SMP Complex Interactions Training Manual

SMP Resource Center

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Acknowledgments

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About this Edition

This July 2021 edition is updated from the previous versions. Previous editions of this manual were published in 2011, 2013, 2015, 2016, and 2020. Additional light edits were made to Chapter 4 in May 2022.

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 and Human Services (DHHS), 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

Email: info@smpresource.org

Training Overview

SMP complex interactions involve complaints of suspected Medicare fraud, errors, or abuse from Medicare beneficiaries, their caregivers, or professionals caring for beneficiaries. These complaints may also involve consumer scams aimed at stealing the identities or preying upon the personal finances and property of Medicare beneficiaries.

Training Goal

The goal of SMP Complex Interactions Training is to provide you with the necessary skills and resources to manage SMP complex interactions, conduct referrals, and close cases in SIRS.

About this Manual

This training manual provides information on the following topics.

Chapter 1: Working with National and State Partners provides an overview of how SMPs, national partners, and state partners work together to manage complaints of fraud, errors, and abuse.

Chapter 2: Determining Errors vs. Suspected Fraud or Abuse guides you through the process to gather information, write great case notes, and decide if the complex interaction is an error or suspected fraud or abuse.

Chapter 3: Resolving Errors and Claiming Dollars guides you through the process of working with the beneficiary to resolve issues involving errors.

Chapter 4: Managing Referrals (a.k.a. "Where and When to Refer") guides you through the process of managing and referring cases of suspected fraud and abuse, including examples and instructions to enter the case in the SMP Information and Reporting System (SIRS) for a wide variety of common issues.

Tip Box

Throughout the manual, look for "tip" boxes (like this one), which highlight key tips.

State and Local Information

Throughout the manual, look for "state and local information" boxes (like this one) to help you track information and resources that may be used locally.

Throughout the manual, look for "caution" boxes (like this one), which highlight areas to watch out for!

Chapter 5: Claiming Dollars on Referrals guides you through the process of collecting the necessary documents to close a referred case in SIRS and receive credit on the OIG Report for dollar amounts associated with the case.

The **Appendices** offer additional resources related to managing complex interactions and making referrals.

About this Training

This training is intended for SMP complex interactions specialists: SMP team members who handle complex interactions. It is designed to help you effectively manage the types of complex questions that are asked of SMPs across the country and in your local area and provide a professional, accurate, consistent response.

SMP Counselors vs. SMP Complex Interactions Specialists

- SMP counselors are trained to answer basic SMP questions and provide individual education about how to prevent, detect, and report Medicare fraud, errors, and abuse.
- SMP complex interactions specialists are trained to help beneficiaries address suspected Medicare fraud, errors, and abuse.

Additional Training

Prior to taking this SMP Complex Interactions Training, it is recommended that you complete both SMP Foundations Training and SMP Counselor Training.

- SMP Foundations Training provides a foundation of knowledge in three main content areas: the SMP program, Medicare basics, and Medicare fraud, errors, and abuse.
- SMP Counselor Training explains how to answer basic SMP questions and provide individual SMP education consistently across the country.

All SMP complex interactions, including cases involving fraud and abuse and cases involving errors, are entered in SIRS (the SMP Information and Reporting System). SIRS is also used to make referrals of complex interactions. In order to manage complex interactions and make referrals of suspected Medicare fraud, errors, or abuse, you will most likely also need to receive training in using SIRS. Although you can expect some references to SIRS in this manual, comprehensive data entry instruction is outside the scope of this manual.

State and Local Information #1: SMP Roles

Which role(s) will you perform for your SMP? If you're not sure, talk with your SMP director or coordinator of volunteers.

State and Local Information #2: SIRS Data Entry

Will you enter complex interactions and/or other data in SIRS? If you're not sure, talk with your SMP director or coordinator of volunteers.

State and Local Information #3: Training

What training is expected of you as an SMP complex interactions specialist? For more information about expectations in your state, see your SMP job description and/or talk with your SMP director or coordinator of volunteers.

- It is possible to assist in managing complex interactions without knowledge of SIRS. However, the SMP process for referrals of suspected Medicare fraud and abuse to the OIG Hotline via ACL or CMS requires using SIRS.
- SMP representatives who are involved with complex interactions but not referrals will need to work closely with an SMP team member who uses SIRS and knows how to make a referral of suspected Medicare fraud or abuse. This approach will require highly coordinated teamwork.

Additional training may also be provided by your SMP on other topics. Training for SMP team members on a variety of topics is available the SMP Resource Library and TRAX: Training Tracker. See Appendix B for information about resources.

SMP
Senior Medicare Patrol
Resource Center

SMP Complex Interactions Training Manual

CHAPTER 1: Working with National and State Partners

Objectives

Upon completion of Chapter 1: Working with National and State Partners, you will be able to describe how SMPs, national partners, and state partners work together to manage complaints of fraud, errors, and abuse.

SMPs and Complaints of Medicare Fraud, Errors, and Abuse

As described in SMP Foundations Training, Medicare fraud, errors, and abuse negatively affect both the Medicare program and individual Medicare beneficiaries. SMPs play a unique role in the fight against fraud, errors, and abuse. The SMP program educates the public on how to prevent, detect, and report suspected Medicare fraud, errors, and abuse. When suspicious behaviors or charges are detected, SMPs educate beneficiaries about how to report their complaint.

When someone contacts the SMP with a complaint, SMP complex interactions specialists help them report complaints of suspected fraud, errors, and abuse and support and assist them during the resolution process.

SMP complex interactions include both cases of suspected errors and cases of suspected fraud or abuse. Cases are handled differently depending on whether they involve an error or suspected fraud or abuse. SMPs collect information and perform extensive research to determine how to proceed with each case they receive.

Basic or Complex Interaction?

Basic interactions focus on educating and informing Medicare beneficiaries, their families, and caregivers about preventing, detecting, and reporting health care fraud, errors, and abuse.

Complex interactions require additional actions beyond providing education or information.

If you need help determining if a question is a basic interaction or a complex interaction (or not an SMP question), see the SMP Counselor Training!

- Regardless of whether an SMP complex interaction is suspected to be an error, fraud, or abuse, information should be collected as described in Chapter 2, and the case should be entered in SIRS.
- Cases of suspected errors are resolved by the SMP and the beneficiary, as described in Chapter 3. Cases determined to be a misunderstanding may be resolved through education.
- SMPs do not investigate cases of suspected fraud or abuse! These cases are referred to national and state partners to help address them. In cases involving suspected fraud or abuse, the SMP works with national partners as described throughout the rest of this chapter and Chapter 4.

National Partnerships to Stop Fraud, Errors, and Abuse

Preventing and detecting potential Medicare fraud, errors, and abuse involves a cooperative effort among beneficiaries, SMPs, health care providers, federal agencies, and state agencies. Beneficiaries have many avenues to choose from when they wish to report potential health care fraud, errors, or abuse: 1-800-Medicare, their health care provider, their private Medicare plan, the OIG Hotline, or the SMP program. 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.

Although SMPs work with the public to identify and refer cases of suspected fraud and abuse, it is up to CMS, the OIG, and law enforcement to investigate, prosecute, and resolve these cases.

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), described in SMP Foundations Training, 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.

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

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

Additional national partners that help address fraud and abuse include the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC).

A joint HHS / DOJ HCFAC program report for fiscal year 2018 showed that the return on investment (ROI) for the HCFAC program over the last three years (2016-2018) was $4.00 returned for every $1.00 expended. Because the annual ROI can vary from year to year depending on the number and type of cases that are settled or adjudicated during that year, DOJ and HHS use a three-year rolling average ROI for results contained in the report.

Medicare Fraud Strike Force

Medicare Fraud Strike Force teams were first established in March 2007 to harness data analytics and the combined resources of federal, state, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. For information about current activities of the Medicare Fraud Strike Force teams, see the OIG website: https://oig.hhs.gov/fraud/strike-force/.

Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and health care anti-fraud associations. The HFPP aims to foster a proactive approach to detect and prevent health care fraud through data and information sharing.

The HFPP's purpose is to improve the detection and prevention of health care fraud by:

- Exchanging data and information between the public and private sectors
- Leveraging various analytic tools against data sets provided by HFPP partners
- Providing a forum for public and private leaders and subject-matter experts to share successful anti-fraud practices and effective methodologies for detecting and preventing health care fraud

For more information on HFPP activities, visit: https://hfpp.cms.gov.

Provider Fraud and Abuse Laws

There are five major fraud and abuse laws that apply to providers. They are used by the OIG to impose program exclusions and civil monetary penalties and by attorneys to prosecute cases involving fraud and abuse allegations.

- False Claims Act (FCA)
    - Makes it illegal to submit claims for payment to Medicare or Medicaid that the provider knows or should know to be false or fraudulent
    - Includes the "qui tam" provision, which allows persons and entities with evidence of fraud against federal programs or contracts to sue the wrongdoer on behalf of the United States Government
- Exclusion Statute
    - Provides the OIG with the ability to ban providers who have broken the law from further participation in any federally funded health care program
- Anti-Kickback Statute (AKS)

  - Prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or generate federal health care program business

- Civil Monetary Penalties Law
  - Used to impose penalties for fraud and abuse in Medicare and Medicaid
- Physician Self-Referral Law (Stark Law)
  - Prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies

The Affordable Care Act: Tools to Fight Fraud

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, contains many tools to fight fraud that have enhanced 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 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, the 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 expands 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.

How National Partners Help with SMP Complex Interactions

National referral protocols have been established by ACL for SMPs to use when suspected fraud or abuse is brought to the SMP's attention.

The chart below summarizes how complaints are handled when a beneficiary contacts the SMP. An overview is provided on the following pages and in Appendix A.

Type of Complaint	In Original Medicare (Part A or Part B)	In Medicare Advantage (Part C) or Prescription Drug (Part D) Plan
Suspected error	1-800-Medicare	The Medicare plan
Suspected fraud or abuse	OIG Hotline via ACL CMS SMP Part A & B contact	OIG Hotline via ACL CMS SMP Part C & D contact
Compromised Medicare number	1-800-Medicare	

- Details about how to work with 1-800-Medicare and private Medicare plans to gather information and resolve errors are provided in Chapters 2 and 3.
- Details about when and how to refer to the OIG Hotline via ACL, the CMS SMP Part A & B contact, and/or the CMS SMP Part C & D contact are provided in Chapter 4.
- Details about how to handle cases involving compromised Medicare numbers are also provided in Chapter 4. For more information to help beneficiaries report identity theft to the FTC, see the *SMP Counselor Training Manual.*

How CMS Handles Complaints of Medicare Fraud, Errors, and Abuse

CMS addresses fraud, errors, and abuse in the Medicare system. As illustrated in the grid on the previous page, 1-800-Medicare helps beneficiaries and SMPs address errors. Complaints of suspected fraud or abuse when the beneficiary is in Original Medicare, are referred to the CMS SMP Part A & B contact. Complaints of

suspected Part C and D marketing violations, Part A (hospital) and B (medical / doctor services) complaints when the beneficiary is in a Medicare Advantage plan, and complaints about suspected fraud or abuse with a Prescription Drug Plan, are referred to the CMS SMP Part C & D contact.

Addressing Suspected Errors. CMS becomes involved in errors because CMS contractors are responsible for adjusting Medicare claims. 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 Medicare Summary Notice (MSN) or Explanation of Benefits (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.
- CMS expects providers to refund as promptly as possible any money incorrectly collected from Medicare, beneficiaries, or others.

Addressing Suspected Abuse. When abuse is determined and administrative action is needed to address it, such as an order to return funds to Medicare or the plan, re-education, or a warning, CMS initiates that action.

- When overpayments are discovered, health care providers and suppliers are asked to repay Medicare. They are also provided with education and/or warnings. If Medicare or a plan had overpaid a provider or supplier due to faulty claims, the overpayment can be deducted from current or future claims.
- If patterns emerge, future claims by that provider may be subjected to a review before payment is authorized. If patterns of abuse continue despite warnings, CMS refers these cases to the OIG and other federal law enforcement partners.
- Finally, providers and suppliers can be suspended or expelled from the Medicare program, and/or CMS may impose civil monetary penalties for certain abuses.

Addressing Suspected Fraud. When CMS suspects fraud and criminal intent, it turns cases over to the OIG and other law enforcement entities.

How CMS Handles Complaints of Compromised Medicare Numbers

If a beneficiary's Medicare number is compromised, the SMP should refer them to contact 1-800-Medicare, as described in Chapter 4.

Normally, 1-800-Medicare does not issue new Medicare Beneficiary Identifiers (MBIs). However, in rare circumstances, 1-800-Medicare customer service representatives (CSRs) can request a new Medicare number for a beneficiary.

1-800-Medicare CSRs will try to determine whether the beneficiary just needs a replacement *card* or whether they need a new Medicare *number*.

- If a beneficiary says that they lost their card inside their home, then the CSR will order a replacement card.
- If the beneficiary has reason to believe that their number was stolen, the CSR will gather more information to determine if a new Medicare number is warranted, e.g. if the beneficiary's purse or wallet was stolen, or if they accidentally gave out their Medicare number over the phone.

Although SMPs can assist beneficiaries by reporting a compromised Medicare number to CMS, only the beneficiary can request a new Medicare number. Beneficiaries must contact Medicare on their own behalf to request a new number if their current number is compromised.

What Does CMS Tell Beneficiaries?

The 1-800-Medicare call center scripts include the following language that CSRs share with beneficiaries related to requesting new Medicare numbers:

You must protect your Medicare number and only share it for Medicare-related business. You cannot request a change to your Medicare number for personal preference, such as to request a specific number that is easy to remember. You also cannot request a Medicare number that contains or excludes certain numbers or letters. This new number is unique and system-generated. Only you or your authorized representative can make this request because a Medicare number is personally identifiable information.

When you request a new Medicare number, there are a few things that are important for you to know:

- *You will be responsible for letting doctors, pharmacies, and other medical providers know about your new number;*
- *You can only use your new number for services once you receive it; and*
- *You are still responsible for payments, such as copayments, for services you received under your old number.*

If the beneficiary also provided their Social Security number, the beneficiary should also report the issue to the FTC and FCC, as described in Chapter 4 and the *SMP Counselor Training Manual*. If the beneficiary is unable to do so on their own, it is within the scope of the SMP mission to help take these steps for cases related to Medicare fraud and abuse, such as medical identity theft.

How the OIG Hotline Handles Complaints of Medicare Fraud and Abuse

The Administration for Community Living (ACL) has developed a national referrals partnership with the OIG Hotline for the SMP program. Under this partnership, SMP referrals of suspected fraud and abuse that involve Medicare-covered services are routed to the OIG Hotline by ACL headquarters.

This process has several advantages:

1. It serves as a quality check and way to enhance a case prior to submission to the OIG Hotline.
2. It involves law enforcement (the OIG) as soon as possible once the SMP has learned about a case of suspected fraud.
3. The OIG Hotline works closely with CMS. The OIG routes cases to CMS, as needed, for further work-up. CMS reports back to the OIG about actions taken.
4. A long-term goal of this partnership is to better credit the SMP program for its impact against fraud and also to better tell the SMP story.

OIG Referrals: National vs. Local

When making referrals to the OIG, SMPs should **always** follow the national referrals process to make the referral to the OIG Hotline via ACL, using the functionality within SIRS (described in Chapter 4).

If the SMP chooses to make a referral to their local OIG, this should be done **in addition** to the referral to the OIG Hotline.

Addressing Suspected Fraud. The OIG is concerned primarily with fraud and criminal activity in the Medicare and Medicaid systems. 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.
- Send the complaint to CMS or the OIG regional office for further research and review before determining whether or not to investigate.
- Involve other state and federal law enforcement agencies, such as the Federal Bureau of Investigation (FBI) or Medicaid Fraud Control Units (MFCUs) (explained later in this chapter).

- If an investigation has been opened, a beneficiary or complainant may occasionally be contacted by the OIG for more information. Even then, the OIG will not be able disclose any information on the status of a case.
- Seek criminal or civil prosecution.
- Seek administrative sanctions (termination, agreements, etc.).
- Assess penalties.
- Impose sanctions or exclusion from federal programs, including Medicare and Medicaid.
- Work with CMS to impose civil monetary penalties (CMPs) up to $10,000 for repeated limiting charge violations.

Who's the Complainant?

A complainant is anyone who submits a complaint to the SMP about potential Medicare fraud, errors, or abuse. Although the complainant is often the beneficiary, they could be a caregiver or a health care provider. SMP referrals are made on behalf of the complainant by the SMP.

How State Partners Help with SMP Complex Interactions

Additional referral protocols have been established by ACL and by individual SMP programs when other issues related to fraud, errors, and abuse are brought to the SMP's attention. The types of complaints shown in the grid below are referred to the state partners indicated. Additional information is provided on the following pages and in Appendix A.

State / Local Partner	Type of Complaints They Help Resolve
State Medicaid Agency	• Errors related to **Medicaid** claims • Cases of suspected **Medicaid** fraud or abuse if the issue was perpetrated by a beneficiary
Medicaid Fraud Control Unit (MFCU)	Cases of suspected **Medicaid** fraud or abuse
State Department of Insurance	Complaints against agents or brokers Cases of suspected **Medigap** fraud or abuse
Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)	**Quality-of-care** issues
State Medical Board	
State Long-Term Care Ombudsman	

Medicaid Complaints

Though the SMP program mission is to serve Medicare beneficiaries and their caregivers, many Medicare beneficiaries are dually enrolled in Medicare and Medicaid. These beneficiaries are called "dual-eligibles." When there are improper Medicare payments on a claim for a dually enrolled beneficiary through fraud, errors, or abuse, the integrity of the Medicaid program is also compromised.

The Medicaid program is vulnerable for the same reasons that the Medicare program is vulnerable – fraud and abuse may be committed by both providers and beneficiaries. Most of the laws governing Medicare fraud and abuse also apply to Medicaid.

The SMP is not tasked with knowing whether each scenario is fraud, an error, or abuse or deciding whether the provider acted alone or a beneficiary was also involved. Because of this, all Medicaid complaints are referred to both the state Medicaid agency and the state Medicaid Fraud Control Unit (MFCU, pronounced "moo-foo-coo"). In addition, these complaints are referred to the OIG Hotline, via ACL.

- The OIG Hotline investigates and involves the justice system when legal action is needed.
- State Medicaid agencies help resolve errors related to Medicaid claims and also handle cases of suspected Medicaid fraud or abuse if the issue was perpetrated by a beneficiary instead of a provider. To find your state Medicaid agency, visit the Medicaid website: www.medicaid.gov.
- The state MFCUs investigate and prosecute Medicaid provider fraud. They are also charged with collecting any overpayments they identify while carrying out their activities. To find your state MFCU, visit the National Association of Medicaid Fraud Control Units website: www.namfcu.net.

Medigap Complaints

SMPs may also hear about complaints related to Medigap. Each state Department of Insurance regulates agents and insurers, which includes helping with cases of suspected Medigap fraud or abuse by enforcing compliance with Medigap marketing rules and policy standards. To find your state Department of Insurance, use the interactive map on the National Association of Insurance Commissioners website: www.naic.org.

Quality-of-Care Complaints

Complaints related to quality-of-care issues are referred to BFCC-QIOs (Beneficiary and Family Centered Care Quality Improvement Organizations), state medical boards, and/or state long-term care ombudsmen.

BFCC-QIO

There are two Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) that manage all beneficiary quality-of-care complaints in all 50 states and three territories. The Quality Improvement Organization (QIO) program under CMS focuses on helping providers deliver the right care at the right time. The program is also designed to ensure people with Medicare get the care they deserve, which ultimately improves care for everyone. QIOs also help Medicare beneficiaries exercise their right to high-quality health care. Patients benefit from the QIO program's charge to address beneficiaries' quality-of-care complaints and discharge appeals as well as from the QIO improvement initiatives those complaints and appeals inspire.

CMS QIO Concerns

There is a QIO review mailbox that is monitored daily by CMS and concerns are distributed to the appropriate contact person. SMPs can email QIOConcerns@cms.hhs.gov if they have a complaint against the BFCC-QIO.

The BFCC-QIO will decide if your concerns will be handled through Immediate Advocacy or a formal review process. Immediate Advocacy is an informal process used to quickly resolve a verbal complaint. If you and your QIO representative agree to use Immediate Advocacy, the BFCC-QIO contacts your doctor or other health care provider at once on your behalf. Formal and informal reviews aren't meant to punish health care providers. They help improve the effectiveness and quality of services offered to people with Medicare.

You have the right to a fast appeal if you think your Medicare-covered services are ending too soon (like if your hospital says that you must be discharged and you disagree). Ask your BFCC-QIO to help file an appeal.

For more information about BFCC-QIOs, go to www.cms.gov and search for "QIO" or go to https://www.cms.gov/files/document/hc-quality-safety-concerns508.pdf.

State Survey Agencies

State survey agencies oversee health care facilities taking part in Medicare or Medicaid and are also part of state health departments. They certify that the care and services given to residents and patients meet federal and state regulations. If not, the facility may be subject to enforcement actions (like fines) when not in compliance and there are immediate risks to resident safety or harm has occurred. You can contact your State Survey Agency if you:

- Have a complaint about improper care or unsafe conditions in health care settings like a hospital, home health agency, hospice, rehabilitation facility, nursing home, dialysis or transplant center, or clinical laboratory; or
- Are worried about the health care, treatment, or services that you or someone else did or didn't get.

State Medical Boards

State medical boards can often help with and act on concerns you have with your doctor or other health care provider, like unprofessional conduct, incompetent practice, or licensing questions or concerns. There are several types of state medical boards for health professionals. The most common provider types and information about how to access each one is provided below.

- ✓ **Chiropractors:** State Chiropractic Board
  - The Federation of Chiropractic Licensing Boards (FCLB) has an online directory: www.fclb.org/ChiropracticBoards/tabid/439/Default.aspx.
- ✓ **Dentists:** State Dental Board
  - The American Association of Dental Boards (AADB) has an online directory: www.dentalboards.org/.
- ✓ **Nurses:** State Nursing Board
  - The National Council of State Boards of Nursing (NCSBN) has an online directory: www.ncsbn.org/47.htm.
- ✓ **Pharmacists:** State Board of Pharmacy
  - The National Association of Boards of Pharmacy (NABP) has an online directory: www.nabp.net/boards-of-pharmacy/.
- ✓ **Physicians:** State Board of Medical Examiners
  - The Federation of State Medical Boards (FSMB) has an online directory: www.fsmb.org/state-medical-boards/contacts.

State Long-Term Care Ombudsman

The state Long-Term Care (LTC) Ombudsmen are advocates for residents of nursing homes and assisted living facilities. These LTC Ombudsman Programs work with residents to resolve concerns related to the health, safety, welfare, and rights of individuals who live in LTC facilities, like nursing homes and other residential care communities. Under the federal Older Americans Act, every state is required to have an ombudsman program that addresses complaints and advocates for improvements in the long-term care system. The National Long-Term Care Ombudsman Resource Center is funded by the Administration for Community Living (ACL). To find the ombudsman in your state, visit: www.ltcombudsman.org.

State and Local Information #4: Referral Partnerships

Does your SMP have any relationships with state or local contacts for additional referrals not described in this chapter? For more information, talk to your SMP director or coordinator of volunteers.

What's Next?

Now that we've covered how SMPs, national partners, and state partners work together to manage complaints of fraud, errors, and abuse, you're ready to learn how to manage complex interactions. You'll start by learning how to determine whether complaints are errors or suspected fraud or abuse. Then, you'll learn how to resolve errors, as well as how to make referrals of complex interactions so that national and state partners can help address them.

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CHAPTER 2: Determining Errors vs. Suspected Fraud or Abuse

Objectives

Upon completion of Chapter 2: Determining Errors vs. Suspected Fraud or Abuse, you will be able to:

1) Work with the beneficiary, 1-800-Medicare, plans, and providers to collect the necessary information to enter a complete complex interaction in SIRS
2) Write great case notes and set the stage to resolve an error or make a referral
3) Decide if the complex interaction is an error or suspected fraud or abuse

Gathering Information

To determine how to handle each complex interaction, including whether you should suspect an error (which can be resolved by the SMP and the beneficiary) vs. fraud or abuse (which must be referred to a national partner for further action), you will need to collect a lot of information.

Detailed information about each complex interaction must be entered in SIRS as applicable for each case, including beneficiary information, complainant information (if the complainant is someone other than the beneficiary), subject information (who the complaint is against, e.g., the provider), and additional case information, including detailed case notes.

Interviewing the Beneficiary

Start gathering information by interviewing the beneficiary or complainant. Ask them to briefly summarize the issue. While they talk, take notes of all information that might be pertinent to the issue. Once you have the basic information about their complaint, follow up to request information in each of the following areas (if not already provided) to make sure you have all the details you need to start building their case.

Enter it Now or Enter it Later!

SIRS is often accessed multiple times for each complex interaction as the case is developed. You can enter the case in SIRS while you collect information from the beneficiary, or you can write down case information and type it into SIRS later. The Beneficiary Intake Form may be helpful for collecting information while talking to a beneficiary. Also document all the time you spend working on each case in SIRS. SIRS training resources are available in the SMP Resource Library. See Appendix B for details.

State and Local Information #5: SIRS Data Entry Processes

Does your SMP have specific instructions on when and how to enter complex interactions into SIRS? Does your state have a protocol and/or tips to record all your casework time in SIRS? Ask your SMP director or coordinator of volunteers.

Beneficiary Information

- Start with the basics: first and last name, Medicare number, date of birth, phone number, email, address, city, state, zip code, and county.
- As applicable to the complex interaction, also ask for the Medicaid number and any other pertinent information.
- If you think you might need to refer the complex interaction, explain to the beneficiary that the person who receives the referral (e.g., from CMS or the OIG) may need to contact them to follow up on their case. Receiving the beneficiary's permission to be contacted may increase the chances of resolving their case.

Multiple Beneficiaries

SMPs often work with not just one Medicare beneficiary, but multiple beneficiaries who have experienced the same issue related to Medicare fraud, errors, or abuse. For example, a married couple may be dealing with the same provider on similar issues. When working with multiple beneficiaries, a separate case must be entered in SIRS for each beneficiary involved.

Complainant Information

- If the person reporting the complaint is not the beneficiary, you will also need to collect the complainant's contact information: first and last name, phone number, email, relationship to the beneficiary, address, city, state, and zip code.
- If you think you might need to refer the complex interaction, explain to the complainant that receiving their permission to be contacted may increase the chances of resolving the case.

Subject Information

- The subject is the physician, provider, supplier, or plan the complaint is against. There must be at least one subject to submit the case to the OIG hotline.
- Start with the basics: Who is the subject? As applicable to the complex interaction, ask the subject's organization name, first and last name, phone number, provider number, email, website, address, city, state, zip code, and any other information (for example, the position, role, or title of the subject).

"Subject" Tab in SIRS

When entering each complex interaction in SIRS, the subject information is entered on a separate tab from all other case information.

After entering the rest of the case information in SIRS, click the "Subject" tab to enter details about the physician, provider, or plan the complaint is against. For training and resources with instructions to enter the case in SIRS, see Appendix B.

- If the subject is a provider, as applicable to the case, you may also need to find out if they participate in Medicare and if they accept assignment.
- Ask the complainant if they have contacted the provider and voiced concerns directly. If the answer is "yes," find out how the provider responded. If the answer is "no," ask why.

Additional Case Information

- Topic(s) Discussed: Which topics are related to this complaint?
- Issue(s): Which issues are related to this complaint.
- Appeal Filed: Find out if an appeal has already been filed and, if so, ask what the complainant knows about the status of the appeal. More information about appeals is provided in Chapter 3.
- Documentation: Documentation is often needed to help resolve the issue, whether it's an error or suspected fraud or abuse. For example, if any questionable charges are shown on the beneficiary's MSN or EOB, a copy of the MSN or EOB should be collected and uploaded with the complex interaction in SIRS. Later, when the issue is resolved, additional documentation is needed to show the total amount that was questioned and resolved. See Chapters 3 and 5 for more information about documentation needed to close the case and claim dollars on the OIG Report.

Topics and Issues in SIRS

Lists of possible topics and issues are available in SIRS as you enter each complex interaction. In SIRS, the "Topics Discussed" field is used for all types of SMP interactions, and the "Issues" field is used only for complex interactions. See the SIRS Complex Interactions Job Aid for data entry instructions.

Get it While You Can!

When requesting documentation from beneficiaries, ask them to send the entire MSN or EOB, including the front and back of all pages. This will ensure all information is available to research and resolve the case as needed.

State and Local Information #6: Gathering Information

Does your SMP have any additional intake guidelines governing the amount and type of information you must request from a complainant? Ask your SMP director or coordinator of volunteers.

Keep It Confidential!

Follow SMP policies for the safe, confidential, and secure transport and storage of documents. For more information, see the section called "Proper Handling of Sensitive Information" later in this chapter.

Don't Forget the Actions, Status, and Case Notes!

In addition to the fields described here, the SMP actions, beneficiary actions, and status of each complex interaction must be entered in SIRS for each case.

Three main categories of statuses include "open" (used when the case is still in progress by the SMP or awaiting a response on a referral), "closed" (used when the case is resolved and documented as such), and "suspended" (used when no further action can be taken by the SMP and information about a resolution is not anticipated). Actions and statuses are described in Chapter 4 and in the SIRS Complex Interactions Job Aid. Detailed case notes must also be entered for each case, as described below.

Writing Great Case Notes

After your initial interview with the beneficiary, you have the basic information you need to start writing some really great case notes!

Your case notes should summarize the situation as the beneficiary or complainant described it to you. They should provide a concise, clear, well-written narrative that will make sense to someone who wasn't sitting with you when you met with the complainant. The notes should grab their attention and help them understand the issue.

Three Steps to Great Case Notes

1) As you interview the beneficiary, start working on your case notes on paper or use the Beneficiary Intake Form.
2) Add to your case notes as you learn more information about the case.
3) When you're ready to enter your case notes in SIRS, edit them to make them great, as described in this section and in ACL's Guided Narrative resource (see Appendix B for resources).

The Importance of Case Notes

Your case notes are a crucial aspect of your case – for both errors and for cases of suspected fraud or abuse.

- For errors, your case notes help explain the situation. If someone else in your SMP is working on the issue with you, they can be used to document your progress working on and resolving the issue and they're necessary in case the issue turns into a referral later.
- For referrals of suspected fraud or abuse, your case notes are your opportunity to provide a well-written, thorough narrative that will grab the attention of investigators and explain the situation to ACL, the OIG, and/or CMS.

For both errors and referrals, your case notes also explain the situation if you're able to claim dollars later, as described in Chapter 3 for errors and Chapter 5 for referrals.

Questions to Answer Before Writing Your Case Notes

When writing your case notes, include: details about who, what, when, and where; attachments; SMP and beneficiary actions; and follow-up information. Some suggested questions to answer before writing your case notes are provided below. The exact questions that need to be answered will vary depending on the nature of the issue.

Who?	Who is the beneficiary (name, date of birth, type of Medicare plan)? Who is the complainant (if other than the beneficiary)? Who is the subject / provider? Who was involved from the SMP (name and role)? What is the name of the insurance program or health care payer: Original Medicare, Medicaid, or Medicare plan?
What?	What is the issue? • If you think it's an error, what makes you think so? • Was the beneficiary's Medicare number compromised? Was their Social Security number (SSN) compromised? • Have any claims already been submitted by the provider? If so, what is / are the claim number(s)? • Is the beneficiary enrolled in Original Medicare (Part A and Part B) or in a Medicare Advantage plan (Part C)? What is / are the effective date(s)? • If the issue involves a prescription drug, does the beneficiary have Part D coverage? • Is the beneficiary dually enrolled in Medicare and Medicaid? • Does the beneficiary have a Medigap (Medicare Supplement Insurance) policy? • What type of health care service(s) were received and involved with the issue? • If it's suspected fraud or abuse, what type of scam is it (durable medical equipment, or DME; genetic testing; etc.)?
When?	When did the issue occur (date)? What is the date of the service or event being questioned?
Where?	Where did the issue occur: at a specific location (e.g., the provider's office, health fair, etc.) or by phone?
Attachments	As mentioned earlier, providing documents to substantiate the issue is extremely important because this will help the SMP resolve an error or help the investigator when reviewing the issue. If there are attachments, what are they? Typically, the MSN or EOB should be attached for evidence. If no MSN or EOB is attached, explain why.
Actions and Follow-up	What actions have already been taken (by the beneficiary and/or SMP)? What actions remain?

Tips on Writing Great Case Notes

Once you've gathered the necessary information, consider the following tips to help you write some great case notes:

- Use ACL's Guided Narrative resource as a template to ensure all necessary information is included in your case notes.
- Briefly describe the situation as the complainant described it to you. Include details about who, what, when, where, the attachments, the SMP and beneficiary actions, and follow-up information (e.g. the answers to the questions on the previous page).
- Include only the facts. Do not enter subjective observations.
- Avoid using acronyms, including state-specific acronyms. If you do need to use them, make sure you explain what they mean. However, federal / national organizations such as CMS, SMP, and OIG are commonly understood.
- Record actions you take for complainants and/or that complainants took on their own behalf. For example, if you contacted another party on their behalf (Medicare, plan, doctor's office), be sure to include the date, time, and name of the person you talked to, what you talked to them about, and any resolutions.
- As you write your case notes, keep in mind that they will be read by others. Use complete sentences and make sure they will make sense to someone who wasn't sitting with you when you met with the complainant.

Guided Narrative = Great Case Notes!

ACL's Guided Narrative resource is a template that was designed to help you write great case notes. This template is required for referrals to the OIG Hotline and highly recommended for all other referrals. See Appendix B for information about resources.

Notes Fields in SIRS

Use the "Case Notes" field in SIRS to enter the notes you create using ACL's Guided Narrative resource.

Use the "Notes" field in SIRS to enter any initial notes you want to make for your own reference, e.g. to track your progress on the case.

See the SIRS Complex Interactions Job Aid for detailed instructions to enter all notes in SIRS.

SMP Casework Training

The SMP Casework Training Series provides information about the current SMP complex interactions casework process. The series includes three events: Building a Case Webinar, Where to Refer Webinar, and Using SIRS to Make and Document Your Referral Webinar.

The From Scam Call to Submission: SMP Casework in Action was a 2021 conference presentation.

- Due to system limitations on the OIG Hotline referral form, case notes should be no more than 2,000 characters (including spaces). For more information about entering case notes in SIRS, see the Guided Narrative and other SIRS training resources described in Appendix B.

2,000 Character Limit!

For referrals to the OIG Hotline, case notes must be less than 2,000 characters (including spaces).

Working with the Beneficiary

Beneficiaries may or may not be fully prepared with the facts you need when they first call. You may need to request additional information before determining the next best step or before taking any action. Information may be needed from a provider, Medicare, a Medicare Advantage plan, or the beneficiary's own records.

When beneficiaries are capable of taking basic preliminary steps on their own behalf, the SMP is not expected to collect all of the information needed to build the case or to manage the resolution of every suspected error on health care statements. Some complainants may need the SMP's guidance and can gather additional information on their own. Others may not be able to navigate the complex health care system alone and may ask the SMP to make contacts on their behalf.

Steps for the Beneficiary

In cases of suspected fraud or abuse, both the SMP and the beneficiary may need to work together to resolve different aspects of the complex interaction.

For example, in cases of compromised Medicare numbers, the beneficiary will need to contact 1-800-Medicare. See Chapter 4 for details about what steps should be taken by beneficiaries vs. SMPs in a variety of scenarios.

Ultimately, you will need to work with the beneficiary to either resolve the issue (if it's an error) or to collect the information needed to make a referral to a national partner (if you determine it's a case of suspected fraud or abuse).

When Beneficiaries Face Collections

When claims are denied or disputed, beneficiaries' bills may be sent to collections if they are unwilling or unable to pay the associated out-of-pocket expenses. The SMP is not expected to help the beneficiary with the details of the collections process but can suggest next steps and available resources.

You can suggest that the beneficiary contact the provider or you can ask the beneficiary for permission to contact the provider on their behalf. The provider has the ability to note that the matter is under review or in dispute and can stop the bills from coming until the matter is resolved. If the beneficiary is still sent to collections, the provider can later get incorrect charges pulled from collections.

Refusing to pay generally works best for beneficiaries when it is very clear that the error is on the part of the provider, not the beneficiary, such as when a provider is billing for a service that was never provided. In other circumstances, it may be best for the beneficiary to set up a payment plan in order to avoid collections. This approach could be preferred in a case where a beneficiary did receive a service but is disputing some detail of the bill – that it was "upcoded," that the service should have been covered by Medicare and wasn't, etc.

Many Medicare beneficiaries are living on a fixed income. If they find themselves legitimately responsible for a high medical bill, they may need the help of other service organizations that assist persons facing financial hardship.

State and Local Information #7: Low-Income Resources

Do you know how to directly connect beneficiaries who are on a fixed income with resources (e.g. if you are housed at a AAA)? If not, where can you send beneficiaries for help? Ask your SMP director or coordinator of volunteers.

Abusive Collection Practices

There are federal and state laws protecting consumers from abusive, deceptive, and unfair debt collection practices. For information on fair debt collection, view the National Consumer Law Center's website and publications: www.nclc.org.

Proper Handling of Sensitive Information

Whenever you handle a beneficiary's sensitive, personal identifying information or other confidential information, keep in mind the privacy recommendations within your SMP project's grant terms and conditions and the SMP Volunteer Risk and Program Management (VRPM) information technology policies. Though the policies were created with volunteers in mind, they reflect best practices for paid personnel as well. The consequences of a data breach are far-reaching. They impact all parties involved: the beneficiary whose sensitive, personal identifying information was compromised and the person or agency whose negligence led to the breach.

Privacy Training

Privacy & Confidentiality Training is available in TRAX. See Appendix B for details.

You may need to take extra precautions when a complainant is not the beneficiary but is providing information about a beneficiary. If the beneficiary is incapacitated, you may want to request proof that the complainant has power of attorney or other similar legal status before the SMP takes any action on the behalf of the beneficiary.

State and Local Information #8: Handling Sensitive Information

What are your SMP's policies and procedures related to handling sensitive information and keeping confidential documents secure? Talk to your SMP director or coordinator of volunteers.

Beneficiary Access to Medicare Information

Original Medicare Information: 1-800-Medicare and Medicare.gov Accounts

Beneficiaries enrolled in Original Medicare can call 1-800-Medicare for claims information and other details regarding their Medicare benefits. In addition, logging in or creating an account at Medicare.gov is recommended for beneficiaries enrolled in Original Medicare who want to see the most recent claims activity on their account. However, many older adults either lack access to a computer or have barriers to computer use, such as vision impairment, memory impairment, or language barriers.

SMP Access to Medicare.gov accounts

SMP grantees may access Medicare.gov account credentials to assist with troubleshooting Medicare beneficiary billing errors and obtaining documentation; however, they may do so **ONLY** with explicit Medicare beneficiary permission and **ONLY** when necessary.

See the Creating and Using Medicare Accounts entry in the SMP Resource Library for more information.

Media Requests for Beneficiary Complaint Information

SMPs rely on the media to assist with warning the public of issues, however, SMPs must ensure they do not disclose specific case information when working with the media. If you receive requests for information related to a complaint filed by a beneficiary, discuss with your SMP director how to handle these situations.

ACL has provided the following language that may be shared.

The Senior Medicare Patrol (SMP) program is an education and outreach program funded by the Federal government. Our mission is to empower and assist Medicare beneficiaries, their families, and caregivers, to protect, detect, and report healthcare fraud, errors, and abuse. We are not investigators. We provide information to Medicare beneficiaries, answer questions, and assist with referrals to CMS and law enforcement as needed. We cannot provide any information on the beneficiaries we serve or specific details on issues that have come to our attention.

Medicare Advantage and Prescription Drug Plan Information

Beneficiaries enrolled in private Medicare plans (Part C and/or Part D) can contact their plan, call 1-800-Medicare, or visit Medicare.gov to log into (or create) a secure Medicare account for claims information and other details regarding their Medicare benefits. Depending on the situation, it may be appropriate to have the beneficiary contact their plan directly with their concerns and get back to you with the results.

Health Care Providers

If the issue is related to a claim with a health care provider, it may be appropriate to have the beneficiary contact their provider directly with their concerns and get back to you with the results. However, in certain situations, it may be best to avoid contacting the provider in case it will impede investigation efforts by national partners. Information to help make this decision is provided throughout this manual.

SMP Access to Medicare Information

Original Medicare Information: CMS Unique ID with 1-800-Medicare

The CMS Unique ID is used for SMP complex interactions to research claims and coverage issues on the beneficiary's behalf. It can also be used to request copies of the MSN be sent to the beneficiary. If the beneficiary is unable or unwilling to call 1-800-Medicare or if you determine that it would be more effective for you to speak directly with 1-800-Medicare about a claim, you can use your CMS Unique ID with 1-800-Medicare.

CMS Unique IDs for SMPs

CMS Unique IDs are intended for active, properly screened and trained SMP complex interactions specialists who have been authorized by their state's SMP or SHIP director, have completed an annual confidentiality agreement, and have received annual privacy training from their SMP or SHIP.

Since CMS Unique IDs provide access to beneficiary personal Medicare information, they are not intended for every SMP team member. They are used by active, approved, screened, and trained SMP and SHIP (State Health Insurance Assistance Program) team members as a form of verification to provide access to certain beneficiary information when assisting a Medicare beneficiary.

CMS Unique ID Training

Training and resources to help SMP complex interactions specialists understand how to use their CMS Unique ID are available in the SMP Resource Library. See Appendix B for details.

CMS Unique ID holders can speak to 1-800-Medicare customer service representatives (CSRs) by calling 1-888-647-6701, the phone number designated by CMS for SHIP and SMP CMS Unique ID holders. Without a CMS Unique ID and the use of this designated phone number, SMP and SHIP team members could not talk with 1-800-Medicare CSRs on behalf of beneficiaries regarding their services, claims, or providers unless the beneficiary initiated the call in the presence of the SMP or SHIP team member.

Medicare Advantage and Prescription Drug Plan Information

In addition to using the CMS Unique ID to talk to 1-800-Medicare in reference to claims in a Part C (Medicare Advantage) or Part D (prescription drug plan), the CMS Unique ID can also be used for speaking with representatives from Part C and Part D plans who have agreed to participate in the CMS Unique ID program and the

Benefits Coordination & Recovery Center (BCRC) for CMS. See the participating plans list (in the CMS Unique ID User Resources entry in the SMP Resource Library) to see if the plan you need to contact participates. If they are on the list, you can use your CMS Unique ID to contact the plan to obtain claim information. If they are not on the list, you will need to have the beneficiary call themselves, call with the beneficiary on the phone, or get a signed release of information from the beneficiary (as described below).

Release of Information

When using your CMS Unique ID to contact 1-800-Medicare or participating plans on a beneficiary's behalf, you do not need to obtain a release of information. You also do not need a release of information to make a referral of suspected fraud or abuse.

However, if you need to contact a beneficiary's health care provider on their behalf or if you need to contact a plan that doesn't participate in the CMS Unique ID program, the provider or plan will probably request a release of information. If so, they may require you to use their release of information or they may be willing to accept a release of information provided by your SMP.

State and Local Information #9: Release of Information

Does your SMP have a standard release of information for you to use when needed? Talk to your SMP director or coordinator of volunteers.

Deciding if the Issue is an Error vs. Suspected Fraud or Abuse

All of this information gathering will take time, often requiring many phone calls. The information you and the beneficiary gather will help you determine whether you suspect that the complex interaction is an error (which can be resolved by the SMP and the beneficiary) vs. fraud or abuse (which must be referred to a national and/or state partner for further action) and what steps should be taken next.

This is where basic knowledge of Medicare is essential. The *SMP Foundations Training Manual* provides general information about Medicare. The *SMP Counselor Training Manual* provides information about how to review Medicare statements and answer basic SMP questions as well as guidance on how to handle questions that aren't related to the SMP mission and situations that aren't considered to be SMP complex interactions.

SIRS Follow-up

As mentioned earlier, you should start entering each complex interaction in SIRS during or after your initial conversation with the beneficiary to record information you already know at that point.

As you work on the case, you should update the complex interaction in SIRS each time you discover new information or collect documentation from the beneficiary or a provider and when you resolve an error or make a referral.

If more advanced knowledge of Medicare is needed to research an issue, see Medicare's website (www.Medicare.gov), CMS' website (www.cms.gov), or contact your SHIP for assistance. To find the SHIP in your state, visit the SHIP National Technical Assistance Center website: www.shiphelp.org.

Errors

Most complaints of suspected health care fraud, errors, and abuse received by SMPs arise after a health care service has been provided or a bill or statement has been received. The first question to consider is: Could the issue be just an error?

Most providers are legitimate and are simply unaware that they did something wrong. When reviewing each case, it is important to rule out error before making any assumptions that the issue is fraud or abuse. Consider the patient / provider relationship and, when possible, give the provider the benefit of the doubt.

Errors can be resolved by the SMP and the beneficiary by following up with 1-800-Medicare, the plan, and/or the provider as described in Chapter 3.

Suspected Fraud or Abuse

If you rule out error or if the suspected error is not resolvable at the provider level, you should refer the complaint to investigative entities as suspected fraud or abuse. It is important to remember that these cases should be considered **suspected** fraud or abuse. It will take an investigation by the appropriate entities to make a legal determination.

Intentionality

As described in the *SMP Foundations Training Manual*, the primary distinction between fraud and abuse lies with intent. Unlike abuse, which is not knowing / unintentional, fraud assumes "criminal intent." SMPs aren't usually in the position to determine "intentionality" – that significant dividing line between determining whether there is suspected fraud or abuse. The determination of intentionality will be made by the investigative entities that receive SMP referrals. Because of these factors, you will not need to determine whether a complaint involves abuse vs. fraud in order to make an appropriate referral.

Patterns of "Error"

A pattern of error by a particular provider or plan increases the likelihood of fraud or abuse and is considered a red flag. SMPs are usually not in a position to determine patterns unless they have received multiple complaints about a particular provider or plan. However, if the beneficiary or the SMP does notice a pattern, a referral should be made for further investigation.

Where to Refer Patterns of Error

Patterns of error should be referred to the OIG Hotline via ACL when they involve a provider and to the CMS SMP Part C & D contact when they involve a plan. See Chapter 4 for more information about where to refer each type of scenario involving suspected fraud or abuse.

Immediate Referrals to the OIG Hotline and ACL

Though ACL generally encourages SMPs to compile all possible case documentation (within reason) prior to submission to OIG via ACL in SIRS, there are a number of case types that we ask to be passed on as soon as possible.

Examples of such cases include:

- Direct, active patient harm cases
- Potential medical fraud (e.g., patient injuries, patient negligence, improper treatments, medical errors, or death) which are a direct result of the medical care improperly dispensed or not dispensed.
- New fraud schemes
- National scope fraud schemes
- Schemes that impact multiple states or include companies that are national in scope

When submitting a case that fits one of these criteria and/or when in doubt about whether your case referral should be expedited, please enter the case in SIRS and send the reference number(s) and a brief sanitized description of the case to smp@acl.hhs.gov and SIRS@smpresource.org.

Questions to Consider

As you review the initial information from the beneficiary, consider the following questions to determine whether the complex interaction is likely to be an error vs. fraud or abuse:

- ✓ Has the beneficiary tried to reach out to the provider, facility, supplier, etc. about the issue? If yes, what was the result? If no, why not?
- ✓ What documentation of the issue does the beneficiary have ready to share with the SMP (e.g., MSN's, provider bill, etc.)?
- ✓ Does it seem like it might be a billing error that the provider can correct with Medicare, another payer, or the beneficiary?
  - If so, attempt to resolve it at the provider level, as described in Chapter 3.
  - If not, proceed with a referral, as described in Chapter 4.
- ✓ Is a provider who participates in Medicare (as described in SMP Counselor Training) unwilling to bill according to Medicare's rules?
  - If so, proceed with a referral.

- ✓ Does the provider's behavior seem particularly egregious and far outside the realm of possible error?
  - If so, proceed with a referral of suspected fraud rather than contacting the provider (or making further contact with them, if contact was already made).
- ✓ Have you received other complaints of errors about this provider?
  - If so, there may be a pattern of error, not an isolated incident. Proceed with a referral.
- ✓ If the claim was denied or rejected, did the beneficiary sign an ABN (Advance Beneficiary Notice)? If so, was it blank?
  - If the ABN was blank, proceed with a referral.
  - If they would like to appeal, see Chapter 3 for more information.

Watch Out for Blank ABNs!

The ABN is a notice a provider or supplier may have asked a beneficiary with Original Medicare to sign stating that Medicare may not pay for certain services. See SMP Counselor Training for more information on ABNs.

What's Next?

Regardless of whether you decide to move forward with the complex interaction as an error or suspected fraud or abuse, you'll need to determine what steps should be taken next by you and the beneficiary.

- Steps to resolve errors are described in Chapter 3.
- Steps to make a referral of cases of suspected fraud or abuse are described in Chapter 4.

SMP Complex Interactions

Training Manual

CHAPTER 3: Resolving Errors and Claiming Dollars

Objectives

Upon completion of Chapter 3: Resolving Errors and Claiming Dollars, you will be able to work with the beneficiary as needed to resolve issues involving errors.

Resolving Errors

Complex interactions that involve suspected errors typically begin when a beneficiary notices a discrepancy on their MSN, EOB, or other bill from a provider.

When following up on cases of suspected errors, some good rules of thumb are:

- ✓ A responsive provider will work with the beneficiary or caregiver to correct errors or better explain charges.
- ✓ If an error is suspected, counsel the complainant to contact the health care provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan to work it out. If the beneficiary requests, the SMP can assist with these steps. If they are willing and able to make the contacts on their own, ask the complainant to call you back if the response is inadequate. Also ask the complainant to call you back if the issue is resolved and cost savings result so that the savings can be documented by the SMP program.
- ✓ An inadequate response from a health care provider, Medicare Advantage plan, or Medicare Prescription Drug Plan may point to a pattern, leading to suspected abuse or fraud.
- ✓ If you think the complaint might be part of a pattern being seen by your SMP or the national SMP network, you should escalate the complaint to suspected fraud or abuse and make a referral on behalf of the complainant (as described in Chapter 4). It may look like an error when looked at in isolation; however, when viewed in the context of the larger health care environment, patterns of error are suspected abuse or fraud.

The Importance of Resolving Errors

When SMPs help beneficiaries resolve errors, these issues are considered SMP complex interactions. Resolving errors is an important part of the SMP mission because it helps the beneficiary, Medicare, and/or others save or recover money that would otherwise have been lost.

Issues involving errors are entered in SIRS, research done by the SMP is tracked in SIRS, and any dollar amounts saved or recovered are shown on the OIG Report (if the SMP provides proper documentation and closes the complex interaction in SIRS, as described later in this chapter).

Steps for the Beneficiary

For issues involving suspected errors, advise the beneficiary to take the following steps:

- Contact the health care provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan first to try and correct the error.
- Contact the SMP again if the issue is resolved and provide documentation to verify both the original charges and the corrected amounts (as described later in this chapter).
- Contact the SMP again if the billing issue is not resolved.

Steps for the SMP

For issues involving suspected errors, the following steps should be taken by the SMP:

- Reach out to the health care provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan with or on behalf of the beneficiary as needed.
- Even if the beneficiary contacts the health care provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan to try and correct the error, the SMP may need to take these actions also to rule out error.
    - See Chapter 2 for information about using the CMS Unique ID to contact 1-800-Medicare and participating Part C and D plans or using a release of information to contact providers.
- Enter the case in SIRS, including all pertinent information as described in Chapter 2 and the SIRS Complex Interactions Job Aid. For specific instructions on which topics and issues to select in SIRS, see the appropriate topic in Chapter 4.
- After resolving the error, collect documentation to show the amount that was saved or returned to the beneficiary and/or Medicare and close the case, as described later in this chapter.

Errors Related to Coordination of Benefits

Some errors brought to the SMP's attention may be the result of mistakes, confusion, or problems related to a Medicare beneficiary's other health coverage. Depending on the circumstances, Medicare may be the "secondary payer," not the primary payer. Medicare Secondary Payer (MSP) is the term generally used when the Medicare program does not have primary payment responsibility – that is, when another entity has the responsibility for paying before Medicare. In some cases, the beneficiary may have forgotten to notify Medicare about other coverage or there may have been a mistake made at some level within the Medicare claims processing system.

If a beneficiary has other health coverage besides Medicare, and many do, coordination of benefits rules decide which pays first.

Examples of health care coverage that may pay first include employer group health plans (when the beneficiary is still working), Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), retiree health plans, no-fault insurance and liability insurance, and workers' compensation insurance.

Look for this in the notes section of the MSN…

"Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer."

Conditional Payments

Sometimes, SMPs receive complaints and questions related to what Medicare calls a "conditional payment." A conditional payment is a payment Medicare makes for services another payer may be responsible for. Medicare makes this conditional payment so the beneficiary won't have to use their own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare when a settlement, judgment, award, or other payment is made. If Medicare makes a conditional payment for an item or service and the beneficiary receives a settlement, judgment, award, or other payment for that item or service from an insurance company later, the conditional payment must be repaid to Medicare. The beneficiary is responsible for making sure Medicare gets repaid for the conditional payment.

Questions about who pays first and conditional payments should be directed to the Benefits Coordination & Recovery Center (BCRC). SMPs can call the BCRC at 1-855-798-2627 using their CMS Unique ID, as described in the CMS Unique ID User Resources entry in the SMP Resource Library.

Beyond Errors

Some situations might at first seem like an error (or even fraud or abuse) but may turn out to have a different explanation. These situations are often complicated enough that they can't be fully understood until further research is done, which is why these cases are handled by SMP complex interactions specialists instead of SMP counselors.

Appeals

One example of this type of situation is issues involving a claim denied or rejected by Medicare. If payment for charges submitted to Medicare was denied, the beneficiary has the right to appeal. As you research issues involving a denied claim, you or the beneficiary may disagree with Medicare's decision and decide the beneficiary should file an appeal. In these situations, the first step is for the beneficiary (or you, if the beneficiary needs help) to follow up with the provider to make sure the claim made to Medicare correctly reflects the service provided.

Appeals and Referrals

If the beneficiary has already appealed a claim, it may be preferable to wait for the result before referring the case for further investigation. However, criminal violations of the law should still be referred to the appropriate investigative entity even if an appeal will be or has been filed.

Help with Appeals: SHIP

Filing appeals is generally outside of the scope of the SMP program. However, it is important to be familiar with the process so that you can appropriately counsel beneficiaries about the steps to take and the service providers available to help them. The appeals process is explained to beneficiaries on their MSN if they are in Original Medicare. Part C and D plans send beneficiaries information about their appeals process whenever a claim is denied or rejected. SHIPs are considered the primary experts and client advocates regarding the appeals process. To find the SHIP in your state, visit the SHIP National Technical Assistance Center website: www.shiphelp.org.

Observation Status

Another situation that may be perceived by beneficiaries as an error can instead be explained by the hospital placing the beneficiary in what is called "observation status."

Observation status is used by hospitals to assess whether a patient (usually in the emergency department) should receive continued outpatient treatment, be admitted as an inpatient, or be discharged. The financial difference between observation status and inpatient status to the Medicare beneficiary can be significant. Costs for observation status, which is outpatient, fall under Part B and inpatient costs fall under Part A. Observation status costs are even greater for patients without Part B. Additionally, there are implications after hospitalization. Observation status does not count toward the three inpatient days required for skilled nursing facility (SNF) coverage.

Patients are often unaware that they are classified under observation status vs. inpatient and are unaware of the implications. Efforts by CMS to address these issues include the "Two-Midnight" rule and the Medicare Outpatient Observation Notice (MOON).

What Can Be Done About Observation Status?

Observation status is very hard to fight, and addressing these issues is outside of the scope of the SMP program. However, SMPs can help educate beneficiaries about what actions to take.

- Beneficiaries can take action at the beginning of a hospital stay to try to stop observation before it starts. They can ask the hospital doctor to admit them as an inpatient based on needed care, tests, and treatments, and they can ask their regular physician to contact the hospital doctor to support this request.
- Beneficiaries can file an appeal with Medicare if their nursing home coverage is denied or rejected.
- Beneficiaries can file a complaint with their state health department if they did not receive the MOON as required by CMS.

- **Two-Midnight Rule:** The two-midnight rule addresses vulnerabilities in hospitals' use of observation status vs. inpatient status. The rule establishes that inpatient status is generally appropriate if physicians expect hospital care to last at least two midnights. The goals of the rule are to decrease the use of short inpatient stays (less than two midnights), decrease the use of long outpatient stays (two midnights or longer), and promote the consistent use of inpatient and outpatient status in hospitals.

Consequences of Observation Status

Observation status can result in thousands of dollars in hospital bills and thousands more in nursing home bills after a hospital stay. Patients who don't have Medicare Part B are responsible for the full cost of the hospitalization.

- **Medicare Outpatient Observation Notice (MOON):** Since hospital classification of a patient as an inpatient or under observation has significant impacts on a patient both financially and in post-hospital care, CMS developed the Medicare Outpatient Observation Notice (MOON) to help ensure that patients are aware of their status. When receiving observation services, patients may be delivered the MOON before receiving more than 24 hours of care and no later than 36 hours after services are initiated or at discharge, if sooner. An oral explanation of the MOON must be given, ideally when the notice is delivered.

Collecting Documentation to Close Complex Interactions Involving Errors

Once final resolution of the issue has been reached, any findings and final documentation are added to the complex interaction and it is closed in SIRS.

The Importance of Documentation

Documentation Helps Beneficiaries and the SMP Program

Educate beneficiaries to request a copy of the corrected or $0 balance bill or statement as proof that their billing complaint was resolved. This is important for their records and also for your SMP, who will need a copy to document cost avoidance, savings, and recoveries for the OIG Report.

As described in SMP Foundations Training, the OIG Report of SMP performance measures is published each year and is available to the public. As part of the OIG Report, the SMP program is measured on financial information related to complex interactions. The ability of each SMP program to receive credit for cost avoidances, savings to the beneficiary or others, and expected recoveries to Medicare, Medicaid, or a Medigap plan is one way to ensure the continued support of Congress for the SMP program. Proper documentation must be collected before the case can be closed and any dollar amounts can be claimed on the OIG Report.

SMP Performance Measures Related to Claiming Dollars

On the OIG Report, performance measures (PMs) 6 to 12, shown in the grid below, are related to dollars. Dollars may be claimed for both errors and referrals – once they are resolved and proper documentation is collected.

PM #	PM Name
6	Cost Avoidance
7	Expected Medicare Recoveries
8	Additional Expected Medicare Recoveries
9	Expected Medicaid Recoveries
10	Additional Expected Medicaid Recoveries
11	Actual Savings to the Beneficiary
12	Other Savings

Additional Resources

For more information about closing complex interactions and the documentation needed to claim dollars on the OIG Report, use your resources!

- See ACL's SMP Performance Measures Definitions and Guidance document for detailed descriptions of each performance measure.
- See the OIG Report Webinar for samples of acceptable documentation.
- See Chapter 5 for information about claiming dollars on referrals.
- See the SIRS Complex Interactions Job Aid for instructions to close a case in SIRS.

For help finding resources in the SMP Resource Library, see Appendix B.

Examples of Documentation

Documents should clearly provide the beneficiary's name, service date, service(s) provided, and dollar amounts. Here are some examples of documentation that meet OIG Report standards for claiming dollars on errors:

- Copy of a canceled check or a reimbursement check
- Corrected hospital billing statement
- Letter from a provider or supplier explaining the amount of the savings or recovery
- Letter or other evidence from a CMS representative

Working with the Beneficiary to Collect Documentation

Although you can rely on your CMS Unique ID with 1-800-Medicare to conduct claims research, 1-800-Medicare is not able to provide SMPs with documentation about changes made to Medicare claims as a result of SMP intervention (such as corrected MSNs). That information can only be sent to the beneficiary. Because of this, getting credit on the OIG Report for recoveries and savings is dependent upon your ability to obtain documentation from beneficiaries, caregivers, or other sources.

Another option may be creating and using a Medicare.gov account. SMP grantees may create and access Medicare.gov accounts to assist with troubleshooting Medicare beneficiary billing errors and obtaining documentation; however, they may do so **ONLY** with explicit Medicare beneficiary permission and **ONLY** when necessary. See the Creating and Using Medicare Accounts entry in the SMP Resource Library for more information.

Since beneficiaries are often your only source of this information, you must work with them to gather the necessary documentation and upload it in SIRS. In many cases, you will receive copies of MSNs, EOBs, and health care bills from the complainant documenting the potential error or other suspicious activity.

Inform complainants that they will also need to provide you with documentation showing corrections or reimbursements. This allows you to

Educating Beneficiaries Can Lead to Dollars on the OIG Report!

When SMPs educate beneficiaries and other complainants about how to resolve their own issues involving errors, the SMP can still get credit for any costs that are avoided or dollars that are saved.

As you work with beneficiaries who are willing and able to resolve their own errors, ask them to follow up with the SMP to provide information and documentation once the case is resolved. This extra step by the beneficiary will lead to the SMP getting credit on the OIG Report, which helps with continued funding of the program.

What to Do When You Can't Get Documentation

The documentation needed to substantiate dollars on the OIG Report may be difficult or impossible to obtain. SMPs must rely on outside entities to obtain this documentation, putting the ability to get credit for these monetary outcomes outside SMP control. ACL understands that the value of the SMP program goes beyond the ability to document recoveries, savings, and cost avoidance. However, when working with complex interactions, it is still important to at least seek documentation.

If you are unable to collect the necessary documentation, you will need to change the status of the complex interaction in SIRS to "Suspended." This will close the case without including any dollars on the OIG Report. See the SIRS Complex Interactions Job Aid for details on statuses and how to close a case.

account for the cost avoidances and savings in a way that fulfills the OIG's audit requirements. Such accounting is vital to the success of the SMP program and impacts not just your state but the SMP network as a whole.

What's Next?

Once you've resolved the error, uploaded documentation in SIRS, and closed the case, you're done with the issue! However, while working on the issue, if fraud or abuse is suspected, see chapter 4.

SMP
Senior Medicare Patrol
Resource Center

SMP Complex Interactions Training Manual

CHAPTER 4: Managing Referrals (a.k.a. "Where and When to Refer")

Continued…

Objectives

This chapter guides you through the process of managing and referring cases of suspected fraud and abuse, including examples and instructions to enter the case in SIRS for a wide variety of common issues.

Upon completion of Chapter 4: Managing Referrals (a.k.a. "Where and When to Refer"), you will be able to:

1) Manage SMP complex interactions following the processes outlined in this manual and, when necessary, conduct a referral to the appropriate entity for further action.
2) Identify and follow up on situations in which beneficiaries are targets of inappropriate marketing or solicitation.

How to Use this Chapter

This chapter is intended to be used as a reference guide to help you manage a wide variety of referrals. Instead of reading the entire chapter word for word, you may prefer to read the introductory information and examples in each section upfront, then refer back to this chapter for step-by-step instructions when you encounter one of the example scenarios.

Common Beneficiary and SMP Actions

For issues involving suspected fraud or abuse, the SMP and the beneficiary often need to work together to resolve different aspects of the complex interaction.

Steps for the Beneficiary

Steps for the beneficiary are outlined in each scenario throughout this chapter. For example:

- In cases involving compromised Medicare numbers, the beneficiary will need to contact 1-800-Medicare.

Overlapping Issues

When more than one issue is involved, review the table of contents for this chapter and cross-reference all applicable scenarios as needed.

- In cases involving compromised Social Security numbers, the beneficiary will also need to contact the FTC (Federal Trade Commission) and the FCC (Federal Communications Commission).
- In cases involving quality-of-care issues, the beneficiary will need to contact the BFCC-QIO (Beneficiary and Family Centered Care Quality Improvement Organization) and their long-term care ombudsman.
- When the issue is resolved, the beneficiary should contact the SMP to provide documentation to verify both the original charges and the corrected amounts (as described in Chapter 5).

Steps for the SMP

Steps for the SMP are also outlined in each scenario throughout this chapter. For example:

- Guidance on where to refer each case based on the scenario described
- Additional information that might be needed before the case can be referred
- Instructions about which options to select in specific data fields in SIRS
- Additional follow-up that may be needed outside of SIRS

After the case is resolved, the SMP should collect documentation to show the amount that was saved or recovered and close the case, as described in Chapter 5.

Common SMP Referrals

As you read through this chapter, also see Appendix A for a summary of where to send each type of referral. SMP referrals are most commonly made to the OIG Hotline via ACL and to the CMS SMP Part A & B contact. However, depending on the scenario, referrals may be made to a variety of other national and state partners, such as the CMS SMP Part C & D contact, the Medicaid Fraud Control Unit, the state Department of Insurance, etc.

Referrals to the Local OIG

As mentioned in Chapter 1, when making referrals to the OIG, SMPs should always follow the national referrals process described in this chapter. If your SMP has a relationship with your local OIG office and you'd like to make a referral to your local OIG **in addition** to the referral to the OIG Hotline, make sure to include in the case notes the local OIG officer's name and contact information and if the OIG officer also referred the case to the national OIG Hotline.

Referrals to CMS

When making referrals to CMS, as described throughout this chapter, be sure to follow the referral instructions within the specific document in the CMS Contact Lists: Referrals to CMS entry. Also print or save the Full Data PDF along with all documentation from SIRS and send it in a secure manner to the CMS contact. For more details on encryption and password-protecting, see the Delivering Personal Protected Information (PPI) Remotely document in the COVID-19 Toolkit for Professionals.

Key Referrals Acronyms: FFS, PDP, MSN, and EOB

- When the beneficiary receives Medicare Part A and Part B through Original Medicare, this is also known as Fee-for-Service (FFS). A beneficiary enrolled in Original Medicare receives a Medicare Summary Notice (MSN).
- When a beneficiary receives Medicare Part A and B through a Part C, or Medicare Advantage Plan, they receive a similar notice called the Explanation of Benefits (EOB).
- A beneficiary in a Part D, or Prescription Drug Plan (PDP), receives an EOB for prescription drug claims.
- The acronyms FFS and PDP are used throughout this chapter when referencing referrals related to Part A & B (FFS) and Prescription Drug Plans (PDP).
- For more information about MSNs and EOBs, see SMP Foundations Training and SMP Counselor Training.

Steps for Common Scenarios

The rest of this chapter provides examples of common SMP scenarios, together with specific beneficiary and SMP actions to manage each type of complaint.

New Information on a Closed Case?

If the beneficiary calls back because of a claim being processed or a bill being received, and the case is closed in SIRS, the SMP will update the status of the case to be open and follow the steps within the appropriate scenario from this chapter, which may include resubmitting the case to the OIG Hotline.

Ambulance Services

Medicare covers ambulance services when they are medically necessary. To qualify for coverage, the ambulance and its crew must meet certain standards and be the only safe means of transporting a patient to an appropriate facility like a hospital, skilled nursing facility, or dialysis center where the patient receives Medicare-covered services.

Examples: Ambulance Services Fraud

- Taking patients by ambulance when another type of vehicle, such as a wheelchair van or automobile, could transport them safely
- Billing for more mileage than the actual distance covered in an ambulance trip
- Upcoding transport claims from basic life support to advanced life support
- Billing for emergency transport when there was no emergency
- Transporting patients to noncovered destinations

Beneficiary and SMP Action Items: Ambulance Services Complaints

Steps for the Beneficiary

- Is it an error? Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan first to try to resolve the issue.
- Contact the SMP again if the issue is not resolved (see the steps below for SMP follow-up).

Steps for the SMP – Initial

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark all applicable issues, e.g.: "Billing Error," "Billing for Services Different From Received," "Billing for Services Not Provided," and/or "Double Billing."
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Ambulance" as the topic.
    - If you also suspect medical identity theft, be sure to also follow the steps in this chapter for a compromised Medicare number and/or compromised Social Security number. (**Tip:** See the Medical Identity Theft section.)
    - In the referred beneficiary action(s) section, mark as needed:
        - "Referred beneficiary to contact Provider/Practitioner"
        - "Referred beneficiary to 1-800-Medicare"
        - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
        - "Referred beneficiary to contact Secondary Insurer/Plan"
    - In the SMP actions section, mark as needed:
        - "SMP contacted 1-800-Medicare"
        - "SMP contacted Medicare Advantage Plan or Part D Plan"
    - Mark the status as "Open – Research in Progress by SMP, less than one year" and enter today's date as the date of last status update.

Steps for the SMP – Follow-up

- If the beneficiary calls back because they were able to resolve the issue on their own, collect documentation and close the case (as described in Chapter 3).
- If the beneficiary calls back because they were not able to resolve the billing issue or they do not receive a corrected MSN or EOB, follow these steps.

- Follow up to rule out error: Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan as needed.
- Update the case in SIRS, completing and updating all applicable fields and case notes as needed. Specific instructions for this type of scenario include:
  - In the SMP action section, mark:
    - "SMP contacted OIG"
    - "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

      Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
    - "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

      Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
    - If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."
  - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
  - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
  - In the Workflow Option Date field, enter today's date.
  - Change the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.
  - After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.
- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Beneficiary Participation in Fraud

It is fraudulent for beneficiaries to conspire with providers (or scam artists posing as providers) to falsely bill Medicare. Beneficiaries who knowingly participate in fraud are unlikely to contact the SMP. It is more likely for this type of behavior to be brought to the SMP's attention by a third party. These reports are rarely received by SMPs, but when they do occur, they must be referred to the OIG Hotline via ACL.

Examples: Beneficiary Participation in Fraud

- Using another person's Medicare or Medicaid card to obtain medical care (medical identity theft in addition to Medicare fraud)
- Accepting money, gifts, or services in exchange for their Medicare or Medicaid number
- Participating in recruiting schemes:
  - Recruiters will solicit beneficiaries for their Medicare or Medicaid numbers in exchange for cash, gifts, and "free" services, such as transportation.
  - Some beneficiaries have been known to act as recruiters themselves, accepting money to recruit other beneficiaries to participate in a scheme.
  - Some of these schemes involve the provision of health care services that are phony, unnecessary, or possibly even harmful to participating beneficiaries.

Beneficiary and SMP Action Items: Beneficiary Participation in Fraud

Steps for the Beneficiary – N/A

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
  - Click "Yes" to add more information.
  - In the Fraud, Error, or Abuse section, mark "Beneficiary Perpetrated Fraud" as the applicable issue, along with any others that apply.
  - In the Detail(s) of Fraud, Error, or Abuse section, mark the appropriate topic based on the area of fraud the beneficiary is participating in, e.g.: "Durable Medical Equipment (DME)," "Hospice," "Genetic/DNA Testing," etc.
  - In the SMP action section, mark:

- "SMP contacted OIG"
- "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

  Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
- "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

  Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
- If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."

- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
- In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
- In the Workflow Option Date field, enter today's date.
- Mark the status as "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.
- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

DME: Billed and Received

Examples: DME - Billed and Received

- Providing unnecessary equipment
- Providing equipment to a person not eligible for Medicare or Medicaid
- Paying kickbacks or referral fees for patients

- Upcoding or billing for different or more expensive equipment than provided
- Suppliers offering beneficiaries “free” equipment or supplies but billing Medicare and/or Medicaid
- Suppliers providing medical equipment or supplies that the beneficiary never requested or didn’t need
- Beneficiaries knowingly accepting money, gifts, or unnecessary equipment and supplies from a supplier in exchange for their Medicare number
- Suppliers delivering an off-the-shelf product to the beneficiary but billing Medicare and/or Medicaid for a more costly product

Beneficiary and SMP Action Items: DME - Billed and Received

Steps for the Beneficiary

- Is it an error? Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan first to try to resolve the issue.
    - If medical identity theft is suspected, for example, suspicious claims on the MSN or EOB, receipt of unsolicited braces, etc., have the beneficiary follow the steps in this chapter for a compromised Medicare number and/or Social Security number. (**Tip:** See the Medical Identity Theft section.)
- Refuse the box if possible. If it has already been delivered, open the box and provide the following information to the SMP:
    - The return label on the outside of the box
    - All documentation inside of the box
    - Pictures of the equipment inside of the box
- Call the supplier and ask for a return label.
    - Suppliers must accept returns but do not have to pay for the return label.
        - If they do not know who the supplier is or if the supplier refuses to pay for the return and send a return label, the equipment can be donated.
    - Return the supplies using the label provided. Track the return of the package with USPS, FedEx, or UPS.
        - Keep record of the tracking receipts and confirmation of the return.
- Contact the SMP and follow the steps in the follow-up section if they receive the MSN / EOB with the DME charges removed.

Steps for the SMP – Initial

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Other Fraud, Error, or Abuse" and "Scams" as the issue, along with any others that apply and enter "Billing for services not requested" in the Other Fraud, Error, or Abuse Details field.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Durable Medical Equipment (DME)" as the topic, along with any others that apply.
    - If you also suspect medical identity theft, be sure to also follow the steps in this chapter for a compromised Medicare number and/or compromised Social Security number. (Tip: See the Medical Identity Theft section.)
    - In the referred beneficiary action(s) section, mark as needed:
        - "Referred beneficiary to contact Provider/Practitioner"
        - "Referred beneficiary to 1-800-Medicare"
        - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
        - "Referred beneficiary to contact Secondary Insurer/Plan"
    - In the SMP actions section, mark as needed:
        - "SMP contacted 1-800-Medicare"
        - "SMP contacted Medicare Advantage Plan or Part D Plan"
        - "SMP contacted OIG"
        - "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

          Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
        - "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

          Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
        - If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."
    - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.

  - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
  - In the Workflow Option Date field, enter today's date.
  - Change the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.
  - After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Steps for the SMP – Follow-Up

- If the beneficiary calls back because they were able to resolve the issue on their own or CMS took action, collect documentation and open a new case to claim the dollars (as described in Chapter 5) and leave this case open.

DME: Billed but Not Received

Examples: DME - Billed but Not Received

- Suppliers or doctors billing Medicare and/or Medicaid for equipment or supplies that the beneficiary never received
- Suppliers billing Medicare and/or Medicaid for items after the individual who used them passed away

Beneficiary and SMP Action Items: DME - Billed but Not Received

Steps for the Beneficiary

- Is it an error? Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan first to try to resolve the issue.
  - If medical identity theft is suspected, for example, suspicious claims on the MSN or EOB, receipt of unsolicited braces, etc., have the beneficiary follow the steps in this chapter for a compromised Medicare number and/or Social Security number. (**Tip:** See the Medical Identity Theft section.)

- If the beneficiary has not received the item, inform them they should refuse any unexpected packages if they are able.
- Contact the SMP again if:
    - They receive a box they could not refuse. (**Tip:** Follow the steps in the section for DME: Billed and Received.)
    - They receive the MSN / EOB with the DME charges removed.

Steps for the SMP – Initial

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Billing for Services Not Provided" and "Scams" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Durable Medical Equipment (DME) " as the topic, along with any other others that apply.
    - Since medical identity theft is suspected, in the Fraud, Error, or Abuse section, mark "Medical Identity Theft" as the issue and in the Detail(s) of Fraud, Error, or Abuse section, mark "Compromised Medicare Number" as the topic. Be sure to also follow the steps in this chapter for a compromised Medicare number.
    - In the referred beneficiary action(s) section, mark as needed:
        - "Referred beneficiary to contact Provider/Practitioner"
        - "Referred beneficiary to 1-800-Medicare"
        - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
        - "Referred beneficiary to contact Secondary Insurer/Plan"
    - In the SMP actions section, mark as needed:
        - "SMP contacted 1-800-Medicare"
        - "SMP contacted Medicare Advantage Plan or Part D Plan"
        - "SMP contacted OIG"

What If the CSR Doesn't Know About Unique IDs?

If you have an issue with your CMS Unique ID due to the CSR's lack of understanding of the CMS Unique ID process, use the CMS Unique ID Complaint Form to submit the complaint. See Appendix B for more information about resources.

- "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

  Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.

- "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

  Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.

- If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."

- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
- In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
- In the Workflow Option Date field, enter today's date.
- Change the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Steps for the SMP – Follow-Up

- If the beneficiary calls back because they were able to resolve the issue on their own or CMS took action, collect documentation and open a new case to claim the dollars (as described in Chapter 5) and leave this case open.

DME: Not Billed but Received or Refused

Examples: DME - Not Billed but Received or Refused

- Beneficiary receives a box or package of braces that they did not request

- Beneficiary refuses a box or package that they were not expecting

Beneficiary and SMP Action Items: DME - Not Billed but Received or Refused

Steps for the Beneficiary

- Is it an error? Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan first to try to resolve the issue.
    - If medical identity theft is suspected, for example, suspicious claims on the MSN or EOB, receipt of unsolicited braces, etc., have the beneficiary follow the steps in this chapter for a compromised Medicare number and/or Social Security number. (**Tip:** See the Medical Identity Theft section.)
- Refuse the box if possible. If it has already been delivered, open the box and provide the following information to the SMP:
    - The return label on the outside of the box
    - All documentation inside of the box
    - Pictures of the equipment inside of the box
- Call the supplier and ask for a return label.
    - Suppliers must accept returns but do not have to pay for the return label.
        - If they do not know who the supplier is or if the supplier refuses to pay for the return and send a return label, the equipment can be donated.
    - Return the supplies using the label provided. Track the return of the package with USPS, FedEx, or UPS.
        - Keep record of the tracking receipts and confirmation of the return.
- Contact the SMP again if they see on their MSN / EOB that Medicare or their plan is charged for the items. (**Tip:** Follow the steps in the section for DME: Billed and Received.)

Steps for the SMP – Initial

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click “Yes” to add more information.
    - In the Fraud, Error, or Abuse section, mark “Billing Error,” “Scams,” and “Other Fraud, Error, or Abuse” as the issue, along with any others that

apply and enter "DME Received/Refused but Not Billed" in the Other Fraud, Errors, and Abuse Details field.

- In the Detail(s) of Fraud, Error, or Abuse section, mark "Durable Medical Equipment (DME) " as the topic, along with any others that apply.
- Since medical identity theft is suspected, in the Fraud, Error, or Abuse section, mark "Medical Identity Theft" as the issue and in the Detail(s) of Fraud, Error, or Abuse section, mark "Compromised Medicare Number" as the topic. Be sure to also follow the steps in this chapter for a compromised Medicare number.
- In the referred beneficiary action(s) section, mark as needed:
  - "Referred beneficiary to contact Provider/Practitioner"
  - "Referred beneficiary to 1-800-Medicare"
  - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
  - "Referred beneficiary to contact Secondary Insurer/Plan"
- In the SMP actions section, mark as needed:
  - "SMP contacted 1-800-Medicare"
  - "SMP contacted Medicare Advantage Plan or Part D Plan"
  - "SMP contacted OIG"
  - "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

    Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
  - "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

    Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
  - If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."
- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
- In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
- In the Workflow Option Date field, enter today's date.
- Change the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.

  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.
  - After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Steps for the SMP – Follow-Up

- If the beneficiary calls back because they were able to resolve the issue on their own or CMS took action, collect documentation and open a new case to claim the dollars (as described in Chapter 5) and leave this case open.

DME: Improper Marketing

Examples: DME - Improper Marketing

- Suppliers requesting beneficiary Medicare and/or Medicaid numbers at a presentation, during a sales pitch, or in an unsolicited phone call. This also includes suppliers faxing providers for approval of DME items not requested by a beneficiary.

Beneficiary and SMP Action Items: DME - Improper Marketing

Steps for the Beneficiary – N/A

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
  - Click "Yes" to add more information.
  - In the Fraud, Error, or Abuse section, mark "Other Fraud, Error, or Abuse" and "Scams" as the issue, along with any others that apply, and enter "Improper Marketing" in the Other Fraud, Errors, and Abuse Details field.
  - Detail(s) of Fraud, Error, or Abuse section, mark "Durable Medical Equipment (DME)" as the topic, along with any other that apply.
  - In the SMP action section, mark:

- "SMP contacted 1-800-Medicare"
- "SMP contacted Medicare Advantage Plan or Part D Plan"
- "SMP contacted OIG"
- "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

  Note: In the case notes section, indicate that you made the referral to the CMS SMP A & B contact.

- "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

  Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.

- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
- In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
- In the Workflow Option Date field, enter today's date.
- Change the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

Employee Complaints: Current / Former Employee Complaint

Current or former employees who wish to file a complaint against their employer may do so by working with the OIG or working with a lawyer to try and claim a portion of any restitution (qui tam). They may even wish to file a complaint anonymously, which is explained later in this section.

Example: Employee Complaints - Current / Former Employee Complaint

- A current or former employee wants to file a complaint.

  Note: *Occasionally current / former employees will refer to themselves as "whistleblowers."*

  - A true "whistleblower" case is one where an HHS-related individual (see applicable categories in the link below) wishes to make a complaint about something or someone within the agency. This has significant legal protections (and complexities) associated with it. For more information, visit: https://oig.hhs.gov/fraud/report-fraud/whistleblower.asp.

Where to Refer?

All true whistleblower cases should be referred to HHS-OIG immediately. This can be done by contacting the OIG Hotline and identifying the case as a whistleblower case when doing so. Also contact the ACL SMP program manager and your ACL project officer to keep them in the loop.

Beneficiary and SMP Action Items: Employee Complaint - Current / Former Employee Complaint

Steps for the Beneficiary – N/A

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
  - Click "Yes" to add more information.
  - In the Fraud, Error, or Abuse section, mark "Employee Complaint" and any other issues that apply to the fraud, e.g.: "Billing for Services Different From Received," "Billing for Services Not Provided," "Kickbacks," "Other Fraud, Error, or Abuse," etc.
  - In the Detail(s) of Fraud, Error, or Abuse section, mark the appropriate topics based upon the area of fraud, e.g.: "Durable Medical Equipment (DME)," "Hospice," "Genetic/DNA Testing," etc.
  - In the SMP action section, mark:
    - "SMP contacted OIG"
  - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
  - In the case notes section, indicate that this is a "current / former employee complaint."
  - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
  - In the Workflow Option Date field, enter today's date.

  - Mark the status as "Open- Awaiting Response to Referral" and enter today's date as the Date of Last Status Update.
  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- Email the ACL SMP program manager and your ACL project officer the reference number to keep them in the loop.

Employee Complaints: Qui Tam Relator Complaint

Example: Employee Complaints - Qui Tam Relator Complaint

- Someone who wishes to be a "qui tam" relator. This individual is specifically interested in filing a lawsuit on behalf of the government and is expecting a percentage of any recovery that comes from it, also called a reward. This is a special category of complaint.

Beneficiary and SMP Action Items: Employee Complaints - Qui Tam Relator Complaint

Steps for the Beneficiary – N/A

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
  - Click "Yes" to add more information.
  - In the Fraud, Error, or Abuse section, mark all applicable issues based on the fraud, e.g.: "Billing for Services Different From Received," "Billing for Services Not Provided," "Kickbacks," "Other Fraud, Error, or Abuse," etc.
  - In the Detail(s) of Fraud, Error, or Abuse section, mark the appropriate topics based upon the area of fraud, e.g.: "Durable Medical Equipment (DME)," "Hospice," "Genetic/DNA Testing," etc.
  - In the SMP action section, mark:
    - "Other SMP Action"
  - In the case notes section, indicate that you directed the complainant to call 1-800-HHS-TIPS and clearly identify themselves as a potential qui tam relator. They will be able to assist them on how to continue with their qui tam relator complaint.
- Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.

Employee Complaints: Anonymous Complaint

Example: Employee Complaints - Anonymous Complaint

- If an individual wishes to remain anonymous for an SMP complaint, they can do so, but need to be informed it's highly unlikely that the OIG will choose to commit resources to the case without a known witness. Regardless, an anonymous complaint is better than none and can help drive data analytics if enough complaints are received regarding an individual or entity.
    - *If a complainant wants more information about filing an anonymous complaint, please refer them to: https://www.hhs.gov/answers/fraud/do-i-have-to-identify-myself-when-reporting-fraud/index.html.*

Beneficiary and SMP Action Items: Employee Complaints - Anonymous Complaint

Steps for the Beneficiary – N/A

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark all applicable issues based on the fraud, e.g.: "Billing for Services Different From Received," "Billing for Services Not Provided," "Kickbacks," "Other Fraud, Error, or Abuse," etc.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark the appropriate topics based upon the area of fraud, e.g.: "Durable Medical Equipment (DME)," "Hospice," "Genetic/DNA Testing," etc.
    - In the SMP action section, mark:
        - "SMP contacted OIG"
    - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
    - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
    - In the Workflow Option Date field, enter today's date.
    - Mark the status as "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
    - After saving this tab, click on the subject tab to add all entities of concern and their contact information.

Genetic Testing / DNA Testing / Cancer Screening: Witnessed but Not Participated In

Examples: Genetic Testing – Witnessed but Not Participated In

In these scenarios, there were no claims submitted to Medicare for genetic testing for the beneficiary.

- A company is witnessed requesting beneficiary Medicare numbers at a community event, a local fair, a farmer's market, a parking lot, or any other event
- A company is witnessed on social media or television advertising free genetic testing or screening to diagnose or predict cancer or genetic disorders.
- A company makes an unsolicited call to a beneficiary.

Beneficiary and SMP Action Items: Genetic Testing - Witnessed but Not Participated In

Steps for the Beneficiary – N/A

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Scams" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Genetic/DNA Testing" as the topic, along with any others that apply.
    - **Reporting / referring the case with no identifying information:** The OIG and CMS cannot open a case without information that can be used in an investigation. If no identifying information is available, you should still enter the case in SIRS but do not refer it on to either the OIG or CMS.
        - Mark the status as "Closed – Other" and enter today's date as the date of last status update.
    - **Reporting / referring the case with identifying information:** Only follow these steps if you have the name and contact information for the company or representative involved.
        - In the SMP action section, mark:
            - "SMP contacted OIG"
        - In the documents section, upload all pertinent documentation, especially any flyers, brochures, or business cards.

Tip: In these cases, it's particularly important to include the agent's name and contact information in the "Subject" fields in SIRS if available.

- In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
- In the Workflow Option Date field, enter today's date.

- Mark the status as "Closed- Referral No Action Required" and enter today's date as the Date of Last Status Update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.

Genetic Testing / DNA Testing / Cancer Screening: Participated In

Examples: Genetic Testing - Participated In

In these scenarios there were claims submitted to Medicare for genetic testing, even if the beneficiary was an unwilling or unknowing participant.

- Medicare is billed for a test or screening that was not medically necessary and/or was not ordered by a beneficiary's treating physician.
- A company offering "free" testing without a treating physician's order and then billing Medicare. These tests go by many names and claim to test for many things. Here are some examples of ways these tests may be advertised:
  - Cancer screening / test
  - DNA screening / test
  - Hereditary cancer screening / test
  - Cardiac genetic screening / test
  - Dementia screening / test
  - Parkinson's screening / test
  - Pharmacogenomics – medication metabolization
- A company providing a test or screening that the beneficiary never requested or didn't need
- A company billing Medicare for screening services that are not covered by Medicare or for screenings that do not apply to the beneficiary

Note: If the beneficiary willingly gave the vendor / agent the cheek swab, CMS may not be able to reverse the charges; however, these cases should still be referred to both the OIG and the CMS SMP contact for review.

Beneficiary and SMP Action Items: Genetic Testing - Participated In

Steps for the Beneficiary

- Since medical identity theft is suspected, have the beneficiary follow the steps in this chapter for a compromised Medicare number and/or Social Security number. (**Tip:** See the Medical Identity Theft section.)
- Contact the SMP again if they receive the MSN / EOB with the genetic testing charges removed.

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Scams" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Genetic/DNA Testing" as the topic, along with any others that apply.
    - Since medical identity theft is suspected, in the Fraud, Error, or Abuse section, mark "Medical Identity Theft" as the issue and in the Detail(s) of Fraud, Error, or Abuse section, mark "Compromised Medicare Number" as the topic. Be sure to also follow the steps in this chapter for a compromised Medicare number.
    - **Reporting / referring the case with no identifying information**: The OIG and CMS cannot open a case without information that can be used in an investigation. If no identifying information is available, you should still enter the case in SIRS but do not refer it on to either the OIG or CMS until you have received the MSN or EOB.
        - In the referred beneficiary action(s) section, mark as needed:
            - "Referred Beneficiary to 1-800-Medicare"
            - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
        - In the SMP action section, mark as needed:
            - "SMP contacted 1-800-Medicare"
            - "SMP contacted Medicare Advantage Plan or Part D Plan"
        - **Note:** The beneficiary (or SMP using their CMS Unique ID) has already given all of the information available to 1-800-Medicare or the plan.

- Mark the status as “Closed – Referral No Action Required” and enter today’s date as the date of last status update.

- **Reporting / referring the case with identifying information:** Only follow these steps if you have the name and contact information for the company or representative involved or have the MSN or EOB.
  - In the referred beneficiary action(s) section, mark as needed:
    - “Referred Beneficiary to 1-800-Medicare”
    - “Referred beneficiary to contact Medicare Advantage Plan or Part D Plan”
  - In the SMP actions section, mark:
    - “SMP contacted 1-800-Medicare,” if applicable
    - “SMP contacted Medicare Advantage Plan or Part D Plan,” if applicable
    - “SMP contacted OIG”
    - “SMP contacted CMS Regional Office” (for a Part A or Part B (FFS) claim)

      Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
    - “SMP contacted CMS Liaison” (for a Part C (Medicare Advantage) or Part D (PDP) claim)

      Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
  - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, bills, flyers, brochures, or business cards.
  - In the SMP Workflow Options field, mark “Refer to OIG Hotline via ACL.”
  - In the Workflow Option Date field, enter today’s date.
  - Mark the status to “Open – Awaiting Response to Referral” and enter today’s date as the date of last status update.
  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.
  - After saving the form, return to the “Interaction” tab and click the “Print Full Data PDF” button to print or save a copy of the summary report for the case.

- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

Genetic Testing / DNA Testing / Cancer Screening: Not Billed but Kit Received or Refused

Examples: Genetic Testing / DNA Testing / Cancer Screening: Not Billed but Kit Received or Refused

- Beneficiary receives a test kit that they did not request
- Beneficiary refuses a box or package that they were not expecting

Beneficiary and SMP Action Items: Genetic Testing / DNA Testing / Cancer Screening: Not Billed but Kit Received or Refused

Steps for the Beneficiary

- Since medical identity theft is suspected, have the beneficiary follow the steps in this chapter for a compromised Medicare number and/or Social Security number. (**Tip:** See the Medical Identity Theft section.)
- Refuse the kit if possible. If it has already been delivered, open the kit and provide the following information to the SMP:
  - The return label on the outside of the kit
  - All documentation included with the kit
  - Pictures of the kit
- Call the supplier and ask for a return label.
  - Suppliers must accept returns but do not have to pay for the return label.
    - If they do not know who the supplier is or if the supplier refuses to pay for the return and send a return label, the equipment can be discarded.
  - Return the supplies using the label provided. Track the return of the package with USPS, FedEx, or UPS.
    - Keep record of the tracking receipts and confirmation of the return.
- Contact the SMP again if they see on their MSN / EOB that Medicare or their plan is charged for any genetic tests. (**Tip:** Follow the steps in the section for Genetic Testing / DNA Testing / Cancer Screening: Participated In.)

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Billing Error," "Scams," and "Other Fraud, Error, or Abuse" as the applicable issues, along with any others that apply and enter "Genetic Testing Kit Received/Refused but Not Billed" in the Other Fraud, Errors, and Abuse Details field.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Genetic/DNA Testing" as the topic, along with any others that apply.
    - Since medical identity theft is suspected, in the Fraud, Error, or Abuse section, mark "Medical Identity Theft" as the issue and in the Detail(s) of Fraud, Error, or Abuse section, mark "Compromised Medicare Number" as the topic. Be sure to also follow the steps in this chapter for a compromised Medicare number.
    - **Reporting / referring the case with no identifying information**: The OIG and CMS cannot open a case without information that can be used in an investigation. If no identifying information is available, you should still enter the case in SIRS but do not refer it on to either the OIG or CMS until you have received the MSN or EOB.
        - In the referred beneficiary action(s) section, mark as needed:
            - "Referred Beneficiary to 1-800-Medicare"
            - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
        - In the SMP action section, mark as needed:
            - "SMP contacted 1-800-Medicare"
            - "SMP contacted Medicare Advantage Plan or Part D Plan"
        - **Note:** The beneficiary (or SMP using their CMS Unique ID) has already given all of the information available to 1-800-Medicare or the plan.
        - Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.
    - **Reporting / referring the case with identifying information:** Only follow these steps if you have the name and contact information for the company or representative involved or have the MSN or EOB.

- In the referred beneficiary action(s) section, mark as needed:
  - "Referred Beneficiary to 1-800-Medicare"
  - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
- In the SMP actions section, mark:
  - "SMP contacted 1-800-Medicare," if applicable
  - "SMP contacted Medicare Advantage Plan or Part D Plan," if applicable
  - "SMP contacted OIG"
  - "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

    Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
  - "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

    Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, bills, flyers, brochures, or business cards.
- In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
- In the Workflow Option Date field, enter today's date.
- Mark the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.
- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

Home Health Services

Medicare covers home health services provided by nurses, therapists, and home health aides who come to the beneficiary's home if they need skilled care and are homebound. Medicare spends over $18 billion a year on these services.

Examples: Home Health Fraud

- Billing for services when patients do not meet Medicare's definition of "homebound"
- Billing for services that are not medically necessary
- Billing for services or visits that were not provided
- Offering incentives to doctors to falsely certify someone as homebound
- Billing for housekeeping as skilled nursing or other therapy
- Offering things such as free groceries or a free ride in exchange for beneficiary Medicare and/or Medicaid numbers or to switch to a different home health agency
- Charging a copayment for home health services
- Asking beneficiaries to sign forms verifying that Medicare home health services were provided, even though no services were provided
- Beneficiaries who accept cash or gifts in exchange for going along with a home health scam

Beneficiary and SMP Action Items: Home Health Complaint

Steps for the Beneficiary

- Is it an error? Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan first to try to resolve the issue.
- Contact the SMP again if the issue is not resolved (see the steps below for SMP follow-up).

Steps for the SMP – Initial

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Enrollment / Disenrollment Issues" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Home Health Care" as the topic, along with any others that apply.

- If you also suspect medical identity theft, be sure to also follow the steps in this chapter for a compromised Medicare number and/or compromised Social Security number. (**Tip:** See the Medical Identity Theft section.)
- In the referred beneficiary action(s) section, mark as needed:
  - "Referred beneficiary to contact Provider/Practitioner"
  - "Referred beneficiary to 1-800-Medicare"
  - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
  - "Referred beneficiary to contact Secondary Insurer/Plan"
- In the SMP actions section, mark as needed:
  - "SMP contacted 1-800-Medicare"
  - "SMP contacted Medicare Advantage Plan or Part D Plan"
- Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.

Steps for the SMP – Follow-up

- If the beneficiary calls back because they were able to resolve the issue on their own, collect documentation and close the case (as described in Chapter 3).
- If the beneficiary calls back because they were not able to resolve the billing issue or they do not receive a corrected MSN or EOB, follow these steps.
  - Follow up to rule out error: Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan as needed.
  - Update the case in SIRS, completing and updating all applicable fields and case notes as needed. Specific instructions for this type of scenario include:
    - In the SMP action section, mark:
      - "SMP contacted OIG"
      - "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

        Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
      - "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

        Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.

- If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."

- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
- In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
- In the Workflow Option Date field, enter today's date.
- Change the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

o Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

o If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Hospice Services

Hospice is an increasingly important benefit for the Medicare population and hospice fraud is a scam that threatens this benefit for all beneficiaries. Scammers convince beneficiaries to agree to hospice care even though they do not qualify for the benefit.

Examples: Hospice Care Fraud

- Falsely certifying and providing services to beneficiaries who are not terminally ill
- Falsely certifying or failing to obtain physician certification on plans of care
- Paying incentives to referral sources (such as physicians and nursing homes)
- Billing for a higher level of care than was actually provided
- Targeting assisted living facility and/or nursing home residents whose life expectancy exceeds six months

- Targeting beneficiaries with high-pressure marketing of hospice services to ineligible beneficiaries
- Providing inadequate or incomplete services including, for example, no skilled visits in the last week of life
- 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)
- Keeping a beneficiary on hospice care for long periods of time without medical justification
- Providing less care on the weekends and disregarding a beneficiary's care plan

Beneficiary and SMP Action Items: Hospice Care Complaint

Steps for the Beneficiary

- Since medical identity theft is suspected, have the beneficiary follow the steps in this chapter for a compromised Medicare number and/or Social Security number. (Tip: See the Medical Identity Theft section.)
- Contact the SMP again if the issue is not resolved (see the steps below for SMP follow-up).

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Enrollment / Disenrollment Issues" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Hospice" as the topic, along with any others that apply.
    - If you also suspect medical identity theft, be sure to also follow the steps in this chapter for a compromised Medicare number and/or compromised Social Security number. (**Tip:** See the Medical Identity Theft section.)
    - In the referred beneficiary action(s) section, mark as needed:
        - "Referred beneficiary to contact Provider/Practitioner"
        - "Referred beneficiary to 1-800-Medicare"
        - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
        - "Referred beneficiary to contact Secondary Insurer/Plan"
    - In the SMP actions section, mark as needed:

- "SMP contacted 1-800-Medicare"
- "SMP contacted Medicare Advantage Plan or Part D Plan," if applicable
- "SMP contacted OIG"
- "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

  Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
- "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

  Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.

- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, bills, flyers, brochures, or business cards.
- In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
- In the Workflow Option Date field, enter today's date.
- Mark the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.
- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Kickbacks

In federal health care programs, paying for referrals is a crime. Many times, kickbacks may be related to another issue (DME, genetic / DNA testing, hospice, marketing violations, etc.), so you will also need to check that section for possible additional steps for the beneficiary and/or SMP.

Examples: Kickbacks

- Paying or receiving an illegal kickback related to Medicare services or Medicare billing.
- A medical equipment or home health provider offers items such as cash, gifts, or free vacations to doctors who refer Medicare and/or Medicaid patients to them.

Beneficiary and SMP Action Items: Kickbacks

Step for the Beneficiary

- Provide the SMP with all documentation related to the suspected kickback.

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Kickbacks" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark all applicable topics, e.g.: "Home Health Care," "Hospice," "Medicare Part A and B," etc., along with any others that apply.
    - If you also suspect medical identity theft, be sure to also follow the steps in this chapter for a compromised Medicare number and/or compromised Social Security number. (Tip: See the Medical Identity Theft section.)
    - In the SMP action section, mark:
        - "SMP contacted OIG"

          Note: Nothing else needs to be done for Part A or Part B (FFS) claim.
        - "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

          Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
        - If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."
    - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
    - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."

- In the Workflow Option Date field, enter today's date.
- Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.
- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.
- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Marketing Violations: Medigap

The sale of Medigap policies is governed by state Department of Insurance restrictions, which may or may not be as strict as the federal regulations governing the sale of Part C or Part D plans (which are described in the next section).

Examples: Medigap Marketing Complaints

- Examples of Medigap marketing complaints are very similar to examples of Part C and D marketing complaints, which are provided in Appendix C: Can They Do That?

  Note: Unless an agent is involved, marketing complaints related to Medigap are not handled by the state Department of Insurance. Referrals of this nature vary by state. You may want to discuss options with the consumer protection division at your state attorney general's office.
- Lead Generator Complaints

  It is not unusual for SMPs to receive complaints from beneficiaries about suspicious mailings, often postcards, that turn out to be what are called "lead generators." Lead generators are ways of developing contact lists for insurance solicitation and are commonly seen in connection with the sales of Medigap plans.

  Unless a Part C or Part D product is involved, CMS does not have any regulatory oversight of such materials. Some states do regulate lead generators, however. Check with your state Department of Insurance to determine whether or not a

particular postcard or other lead-generating solicitation is illegal and should be referred to them.

- Government Look-Alike Mail

  Mailings should make it clear that they come from a private organization, not a government entity. If the lead-generating mail is designed to appear to have come from the government, refer it to the U.S. Postal Service.

Beneficiary and SMP Action Items: Medigap Marketing Violations

Steps for the Beneficiary

- Have the beneficiary call their Medigap plan to make sure they're still in the plan of their choosing.
- To report government look-alike mail and other scams involving the U.S. mail, beneficiaries can contact the nearest Postal Inspection Service office in one of three ways:
  1. Call 1-877-876-2455.
  2. Visit www.uspis.gov to report suspected fraud online.
  3. Mail queries to this address:

     Criminal Investigations Service Center
     Attn: Mail Fraud
     433 W. Harrison Street, Room 3255
     Chicago, Il 60699-3255
- Have the beneficiary keep the mailing in case they are asked to send the suspicious mailing to the postal inspector.

  Tip: To learn more about mail fraud or to report suspected fraud, visit the U.S. Postal Inspection Service website at www.uspis.gov.

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
  - Click "Yes" to add more information.
  - In the Fraud, Error, or Abuse section, mark "Marketing Fraud" as the issue, along with any others that apply.
  - In the Detail(s) of Fraud, Error, or Abuse section, mark "Medigap or Supplemental Insurance" as the topic, along with any others that apply.
  - In the SMP action section, mark:
    - "SMP contacted 1-800-Medicare"

- "SMP contacted State Insurance Department"
- "Other SMP Action"

  Note: Enter "Beneficiary contacted the Post Office" in the other SMP action details field.

- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, bills, flyers, advertisements, or business cards.
- In the case notes section, emphasize the actions taken by the agent that you suspect may violate your state's laws, and suggest that the agent's records be reviewed for any prior complaints.
- Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

- Fax the report to your state Department of Insurance (www.naic.org).

Marketing Violations: Part C (Medicare Advantage) and Part D (PDP) Communications and Marketing

Unlike Original Medicare, Medicare Part C and Part D are administered, marketed, and sold by private insurance companies and they come under the jurisdiction of both CMS and the state insurance departments. CMS has developed guidelines for marketing Part C and Part D insurance that protect Medicare beneficiaries from manipulative and deceptive sales and enrollment tactics.

Plan sponsors and their representatives, including agents and brokers, must follow strict guidelines when they wish to market to beneficiaries. Marketing is equivalent to "steering" beneficiaries toward their plan. A fundamental principle is that marketing cannot be conducted under the guise of education. Providing neutral information can be considered education. Selling a product can be considered marketing. In practice, however, it's not that simple, considering CMS publishes a lengthy document with guidance on the subject.

Complaints of suspected plan compliance and enforcement violations, including but not limited to Part C and Part D communications and marketing violations, are referred to your local State Health Insurance Assistance Program (SHIP), 1-800-Medicare, the CMS SMP Part C & D contact within the CMS Regional Offices (ROs),

and the state Department of Insurance, depending upon the nature of the issue. SMPs may refer any complaints against agents or brokers to their state Department of Insurance concurrently with the referral to the CMS SMP Part C & D contact.

To find your state Department of Insurance, use the interactive map on the National Association of Insurance Commissioners website: www.naic.org.

Examples: Suspected Part C and Part D Communications and Marketing Violations

For a detailed list of examples of both acceptable and unacceptable practices in Part C and Part D communications and marketing, see Appendix C.

Okay or Not Okay?

See Appendix C: Can They Do That? for detailed information about Medicare Part C and Part D plan communications and marketing guidelines and violations.

Beneficiary and SMP Action Items: Suspected Part C and Part D Communications and Marketing Violations

Steps for the Beneficiary – N/A

Steps for the SMP

- Call 1-800-Medicare using your CMS Unique ID to:
    - Confirm the beneficiary is still in Original Medicare or the Medicare Advantage or Part D plan of their choosing.
        - If they are not, work with the CSR to have the beneficiary retroactively enrolled in their previous plan or Original Medicare.
            - Have the CSR enter the complaint into the Complaints Tracking Module (CTM).
                - Tell the CSR this is a marketing misrepresentation complaint.
                - Document the CTM complaint number from the CSR.
        - If they are in the correct plan, and they do not need to be retroactively enrolled, the entry into CTM can be done by referring the case to the CMS C/D contact, as described below, instead of through 1-800-Medicare.

          Note: Retroactive enrollments can only be done through 1-800-Medicare and are not sent to the CMS C/D contact.
- Contact your local SHIP for questions and assistance as needed with retroactive enrollments, referrals, and ensuring all aspects of the complaint were handled.

Note: If your local SHIP has CTM access, SHIP can enter the CTM complaint and request retroactive enrollment directly as an alternative to contacting 1-800-Medicare.

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Marketing Fraud" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Medicare Part D" or "Medicare Advantage" as the topic, along with any others that apply.
    - In the SMP action section, mark as appropriate:
        - "SMP contacted 1-800-Medicare"
        - "SMP contacted CMS Liaison"
        - "SMP contacted SHIP"
        - "SMP contacted State Department of Insurance"

          Note: If you check "SMP contacted CMS Liaison," in the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
    - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, bills, flyers, advertisements, or business cards.

      Tip: In these cases, it's particularly important to include the agent's name and contact information in the "Subject" fields in SIRS if available.
    - Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.
    - After saving this tab, click on the subject tab to add all entities of concern and their contact information.
    - For cases not involving retroactive enrollment:
        - Return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

          Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.
        - See the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library for the Universal Contact Form that needs to be completed for referrals to the CMS Part C/D contact for marketing violations.

Note: Retroactive enrollments are handled by contacting 1-800-Medicare (or local SHIP with CTM access), they are not referred to the CMS Part C/D contact.

- Fax or email the contact form, full data PDF, and supporting documentation to the appropriate CMS Part C/D contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

- If this is a complaint against an agent or broker, fax the report to your state Department of Insurance (www.naic.org).

Medical Identity Theft: Compromised Medicare and/or Health ID Numbers

Medical Identity (ID) theft occurs when someone steals personal information – such as a beneficiary's name and Medicare number – and uses the information to get medical treatment, prescription drugs, surgery, or other services and then bills insurance (such as Medicare) for it. When Medicare beneficiaries fall prey to consumer scams aimed at obtaining Medicare and/or health ID numbers, their Medicare and/or health ID number is considered to be "compromised" as a result of medical identity theft.

Medical identity theft can also affect beneficiaries' medical and health insurance records. Every time a thief uses a beneficiary's identity to get or bill for care, a record is created with incorrect medical information about them. That information might include:

- A different blood type
- An inaccurate history of drug or alcohol abuse
- Test results that do not belong to the beneficiary
- A diagnosis of an illness, allergy, or condition that the beneficiary doesn't have

Examples: Medical Identity Theft - Compromised Medicare and/or Health ID Numbers

In these scenarios, the beneficiary has given out their Medicare and/or health ID number.

Tip: If they also gave out their Social Security number, see the next section for additional steps.

- The beneficiary giving their Medicare and/or health ID number out over the phone or internet to someone offering DME, genetic testing, back braces, etc.
- The beneficiary giving their Medicare and/or health ID number out at a fair or other gathering as a check-in or to receive free services

- The beneficiary giving their Medicare and/or health ID number out in response to a television or radio commercial, Facebook ad, postcard, or print ad requesting Medicare number

Beneficiary and SMP Action Items: Medical Identity Theft - Compromised Medicare and/or Health ID Numbers

Steps for the Beneficiary

- Call 1-800-Medicare (and as applicable, also call the Medicare Advantage plan and/or the Prescription Drug plan) to:
    - Let them know that someone contacted them to try and get their Medicare and/or health plan ID number and provide as many details as possible.
    - Report that their Medicare and/or health plan ID number has been compromised (the beneficiary may call, or the SMP may call on their behalf using their CMS Unique ID)
    - Ask if a new Medicare and/or health plan ID number can be issued (only the beneficiary can make this request)

      Note: The CSR (customer service representative) will ask questions to determine if a new card should be issued. They must follow guidelines in making this determination and a new card may not be issued every time a request is made.
- Watch their MSNs or EOBs for any charges for services or items that they did not request or did not receive. Call the SMP if they find any.

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click “Yes” to add more information.
    - In the Fraud, Error, or Abuse section, mark “Compromised Medicare Number” and “Scams” as the issues, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark the appropriate topic based on the solicitation, e.g.: “Durable Medical Equipment (DME),” “Hospice,” etc.
    - In the referred beneficiary action(s) section, mark as needed:
        - “Referred beneficiary to 1-800-Medicare”
        - “Referred beneficiary to contact Medicare Advantage Plan or Part D Plan”
        - “Referred beneficiary to contact Secondary Insurer/Plan”

- In the SMP actions section, mark as needed:
  - "SMP contacted 1-800-Medicare"
  - "SMP contacted Medicare Advantage Plan or Part D Plan"
- **Reporting / referring the case with no identifying information:** The OIG and CMS cannot open a case against a company or representative without information that can be used in an investigation. If no identifying information is available, you should still enter the case in SIRS but do not refer it on to either the OIG or CMS.
  - **Note:** The beneficiary (or SMP using their CMS Unique ID) has already given all of the information available to 1-800-Medicare, the Medicare Advantage plan, and/or the Prescription Drug plan.
  - Mark the status as "Closed – Other" and enter today's date as the date of last status update.
- **Reporting / referring the case with identifying information:** Only follow these steps if you have the name and contact information for the company or representative involved.
  - In the SMP action section, mark:
    - "SMP contacted OIG"
  - In the documents section, upload all pertinent documentation, especially any flyers, brochures, or business cards.
  - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
  - In the Workflow Option Date field, enter today's date.
  - If medical identity theft is the only concern, mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update. If there is another issue involved, mark the status according to that issue instead.
  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.

Medical Identity Theft: Compromised Social Security Number

Examples: Medical Identity Theft - Compromised Social Security Number

In these scenarios, the beneficiary has given out all or part of their Social Security number (but not their Medicare and/or health ID number).

Tip: If they also gave out their Medicare and/or health ID number, see the previous section for additional steps.

- A beneficiary gives out their social security number in response to a consumer scam like the grandparent scam
- A beneficiary gives out their social security number in response to a phishing email claiming to be their bank

Beneficiary and SMP Action Items: Medical Identity Theft - Compromised Social Security Number

Steps for the Beneficiary

- Report it to the Federal Trade Commission: https://www.identitytheft.gov/.
- Report it to local law enforcement as identity theft.
- Report it to the Federal Communications Commission (FCC) if you believe it was a spoofed number that called: https://consumercomplaints.fcc.gov/hc/en-us/articles/115002234203-Unwanted-Calls-Phone-.
- Report it to the Office of Inspector General Social Security Administration (OIG SSA): https://oig.ssa.gov/.
- Watch their MSNs or EOBs for any charges for services or items that they did not request or did not receive. Call the SMP if they find any.

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click “Yes” to add more information.
    - In the Fraud, Error, or Abuse section, mark “Compromised Social Security Number” as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark “Consumer Protection” as the topic, along with any others that apply.
    - In the referred beneficiary action(s) section, mark:
        - “Referred Beneficiary to Federal Trade Commission”

          Note: In the case notes section, also indicate that you referred the beneficiary to local law enforcement, the FCC, and the OIG SSA.
    - Mark the status as “Closed – Referral No Action Required” and enter today’s date as the date of last status update.
    - After saving this tab, click on the subject tab to add all entities of concern and their contact information.

Medical Identity Theft: Noncompromised Medicare Number

Examples: Medical Identity Theft - Noncompromised Medicare Number

In these scenarios, the beneficiary has not given out all or part of their Medicare number.

- Someone requested the beneficiary's Medicare and/or health ID number out over the phone or internet to receive DME, genetic testing, back braces, etc.
- Someone requested the beneficiary's Medicare and/or health ID number at a fair or other gathering as a check-in or to receive free services

Beneficiary and SMP Action Items: Medical Identity Theft - Noncompromised Medicare Number

Steps for the Beneficiary

- Call 1-800-Medicare (and as applicable, also call the Medicare Advantage plan and/or the Prescription Drug plan) to let them know that someone contacted them to try and get their Medicare and/or health ID number and give them as many details as possible.

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Scams" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark the appropriate topic based on the solicitation, e.g.: "Durable Medical Equipment (DME)," "Hospice," etc.
    - **Reporting / referring the case with no identifying information:** The OIG and CMS cannot open a case without information that can be used in an investigation. If no identifying information is available, you should still enter the case in SIRS but do not refer it on to either the OIG or CMS.
        - **Note:** The beneficiary (or SMP using their CMS Unique ID) has already given all of the information available to 1-800-Medicare, the Medicare Advantage plan, and/or the Prescription Drug plan.
        - Mark the status as "Closed – Other" and enter today's date as the date of last status update.

- **Reporting / referring the case with identifying information:** Only follow these steps if you have the name and contact information for the company or representative involved.
  - In the referred beneficiary action(s) section, mark:
    - "Referred Beneficiary to 1-800-Medicare"
  - In the SMP action section, mark:
    - "SMP contacted OIG"
    - "SMP contacted 1-800-Medicare," if applicable
  - In the documents section, upload all pertinent documentation, especially any flyers, brochures, or business cards.
  - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
  - In the Workflow Option Date field, enter today's date.
  - Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.
  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.

Persistent Customer Service Issues: Part C or Part D

Although customer service issues are not considered to be SMP complex interactions in and of themselves, if customer service issues persist and accumulate, they become compliance issues.

Examples: Part C or Part D Persistent Customer Service Issues

- Customer service channels have been tried and failed.
- Plans are unresponsive to customer service complaints.

Beneficiary and SMP Action Items: Part C or Part D Persistent Customer Service Issues

Steps for the Beneficiary – N/A

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
  - Click "Yes" to add more information.

- In the Fraud, Error, or Abuse section, mark "Other Fraud, Errors, or Abuse" as the issue, along with any others that apply. Enter "Customer Service Issues" in the Other Fraud, Errors, and Abuse Details field.
- In the Detail(s) of Fraud, Error, or Abuse section, mark "Medicare Part D" or "Medicare Advantage" as the topic, along with any others that apply.
- In the SMP action section, mark:
  - "SMP contacted CMS Liaison"

    Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
- In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
- Change the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.
- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.

Prescription Services: Pharmacy Complaints

Retail, mail order, and long-term care pharmacies must abide by the same laws that apply to providers.

Examples: Prescription Services – Pharmacy Complaints

- Prescription Issues
  - Filling a prescription for a generic drug but billing for a brand name drug that costs more
  - Prescription drug switching: Switching medications for financial gain
  - Prescription drug shorting: When the pharmacist provides less than the prescribed quantity and intentionally does not inform the patient but bills for the fully prescribed amount

  - Splitting a prescription inappropriately – for example, splitting a 30-day prescription into four 7-day prescriptions. This incurs additional costs in the form of copayments and dispensing fees
  - Dispensing adulterated prescription drugs
  - Forging and altering prescriptions
  - Dispensing drugs that are expired or have not been stored or handled in accordance with manufacturer and FDA requirements
- TrOOP (True Out-of-Pocket Cost) manipulation
  - TrOOP manipulation occurs when a pharmacy falsely reports that a beneficiary has not satisfied the required deductible (when the beneficiary actually has), generating excess charges to the beneficiary.
  - TrOOP manipulation also occurs when a pharmacy falsely reports that the beneficiary has satisfied the deductible (when the beneficiary actually has not), generating excess charges to Medicare.
- Steering a beneficiary toward a certain plan or drug, or for formulary placement
- Inappropriate billing practices
  - Billing for brand names when generics are dispensed
  - Billing for covered drugs when noncovered drugs are dispensed
  - Billing for nonexistent prescriptions
  - Billing for prescriptions that are never picked up
  - Charging the retail price rather than the negotiated price
  - Bait and switch pricing, which occurs when a beneficiary is led to believe that a drug will cost one price but at the point of sale the beneficiary is charged a higher amount

    NOTE: *Drugs may be billed to Part B and/or Part D for beneficiaries enrolled in Original Medicare or Part C for beneficiaries with a Medicare Advantage plan that includes prescription drug coverage.*
- Script mills
  - Prescriptions written that are not medically necessary, often in mass quantities, and often for individuals who are not patients of a provider
- Kickbacks (See the Kickbacks section.)
  - Prescribing based on illegal inducements rather than on the clinical needs of the patient

Beneficiary and SMP Action Items: Prescription Services - Pharmacy Complaints

Steps for the Beneficiary

- Is it an error? Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan first to try to resolve the issue.
- Contact the SMP again if the issue is not resolved (see the steps below for SMP follow-up).

Steps for the SMP – Initial

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Billing Error," "Billing for Services Different From Received," "Billing for Services Not Provided," and/or "Double Billing" as the issues, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Medicare Part D" as the topic, along with any others that apply.
    - If you also suspect medical identity theft, be sure to also follow the steps in this chapter for a compromised Medicare number and/or compromised Social Security number. (Tip: See the Medical Identity Theft section.)
    - In the referred beneficiary action(s) section, mark as needed:
        - "Referred beneficiary to contact Provider/Practitioner"
        - "Referred beneficiary to 1-800-Medicare"
        - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
        - "Referred beneficiary to contact Secondary Insurer/Plan"
    - In the SMP actions section, mark as needed:
        - "SMP contacted 1-800-Medicare"
        - "SMP contacted Medicare Advantage Plan or Part D Plan"
    - Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.

Steps for the SMP – Follow-up

- If the beneficiary calls back because they were able to resolve the issue on their own, collect documentation and close the case (as described in Chapter 3).
- If the beneficiary calls back because they were not able to resolve the billing issue or they do not receive a corrected MSN or EOB, follow these steps.

- Follow up to rule out error: Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan as needed.
- Update the case in SIRS, completing and updating all applicable fields and case notes as needed. Specific instructions for this type of scenario include:
  - In the SMP action section, mark:
    - "SMP contacted OIG"
    - If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."
    - If this also applies to a Medicare Part D plan, mark "SMP contacted CMS Liaison"

      Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
  - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
  - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
  - In the Workflow Option Date field, enter today's date.
  - Mark the status as "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.
  - After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

    Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.
- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.
- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Prescription Services: Opioid Fraud and Abuse

Examples: Prescription Services – Opioid Fraud and Abuse

- A beneficiary finds that Medicare has been billed for prescriptions that that they did not receive or were not prescribed
- A complainant has determined that a Medicare beneficiary is being overprescribed pain medication (opioids) like hydrocodone, oxycodone, morphine, codeine, fentanyl, etc.
- A complainant or the SMP suspects that a pharmacy may be involved in drug diversion involving opioids

Beneficiary and SMP Action Items: Prescription Services - Opioid Fraud and Abuse

Steps for the Beneficiary – N/A

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Other Fraud, Error, or Abuse" as the issue, along with any others that apply and enter "Overprescribing" or "Drug diversion" in the Other Fraud, Errors, and Abuse Details field.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark "Opioid Fraud and Abuse" as the topic, along with any others that apply.
    - If you also suspect medical identity theft, be sure to also follow the steps in this chapter for a compromised Medicare number and/or compromised Social Security number. (Tip: See the Medical Identity Theft section.)
    - In the SMP action section, mark:
        - "SMP contacted OIG"
        - If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."
        - If this also applies to a Medicare Part D plan, mark "SMP contacted CMS Liaison"

          Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
    - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
    - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
    - In the Workflow Option Date field, enter today's date.

- Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update, as long as incorrect billing is not involved.
- After saving this tab, click on the subject tab to add all entities of concern and their contact information.
- After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

  Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.

- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.
- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Provider Services

Providers must comply with the Medicare laws described in Chapter 1. Since provider services apply to many different types of situations, this section includes an extensive list of examples.

Watch Out for Overlapping Issues!

Many of the examples in this section could also apply to other service areas. Cross-reference other sections in this chapter as needed.

Examples: Provider Fraud

- Billing for "phantom patients"
  - A doctor or therapist bills Medicare and/or Medicaid for a service that was never provided. Some health care providers have even been caught billing for patients who have died.
- Double billing
  - A health care provider bills Medicare and/or Medicaid twice for the same procedure or service.
  - Being billed full price for anesthesiology, e.g., by both the certified registered nurse anesthetist who administered it and their supervisor.
- Billing for or providing unneeded or medically unnecessary services
  - Billing for drug testing of beneficiaries who did not need it.
- Billing for an additional x-ray because the first one was done on the wrong body part in error.
- Billing the beneficiary when Medicare denies the claim and the MSN states that

the beneficiary responsibility is $0.

- Balance billing when a beneficiary is a qualified Medicare beneficiary (QMB)
    - A doctor charges Medicaid for a service and then bills the patient for the difference between what Medicaid pays and what the doctor would like to be paid.

      Tip: See the *SMP Counselor Training Manual* for more information about the QMB program.

QMB and Balance Billing

When you call 1-800-Medicare using your CMS Unique ID, the CMS customer service representative (CSR) can verify qualified Medicare beneficiary (QMB) status in their database and instruct the beneficiary to tell their provider that they may not be billed. For model letters that a beneficiary or advocate can send to a provider, see the Justice in Aging improper billing toolkit.

If you do not successfully resolve the billing problem with the provider, continue with the referral to the CMS A/B contact and they will refer the issue to the Medicare Administrative Contractor (MAC) for the region where the beneficiary lives. The MAC will send a letter to the provider instructing the provider to return any payments received from the QMB and to cease any current billing or collection effort. Importantly, the MAC will also send a letter to the beneficiary with a copy of the provider communication and with instructions not to pay the bill.

- Incorrect reporting of diagnoses to maximize payments
    - Providing a diagnosis that will qualify a patient for hospice care when there is no real indication that the patient has a terminal illness with a six-months-or-less life expectancy. (See the Hospice Services section.)
- Incorrect reporting of procedures to maximize payments, such as “upcoding”
    - Medicare pays for many physician services using evaluation and management (commonly referred to as “E&M”) codes. New patient visits generally require more time than follow-up visits for established patients, and therefore E&M codes for new patients command higher reimbursement rates than E&M codes for established patients. An example of upcoding is an instance when a provider provides a follow-up office visit or follow-up inpatient consultation but bills using a higher level E&M code as if the provider had provided a comprehensive new patient office visit or an initial inpatient consultation.
- Billing for services not provided or supplies not furnished
- Deliberate duplicate billing in an attempt to get paid twice, such as:
    - Billing both Medicare and a beneficiary for the same service.
    - Billing both Medicare and another insurer for the same service.

- Billing for time not spent in the room
    - A beneficiary must physically occupy a room to incur a daily room charge. A written order to admit as inpatient does not meet the definition of room occupancy.
- Altering claims forms, electronic claims records, medical documentation, etc., to obtain a higher payment amount
- Unbundling or "exploding" charges
    - Billing separately for services already included in a bundled fee, like billing for an evaluation and a management service the day after surgery when those services would normally be included in the original surgery claim.
    - Billing the physician's reading of an x-ray separate from billing for a visit charge (since the visit charge already includes the reading of an x-ray).
    - Billing for medical supplies that are routinely part of an ICU; the services, supplies, or equipment are considered routine and included in the room charge.
    - Charging an "oral administration fee" for the nurse handing the beneficiary medication when this is a routine nursing service and considered part of the room and board charge.
    - Billing a single comprehensive metabolic panel as separate lab tests.
- Billing based on "gang visits"
    - A physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients.
- Billing noncovered or nonchargeable services as covered items
    - Clipping toenails for an older person (not billable to Medicare without qualifying foot conditions) but charging for nail debridement (billable to Medicare).
- Billing for services that were performed by an improperly supervised or unqualified employee
- Billing for services that were performed by an employee who has been excluded from participation in federal health care programs
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Paying for referral of patients (see the section on kickbacks.):
    - In exchange for ordering diagnostic tests and other services.
    - In exchange for medical equipment.
- Offering "free services" in exchange for utilizing the provider's services

NOTE: *This does not include free prescription drug samples provided by the physician as part of a visit. Many drug and biologic companies provide*

physicians with free samples that the physicians may give to patients free of charge. It is legal to give these samples to patients for free, but it is illegal to sell the samples.

- Paying Medicare and/or Medicaid patients for utilizing the provider's business
- Routinely waiving copays
    - Waiving copays cannot be advertised, done routinely, or used as an inducement.

      NOTE: *Physicians may waive copays on a case-by-case basis if they determine in good faith that an individual is in financial need or if all reasonable efforts to obtain payment have failed.*
- Completing Certificates of Medical Necessity (CMN) for patients not personally and professionally known by the provider
- Participating in schemes involving collusion between a provider and a beneficiary or between a supplier and a provider, resulting in higher costs or charges to the Medicare program
- Physicians should not have beneficiaries sign blank ABNs (Advance Beneficiary Notices)
- Providing false or misleading information
- Misrepresenting dates of service
- Misrepresenting locations of service
- Misrepresenting the provider of a service
- Billing for replacing or fixing of devices that were replaced or fixed under warranty
- Billing for a private room when a semiprivate room was not available or the private room was not requested by the beneficiary or physician
- Misrepresentations regarding:
    - Dates and/or descriptions of the services furnished.
    - Identity of the beneficiary.
    - Identity of the individual who furnished the services (for example, using another prescriber's Drug Enforcement Agency number or prescription pad).

Beneficiary and SMP Action Items: Provider Complaint

Steps for the Beneficiary

- Is it an error? Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan first to try to resolve the issue.

- Contact the SMP again if the issue is not resolved (see the steps below for SMP follow-up).

Steps for the SMP – Initial

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark all applicable issues, e.g.: "Billing Error," "Billing for Services Different From Received," "Billing for Services Not Provided," and/or "Double Billing" as the issues, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark the area of Medicare affected by the billing, e.g.: "Home Health Care," "Hospice," "Medicare Part A and B," etc. as the topic, along with any others that apply.
    - If you also suspect medical identity theft, be sure to also follow the steps in this chapter for a compromised Medicare number and/or compromised Social Security number. (Tip: See the Medical Identity Theft section.)
    - In the referred beneficiary action(s) section, mark as needed:
        - "Referred beneficiary to contact Provider/Practitioner"
        - "Referred beneficiary to 1-800-Medicare"
        - "Referred beneficiary to contact Medicare Advantage Plan or Part D Plan"
        - "Referred beneficiary to contact Secondary Insurer/Plan"
    - In the SMP actions section, mark as needed:
        - "SMP contacted 1-800-Medicare"
        - "SMP contacted Medicare Advantage Plan or Part D Plan"
    - Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.

Steps for the SMP – Follow-up

- If the beneficiary calls back because they were able to resolve the issue on their own, collect documentation and close the case (as described in Chapter 3).
- If the beneficiary calls back because they were not able to resolve the billing issue or they do not receive a corrected MSN or EOB, follow these steps.

- Follow up to rule out error: Contact the provider, 1-800-Medicare, the Medicare Advantage plan, and/or the Medicare Prescription Drug Plan as needed.
- Update the case in SIRS, completing and updating all applicable fields and case notes as needed. Specific instructions for this type of scenario include:
  - In the SMP action section, mark:
    - "SMP contacted OIG"
    - "SMP contacted CMS Regional Office" (for a Part A or Part B (FFS) claim)

      Note: In the case notes section, indicate that you made the referral to the CMS SMP Part A & B contact.
    - "SMP contacted CMS Liaison" (for a Part C (Medicare Advantage) or Part D (PDP) claim)

      Note: In the case notes section, indicate that you made the referral to the CMS SMP Part C & D contact.
    - If Medicaid was also involved, mark "SMP contacted MFCU or Medicaid Office."
  - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
  - In the SMP Workflow Options field, mark "Refer to OIG Hotline via ACL."
  - In the Workflow Option Date field, enter today's date.
  - Change the status to "Open – Awaiting Response to Referral" and enter today's date as the date of last status update.
  - After saving this tab, click on the subject tab to add all entities of concern and their contact information.
  - After saving the form, return to the "Interaction" tab and click the "Print Full Data PDF" button to print or save a copy of the summary report for the case.

    Note: The Print Full Data PDF does not pull the documentation uploaded in SIRS. The documentation will need to be added when sending the report to CMS.
- Fax or email the report to the appropriate CMS SMP contact according to the instructions in the CMS Contact Lists: Referrals to CMS entry in the SMP Resource Library.
- If Medicaid was involved, also follow up with the MFCU (www.namfcu.net) and Medicaid Office (www.medicaid.gov).

Quality-of-Care Complaints: Hospital or Home Setting

Complaints alleging malpractice or poor quality of care may or may not involve a fraudulent situation. SMPs should refer these complaints to the following organizations, based on the nature of the complaint. Keep in mind that the SMP program does not have a national referrals relationship with these organizations, so you will need to work with your state organizations as described in the steps below.

Examples: Poor Quality of Care and Discharge Appeal Complaints in a Hospital or Home Setting

- Complaints about inappropriate discharges from a hospital or facility
- Complaints about providers discontinuing services too early
- Complaints about ill treatment in a facility
- Provider malpractice or quality concerns
- Drug errors (like being given the wrong drug or being given drugs that interact in a negative way)
- Getting unnecessary or inappropriate treatment (like being given the wrong treatment or treatment you didn't need)
- Getting unnecessary or inappropriate surgery (like being operated on for a condition that could've been effectively treated with drugs or physical therapy)
- Not getting treatment after your condition changed (like not getting treatment after abnormal test results or when you've had a complication)
- Getting incomplete discharge instructions and/or arrangements

Beneficiary and SMP Action Items: Poor Quality of Care and Discharge Appeal Complaints in a Hospital or Home Setting

Steps for the Beneficiary

- Contact the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for help with the complaint. BFCC-QIO helpline information is available at http://www.qioprogram.org/contact-zones and/or http://www.qualitynet.org/dcs/ContentServer?cid=1228774346765&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page.
- If malpractice or quality concerns are suspected, contact the state medical board associated with the complaint.
- Suggest other appropriate avenues to pursue in order to remedy the situation:
    - Contact the prescribing physician and ask them to reconsider their decision to discharge.
    - Seek a second opinion from another doctor.

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click "Yes" to add more information.
    - In the Fraud, Error, or Abuse section, mark "Quality of Care" as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark the correct agency or part of Medicare, e.g.: "Home Health Care," "Hospice," "Medicare Part A and B," etc. as the topic, along with any others that apply.
    - In the referred beneficiary action(s) section, mark:
        - "Referred beneficiary to contact Quality Improvement Organization (QIO)"
    - If malpractice or quality concerns are suspected:
        - In the Detail(s) of Fraud, Error, or Abuse section, mark "Other Fraud, Errors, and Abuse" as a topic and enter "Malpractice" or "Quality concerns" in the Other Fraud, Errors, and Abuse Details field.
        - In the SMP action section, mark "Other SMP Action."
        - In the Other SMP Action Details field, indicate that you referred the beneficiary to contact the state medical board (fsmb.org/contact-a-state-medical-board, Medicare.gov/Contacts, or call 1-800-MEDICARE).
    - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
    - Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.
    - After saving this tab, click on the subject tab to add all entities of concern and their contact information.

Quality-of-Care Complaints: Long-Term Care Facilities

Examples: Quality of Care in Long-Term Care Facilities Complaints

- Violation of residents' rights or dignity
- Physical, verbal, or mental abuse, deprivation of services necessary to maintain residents' physical and mental health, or unreasonable confinement

- Poor quality of care, including inadequate personal hygiene and slow response to requests for assistance
- Improper transfer or discharge of patient
- Inappropriate use of chemical or physical restraints
- Any resident concern about quality of care or quality of life
- Provider malpractice or quality concerns

Beneficiary and SMP Action Items: Poor Quality of Care in a Long-Term Care Setting

Step for the Beneficiary

- Contact the state long-term care ombudsman. To find the ombudsman in each state, visit the interactive map on The National Long-Term Care Ombudsman Resource Center website: www.ltcombudsman.org or ACL.gov/programs/Protecting-Rights-and-Preventing-Abuse/Long-term-Care-Ombudsman-Program.
- If malpractice or quality concerns are suspected, contact the medical board (fsmb.org/contact-a-state-medical-board, Medicare.gov/Contacts, or call 1-800-Medicare) with the complaint.

Steps for the SMP

- Enter the case in SIRS, completing all applicable fields and including detailed case notes using the Guided Narrative template (as described in Chapter 2). Specific instructions for this type of scenario include:
    - Click “Yes” to add more information.
    - In the Fraud, Error, or Abuse section, mark “Quality of Care” as the issue, along with any others that apply.
    - In the Detail(s) of Fraud, Error, or Abuse section, mark “Other” as the topic, along with any others that apply.
    - In the referred beneficiary action(s) section, mark:
        - “Referred beneficiary to contact an Ombudsman”
    - If malpractice or quality concerns are suspected:
        - In the Detail(s) of Fraud, Error, or Abuse section, mark “Other Fraud, Errors, and Abuse” as a topic and enter “Malpractice” or “Quality concerns” in the Other Fraud, Errors, and Abuse Details field.
        - In the SMP action section, mark “Other SMP Action.”

        - In the Other SMP Action Details field, indicate that you referred the beneficiary to contact the state medical board.
    - In the documents section, upload all pertinent documentation, especially any MSNs, EOBs, or bills.
    - Mark the status as "Closed – Referral No Action Required" and enter today's date as the date of last status update.
    - After saving this tab, click on the subject tab to add all entities of concern and their contact information.

What's Next?

Many cases are referred to both CMS and the OIG. Even if you are able to resolve the issue with the provider or CMS, the case will remain open because the OIG could still take action. For cases that are open and awaiting a response to a referral, it can be months or years before a complaint is entirely resolved. See Chapter 5 for tips on setting up Google alerts to help you find out about news related to providers that your SMP has referred for further action once the OIG has taken action on the case. Complaints that are referred to law enforcement will take longer to resolve than complaints addressed by CMS through administrative action. The more egregious the suspected fraud or abuse, the longer it is likely to take to resolve.

Make sure the complainant clearly understands the SMP role vs. the role of the national partner(s) receiving the referral. It is important to set appropriate expectations of your SMP program. SMPs can impact the resolution of fraud and abuse by submitting quality referrals; however, the final outcomes are outside of SMP control.

After a case is closed, your SMP may have the opportunity to claim dollars on the OIG Report. Chapter 5 describes how to collect the necessary documentation and receive credit on the OIG Report for dollar amounts associated with the case.

SMP Complex Interactions Training Manual

CHAPTER 5: Claiming Dollars on Referrals

Objectives

Upon completion of Chapter 5: Claiming Dollars on Referrals, you will be able to collect the necessary documentation to close a referred case in SIRS and receive credit on the OIG Report for dollar amounts associated with the case.

Also see Chapter 3 for basic information about SMP performance measures related to dollars and basic documentation requirements.

State and Local Information #10: Follow-up

As stated at the end of Chapter 4, cases involving referrals may take years before they are ready to be resolved. Will you be the one to follow up on your own cases to close them and claim dollars or will someone else at your SMP complete these steps? If you're not sure, talk with your SMP director or coordinator of volunteers.

Claiming Dollars on Referrals to the OIG Hotline

The most common types of SMP referrals are those made to the OIG Hotline via ACL. The process of claiming dollars on the OIG Report for these referrals is outlined below and on the following pages.

In criminal cases like those referred to the OIG Hotline, the most likely performance measures (PMs) to have dollars claimed are:

- PM 7: Expected Medicare recoveries
- PM 8: Additional expected Medicare recoveries
- PM 9: Expected Medicaid recoveries
- PM 10: Additional expected Medicaid recoveries

"Dollar" PMs 6 – 12

For more information about the SMP performance measures, see ACL's SMP Performance Measures Definitions and Guidance document in the SMP Resource Library, as described in Appendix B.

When a case of suspected fraud is referred to the OIG, CMS, or other federal agency, proper documentation must be available before the case can be closed and any dollar amounts can be claimed on the OIG Report. As you search for provider information, you may find out about a case at varying stages in the process. An outline of the stages is provided here.

Stage 1: Identify Your Providers and Set Up Alerts

Make a list of providers from SIRS.

- In SIRS, access a list of providers for cases your SMP has referred for further action by using Sample Search #6: Subject Details for Open Cases. See the SIRS Complex Interactions Job Aid and/or SIRS Advanced Search Job Aid for details.
- This list includes only open cases. Many cases having to do with DME or DNA / cancer screening are referred to both CMS through 1-800-Medicare and the OIG Hotline via ACL. They may have been closed to claim dollars in a previous year related to the beneficiary and/or Medicare being reimbursed for the item or test. You may need to do additional searches if you do not already have alerts set up for these providers (as described below). Instructions in "Stage 4: Close the Case in SIRS and Request Final Review" explain how to remove previous dollars, change the closed date, and claim additional recoveries.

SIRS Job Aids

The SIRS job aids are available in the SMP Resource Library, as described in Appendix B.

Set up alerts and other watches.

- Set up Google alerts to alert you of news related to providers that your SMP has referred for further action. Instructions to set up Google alerts are available at https://support.google.com. (Tip: Search for "Google alert" or "create an alert.")
- Find your state's attorney general page to check press releases or to get on their email list: https://www.usa.gov/state-attorney-general.
- Check the OIG's Criminal and Civil Enforcement page at: https://oig.hhs.gov/fraud/enforcement/criminal.
- Check the News page (https://www.smpresource.org/News) on the SMP Resource Center's website.
- Pursue other options as applicable to your state or local area.

Note: These are important steps to take because dollars can only be claimed the year that the restitution was determined.

Stage 2: Action is Taken by Law Enforcement

The provider is officially charged with the crime (indicted) in criminal or civil court.

However, it could still be months or years before they go to trial or settle outside of court.

A resolution is reached.

- Pleads guilty
- Found guilty by a court of law
- Accepts a plea agreement or settles out of court
- Found not guilty
  - In this case, you would be able to close the case in SIRS using the status "Closed – Other," marking in the notes that they were found not guilty and therefore there would not be any dollars to claim.

Claiming Dollars on Cases that Settle Out of Court

These situations are handled on a case-by-case basis by ACL and the OIG. If you're ready to close a case that settles out of court and claim dollars on the OIG Report, contact the ACL SMP Program Manager, who will work with the OIG to determine how to handle the case. Also feel free to contact the SMP Resource Center for help as needed.

However, it could still be months before the sentencing date occurs, which is when the provider is actually sentenced and any restitution is determined.

Stage 3: Restitution is Determined

The provider is sentenced.

- During sentencing, the judge will determine the provider's punishment or review the plea agreement. This is also when the judge would determine if and how much restitution should be paid to the Medicare and/or Medicaid programs.

  Note: Until a provider is sentenced, and restitution is awarded, the case will remain open in SIRS and there is nothing more for you to do but watch and wait.

Collect documentation: the Judgment and Commitment Order.

- The Judgment and Commitment Order provides the necessary documentation to close the case and claim dollars on the OIG Report. It includes the sentence imposed by the court or the plea agreement and any monetary penalties.
  - The Judgment and Commitment Order can be obtained by emailing the attorney general on the case.
  - Check the attorney general's website to see if these documents are available electronically: https://www.usa.gov/state-attorney-general.

Note: The press release of the sentencing is not an official document and will not be sufficient documentation to claim dollars.

Collect documentation: proof of referral and determining involvement.

- For referrals to the OIG Hotline via ACL, the OIG can see the date stamp in SIRS to confirm that the case was referred.
- If your attempt to collect documentation from the relevant federal agency is not successful, please contact the OIG for assistance (Alexis Mills, alexis.mills@oig.hhs.gov).

Stop the Presses!

The press release of the sentencing is not an official document and is not sufficient documentation to claim dollars.

Claiming Dollars on Cases with Multiple Subjects

These situations are handled on a case-by-case basis by ACL and the OIG. If you're ready to close a case with multiple subjects and claim dollars on the OIG Report, contact the ACL SMP Program Manager, who will work with the OIG to determine how to handle the case. Also feel free to contact the SMP Resource Center for help as needed.

Stage 4: Close the Case in SIRS and Request Final Review

When you have the documentation to claim dollars on the OIG Report, you're ready to close the case in SIRS. Upload the documentation, enter the dollar amount to claim, and close the case in SIRS, as described below and in the SIRS Complex Interactions Job Aid.

Claim the dollars in SIRS: Multiple open cases related to the same provider.

If there are multiple open cases in your state for the same provider, close all of them and choose one to claim the dollars under. In the explanation field for each of the interactions, include all the other case numbers and the case number of the interaction reflecting the dollars.

- The type of referral will determine which performance measure it is claimed under.
    - PMs 7 & 9: Expected Medicare or Medicaid recoveries
        - Resulted in a new investigation
        - Made a meaningful contribution to an existing investigation
    - PMs 8 & 10: Additional expected Medicare or Medicaid recoveries
        - Validated existing information
- Enter the dollar amount in SIRS in the appropriate field:

  - PM 7: Expected Medicare recoveries
  - PM 8: Additional expected Medicare recoveries
  - PM 9: Expected Medicaid recoveries
  - PM 10: Additional expected Medicaid recoveries
- Change the "Status of Complex Interaction" to "Closed – Action Taken By Referent" and change the "Status of Complex Interaction Date" to be today's date. This will ensure the newly entered dollars are reported on the current OIG report.

Claim the dollars in SIRS: Cases referred to CMS and the OIG Hotline.

In general, CMS will take action before the OIG Hotline when a case is referred to both. When this happens, open a new case in SIRS to claim dollars from CMS, leaving the original open and referred to the OIG Hotline. In the explanation field of both interactions, include the other case number and any dollars that were claimed.

- Enter a new case in SIRS, referencing the original case in the case notes. All documentation related to dollars from the first case will need to be reuploaded into the new case.
- The type of referral will determine which performance measure it is claimed under.
  - PMs 7 & 9: Expected Medicare or Medicaid recoveries
    - Resulted in a new investigation
    - Made a meaningful contribution to an existing investigation
  - PMs 8 & 10: Additional expected Medicare or Medicaid recoveries
    - Validated existing information
- Enter the dollar amount in SIRS in the appropriate field:
  - PM 7: Expected Medicare recoveries
  - PM 8: Additional expected Medicare recoveries
  - PM 9: Expected Medicaid recoveries
  - PM 10: Additional expected Medicaid recoveries
- Leave the original case "Status of Complex Interaction" as "Open – Awaiting Response to Referral" and "Status of Complex Interaction Date" as the date it was referred.
- In the new case, change the "Status of Complex Interaction" to "Closed – Action Taken By Referent" and change the "Status of Complex Interaction Date" to be today's date. This will ensure the dollars from the new case are reported on the current OIG report.

Requesting final review

When all of the documentation has been uploaded into SIRS, you can request a final review from the Center to help make sure that the case will be ready for the OIG Report.

- Email the SMP Resource Center (SIRS@smpresource.org).
- If the Center or the OIG have questions about the documentation provided or the dollar amount claimed, they will follow up with the SMP representative indicated on the case in SIRS.

Stage 5: OIG Allocation of Dollars

One state claiming dollars for a provider

- Once the documentation is reviewed and approved, all the restitution can be claimed by the SMP.

Multiple states claiming the same dollars for a provider

- Once the documentation is reviewed and approved for each case, the OIG will equally divide the claimable dollars between the states, if appropriate.
- The OIG will notify each state of the dollar amount they should enter and in which performance measure. The OIG will also include text the SMP should include in the explanation field explaining that the total restitution was split between the following states.

Claiming Dollars on Other Referrals

The information provided in this section is excerpted from the OIG Report Webinar. It provides an overview of documentation requirements for each performance measure (PM). For documentation samples, FAQs, and additional information about the OIG Report and SMP performance measures, see the OIG Report Webinar. For in-depth guidance about specific performance measures, see ACL's SMP Definitions and Guidance Document. Resources are available in the SMP Resource Library, as described in Appendix B.

Creating and Using Medicare.gov Accounts

SMP grantees may create and access Medicare.gov accounts to assist with troubleshooting Medicare beneficiary billing errors and obtaining documentation; however, they may do so **ONLY** with explicit Medicare beneficiary permission and **ONLY** when necessary. See the Creating and Using Medicare Accounts entry in the SMP Resource Library for more information.

General Documentation Requirements

Although documentation requirements may vary depending on the specific scenario and the PM that is being reported on, the following requirements apply to all scenarios and PMs.

- All dollar amounts for closed cases reported in the PMs must have supporting documentation.
- The same dollar amount cannot be counted under multiple measures. Choose the measure that makes the most sense.
- The explanation field in SIRS should be used to cite specific file names and page numbers showing the original and revised dollar amounts.
- Documents should clearly provide the beneficiary's name, service date, service(s) provided, and dollar amounts.

Performance Measure 6: Cost Avoidance

PM 6 is used to report on situations that include health care expenditures for which the government, a beneficiary, or other entity was relieved of responsibility for payment as a result of the SMP program. In these situations, money was never paid to the provider.

- Typical scenarios include:
  - The beneficiary was billed the full charge for the service when the provider should have billed Medicare.
  - The beneficiary's copay should have been paid by a third-party insurer, not the beneficiary.
  - Medicare should never have been charged because it doesn't cover the specific service billed.

Adequate Supporting Documentation: Cost Avoidance

In addition to the general documentation requirements mentioned earlier, the following requirements are specific to PM 6.

- ✓ Copy of original and revised billing statement from the health care provider showing a zero balance (or a reduced amount, if you are claiming the difference as the cost avoided).
- ✓ Email or letter from the health care provider saying the disputed charge has been removed / reduced.
- ✓ Email or letter from CMS or a Medicare / Medicaid contractor

- Ø May not include a general summary or signed beneficiary statement in lieu of other documentation.
- Ø Written notes / transcript of a phone call are not adequate.

Performance Measures 7 – 10: Medicare and Medicaid Recoveries and Expected Recoveries

PMs 7 – 10 are used to report on situations involving actual and expected Medicare and Medicaid recoveries. This includes both recoveries from overpayments and from situations other than overpayments, usually involving the court. For example:

- Actual and expected Medicare / Medicaid recoveries from overpayments
  - These types of recoveries are in the form of a refund back to Medicare or Medicaid
  - They may include collaboration with a Medicare / Medicaid contractor
- Actual and expected Medicare / Medicaid recoveries other than overpayments (usually civil or criminal cases)
  - These types of recoveries are in the form of settlements, civil judgments, restitutions, fines, or other monetary penalties
  - They may include collaboration with a Medicare / Medicaid contractor, Medicaid Fraud Control Unit (MFCU), or law enforcement agency

    Tip: Use your SMP case number as a reference number in written correspondence to avoid the use of personally identifiable beneficiary information.

Medicare and Medicaid Recoveries for Overpayments

In situations involving recoveries for overpayments, dollars should reflect cases where it was determined that the provider, e.g.:

- Did not provide the service (full refund expected)
- Billed for the same service more than once (full refund expected)
- Billed for a more expensive level of service than was provided (partial refund expected)

Adequate Supporting Documentation for Overpayments

In addition to the general documentation requirements mentioned earlier, the following requirements are specific to PMs 7 – 10 when overpayments are involved.

- ✓ Copy of original and revised billing statement (MSN/EOB) from Medicare/Medicaid/the health care provider showing a zero balance (or a reduced amount, if you are claiming the difference as the savings).
- ✓ Email or letter from the health care provider saying payment has been refunded or a copy of the refund check from the provider.
- ✓ Claims information from a Medicare.gov account – printout or screenshot.
- ✓ Email or letter from CMS, a Medicare / Medicaid contractor, or a law enforcement agency.
- Ø May not include a general summary or signed beneficiary statement in lieu of other documentation.
- Ø Written notes / transcripts of a phone call are not adequate.

Medicare and Medicaid Recoveries for Cases Other Than Overpayments

The chart below provides brief descriptions and examples of PMs 7 – 10 for cases that are not overpayments.

	PMs 7 and 9: Medicare / Medicaid Recoveries	PMs 8 and 10: Additional Medicare / Medicaid Recoveries
Description	The SMP referral prompted law enforcement to open an investigation. The SMP referral provided a meaningful contribution to an existing case.	There already was an investigation on the health care provider(s) and the SMP referral corroborated existing information.
Examples	The SMP provided: • New information that furthered a case • Ongoing assistance to a case • Beneficiaries who testified or were interviewed	The SMP provided information on potentially fraudulent billing by a provider. This information corroborated the information gathered for an existing case.

Adequate Supporting Documentation for Cases Other Than Overpayments

In addition to the general documentation requirements mentioned earlier, the following requirements are specific to PMs 7 – 10 for cases that do not involve overpayments.

- Dollars claimed must be traceable back to the SMP.
- Credit is given for the provider(s) the SMP identified in its referral.
    - Example: If the SMP provided information on one provider and there were two from the same company that were sentenced, the SMP only gets credit on the one that it identified.
- Ideal (and not ideal) supporting documentation includes:
    - ✓ Email from the investigative agency noting the level of SMP involvement in the case.
    - ✓ Contact information for the relevant investigator.
    - ✓ A Judgment and Commitment Order that clearly states the restitution / penalty amount. If not available, provide a sentencing date.
        - The Judgment and Commitment Order or sentencing date must have occurred in the OIG Report year in question.
    - Ø No plea agreements or other court documents that occur before sentencing – they are not considered final.
    - Ø Submission of just press releases.

Performance Measures 11 & 12: Savings to Beneficiaries and Others

PM 11 is used to report on situations involving savings to beneficiaries, and PM 12 is used to report on situations involving other savings. These include:

- Actual savings to the beneficiary: amount recouped to beneficiaries (e.g., copays, deductibles, or other out-of-pocket expenses).
- Other savings: amount recouped to an entity other than Medicare, Medicaid, or a beneficiary (e.g., a secondary health insurer such as Tricare).

Adequate Supporting Documentation: Savings to Beneficiaries and Others

In addition to the general documentation requirements mentioned earlier, the following requirements are specific to PMs 11 and 12.

- ✓ A copy of a canceled check, corrected hospital bill, or letter / email from the provider noting a refund.
- ✓ Email or letter from CMS, a Medicare / Medicaid contractor, Medicaid Fraud Control Unit, or law enforcement agency.
- ✓ For PM 6 (cost avoidance for beneficiaries only) and 11 (savings to beneficiaries): The OIG will accept a signed statement from the beneficiary for cost avoidance or refunds under $100.

What's Next?

Now that you have learned how to manage SMP complex interactions and, when necessary, conduct a referral to the appropriate entity, talk with your SMP director or coordinator of volunteers about additional training that you may need or what you need to do to make sure you are ready to begin your work as an SMP complex interactions specialist.

SMP Complex Interactions Training Manual

Appendices

Appendix A: SMP Referrals Flow Chart

Chapter 4 provides step-by-step instructions for making referrals for a variety of scenarios. The chart below serves as a quick reference guide to make it easier to find each scenario in Chapter 4.

Note: Many cases involve multiple scenarios. For each case, review the entire chart to identify all scenarios related to the case, then reference the pages and instructions for all related scenarios.

Appendix B:
SMP Complex Interactions Resources

This appendix provides information about resources related to SMP complex interactions that are available by logging in to the SMP Resource Center's website: www.smpresource.org.

Logging in to the Library and TRAX

The "SMP Login" area of the website provides access to the SMP Resource Library and/or TRAX: Training Tracker, depending on each team member's access level.

- The SMP Resource Library is a searchable database of materials produced by SMPs or for SMPs. If you have access to the library, you can search for resources yourself.
- TRAX: Training Tracker is the training tracking system for the SMP network. It allows SMPs to take, assign, and track training and assessments. If you only have access to TRAX, someone at your SMP will need to assign resources to you.

State and Local Information #11: The SMP Resource Library and TRAX: Training Tracker

Will you have access to the SMP Resource Library and/or TRAX: Training Tracker? Ask your SMP director or coordinator of volunteers.

Complex Interactions Resources

- Guided Narrative
- Beneficiary Intake Form

Recommended Training Curricula in TRAX

The following curricula are recommended for SMP complex interactions specialists. They are available in TRAX > Available Training > Curriculum tab.

- **SMP Foundations Training** provides a foundation of knowledge in three main content areas: the SMP program, Medicare basics, and Medicare fraud, errors, and abuse.
- **SMP Counselor Training** explains how to answer basic SMP questions and provide individual SMP education consistently across the country.
- SIRS training is available based on your role in SIRS and at your SMP:
    - **SIRS Training – Basic Data Entry** helps SMPs enter their own basic data in SIRS.
    - The **SIRS Training Series** provides comprehensive training to help SMPs enter, review, and edit their data and team members in SIRS.

- **SMP Complex Interactions Training** provides training on how to manage SMP complex interactions, conduct referrals, and close cases in SIRS. Exact items included within the curriculum are subject to change. As of June 2020, the items in this curriculum include:
  - *SMP Complex Interactions Training Manual*
  - SMP Casework Training Series:
    - Building a Case Webinar
    - Where to Refer Webinar
    - Using SIRS to Make and Document Your Referral Webinar
  - Can They Do That? Webinar
  - SIRS Complex Interactions Job Aid
  - Guided Narrative (for the Case Notes in SIRS)
  - CMS Contact Lists: Referrals to CMS
  - Complex Interactions Training Assessment
- **CMS Unique ID Training** provides training to CMS Unique ID users on how to use their unique IDs and addresses issues related to privacy and confidentiality.
  - CMS Unique ID User Resources
  - Using Your CMS Unique ID Webinar
  - Privacy and Confidentiality Online Course
  - Privacy and Confidentiality Assessment

Search Tips

To find additional complex interactions resources, search for keywords "complex interaction." To find CMS Unique ID resources, search for keywords "unique ID." For SIRS resources, search for keyword "SIRS."

Recommended Resources

In addition to the curricula described above and on the previous page, the following resources are also recommended for SMP complex interactions specialists. They are available in TRAX > Available Training or by searching in the SMP Resource Library:

- SMP Performance Measures Definitions and Guidance
- OIG Report Training curriculum
- Privacy & Confidentiality Training curriculum

Additional Resources at www.smpresource.org

In addition to resources described in this appendix, the SMP Resource Center's website home page provides information about the SMP program to the general public and SMPs. For example, see the News page for links to news articles related to the SMP mission, including scams and government takedowns, and see the Medicare Fraud > Fraud Schemes page for information about common scams.

The Resources for SMPs section of the website provides information intended primarily for SMPs. For more information about resources on the home page and in the Resources for SMPs section, see the *SMP Foundations Training Manual*.

Appendix C: Can They Do That?

Medicare Part C and Part D Plan Communications and Marketing Guidelines

This appendix provides definitions of key terms related to CMS' Medicare Communications and Marketing Guidelines, key points about education vs. marketing, and examples of common acceptable (Okay) and unacceptable (Not Okay) practices that may be seen by beneficiaries.

Definitions: Communications, Marketing, and Education

Before reviewing the examples, it's important to understand key terms as they are used in CMS' Medicare Communications and Marketing Guidelines.

- **Education** is informing a beneficiary in an unbiased way about Original Medicare, Medicare Advantage plans, Part D plans, and Medicare Advantage plan products.
- **Communications** are activities and materials used to provide information to current and prospective enrollees. This means that all activities and materials aimed at prospective and current enrollees, including their caregivers and other decision-makers associated with a prospective or current enrollee, are "communications."
    - **Marketing** is a subset of communications and includes activities and the use of materials by the Plan / Part D sponsor with the intent to draw a beneficiary's attention to a plan or plans and to influence a beneficiary's decision-making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, to be considered marketing it must contain information about the plan's benefit structure, cost sharing, measuring, or ranking standards. Marketing must have the intent and required content. Any rules that apply to communications also apply to marketing.

Key Points: Education vs. Marketing Events

The way an event is conducted and advertised is crucial to determining whether or not a violation of the CMS communications and marketing rules has occurred. Many activities allowed at marketing events are prohibited at education events.

Education vs. Marketing

Plans **may** provide education at a marketing event, but they **may not** market or sell at an education event.

Here are some overarching guidelines:

- **Education events** must be clearly and explicitly advertised to beneficiaries as educational. Education events may be hosted either by the plan sponsor or by an outside entity. Education events must not include any marketing or sales activities such as the distribution of marketing materials or the distribution or collection of plan applications or enrollment forms.

- At **marketing / sales events,** plans / Part D sponsors must submit talking points, if applicable, and presentations to CMS prior to use, including those to be used by agents / brokers. Plan sponsors may promote specific benefits, premiums, or services offered by the plan. Plan sponsors may conduct a formal event where a presentation is provided to Medicare beneficiaries or an informal event where plan sponsors are only distributing health plan brochures and pre-enrollment materials. Events may be conducted in one-on-one settings. Plan sponsors may also accept enrollment forms and perform enrollment at marketing / sales events.

Examples: Acceptable (Okay) and Unacceptable (Not Okay) Practices

The chart on the following pages summarizes CMS' Medicare Communications and Marketing Guidelines, but it is by no means exhaustive. To review the complete set of CMS Medicare Communications and Marketing Guidelines, visit: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

Where to Refer?

Cases involving unacceptable practices involving Part C and Part D plan communications and marketing are referred to the CMS SMP Part C & D contact, as described in Chapter 4.

Okay	NOT Okay
Advertising	
Okay: ✓ Sales / marketing event advertising (in any form of media) states: ○ "A salesperson will be present with information and applications." ○ "For accommodation of persons with special needs at sales meetings, call <insert phone and TTY number>." ✓ Educational event advertising clearly states it's "educational."	**Not Okay:** Ø Communications that convey the false impression that the product(s) is approved, endorsed, or authorized by Medicare or any other government agency. Ø Sending unsolicited text messages to a beneficiary. Ø Making unsolicited phone calls to a beneficiary / leaving unsolicited voicemails, unless the plan is contacting its members about plan business.
Okay: ✓ Plans / agents can send unsolicited emails but must provide a process to opt out from receiving.	**Not Okay:** Ø Communications that use the term "free" to describe a zero-dollar premium, reduction in premiums (including Part B buy-down), reduction in deductibles or cost sharing, low income subsidy (LIS), or cost sharing for individuals with dual eligibility.
Cobranding (provider logo and plan logo appearing together on materials)	
Okay: ✓ Plans / Part D sponsors that enter into cobranding relationships with network providers / pharmacies must include the following disclaimer: "Other pharmacies / physicians / providers are available in our network."	**Not Okay:** Ø Communications that the plan / Part D sponsor or its cobranding providers / pharmacies imply that the cobranding partner is endorsed by CMS or that its products or services are Medicare-approved. Ø Displaying the name and/or logo of the cobranding pharmacy on the Part D card.

Okay	NOT Okay
Direct Mail	
Okay: ✓ 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 may send unsolicited conventional mail, such as postcards, self-mailers, and reply cards. ✓ Provider affiliation announcements may be made through direct mail, email, telephone, or advertisement. If applicable, the announcement must clearly state the provider may also contract with other plans. ✓ Requesting consent to use protected health information for purposes of marketing.	**Not Okay:** Ø A plan sends out communications regarding other products when the beneficiary has requested to stop receiving communications. Ø Calling prospective enrollees to confirm receipt of mailed information. Ø Plans allowing contracted providers to send marketing material on their behalf.
Enrollment Activities	
Okay: ✓ Plan salesperson is knowledgeable about Medicare and, during a marketing activity, objectively discusses whether or not the plan meets that potential enrollee's individual needs. ✓ Plans must have procedures in place to ensure that enrollees are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy.	**Not Okay:** Ø Plan salesperson removes a beneficiary from Original Medicare and enrolls them in Medicare Advantage without their knowledge or consent. Ø Plan salesperson fails to demonstrate or provide adequate Medicare expertise and enrolls beneficiaries, including those dually eligible in Medicare and Medicaid, in plans that are inappropriate for them. Ø Plan salesperson falsely states that a beneficiary's doctor accepts a plan. Ø Plan salesperson preys upon vulnerable people (limited English, memory impaired, etc.) for purposes of enrolling them in a plan, regardless of whether that plan meets their needs.

Okay	NOT Okay
Enrollment Activities, continued…	
Okay: ✓ Plan outreach materials or salesperson provide initial eligibility screening for beneficiaries dually eligible for Medicare and Medicaid but refer beneficiary to the appropriate state agency to make the final determination. ✓ Only Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs) may limit enrollments to individuals meeting eligibility requirements based on health and/or other status.	**Not Okay:** Ø Plan salesperson "cherry-picks" (selecting or denying beneficiaries based on their illness profile). Ø Plan salesperson enrolls or attempts to enroll a dually eligible beneficiary in a plan, regardless of its appropriateness for that beneficiary. Ø Discrimination against plan enrollees in the delivery of health care services based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location. Ø Plans may not target beneficiaries from higher-income areas or state or imply that plans are only available to seniors rather than to all Medicare beneficiaries.
Events (Marketing and Education)	
Okay: ✓ Providing a **light snack** to prospective beneficiaries by a plan at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed with intent to influence enrollment decisions. ✓ Providing a meal at an event that is for general Medicare education purposes where no marketing occurs. ✓ Educational events hosted in a public venue by a plan or an outside entity. ✓ Marketing events taking place at a kiosk or in a recreational vehicle (RV).	**Not Okay:** Ø Providing a **meal** to prospective beneficiaries by a plan at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed with intent to influence enrollment decisions. Beware of snacks bundled into a meal – NOT okay. Ø Approaching potential enrollees in common areas (e.g., parking lots, hallways, lobbies, sidewalks, etc.).

Okay	NOT Okay
Events (Marketing and Education), continued…	
Okay: ✓ Providing a beneficiary with one or more salesperson business cards at an educational event and responding to questions if asked. ✓ Providing Social Security numbers, bank information, or credit card information at a marketing event if it is needed to verify membership, determine enrollment eligibility, or process an enrollment request. ✓ Requiring consent to an appointment via a signed Scope of Appointment form or on a recorded call to include: ○ Product types to be discussed ○ Date of appointment ○ Beneficiary and agent contact information ○ Statement showing: ○ No obligation to enroll ○ Current or future Medicare enrollment status will not be impacted, and ○ Automatic enrollment will not occur	**Not Okay:** Ø Requiring participants to provide contact information to attend. Ø Sign-in sheets must be clearly labeled as optional at marketing events. Ø Agents or brokers may NOT require a face-to-face meeting to provide plan details. Ø Agents or brokers may NOT solicit individual appointments under the premise that the appointment is only for educational purposes. Ø Marketing a plan without a Scope of Appointment (SOA) form signed beforehand by the beneficiary (may be documented by the beneficiary – signed hard copy, telephonic recording, or electronically signed). Ø Not providing a new SOA if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon.

Okay	NOT Okay
Health Care Settings	
Okay: ✓ On their own initiative or in response to a beneficiary question, providers may provide the names of plans with which they contract and/or participate and discuss merits of different plans. ✓ Conducting sales presentations and distributing and accepting enrollment applications in a common area. ○ Common areas are: common entryways; vestibules; hospital or nursing home cafeterias; waiting rooms; and community, recreational, and conference rooms ✓ Patients are not misled or pressured into participating. ✓ Dual Eligible Special Needs Plans (D-SNPs) open to dually eligible enrollees with differing levels of cost must clearly state how cost sharing and benefits differ depending on the level of Medicaid eligibility and describe the Medicaid benefits, if any, provided by the plan. ✓ Institutional Special Needs Plans (I-SNPs) serving long-term care facility residents may conduct the following in long-term care facilities: ○ Displaying posters ○ Including materials in admission packets ✓ Communications materials may be distributed and displayed in all areas of a health care setting.	**Not Okay:** Ø Plans may NOT allow providers to accept Scope of Appointment or Medicare enrollment forms. Ø Distributing marketing materials where care is being delivered. Ø Cobranded materials that do not contain disclaimer: “Other <Pharmacies / Physicians / Providers> are available in our network.” Ø Plans may not allow contracted providers to: ○ Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider ○ Offer inducements to persuade their patients to enroll in a particular plan or organization ○ Distribute marketing materials / applications in areas where care is being delivered ○ Accept compensation from the plan for any marketing or enrollment activities Ø Conducting sales presentations and distributing and accepting enrollment applications where patients receive care. Restricted areas include: ○ Pharmacy counter areas ○ Exam rooms ○ Hospital patient rooms ○ Dialysis center treatment areas Ø Agents or brokers may NOT visit a long-term care resident who did not request an appointment.

Okay	NOT Okay
Home Visits	
Okay: ✓ A beneficiary requests a visit to their home or long-term care (LTC) facility from a plan salesperson. ✓ 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.	**Not Okay:** Ø A salesperson's initial contact is an unsolicited home or LTC visit – i.e., "door-to-door cold call" sales tactic. Ø Agents or brokers may NOT represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid. Ø Agents and brokers may not leave information such as leaflets, flyers, door hangers, etc., on someone's car or residence (unless the beneficiary is a "no show" for a prescheduled appointment).
Insurance Agent and Broker Credentials	
Okay: ✓ Plan salesperson has a demonstrated knowledge of Medicare, including passing a test. ✓ Agent or broker is licensed in a state and follows state appointment rules. ✓ Plan customer service representatives don't sell plans while doing customer service work but, if they are a licensed agent, they may be able to enroll a beneficiary if the beneficiary requests it. ✓ Plan terminates agents and brokers who violate regulations or laws, notifying the state licensure body and CMS. The bad behavior of individual agents or brokers does not automatically result in a plan losing the right to sell Medicare products.	**Not Okay:** Ø Plan salesperson has not passed a test and/or demonstrates lack of adequate Medicare knowledge. Ø Unlicensed agents and brokers sell Medicare products and break state appointment rules. Ø Plans fail to report termination of agents or brokers to the state licensure body as required. Ø Agents or brokers represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid. Ø Agents or brokers claim that they are recommended or endorsed by CMS, Medicare, or the Department of Health & Human Services (DHHS).

Okay	NOT Okay
Insurance Agent and Broker Credentials, continued…	
	Not Okay: Ø Customer service representatives (CSRs) act simultaneously as both a CSR and a sales / marketing agent / broker. ○ Agents and brokers must make it clear to the beneficiary when their role changes to a marketing / sales role, subject to the beneficiary's request and concurrence.
Promotional Activities / Gifts	
Okay: ✓ Offering promotional activities or items that are of "nominal value." "Nominal value" is currently defined as worth $15 or less based on the retail value of the item or activity and is not in the form of cash or rebates. ✓ Offering promotional activities or items to both current and potential enrollees without discrimination. ✓ MA plans may include information about rewards and incentive programs in marketing materials for potential enrollees.	**Not Okay:** Ø Offering promotional items or activities worth more than $15 at one time or over the course of a year that have an aggregated value of more than $75 per person. Ø Offering items that are considered a health benefit for free as a promotion (e.g., a free checkup). ○ Medicare Advantage rewards and incentives may NOT be used in exchange for enrollment. Ø Marketing that the plan will not disenroll individuals due to failure to pay premiums. Ø Part D plans may NOT offer rewards or incentives.

Okay	NOT Okay
"Scope of Appointment" – Defining the Content of a Sales or Enrollment Contact	
Okay: ✓ A plan salesperson determines in advance with the beneficiary what products will be discussed and possibly sold. The beneficiary's decision is documented in writing or in a recorded telephone conversation. ✓ A beneficiary changes their mind about the scope of the appointment during the appointment (for example, asking about other insurance products). The salesperson documents the beneficiary's oral or written consent with a new scope of appointment and provides the requested information. ✓ Salesperson requests beneficiary personal identifying information needed for enrollment and payment, if the beneficiary agrees to enroll in the plan discussed under the original (or revised and documented) scope of appointment.	**Not Okay:** Ø A plan salesperson has arranged to discuss Part C or Part D insurance with a beneficiary but then initiates a discussion about other insurance products, such as life insurance annuities. Ø Misrepresenting a product as an approved Part C or Part D plan when it is actually a Medigap policy or non-Medicare drug plan. Ø A beneficiary changes their mind about the scope of appointment and the salesperson conducts marketing and/or enrollment activities without documenting the change in the scope. Ø Requiring a face-to-face appointment to provide plan information. Ø Returning uninvited to an earlier "no show." Ø Using high-pressure sales tactics.

Okay	NOT Okay
Telephone Calls ("Outbound" calls to beneficiaries)	
Okay: ✓ A beneficiary has reviewed advertising or attended an educational event and gives permission to be contacted by a plan. ✓ A plan that offers Medigap insurance has initiated a call with a current customer. The customer asks about the plan's Part C and Part D products. The plan records the conversation and provides the requested information. ✓ Outbound calls may be made to beneficiaries currently enrolled in a Part C or Part D plan to conduct "normal business" such as: ○ A beneficiary on "Extra Help" who needs to be reassigned can be called ○ Initiating a phone call to confirm an appointment ○ Contacting members to discuss educational events ○ Contacting former members after the disenrollment date to conduct a disenrollment or quality improvement survey ○ Returning beneficiary phone calls	**Not Okay:** Ø Plans may NOT conduct unsolicited phone calls to beneficiaries with whom they have no prior relationship. Telemarketing is considered an unsolicited outbound telephone call and is prohibited. Ø Agents or brokers may NOT represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid. Ø Beneficiary has taken the proactive step through the Do Not Call registry to prohibit marketing calls from a plan. It is then NOT okay for either the plan or an independent agent hired by the plan to call, even though the plan and beneficiary have a relationship. Ø It is NOT okay for agents or brokers to: ○ Contact beneficiaries to ensure receipt of mailed information ○ Make calls to beneficiaries that resulted from a referral ○ Make calls without permission to beneficiaries who attended an event ○ Make calls to current members who are in the process of disenrolling Ø Plan / Part D sponsor call centers that do not have interpreter services available to answer questions from non-English-speaking or limited-English-proficient (LEP) beneficiaries.

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