education event, such as:
  - Asking all participants to provide personal identifying information as part of a general "sign in" sheet
  - Asking for contact information to participate in a drawing for a prize
- Representing themselves as though they come from or were sent by Medicare, Social Security, or Medicaid
- Requesting Social Security numbers, bank, or credit card info at education or marketing events
- Marketing in the same building where an education event is taking place (or just took place)
- Requiring a face-to-face meeting to provide plan details
- Displaying business cards at educational events or attaching them to educational materials

- Holding an educational event in a private home or other one-on-one setting
- Soliciting individual appointments under the premise that the appointment is only for educational purposes (individual appointments can only be for marketing purposes)

- Offering promotional items or activities over the course of a year that have an aggregated value of more than $75 per person.
- Offering items that are considered a health benefit for free as a promotion (e.g., a free checkup)
- Using high-pressure sales tactics
- Conducting sales presentations and distributing and accepting enrollment applications where patients receive care. Restricted areas include:
  - Waiting rooms
  - Pharmacy counter areas
  - Exam rooms
  - Hospital patient rooms

Prohibited Enrollment Practices

Plan salespersons are prohibited from doing any of the following to enroll a beneficiary in their plan:

- Removing a beneficiary from Original Medicare and enrolling them in Medicare Advantage without their knowledge
- Falsely stating that their doctor accepts the plan
- Preying upon vulnerable people (limited English, memory impaired, etc.) for purposes of enrolling them in a plan, regardless of whether that plan meets their needs
- "Cherry-picking" enrollees (selecting or denying beneficiaries based on their illness profile)
- Enrolling or attempting to enroll a dually eligible beneficiary in their plan, regardless of its appropriateness for that beneficiary
- Arranging to discuss a Medicare Advantage Plan with a beneficiary but then initiating a discussion about other insurance products, such as life insurance annuities
- Misrepresenting a product as an approved Medicare Advantage Plan when it is actually a Medigap policy
- Providers cannot steer beneficiaries to a specific plan in order to further their own financial interests

CMS updates their Medicare Advantage marketing guidelines annually. Visit www.cms.gov and click on "Medicare" to review the most recent guidelines in their entirety.

Nursing Facilities

Skilled Nursing Facilities (SNFs) and nursing facilities (NFs) are commonly known as "nursing homes." Nursing homes serve the most vulnerable older adults, who may be unable to respond to suspected fraud, errors, and abuse on their own behalf. Caregivers and family members often play a crucial role by scrutinizing statements and bringing their concerns to the attention of the appropriate entities, such as the SMP. According to the OIG, some unscrupulous facilities (even some associated with national chains) have taken to fraudulent billing because the current Medicare payment system provides incentives to SNFs to bill for more expensive levels of care that include therapy, even when those levels of care may not be necessary.

To help prevent nursing facility fraud, the Affordable Care Act requires that SNFs and NFs operate a compliance and ethics program that will effectively prevent and detect criminal, civil, and administrative violations. It requires a nationwide program for national and state background checks on prospective direct patient access employees of long-term care facilities and providers.

Nursing Facilities Coverage Issues

Nursing facility care may be paid by Medicare, Medicaid, long-term care insurance, or privately, depending upon the circumstances. To identify suspected Medicare fraud in facilities, it is important to review some of the definitions and coverage criteria specific to SNFs.

SNFs play a crucial role in providing therapy and rehabilitation after a Medicare beneficiary has suffered a debilitating illness or stroke. After a qualifying stay in the hospital, Medicare beneficiaries frequently need rehabilitation and therapy to regain their strength and independence. SNFs are nursing homes that provide skilled nursing care, rehabilitation services such as physical, occupational, or speech therapy, and other services such as assistance with eating, bathing, and toileting.

Medicare Part A (Hospital Insurance) pays for nursing home care when all three of the following requirements are met:

1. The facility is a Medicare-certified SNF.
2. A physician has ordered daily skilled nursing or therapy services.
3. The patient has completed a 3-day minimum medically necessary inpatient hospital stay for a related illness or injury.
    - Note: Days a patient is placed on "observation status" in the hospital do not qualify toward the required 3-day minimum inpatient hospital stay. This has resulted in high out-of-pocket expenses for many beneficiaries who were unaware of their exact inpatient status.

Skilled Care in Nursing Facilities

As you know, some skilled care is provided in the home as part of Medicare's home health benefit. When a beneficiary's medical condition requires it, skilled care is provided in nursing facilities by professional health personnel such as registered nurses, licensed practical/vocational nurses, physical therapists, occupational therapists, speech pathologists, and Audiologists.

Skilled nursing services commonly provided in an SNF include but are not limited to intravenous feeding; insertion, sterile irrigation, and replacement of catheters; application of dressings involving prescription medications; and treatment of extensive decubitus ulcers (bedsores) and other widespread skin disorders.

Benefit Periods

If all coverage criteria are met, Medicare covers up to 100 days of skilled nursing facility care in each benefit period. Medicare pays in full for the first 20 days. For days 21 to 100, the patient is responsible for a daily coinsurance charge. Many Medicare Supplement Insurance (Medigap) policies cover coinsurance charges. Other beneficiaries rely on Medicaid, if they are eligible. There is no Medicare Part A coverage beyond 100 days in each benefit period regardless of a patient's continuing need for skilled care. Medicare Part B may pay for certain services provided in the nursing facility, such as x-rays, laboratory work, physicians' visits, and physical therapy, even if criteria for Medicare Part A coverage of the nursing facility stay are not met.

Nursing Facilities Fraud Schemes

- According to the OIG, fraudulent SNFs typically engage in a type of billing fraud called "upcoding." Upcoding is a misrepresentation of services rendered by using procedure codes not appropriate for the item or service actually furnished. The procedure codes that are used are reimbursed at a higher rate.
    - Example: billing social activities or life services as psychotherapy
- The OIG also reports that another typical scheme is to place the patient into the highest Resource Utilization Group (RUG) category. This category reimburses the rehab center the most Medicare money. The beneficiary receives excessive therapy time that is generally medically unnecessary and could be dangerous to the patient.
- Billing for medical supplies not provided to the patient

News Release: Nursing Facilities

For real-life examples of fraud in nursing facilities, see the following news releases in Appendix C:

- In ***Nationwide Contract Therapy Providers to Pay $30 Million to Resolve False Claims Act Allegations,*** the company allegedly billed for medically unnecessary therapy in order to falsely inflate claims and also engaged in kickbacks.
- In ***Two Companies to Pay $3.75 Million for Allegedly Causing Submission of Claims for Unreasonable or Unnecessary Rehabilitation Therapy at Skilled Nursing Facilities***, the company provided unreasonable or unnecessary therapy to patients in order to increase Medicare reimbursement to the facilities. Claims for reported therapy did not reflect the lower amounts of therapy generally provided to patients over the course of their stay.

Prescription Drugs

In 2014, the OIG made prescription drug fraud a focus, saying this type of fraud is a growing problem, particularly medications provided but not needed, medications billed to Medicare but never provided, and prescription drug diversion. Criminals have moved from the illegal drug trade into the prescription drug black market, in part at the expense of Medicare.

Prescription Drug Coverage Issues

Prescription drugs are covered under all parts of Medicare, though the coverage criteria vary within each part. Fraud affects prescription benefits in all parts of Medicare and is not as tied to specific coverage criteria as the other Medicare-covered services described in this manual. For example, some beneficiary complaints related to prescription benefits involve suspected Part D marketing violations (discussed on pages 86 – 90) or offers of prescription drug discount cards.

Offers of Discount Plans and Cards

It is not unusual for SMPs to get reports from beneficiaries that they were solicited to subscribe to a prescription drug discount card. Though widely available, these cards are a controversial subject among SMPs. The question of their legality and benefit arises often. The Federal Trade Commission (FTC) places prescription drug discount cards in the same category as medical discount plans. They are legal, as long as marketing them does not involve deception or theft. Are they beneficial, however? It depends. Below is a list of common pros and cons raised about the prescription drug discount cards.

Pros	Cons
✓ Can save a beneficiary money on prescriptions while they are in the Part D donut hole, particularly if they don't expect to get out of the donut hole	Ø Can delay getting out of the Part D donut hole
✓ Some are offered by trusted organizations at no cost to the recipient	Ø Some companies use questionable marketing tactics, raising concerns about their ethics and legitimacy
	Ø Some are scams
	Ø The rules pertaining to the cards can be confusing
	Ø Some have fees
	Ø They may not offer a true benefit; for example, they may not be accepted at the beneficiary's pharmacy

Prescription Drug Fraud Schemes

Prescription drug fraud can be committed by any provider who prescribes or dispenses drugs or an employee of such a provider. It can also be committed by persons *posing* as Medicare providers, by Medicare beneficiaries, or by persons who steal from Medicare beneficiaries to sell drugs on the black market (particularly painkillers, such as hydrocodone, oxycodone, and methadone).

Schemes to Falsely Bill Medicare

- Billing for drugs not prescribed
- Billing for amounts beyond the quantity prescribed
- Billing for brand name drugs, but dispensing generic drugs instead
- Billing in excess of a physician's prescription
- Prescription forged by a provider or supplier
- Prescription written and signed by a physician who has not treated or seen the recipient

Schemes to Debit Beneficiary Bank Accounts

Sometimes referred to as $299, $389 or $399 scams because of the amount of money taken, scam artists call beneficiaries, offer a prescription drug discount card for a fee, and ask for their bank account number. There are other variations on this theme, such as:

- Offering a year's supply of prescription drugs for a set fee, requesting the beneficiary's bank account number
- Marketing discount cards for a fee when the cards are actually free
- Marketing cards to beneficiaries even though they are on the National Do Not Call Registry
- Threatening beneficiaries with a loss of health care benefits if they do not make the purchase

Prescription Drug Diversion

Prescription drug diversion is the redirection of prescription drugs for illegitimate purposes. According to the OIG, "a contributing factor may be that this type of fraud can be very lucrative. In Northern California, for example, OIG agents report that a bottle of 30mg Oxycodone tablets are trafficked at a price of $1,100 – $2,400 a bottle. This is up to 12 times the normal price of a legally filled script." The OIG says the problem of drug diversion is complex, and schemes often involve multiple parties.

First, there are drug-seeking beneficiaries. Posing as legitimate patients, they visit doctor after doctor to obtain prescriptions drugs for themselves or to sell for a profit. Then there are the providers who write unlawful, medically unnecessary prescriptions that are then billed to Medicare. In other cases, individuals who have access to vulnerable beneficiaries, such as caregivers or home health aides, steal a Medicare beneficiary's legitimately needed and prescribed painkillers for their own use or for resale.

News Releases: Prescription Drugs

For real-life examples of prescription drug fraud, see the following news releases in Appendix C:

- ***Two Sentenced In Connection With Sunshine Pharmacy Health Care Fraud.*** This case involves prescriptions not filled, provided, or prescribed by a licensed physician as well as claims submitted for beneficiaries without their knowledge or consent and also for deceased beneficiaries.
- ***FTC Cracks Down On Bogus Medical Discount Scam Targeting Seniors.*** This case involves telemarketing calls that pitched a prescription drug discount card that, victims were told, would provide substantially discounted or even free prescription drugs. Many victims were led to believe they had to purchase the card to continue receiving their Medicare benefits.
- ***Pawan Kumar Jain Arrested on Charges of Unlawfully Dispensing Prescription Drugs and Health Care Fraud: 111-Count Federal Indictment Alleges that Jain's Over-Prescribing of Opioid Pain Medication Resulted in the Deaths of Two Patients.*** This case provides an example of drug diversion and health care fraud at a pain management practice.

Closing

Strategies used by unscrupulous individuals involved in health care fraud are ever-changing. It is not possible to outline every kind of fraud scheme in this manual. By having a basic understanding of what fraud looks like, however, you will be better equipped to identify red flags as new fraud trends emerge. In addition to mastering the concepts in this manual, ongoing education is available from your state SMP, the federal agencies discussed in Chapter 3, and the SMP Resource Center.



SMP Foundations Training Manual

APPENDICES

Appendix A: Medicare Resources for Beneficiaries

The following resources can be used when responding to beneficiary questions about Medicare or conducting further research related to SMP work. Please remember to follow the guidelines at your SMP for addressing complaints of suspected fraud and abuse.

- **1-800-MEDICARE**
  - Call 1-800-MEDICARE for questions about general Medicare information or specific eligibility, enrollment, or benefit information.
- **www.acl.gov**
  - The Administration for Community Living (ACL) provides information about the national SMP program on their website.
- **www.cms.gov**
  - The Centers for Medicare & Medicaid Services (CMS) website is a valuable resource for Medicare self-study. It contains the Medicare, Medicare Advantage, and Part D program manuals, which provide coverage, claims processing, and marketing rules and guidance. It has links to the Medicare Learning Network and CMS National Training program resources. It also provided data on enrollment, utilization, provider participation, improper payments, and more.
- **www.ftc.gov**
  - The Federal Trade Commission (FTC) provides the public with information about identity theft, medical identity theft, and consumer scams, including those directed against Medicare beneficiaries.
- **www.healthcare.gov**
  - Learn about the Health Insurance Marketplace, compare plans and pricing, and get insurance
- **www.medicare.gov**
  - The official website for consumer information about Medicare, sponsored by CMS, it provides access to all types of Medicare information, including a list of plans in your area and online access to the *Medicare & You* handbook.
  - The ***Medicare & You* Handbook** is a comprehensive manual on Medicare, and is an excellent resource for both beneficiaries and volunteers. The handbook includes details on benefits as well as guidance for beneficiaries on how to select the right plan. It is re-issued annually and outlines annual changes to Medicare. A generic version is available at www.medicare.gov. Contact 1-800-MEDICARE for a geographically specific version which lists local plans.

- **www.MyMedicare.gov**
    - Beneficiaries can sign up for their own personal account to view and track MSNs and other benefit information online.
- **www.oig.hhs.gov**
    - The official website of the Office of Inspector General (U.S. Department of Health & Human Services). The OIG's website provides educational information about Medicare and Medicaid fraud for the general public and also contains reports on the national anti-fraud effort, including an annual report of SMP performance outcomes data.
- **Railroad Retirement Board**
    - Contact the U.S. Railroad Retirement Board at 877-RRB-5RRB (877-772-5772) or https://secure.rrb.gov regarding retirement/survivor and unemployment/sickness benefit programs for railroad workers and their families.
- **Senior Medicare Patrol (SMP) National Resource Center**
    - The SMP National Resource Center operates a toll-free number (877-808-2468) and also has a national SMP website: www.smpresource.org. The Center's website and toll-free number provide individuals with contact information for the SMP program serving their geographic area.
- **Social Security**
    - Contact Social Security at 1-800-772-1213 or www.ssa.gov for replacement Medicare cards, information about Part A and/or Part B eligibility and enrollment, or to apply for "Extra Help" with Medicare prescription drug costs.
- **State Health Insurance Assistance Program (SHIP)**
    - Contact your local SHIP to get free personalized health insurance counseling, including help making health care insurance decisions, information on programs for people with limited income and resources, and help with claims, billing, and appeals. Call 1-800-Medicare to get the phone number for the SHIP in your state.

Appendix B: Original Medicare vs. Medicare Advantage

When selecting Medicare options, beneficiaries must choose between Original Medicare (Parts A and B) and Medicare Advantage (Part C). While the majority of beneficiaries are enrolled in Original Medicare, approximately one third choose Medicare Advantage. Regardless of their choice, all are considered to be Medicare beneficiaries.

The differences between Original Medicare and Medicare Advantage are important for both beneficiaries and SMPs to note, and are summarized below.

What's the Difference?

	Original Medicare	Medicare Advantage
Hospital and medical insurance	Covered according to Part A and B guidelines	Covers everything covered by Original Medicare, with the exception of some hospice care
Routine hearing, vision, dental care and nonambulance medical transportation services	Not covered	Some plans offer this coverage
Prescriptions	Not covered, outside of what is covered under Part A and B. Beneficiaries can buy Part D for prescription coverage.	Most Medicare Advantage Plans (Part C) offer coverage. Beneficiaries in some types of plans that may not offer prescription drug coverage (e.g., some Private-Fee-for-Service plans) can select a stand-alone Part D drug plan.
Number	Medicare number (contains a Social Security number)	Health plan ID number (doesn't contain a Social Security number)
Card	Medicare card (contains a Social Security number)	Health plan ID card (doesn't contain a Social Security number)
Enrollment and disenrollment	Initial enrollment, general enrollment, and special enrollment periods apply	Initial coverage election, annual election (a.k.a. "open enrollment"), Medicare Advantage disenrollment, and special election periods apply
Assignment	Applies to Part B	Does not apply
Statements	Medicare Summary Notice	Explanation of Benefits
Coinsurance, copayments, deductibles and excess charges	Beneficiary responsibility, unless beneficiaries have supplemental insurance or qualify for assistance with these costs.	Beneficiary responsibility, unless beneficiary qualifies for assistance with these costs. Medigap is not an option.

Appendix C: Medicare Fraud News Releases

Ambulance Services Example #1:

Ambulance Company Driver Sentenced To Prison

News Release from United States Attorney's Office, Eastern District of Pennsylvania, United States Department of Justice
April 3, 2014

PHILADELPHIA – Valeriy Davydchik, 59, of Philadelphia, PA, was sentenced today to 24 months in prison for his role in a conspiracy to defraud Medicare involving Penn Choice Ambulance Inc., located in Camp Hill, PA and Huntingdon Valley, PA. On April 9, 2013, the defendant, Anna Mudrova, Yury Gerasyuk, Mikhail Vasserman, Irina Vasserman, Aleksandr Vasserman, Khusen Akhmedov, and Penn Choice Ambulance Inc. were indicted and charged with conspiracy to commit health care fraud and related charges. All defendants have pleaded guilty and await sentencing before U.S. District Court Judge Juan R. Sánchez.

From September 2009 through January 2013, Penn Choice transported patients who were able to walk and could travel safely by means other than ambulance and who, therefore, were not eligible for ambulance transportation under Medicare requirements. Penn Choice falsified reports to make it appear that the patients needed to be transported by ambulance. Penn Choice billed Medicare for these medically unnecessary services. As a result, Penn Choice caused Medicare to pay more than $1.5 million based on these fraudulent claims. Defendant Davydchik joined Penn Choice in 2011 as an ambulance driver. He transported patients who walked to and from the ambulance, and often drove patients to medical appointments in his personal vehicle. Penn Choice submitted claims to Medicare for ambulance transport for these patients. Defendant Davydchik also falsified records and delivered kick-back payments to Medicare beneficiaries to induce them to be transported by Penn Choice ambulance even though such transport was not medically necessary.

In addition to the prison term, U.S. District Court Judge Juan R. Sanchez ordered defendant Davydchik to pay restitution to Medicare and imposed a 3-year term of supervised release after imprisonment. The Court also ordered the forfeiture of any assets traceable to the offense, and in lieu of assets, a money judgment against the defendant of $870,310.14.

The case was investigated by the Federal Bureau of Investigation and the U.S. Department of Health and Human Services, Office of the Inspector General. It is being prosecuted by Assistant United States Attorney M. Beth Leahy.

Available online at www.justice.gov.

Ambulance Services Example #2

Owners of Los Angeles Ambulance Company Sentenced for Medicare Fraud Scheme

News Release from United States Department of Justice, Office of Public Affairs
May 6, 2014

The owners of Alpha Ambulance Inc. (Alpha), a now-defunct Los Angeles-area ambulance transportation company, have been sentenced in connection with a Medicare fraud scheme.

Acting Assistant Attorney General David A. O'Neil of the Justice Department's Criminal Division, U.S. Attorney André Birotte Jr. of the Central District of California, Special Agent in Charge Glenn R. Ferry of the Los Angeles Region of the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) and Assistant Director in Charge Bill L. Lewis of the FBI's Los Angeles Field Office made the announcement.

Aleksey Muratov, aka Russ Muratov, 32, and Alex Kapri, aka Alex Kapriyelov or Alexander Kapriyelov, 56, were sentenced by U.S. District Court Judge Audrey B. Collins in the Central District of California to serve 108 months and 75 months in prison, respectively. Both Kapri and Muratov pleaded guilty on Oct. 28, 2013, to conspiracy to commit health care fraud.

Muratov and Kapri were owners and operators of Alpha, which specialized in the provision of non-emergency ambulance transportation services to Medicare-eligible beneficiaries, primarily dialysis patients.

According to court documents, Muratov and Kapri knowingly provided non-emergency ambulance transportation to Medicare beneficiaries whose medical condition at that time did not require ambulance transportation. With Kapri's knowledge, Muratov and others at Alpha instructed certain Alpha employees to conceal the Medicare beneficiaries' medical conditions by altering required documents for Medicare reimbursement and creating fraudulent justifications for the transportation. The defendants caused Alpha to submit claims to Medicare that were fraudulent because the transportation was not medically necessary.

Additionally, as the defendants were submitting these false claims, Medicare notified Alpha that the company would be subject to a Medicare audit. In response, Muratov instructed Alpha employees – with Kapri's knowledge – to alter specific documents that would be submitted to Medicare in response to the audit and create false justifications for transportation of the beneficiaries identified.

From at least June 2008 through at least July 2012, Alpha submitted more than $49 million in claims for ambulance transportation. As a result, Medicare paid Alpha more than $13 million for these claims, many of which were fraudulent.

The case was investigated by the FBI and HHS-OIG and was brought as part of the Medicare Fraud Strike Force, under the supervision of the Criminal Division's Fraud Section and the U.S. Attorney's Office for

the Central District of California. This case was prosecuted by Trial Attorneys Blanca Quintero and Alexander F. Porter and Assistant Chief O. Benton Curtis III of the Fraud Section.

Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged more than 1,700 defendants who have collectively billed the Medicare program for more than $5.5 billion. In addition, HHS's Centers for Medicare & Medicaid Services, working in conjunction with HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

To learn more about the Health Care Fraud Prevention and Enforcement Action Team (HEAT), go to: www.stopmedicarefraud.gov.

Available online at www.justice.gov.

Editor's Note:

Since www.stopmedicarefraud.gov is no longer available, you can learn more about the Health Care Fraud Prevention and Enforcement Action Team (HEAT) at https://www.justice.gov/criminal-fraud/health-care-fraud-unit.

DME Suppliers Example:

DME Owner Convicted On All Counts

News Release from United States Attorney's Office, Southern District of Texas, United States Department of Justice
April 2, 2014

HOUSTON – Andrea Michelle Tellison, 47, has been convicted today of 14 counts of health care fraud and seven counts of aggravated identity theft, announced United States Attorney Kenneth Magidson. The jury returned its verdicts this afternoon following three days of trial and less than two hours of jury deliberation.

Tellison, the director of operations, chief compliance officer and co-owner of Texas Durable Medical Company was charged in March 2013 with health care fraud and aggravated identity theft in relation to the submission of approximately $1.48 million worth of enteral nutrition and enteral feeding supply claims to Medicare.

During trial, jurors heard the testimony of six Medicare beneficiaries detailing that they did not need tube feedings and did not receive tube feeding supplies despite Tellison billing thousands of dollars for those items. They also heard from seven Houston area physicians who stated they did not order tube feedings or tube feeding supplies for the Medicare beneficiaries and that they did not authorize Tellison to use their names and UPIN numbers to submit claims to Medicare and Medicaid for those items.

The government presented evidence including many forms that had been signed by Tellison indicating that Medicare beneficiaries needed tube feedings and tube feeding supplies. However, evidence demonstrated she did not order those items for delivery despite billing Medicare for the 29,113 tube feeding supply kits.

Special Agents from the Railroad Retirement Board (RRB) and the FBI testified that in a 2011 interview, Tellison admitted both knowledge of the false and fraudulent claims and the insufficient inventory for delivery to Medicare beneficiaries. A Forensic accountant from the FBI further testified that Tellison not only failed to purchase the 29,113 tube feeding supply kits, but that she also failed to purchase sufficient quantities of nutritional products for delivery. Various representatives from Medicare and Medicaid contractors provided supporting testimony about how these federally funded programs operate and the claims submitted by Tellison.

U.S. District Judge Lee Rosenthal, who presided over the trial, permitted Tellison to remain on pending sentencing to be held later this year. At that time, she faces up to 10 years in federal prison on each count of health care fraud and a mandatory two-year-term for each count of aggravated identity theft which must be served consecutively to each other and to any other prison term imposed.

The investigation into Tellison was the result of a joint investigation conducted by agents from the FBI, RRB - Office of the Inspector General, Department of Health and Human Services – Office of Inspector General and the Texas Attorney General's Office Medicaid Fraud Control Unit. Assistant United States Attorneys Julie Redlinger and Tina Ansari prosecuted the case.
Available online at www.justice.gov.

Home Health Care Example:

Local In-Home Healthcare Provider Pleads Guilty To Fraud Charges

News Release from United States Attorney's Office, Eastern District of Missouri, United States Department of Justice
May 1, 2014

St. Louis, MO – **TINA KUEHL** pled guilty yesterday to bank fraud charges involving her fraudulent statements involving payment of a bank loan. In a separate unrelated case, she and her company, Better Way Home Care, pled guilty to multiple healthcare fraud charges. Kuehl and Better Way represented on billing work sheets and claim forms that patients had received therapy services when they knew that the patients had not received the therapy. Kuehl and Better Way caused the submission of hundreds of reimbursement claims to Medicare for services which they knew had not been provided.

According to court documents regarding the bank fraud charges, in December 2010 Kuehl's mother obtained a $305,000 property loan from the Community Bank of Owensville, MO, a branch of the Maries County Bank. Both Kuehl and her mother are listed on the deed of trust for the property. On many occasions, they did not make timely payments on the loan and in July 2013, Maries Bank foreclosed on the property. After the foreclosure, Kuehl devised a scheme to defraud Maries Bank by submitting fraudulent checks as proof that she had made loan payments to the bank. On six occasions, she changed the payee on copies of unrelated cancelled checks so that it would appear that she had made loan payments to Community Bank of Owensville. She continued the fraud by claiming to have made cash payments to a bank employee on two occasions. The bank employee was on sick leave on the day Kuehl claimed she made the first $4,000 cash payment to the employee at the bank. Kuehl claimed that she made a second cash payment of $6,900 to a bank employee at a truck stop. Finally, Kuehl retained attorneys to represent her after the foreclosure, and falsely told them she had made payments by checks and cash, which the bank had not credited to her loan account.

According to court documents regarding the healthcare fraud charges, Better Way was a home health care agency located in Ellisville, Missouri. Tina Kuehl was the owner, president and administrator of Better Way and was responsible for the day-to-day operations. Medicare pays home health agencies for 60-day episodes of care. Medicare makes two payments to the home health care agencies, the first before the service is provided based on the patient's anticipated need for services and a second payment at the end of the 60-day episode of care based on the actual number of services provided.

Kuehl has no medical or health care education, training or experience, which would qualify her to assess or evaluate patients or determine their care needs. Prior to opening Better Way, she worked in the cosmetology field. Better Way hired nurses and contracted with therapists to assess and evaluate patients and to determine the patients' needs for therapy services. Better Way staff recorded this

information on the Outcome and Assessment Information Set form (OASIS).

To increase the reimbursement that Better Way would receive, Kuehl directed Better Way nurses and other employees to make false statements on the OASIS forms and the reimbursement claim forms. At Kuehl's direction, the staff increased the number of therapy visits, although Kuehl knew the patients did not need and had not received the therapy; falsified the diagnosis codes; and exaggerated the patients' conditions and the reasons the patients were receiving home health care services from Better Way. When some employees refused to increase the number of therapy visits, Kuehl personally increased the number of visits. In some instances the patient had received no therapy at all.

Kuehl, Ballwin, Missouri, pled guilty to one felony count of bank fraud, one felony count of healthcare fraud, two counts of making false statements relating to healthcare and one count of making false statements to federal agents. She appeared before United States District Judge Henry Autrey on Wednesday, April 30. Sentencing has been set for July 28, 2014.

Bank fraud carries a maximum penalty of 30 years in prison and/or fines up to $1 million; healthcare fraud carries a maximum penalty of ten years prison and/or fines up to $250,000; and each of the other charges carry a maximum of five years in prison and/or fines up to $250,000. In determining the actual sentences, a judge is required to consider the U.S. Sentencing Guidelines, which provide recommended sentencing ranges.

This case was investigated by the Office of the Inspector General of the U.S. Department of Health and Human Services, the FBI, and the Missouri Fraud Control Unit of the Missouri Attorney General's Office. Assistant United States Attorney Dorothy McMurtry is handling the case for the U.S. Attorney's Office.

Available online at www.justice.gov.

Hospice Care Example #1:

Owner, Manager, and Hospice Company Indicted for Committing Medicare Fraud

News Release from The Federal Bureau of Investigation, United States Attorney's Office, Western District of Oklahoma, United States Department of Justice
April 17, 2014

OKLAHOMA CITY—A federal grand jury in Oklahoma City has returned an indictment charging Paula Kluding, 38, from Chandler, Oklahoma; Patricia Carter, 42, from Tecumseh, Oklahoma; and Prairie View Hospice Inc. (Prairie View Hospice), an Oklahoma corporation located in Chandler, Oklahoma, with 39 separate counts relating to Medicare fraud, announced Sanford C. Coats, United States Attorney for the Western District of Oklahoma.

According to the indictment, Prairie View Hospice was in business to provide hospice care to Medicare beneficiaries. Hospice care consists of providing health care, medication, medical equipment, and other goods and services to terminally ill patients. Kluding owned Prairie View Hospice and Carter was the general manager. The indictment alleges that from July 2010 through July 2013, the defendants conspired to conceal the true medical condition of Prairie View Hospice's patients and the true quality and quantity of health care services they were receiving in order to "pass" a Medicare audit and to fraudulently obtain money from Medicare. Specifically, it is alleged, among other things, that certain medical documents were falsified to make it appear that nurses had visited patients or conducted necessary assessments when such visits and assessments had not, in fact, been made. Also, nursing notes were falsified to make it appear that patients were in worse health than they actually were in order to justify to Medicare the patient's continued hospice care. It is alleged that Prairie View Hospice, acting through Kluding and Carter, sent the falsified documents to a Medicare subcontractor in response to requests to audit patient files and claims for Medicare reimbursement. The indictment charges the defendants with conspiracy, obstruction of a federal audit, and making false statements in a health care matter.

If convicted, the individual defendants face up to five years' imprisonment and a fine of $250,000 on each count. The indictment also seeks forfeiture of all property and proceeds obtained by the defendants from the alleged criminal acts. Reference is made to the indictment for further information. The defendants are all presumed innocent unless and until proven guilty.

This case is the result of an investigation by the U.S. Department of Health and Human Services Office of Inspector General and the Federal Bureau of Investigation. The case is being prosecuted by Assistant U.S. Attorney Amanda Maxfield Green.

Available online at www.fbi.gov.

Hospice Care Example #2

U.S. Files Complaint Against Philadelphia Hospice Provider And Its Owners And Operators Alleging False Claims On Medicare

News Release from United States Attorney's Office, Eastern District of Pennsylvania, United States Department of Justice
May 21, 2014

PHILADELPHIA – The United States filed a complaint in U.S. District Court today in a whistleblower suit against a now-defunct, for-profit Philadelphia provider of hospice services, Home Care Hospice, Inc. (HCH), and its owners and operators, announced First Assistant United States Attorney Louis D. Lappen. In its complaint, the government alleges that HCH, its Executive Director and owner Alex Pugman, its Development Executive Svetlana Ganetsky, and its *de facto* owner Matthew Kolodesh violated the False Claims Act when they falsely claimed and received millions of taxpayer dollars intended for dying Medicare recipients in need of hospice care. The government further alleges that Pugman, Ganetsky, Kolodesh, and HCH Chief Executive Officer Malvina Yakobashvili thereby unjustly enriched themselves at the expense of the United States. Pugman and Ganetsky, who have pleaded guilty to related criminal charges, are husband and wife, as are Kolodesh and Yakobashvili. In October 2013, a federal jury in the Eastern District of Pennsylvania found Kolodesh guilty of related criminal charges. See http://www.justice.gov/usao/pae/News/2013/October/kolodesh_release.htm

The Medicare hospice benefit is available for a patient who elects palliative treatment (medical care focused on providing relief from pain, stress, and symptoms of terminal illness) and has a life expectancy of only six or fewer months, if the patient's disease runs its normal course. A Medicare patient receiving hospice services no longer receives services designed to cure the patient's terminal illness. Medicare reimburses for different levels of hospice care, including continuous home care (also called crisis care), which is available only for a patient who is experiencing acute medical symptoms resulting in a brief period of crisis and who requires the immediate, short-term provision of skilled-nursing services in order to remain at home. The reimbursement rate for crisis care services is the highest daily rate a hospice can bill Medicare, and hospices are paid hundreds of dollars more on a daily basis for each patient they certify as having received crisis care services rather than routine home hospice services.

The government's complaint alleges that HCH, Pugman, Ganetsky, and Kolodesh knowingly submitted false claims and records (including fabricated records) to Medicare for purported hospice care for patients who were not terminally ill and thus not eligible for the Medicare hospice benefit. The government further alleges that these defendants knowingly submitted or caused the submission of false claims and records (including fabricated records) to Medicare for crisis care services that were not necessary or not actually provided. The government contends that, as a result of the conduct alleged in the

complaint, these defendants violated the False Claims Act and cost the Medicare Program millions of dollars.

Under *qui tam* (whistleblower) provisions of the False Claims Act, certain private citizens may bring civil actions on behalf of the United States and may share in any recovery. If the United States intervenes in an action and proves that a defendant has knowingly submitted false claims, it is entitled to recover three times the damage that resulted and a penalty of $5,500 to $11,000 per claim. This suit was originally filed on behalf of the United States by Maureen Fox and Cathy Gonzales, former HCH employees who discovered the alleged fraud. After they internally reported the alleged fraud, HCH fired Ms. Fox, and Ms. Gonzales quit her position. The *qui tam* action remained in civil suspense for seven years while the United States criminally investigated and prosecuted the perpetrators. In 2012, while the case was still in suspense, and without filing its own complaint at that time, the United States intervened in Ms. Fox's and Ms. Gonzales' False Claims Act claims against HCH, Pugman, Ganetsky, and Kolodesh. In a related action in the Eastern District of Pennsylvania, filed in 2008, the United States obtained injunctive relief restraining financial accounts of HCH, Pugman, Ganetsky, Kolodesh, and Yakobashvili that the United States contends resulted from the alleged fraud.

The case is being investigated by the Office of Inspector General of the U.S. Department of Health and Human Services, and the Organized Crime Section of the Federal Bureau of Investigation, and has been assigned to Assistant United States Attorneys Gerald B. Sullivan and Eric D. Gill. The civil claims asserted against HCH, Pugman, Ganetsky, Kolodesh, and Yakobashvili are allegations only, and there has been no determination of civil liability.

Available online at www.justice.gov.

Nursing Facilities Example:

Nationwide Contract Therapy Providers to Pay $30 Million to Resolve False Claims Act Allegations

News Release from United States Department of Justice, Office of Public Affairs
January 17, 2014

Contract therapy providers RehabCare Group Inc., RehabCare Group East Inc. and Rehab Systems of Missouri and management company Health Systems Inc. have agreed to pay $30 million to resolve claims that they violated the False Claims Act by engaging in a kickback scheme related to the referral of nursing home business, the Justice Department announced today. Additionally, as part of this settlement, the entities have agreed to restructure their business arrangement.

"Health care providers that attempt to profit from illegal kickbacks will be held accountable," said Assistant Attorney General for the Justice Department's Civil Division Stuart F. Delery. "We will continue to advocate for the appropriate use of Medicare funds and the proper care of our senior citizens."

Between March 1, 2006, and Dec. 31, 2011, RehabCare allegedly arranged with Rehab Systems of Missouri to obtain Rehab Systems of Missouri 's contracts to provide therapy to patients residing in 60 nursing homes controlled by Rehab Systems majority-owner James Lincoln. In exchange for this stream of referrals, RehabCare allegedly paid Rehab Systems a $400,000 to $600,000 upfront payment and allowed Rehab Systems to retain a percentage of the revenue generated by each referral.

"The Anti-Kickback Statute is intended to protect patients and federal health care programs from fraud and abuse," said Acting U.S. Attorney for the District of Minnesota John Marti. "We will remain vigilant in pursuing entities that improperly further their financial interest at the expense of the Medicare Trust Fund."

"This settlement sends a message to those who seek to improperly take advantage of the Medicare program," said U.S. Department of Health and Human Services Office of Inspector General Special Agent in Charge Gerald T. Roy. "The Office of the Inspector General, Kansas City Regional Office will continue to work aggressively to eliminate this type of misconduct from our health care system."

"The FBI will continue to work with its partners to combat this type of abuse," said Special Agent in Charge of the FBI's Minneapolis Office J. Chris Warrener. "It remains committed to the elimination of fraud to ensure the integrity of federal health care programs."

This civil settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by Attorney General Eric Holder and Secretary of Health and Human Services Kathleen Sebelius. The

partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered more than $17.1 billion through False Claims Act cases, with more than $12.2 billion of that amount recovered in cases involving fraud against federal health care programs.

The settlement resolves allegations originally brought in a lawsuit filed by a whistleblower under the *qui tam* provisions of the False Claims Act, which allow private parties to bring suit on behalf of the government and to share in any recovery. The whistleblower will receive $5.7 million as its share of the recovery in this case.

The case was handled by the U.S. Attorney's Office for the District of Minnesota with assistance from the Justice Department's Civil Division, the U.S. Attorney's Office for the Eastern District of Missouri, the Federal Bureau of Investigation and the U.S. Department of Health and Human Services Office of Inspector General. This action was supported by the Elder Justice and Nursing Home Initiative that coordinates the department's activities combating elder abuse, neglect and financial exploitation, especially as they impact beneficiaries of Medicare, Medicaid and other federal health care programs.

The lawsuit is captioned *U.S. ex rel. Health Dimensions Rehabilitation Inc. v. RehabCare Group Inc., et. al.,* Case No. 4:12-cv-00848 AGF (E.D. Mo.). The claims settled by this agreement are allegations only; there has been no determination of liability.

Available online at www.justice.gov.

Prescription Drugs – Pharmacy Fraud Example:

Two Sentenced In Connection With Sunshine Pharmacy Health Care Fraud

News Release from United States Attorney's Office, Middle District of Florida, United States Department of Justice
March 31, 2014

Fort Myers, Florida – United States District Judge John E. Steele today sentenced Delmer Holmes Parrish (44) and Patricia Parrish (74), both of Naples, for their roles in a conspiracy to commit health care fraud that operated from Sunshine Pharmacy in Naples, Florida. Delmer Holmes Parrish, a licensed Pharmacist, was sentenced to two years in federal prison. Patricia Parrish was sentenced three years of probation, to include 120 days of home confinement, and ordered to pay a $5,000 fine. Both were also ordered to pay restitution to the United States in the amount of $351,358.14, the proceeds of the crime. Pursuant to their agreement, this amount was paid in full, immediately following the sentencing. As part of the plea agreement, Delmer Holmes Parrish also permanently relinquished his Pharmacist License to the State of Florida.

According to court documents, from in or around February 2009, through in or about July 2012, Delmer Holmes Parrish and Patricia Parrish participated in a conspiracy to defraud federal health care benefit programs out of approximately $351,358.14. Both, along with others, used Sunshine Pharmacy and Sunshine Solutions, both in Naples, to further their unlawful scheme to defraud the government. The co-conspirators submitted and caused claims to be submitted for reimbursement from the Medicaid, Medicare, and TRICARE programs for prescriptions not filled or provided to beneficiaries and recipients, including prescriptions for patients that had not been written or authorized by any duly licensed physician. In addition, the co-conspirators submitted and caused claims to be submitted for reimbursement for prescriptions for beneficiaries and recipients who were deceased. In carrying out the offenses, the conspirators also used the means of identification of individuals who were enrolled in the Medicaid, Medicare, or TRICARE programs without their knowledge or consent. The conspirators also took steps to hide and conceal the scheme to defraud. As a result of the scheme, the government was defrauded of approximately $351,358.14.

According to Brian Martens, Acting Special Agent in Charge of Health and Human Services, Office of Inspector General, in Tampa, “today’s sentencing, which is punctuated by the defendants’ having made 100% restitution to Medicare, clearly demonstrates the success of the Strike Force model.”

This case was brought as part of the Medicare Strike Force and was investigated by the United States Department of Health and Human Services, Office of Inspector General; Department of Defense, Defense Criminal Investigative Service; and the Drug Enforcement Administration with assistance from the Naples Police Department; Collier County Sheriff's Office; and the United States Secret Service. It was prosecuted by Assistant United States Attorney David G. Lazarus.

Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged more than 1,700 defendants who have collectively billed the Medicare program for more than $5.5 billion. In addition, the HHS Centers for Medicare & Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

Available online at www.justice.gov.

Prescription Drugs – Discount Cards Example:

FTC Cracks Down On Bogus Medical Discount Scam Targeting Seniors

U.S. and Canadian Defendants Charged With Deception and Illegal Telemarketing

News Release from The Federal Trade Commission
September 16, 2013

The Federal Trade Commission has moved to shut down a medical discount scheme that scammed seniors across the country by offering phony discounts on prescription drugs and pretending to be affiliated with Medicare, Social Security, or medical insurance providers.

In a complaint filed against the operators of the scam in the United States and Canada, the FTC alleges that seniors in the U.S. were targeted by the deceptive calls. The callers convinced their victims to turn over their bank account numbers and used that information to debit money from victims' accounts.

"This scam, which targeted and deceived our nation's seniors, is as cynical and wanton as they come," said Jessica Rich, Director of the FTC's Bureau of Consumer Protection. "We look forward to bringing this operation to a halt and working to get relief for the victims."

According to the FTC's complaint, the telemarketing calls pitched a prescription drug discount card that, victims were told, would provide substantially discounted or even free prescription drugs. Many victims were led to believe they had to purchase the card to continue receiving their Medicare, Social Security, or medical insurance benefits.

In fact, the prescription drug discount cards the defendants provided to consumers are available for free by calling a toll-free number or visiting a website. The cards generally do not provide any discounts to consumers who already have insurance either through a government program or a private insurer.

The scam was run from both sides of the border. The defendants contacted consumers from a telemarketing boiler room in Montreal. The U.S. defendants then used the bank account information consumers provided in the calls to take approximately $300 from consumers' bank accounts using a "demand draft." Not all consumers who paid for the purported discount card even received it – some victims received nothing at all for their money.

The defendants are charged with violating Section 5 of the FTC Act by deceptively presenting themselves as government or insurance representatives, as well as by telling consumers that the discount plans they were selling could provide substantial discounts on prescription drugs. In addition, the defendants are charged with violating the FTC's Telemarketing Sales Rule for their deceptive acts and for calling consumers whose numbers were on the National Do Not Call Registry. A federal judge in the U.S. District Court for the Northern District of Illinois issued a temporary restraining order halting the defendants' deceptive scheme and freezing their assets.

The U.S.-based defendants in the case include AFD Advisors, LLC, of Wisconsin, which also does business as AFD Medical Advisors; AMG Associates, LLC, of Delaware, which also does business as AMG Medical and AMG Medical Associates; Aaron F. Dupont, individually and as an officer of AFD Advisors and AMG Associates; CAL Consulting, LLC, of Georgia, which also does business as Clinacall; Charles A. Lamborn, III, individually and as an officer of CAL Consulting; and Park 295 Corp, of New York.

The Canadian-based defendants are 9262-2182 Quebec Inc; Stephanie Scebba, individually and as an officer of 9262-2182 Quebec Inc.; 9210-7838 Quebec Inc; and Fawaz Sebal, also known as Frank Sebag, individually and as an officer of 9210-7838 Quebec Inc.

The FTC would like to thank the Canadian Anti-Fraud Centre; Wisconsin Department of Agriculture, Trade and Consumer Protection; Oregon Department of Justice; and Better Business Bureau of Wisconsin for their valuable assistance with this matter.

The FTC also would like to acknowledge the Royal Canadian Mounted Police and the Centre of Operations Linked to Telemarketing Fraud (Project COLT) for their valuable assistance. Launched in 1998, Project COLT combats telemarketing-related crime and includes members of the Royal Canadian Mounted Police, Sureté du Québec, Service de Police de la Ville de Montréal, Canada Border Services Agency, Competition Bureau of Canada, Canada Post, U.S. Department of Homeland Security (U.S. Immigration and Customs Enforcement and the U.S. Secret Service), the U.S. Postal Inspection Service, the Federal Trade Commission, and the Federal Bureau of Investigation. Since its inception, Project COLT has recovered $22 million for victims of telemarketing fraud.

The Commission vote authorizing the staff to file the complaint was 4-0. The complaint was filed in the U.S. District Court for the Northern District of Illinois.

NOTE: The Commission files a complaint when it has “reason to believe” that the law has been or is being violated and it appears to the Commission that a proceeding is in the public interest. The case will be decided by the court.

The Federal Trade Commission works for consumers to prevent fraudulent, deceptive, and unfair business practices and to provide information to help spot, stop, and avoid them. To file a complaint in English or Spanish, visit the FTC’s online Complaint Assistant or call 1-877-FTC-HELP (1-877-382-4357). The FTC enters complaints into Consumer Sentinel, a secure, online database available to more than 2,000 civil and criminal law enforcement agencies in the U.S. and abroad. The FTC’s website provides free information on a variety of consumer topics. Like the FTC on Facebook, follow us on Twitter, and subscribe to press releases for the latest FTC news and resources.

Available online at www.ftc.gov.

Prescription Drugs – Drug Diversion Example:

Pawan Kumar Jain Arrested on Charges of Unlawfully Dispensing Prescription Drugs and Health Care Fraud:

111-Count Federal Indictment Alleges that Jain's Over-Prescribing of Opioid Pain Medication Resulted in the Deaths of Two Patients

News Release from United States Attorney's Office, District of New Mexico, United States Department of Justice
April 17, 2014

ALBUQUERQUE – A federal grand jury has returned an indictment charging Pawan Kumar Jain, 61, of Las Cruces, N.M., with the unlawful dispensing of opioid pain medication and health care fraud charges, announced by Acting U.S. Attorney Damon P. Martinez, Special Agent in Charge Joseph M. Arabit of the DEA's El Paso Field Division and Special Agent in Charge Carol K.O. Lee of the FBI's Albuquerque Division.

Jain was arrested without incidence earlier today by the DEA and FBI. He is scheduled to make his initial appearance in federal court in Las Cruces at 8:30 a.m. tomorrow.

The 111-count indictment, which was publicly posted following Jain's arrest, charges Jain with 61 counts of unlawfully dispensing controlled substances and 50 counts of health care fraud. According to the indictment, Jain allegedly committed the offenses charged between April 2009 and June 2010, in Doña Ana County, N.M. At the time, Jain was a licensed physician with a neurology subspecialty who operated a pain management medical practice in Las Cruces. Jain's medical license was suspended in June 2012 and subsequently revoked in Dec. 2012 by the New Mexico Medical Board.

Each of the 61 dispensing charges alleges that Jain unlawfully dispensed prescription painkillers, primarily Oxycodone and methadone, to patients outside the usual course of medical practice and without a legitimate medical purpose. The maximum statutory penalty for a conviction on each of the 61 dispensing charges is 20 years in prison and a $1,000,000 fine.

The 50 health care fraud charges allege that Jain engaged in a scheme to defraud two health care benefit programs, Medicare and Medicaid, by submitting claims for payment for prescription medications he dispensed to patients outside the usual course of medical practice and without legitimate medical purpose. The maximum statutory penalty for a conviction on each of the health care fraud charges is ten years in prison and a $250,000 fine.

Four counts in the indictment, Counts 1 through 4, expose Jain to enhanced sentencing because the criminal conduct charge allegedly resulted in the deaths of two patients. Counts 1 and 2 of the indictment allege that Jain's unlawful dispensing of prescription painkillers and fraudulent conduct resulted in the death of a patient identified by the initials "M.E.B." According to the indictment, Jain dispensed 540 tablets (40 mg) of Oxycodone and 405 tablets (10 mg) of methadone to M.E.B. between April 22, 2009 and Sept. 29, 2009.

Counts 3 and 4 allege that Jain's unlawful dispensing of prescription painkillers and fraudulent conduct resulted in the death of a patient identified by the initials "N.D."

The statutory penalty for a conviction on each of Counts 1 and 3, which allege the unlawful dispensing of a controlled substance resulting in death, is a mandatory minimum 20 years in prison and a maximum of life in prison. The statutory penalty for a conviction on each of Counts 2 and 4, which allege health care fraud resulting in death, is life imprisonment.

In announcing the indictment, DEA Special Agent in Charge Joseph M. Arabit said, "The diversion and abuse of prescription opioids, such as hydrocodone and oxycodone, threatens the health and safety of our communities and remains a serious concern for law enforcement. It is particularly concerning when a doctor, who is entrusted with the care and well-being of his patients, contributes to this problem by prescribing addictive pain killers in an unprofessional manner absent a legitimate medical purpose. By engaging in this illegal and irresponsible behavior, a medical practitioner violates the trust of those he has a duty to serve, and, most sadly, his actions can result in their death."

"Health care fraud and unlawfully dispensing prescription drugs cost consumers, taxpayers and insurance companies billions of dollars," said FBI Special Agent in Charge Carol K.O. Lee. "Sometimes, as this case alleges, these crimes can even kill. The FBI is proud to work alongside the Drug Enforcement Administration and the U.S. Attorney's Office to make sure physicians who attempt to defraud the government, sometimes with fatal results, are held accountable."

This case was investigated by the DEA's Tactical Diversion Team in El Paso, Texas and the FBI's Healthcare Fraud Unit with assistance from the New Mexico Medical Board and the New Mexico Board of Pharmacy. The case is being prosecuted by Assistant U.S. Attorneys Sarah M. Davenport and Richard C. Williams of the U.S. Attorney's Las Cruces Branch Office.

DEA's Tactical Diversion Squads combine DEA resources with those of federal, state and local law enforcement agencies in an innovative effort to investigate, disrupt and dismantle those suspected of violating the Controlled Substances Act or other appropriate federal, state or local statutes pertaining to the diversion of licit pharmaceutical controlled substances or listed chemicals.

Charges in indictments are merely accusations, and defendants are presumed innocent unless proven guilty.

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