CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

CMS NTP NATIONAL TRAINING PROGRAM

Contents

Lesson 1—Fraud, Waste, and Abuse Overview.....4-15

Lesson 2—Organizations and Strategies to Detect and Prevent Fraud and Abuse..... 16-39

Lesson 3—How You Can Fight Fraud.....40-54

Key Points to Remember.....55

Examples of Successful Fraud Takedowns.....56

Medicare Fraud & Abuse Resource Guide.....57-59

Acronyms.....60-61

Session Objectives

This session should help you:

- Define fraud, waste, and abuse
- Identify causes of improper payments
- Discuss how the Centers for Medicare and Medicaid Services (CMS) fights fraud and abuse
- Explain how you can fight fraud and abuse
- Find sources of additional information

Lesson 1

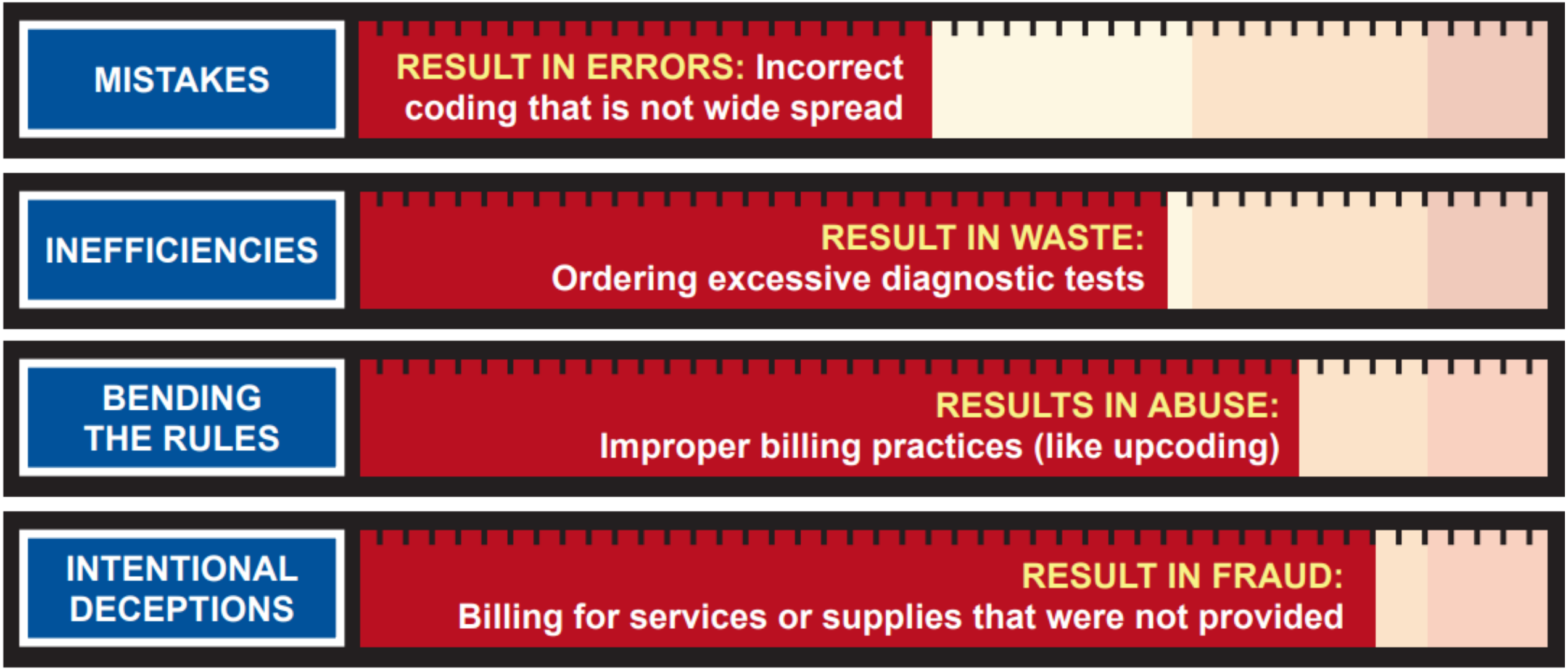
Fraud, Waste, and Abuse Overview

Definitions of Fraud, Waste, and Abuse

Fraud	Waste	Abuse
When someone knowingly deceives, conceals, or misrepresents to obtain money or property from any health care benefit program.	Overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program.	When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards.

The difference between fraud, waste, and abuse depends on circumstances, intent, and knowledge.

Improper Payments and Differences in Fraud, Waste, and Abuse



Protecting Taxpayer Dollars

The Centers for Medicare & Medicaid Services (CMS) must:

- Protect Medicare Trust Funds
  - Medicare Hospital Insurance (HI) (Part A) Trust Fund
  - Supplementary Medical Insurance (SMI) (Part B) Trust Fund
- Protect the public resources that fund Medicaid Programs
- Verify data used to generate Advance Premium Tax Credits in the Marketplace
- Manage the careful balance between paying claims quickly while limiting provider burden and conducting reviews that prevent and detect fraud

Examples of Possible Fraud

- Medicare or Medicaid is billed for services or equipment you never got
- A provider bills Medicare or Medicaid for services that would be considered impossible
- Documents are altered to gain a higher payment
- Dates, descriptions of services, or your identity are misrepresented
- Someone uses your Medicare or Medicaid card with or without your knowledge
- A company uses false information to mislead you into joining a Medicare plan

Who Commits Fraud?

- Most individuals and organizations that work with Medicare and Medicaid are honest
- Sometimes organized crime is at the root of the problem
- Anyone can commit fraud, including:
  - Doctors, pharmacists, other health care providers, and staff
  - Durable medical equipment (DME) suppliers, hospitals, pharmacies, home health organizations, ambulance services, billing companies
  - People with Medicare and/or Medicaid, or individuals who have stolen their identities
  - Telemarketing companies

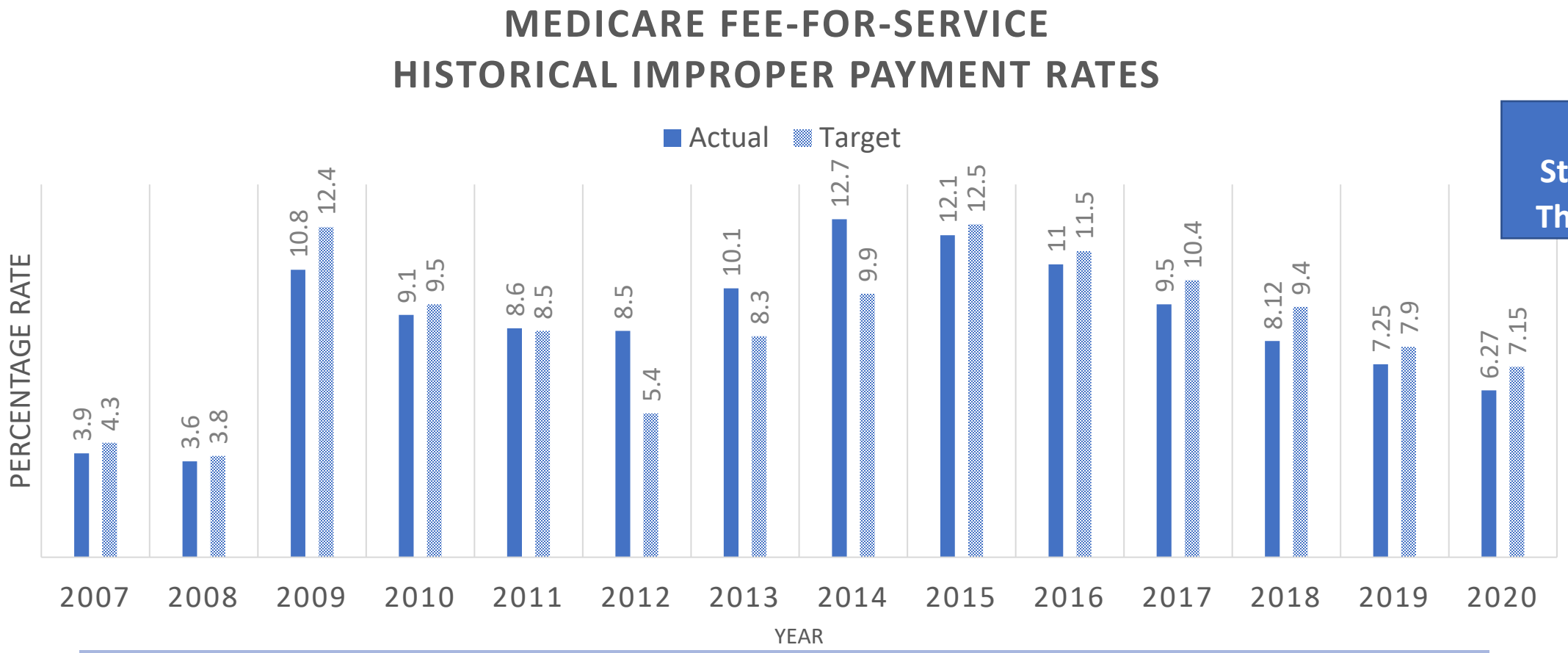
Improper Payments

- Defined as “any payment that shouldn’t have been made or that was made in an incorrect amount…”
- Not all improper payments are fraud, but all payments made due to fraud schemes are improper
- CMS is targeting all causes of improper payments—from honest mistakes to intentional deception
- Most common error is insufficient documentation

Common Causes of Improper Payments

Cause	Percent of 2020 Total
Insufficient Documentation	63.1%
Medical Necessity	16.2%
Incorrect Coding	10.9%
No Documentation	4.4%
Other	5.4%

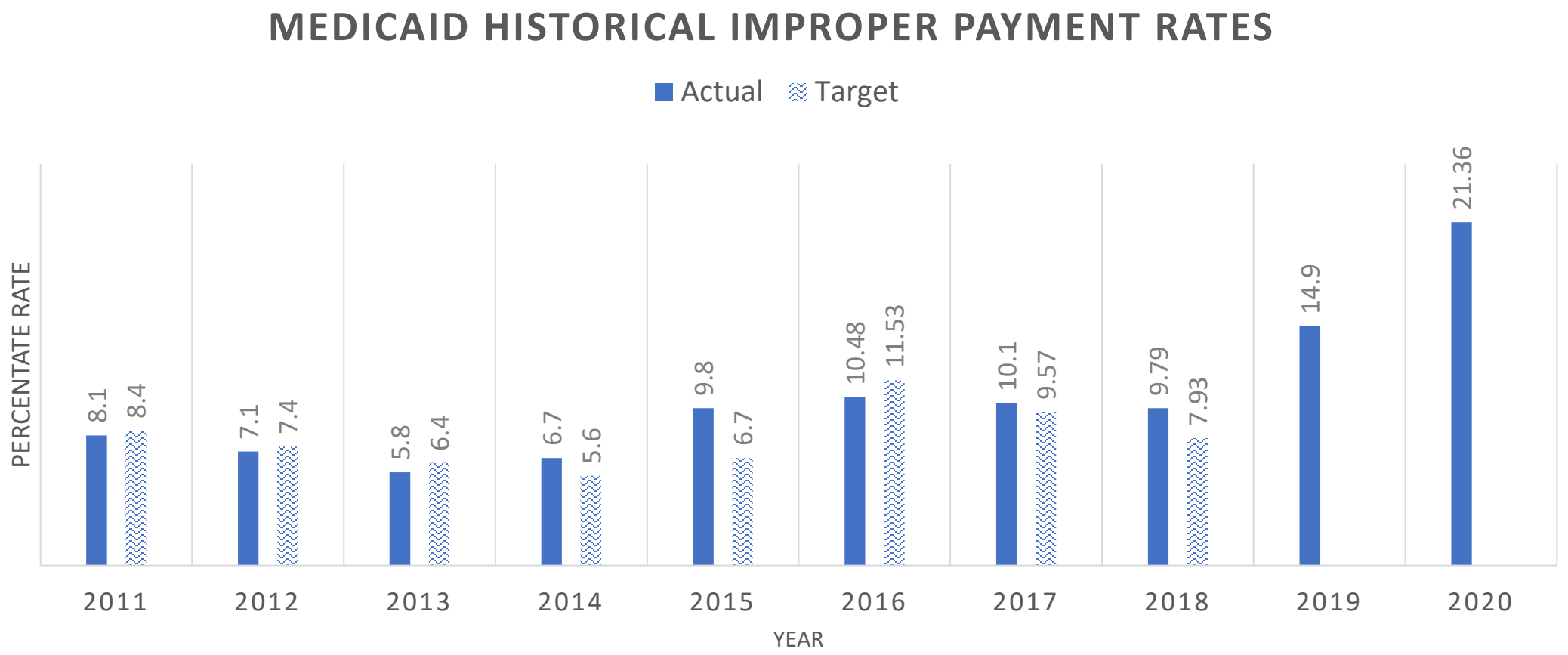
Improper Payment Transparency—Medicare



10% Statutory Threshold

Medicare Fiscal Reporting Year 2020
Error Rate is 6.27%

Improper Payment Transparency—Medicaid



Medicaid Fiscal Reporting Year 2020 Error Rate is 21.36% or $86.49 billion

*These measures are being suspended until 3 years of new eligibility data are gathered and can be inserted into a new baseline in FY 2021. Reduction targets will be reported in FY 2021.

Check Your Knowledge—Question 1

_____ occurs when someone intentionally deceives or makes misrepresentations to get money or property from any health care benefit program.

a. Abuse

b. Improper payment

c. Fraud

d. None of the above

Check Your Knowledge—Question 2

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

a. True

b. False

Lesson 2

Organizations and Strategies to Detect and Prevent Fraud and Abuse

Common Fraud Examples—COVID-19

- The U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) issued an alert to the public about scams involving the novel coronavirus 2019 (COVID-19)
- Scammers are advertising COVID-19 tests, HHS grants, and Medicare prescription cards in exchange for personal information, like your Medicare Number
- Be suspicious:
  - If you're asked to pay out-of-pocket to get a vaccine
  - If you're asked to pay to sign-up for a vaccine or get "early access"
  - Of vaccine advertisements through unsolicited social media, emails, phone calls, or other online contact
  - Of offers to ship or sell vaccines for payment

Ways to Protect Yourself from COVID-19 Fraud Schemes

- You won't be asked for money to get your COVID-19 vaccine or to enhance your ranking for vaccine eligibility
- Be cautious of unsolicited calls, texts, visits, posts, or emails requesting your personal data
- If you need a COVID-19 test, work with your provider or ensure the testing site is legitimate
- Don't share photos of your COVID-19 vaccination card on social media
- Be aware of scammers posing as COVID-19 contact tracers

Consequences of Sharing Your Health Care Information or Number

- Your medical records could be wrong
- If you intentionally participated, you could be charged with health care fraud
- You might lose your benefits
- If you have Medicaid, you could be placed into a lock-in program which limits you to certain doctors, drug stores, and hospitals for activities like
  - Emergency department visits for non-emergency care
  - Using multiple doctors that duplicate treatment or medication

Preventing Fraud in Medicare Health and Drug Plans

- Plan agents and brokers must follow CMS's Marketing Guidelines
- Examples of what plans can't do:
  - Send unwanted emails without an "opt-out" function
  - Visit homes uninvited to encourage enrollment in their plan
  - Call or text non-members (unless given permission)
  - Offer cash to join their plan
  - Give free meals at sales or marketing events
  - Talk about their plan in restricted areas like exam rooms, hospital patient rooms, treatment areas, and pharmacy counters
- If you think an agent or broker broke Medicare plan rules, call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048

Common Fraud Examples—Genetic Testing & Braces

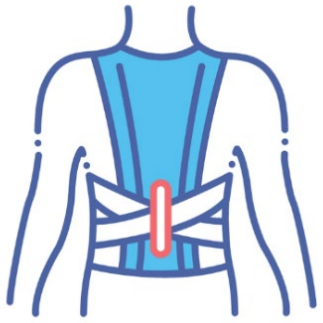
- Medicare covers some genetic testing and some orthotic braces, but only when it's medically necessary and ordered by your doctor
- "Free" screenings, cheek swabs for genetic testing, or medical equipment in exchange for your Medicare information are scams
- Protect yourself:
  - If a genetic testing kit or orthotic braces are mailed to you, don't accept, and return to sender
  - Be suspicious of anyone who offers "free" genetic testing or medical equipment and then requests your Medicare Number
  - Keep a record of any encounters and report them to 1-800-HHS-TIPS (1-800-447-8477) or oig.hhs.gov/fraud/hotline

Telemarketing and Fraud— Durable Medical Equipment (DME)

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

Medicare's Competitive Bidding Program For Certain Durable Medical Equipment, Prosthetics, & Orthotics (DMEPOS)

- Suppliers compete to become Medicare contract suppliers by submitting bids to furnish items in certain Competitive Bidding Areas (CBAs); CBAs can be found at dmecompetitivebid.com/cbic/cbic2021.nsf/DocsCat/H5O2KFK4HO
- Temporary gap period in this program ended December 31, 2020
- Round 2021 is from January 1, 2021 through December 31, 2023
- Covers 2 product categories
  - Off-the-Shelf (OTS) Back Braces
  - OTS Knee Braces



More Information About Competitive Bidding Program (CBP) Round 2021

- Ensures people with Medicare have access to quality items
- Limits fraud and abuse in the Medicare Program
- Saves tax payer dollars
- Medicare sets a Single Payment Amount (SPA)
- People with Medicare who live in or travel to a CBA must use an approved supplier for Medicare to cover their back or knee brace
- Medicare Supplier Directory is at Medicare.gov/medical-equipment-suppliers

Quality of Care Concerns

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

The Centers for Medicare & Medicaid Services (CMS)

- CMS moved beyond the “pay and chase” approach to health care fraud, to a more proactive, transparent approach
- Actions include:
  - Conducting rigorous screenings for health care providers and suppliers
  - Barring or terminating providers and suppliers from all Medicaid Programs and Children’s Health Insurance Program (CHIP) Programs who have their Medicare billing privileges revoked
  - Temporarily stopping enrollment in high-risk areas
  - Temporarily stopping Medicare payments in cases of credible allegations of fraud
  - Coordinating with private and public health payers and other stakeholders to detect and deter fraudulent behaviors within the health care system
  - Providing outreach and education to reach program objectives

CMS' Center for Program Integrity (CPI)

Within CMS, the Center for Program Integrity (CPI) coordinates:

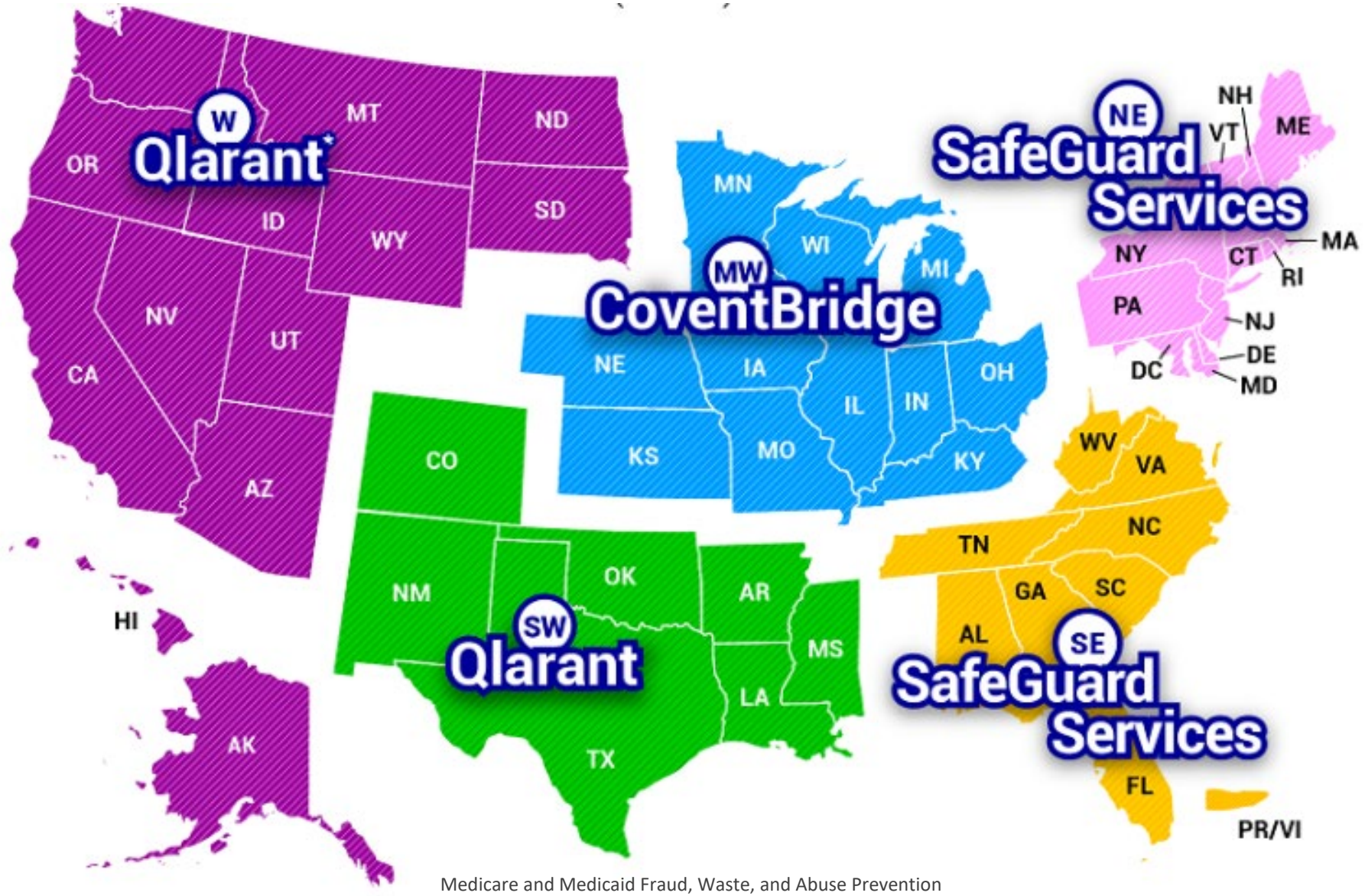
- Anti-fraud, waste, and abuse components
- The work of contractors to investigate Medicare providers
- Audits of Medicaid providers to identify potential overpayments

Program Integrity Contractors

A nationally-coordinated Medicare/Medicaid Program integrity team that cuts across regions and consists of:

- Unified Program Integrity Contractors (UPIC)
- Recovery Audit Program
- Plan Program Integrity Medicare Drug Integrity Contractor (PPI MEDIC)
- Investigative Medicare Drug Integrity Contractor (I-MEDIC)

Unified Program Integrity Contractor (UPIC)



Medicare-Medicaid (Medi-Medi) Data Matching Funds

- Collaboration between State Medical Assistance (Medicaid) offices
- Conduct data analyses and investigations that have the greatest potential for uncovering fraud, waste, and abuse
  - State participation is voluntary
  - Activities are separate tasks under the UPIC contracts
  - UPICs use the matched data to identify fraud, waste, and abuse to conduct investigations with state Medicaid agencies

Recovery Audit Programs

- Recovery Audit Program's mission is to reduce improper Medicare payments by:
  - Detecting and collecting overpayments
  - Identifying underpayments
  - Implementing actions that will prevent future improper payments
- States establish Medicaid Recovery Audit Contractor (RAC) programs to:
  - Identify overpayments and underpayments
  - Coordinate efforts with federal and state auditors

Medicare Drug Integrity Contractors (MEDICs)

- Monitor fraud, waste, and abuse in Medicare Advantage and Medicare drug coverage
- Work with law enforcement and other stakeholders
- Key responsibilities include:
  - Investigating potential fraud, waste, and abuse
  - Investigating complaints alleging Medicare fraud
  - Performing proactive data analyses
  - Identifying program vulnerabilities
  - Referring potential fraud cases to law enforcement agencies
  - Conducting Medicare Advantage Plan and Medicare drug plan audits
  - Providing outreach and education to plan sponsors

CMS Administrative Actions

When CMS suspects fraud, administrative actions include:

- Automatic denials of payment
- Payment suspensions
- Prepayment edits
- Revocation of billing privileges
- Post-payment reviews for determinations
- Referral to law enforcement

Law Enforcement Actions

When law enforcement determines fraudulent activities, enforcement actions include:

- Providers/companies are barred from the programs
- Providers/companies can’t bill Medicare, Medicaid, or CHIP
- Providers/companies are fined
- Arrests and convictions occur
- Corporate Integrity Agreements may be negotiated

Health Care Fraud Prevention Partnership (HFPP)

The Health Care Fraud Prevention Partnership's (HFPP) 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

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

- Joint initiative between the U.S. Department of Health & Human Services (HHS) and U.S. Department of Justice (DOJ)
- The mission of HEAT is to:
  - Help prevent fraud, waste, and abuse in the Medicare and Medicaid Programs
  - Reduce health care costs and improve the quality of care, by ridding the system of perpetrators who prey on people with Medicare and Medicaid
  - Highlight best practices of providers and public sector employees dedicated to ending waste, fraud, and abuse in Medicare
  - Build upon existing partnerships between HHS and DOJ to reduce fraud and recover taxpayer dollars

Medicare Fraud Strike Force Teams

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

Education Efforts

- Provider education helps correct vulnerabilities so that providers:
  - Maintain proper documentation
  - Reduce inappropriate claims submission
  - Protect patient and provider identity information
  - Establish a broader culture of compliance
- Educating people with Medicare helps identify and report suspected fraud

Check Your Knowledge—Question 3

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is a joint anti-fraud initiative between the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Justice (DOJ).

a. True

b. False

Lesson 3

How People with Medicare and Medicaid Can Fight Fraud

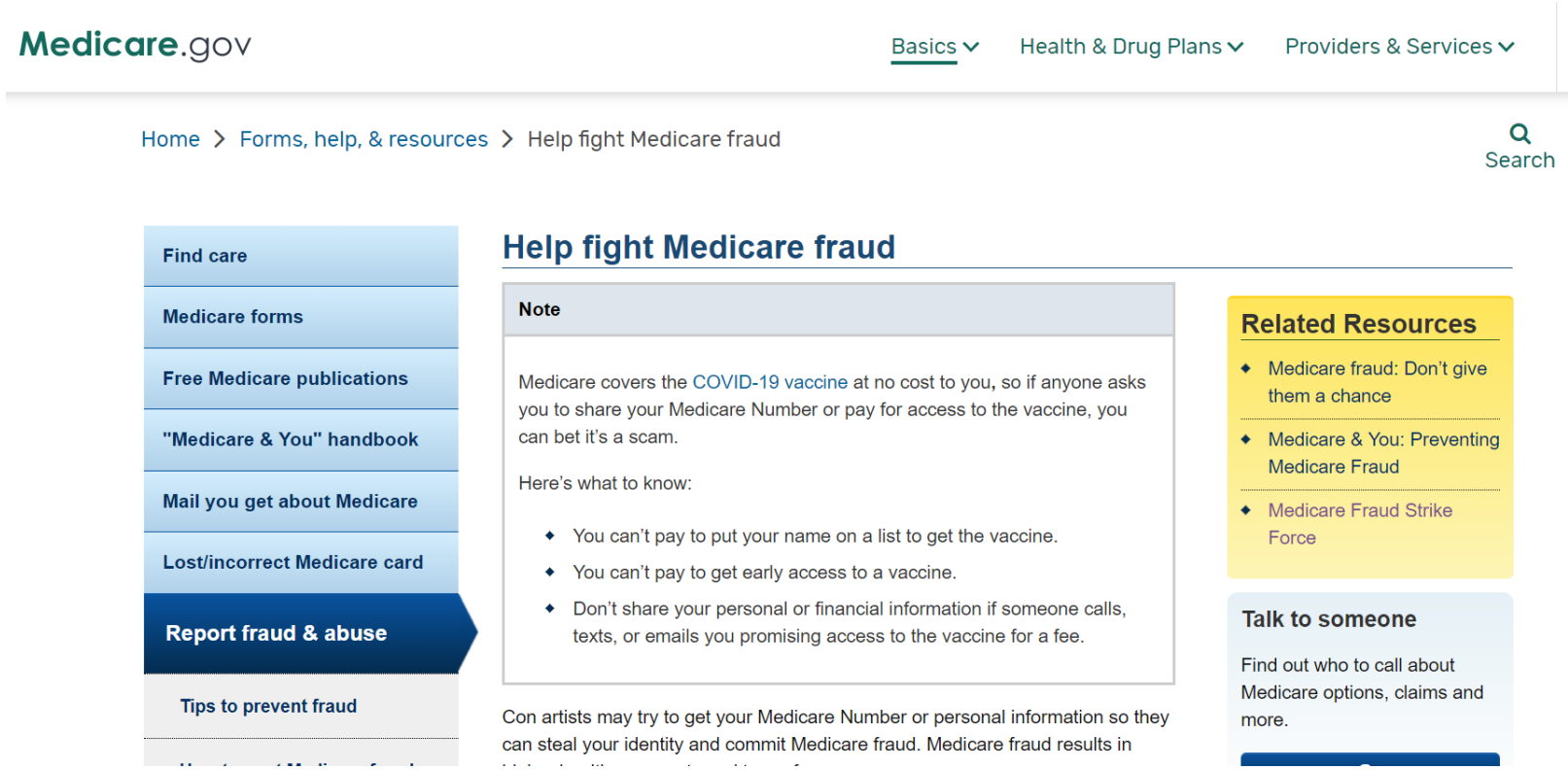
The Senior Medicare Patrol (SMP)

- Educates people with Medicare on preventing, identifying, and reporting health care fraud
- Has active programs in all states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, and Guam
- Seeks volunteers to represent their communities
- Gets complaints from people with Medicare
- Visit smpresource.org or call the nationwide toll-free number: 1-877-808-2468 for more information

Fraud and Abuse Information on Medicare.gov

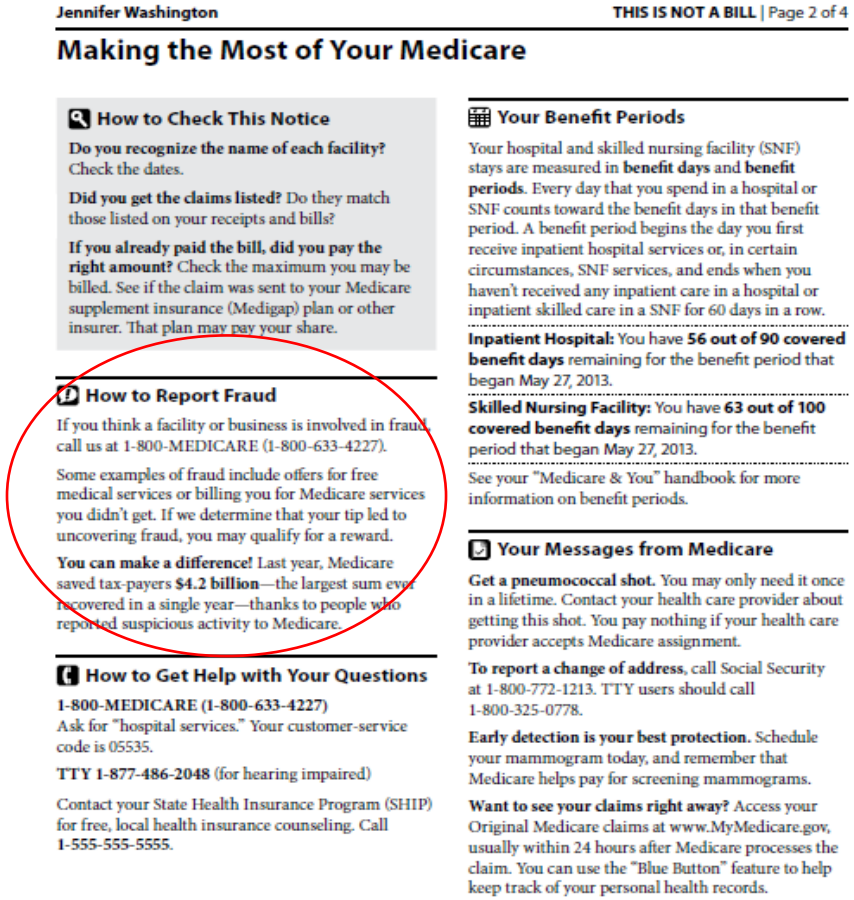
Learn:

- Prevention tips
- How to spot fraud
- How to report fraud
- Rules for Medicare health plans



Medicare Summary Notice (MSN)

- The MSN is designed to make it easy to read and to spot fraud
- Shows all your Original Medicare services or supplies
  - Mailed MSNs show a 3-month period; electronic MSNs (eMSNs) in Medicare account show monthly
  - What Medicare paid
  - What you owe
- Read it carefully



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

Making the Most of Your Medicare

How to Check This Notice

Do you recognize the name of each facility? Check the dates.

Did you get the claims listed? Do they match those listed on your receipts and bills?

If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

How to Report Fraud

If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

You can make a difference! Last year, Medicare saved tax-payers **$4.2 billion**—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

How to Get Help with Your Questions

1-800-MEDICARE (1-800-633-4227)
Ask for "hospital services." Your customer-service code is 05535.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call **1-555-555-5555**.

Your Benefit Periods

Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.

Inpatient Hospital: You have **56 out of 90 covered benefit days** remaining for the benefit period that began May 27, 2013.

Skilled Nursing Facility: You have **63 out of 100 covered benefit days** remaining for the benefit period that began May 27, 2013.

See your "Medicare & You" handbook for more information on benefit periods.

Your Messages from Medicare

Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.

To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

Want to see your claims right away? Access your Original Medicare claims at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can use the "Blue Button" feature to help keep track of your personal health records.

Explanation of Benefits (EOBs)

SAMPLE FROM CMS TEMPLATE

[Insert name of provider]

Claim Number: *[Insert claim number]*

(*[If applicable, insert: [Insert as applicable:* In-network *OR* Out-of-network*]* provider *[plans may add the type of optional supplemental benefits, e.g., "of dental services."]*) *[Insert type of optional supplemental benefits]* are "optional supplemental services." These are extra services for which you pay a separate premium.

Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
		DENIED (Look below for information about your appeal rights.)*]*		may be responsible for paying this amount. Look below for information about your appeal rights.]

- Medicare health and drug plans provide EOBs
- Plans must include information from CMS-developed templates
- Shows all your services or supplies covered by the plan
- Plans may have portals or other electronic access methods to the same information; varies by plan

Medicare Account on Medicare.gov

- Create a secure personal account to access your Medicare information anytime and have a more personalized experience
- With your account, you can:
  - Print an official copy of your Medicare card
  - Access and share your electronic health information
  - Pay your Original Medicare premiums online if you get a bill from Medicare
  - View your Original Medicare claims as soon as they're processed
  - Find plans in your area and create a list of your drugs
  - Get help through live chat

“4Rs” for Fighting Medicare Fraud

- Publication about how you can protect yourself and Medicare from fraud
- The 4Rs are:
  - Record appointments and services
  - Review services provided
  - Report suspected fraud
  - Remember to protect personal information, like your Medicare and Social Security Numbers, credit card and bank account numbers

CMS Product No. 11610 is available at Medicare.gov/Pubs/pdf/11610-4R-for-Fighting-Fraud.pdf

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

- Incoming fraud complaints:
  - Help target certain providers/suppliers for review
  - Show where fraud scams are heating up
- By using the Interactive Voice Response System:
  - Access up to 15 months of Original Medicare claims
  - Check for proper dates, services, and supplies obtained
- If you're calling to report fraud, have this information ready:
  - Provider's name and any identifying number you have
  - Information about the item or service in question (including the date and payment amount)
  - The date on your MSN
  - Your name and Medicare Number

Fighting Fraud Can Pay

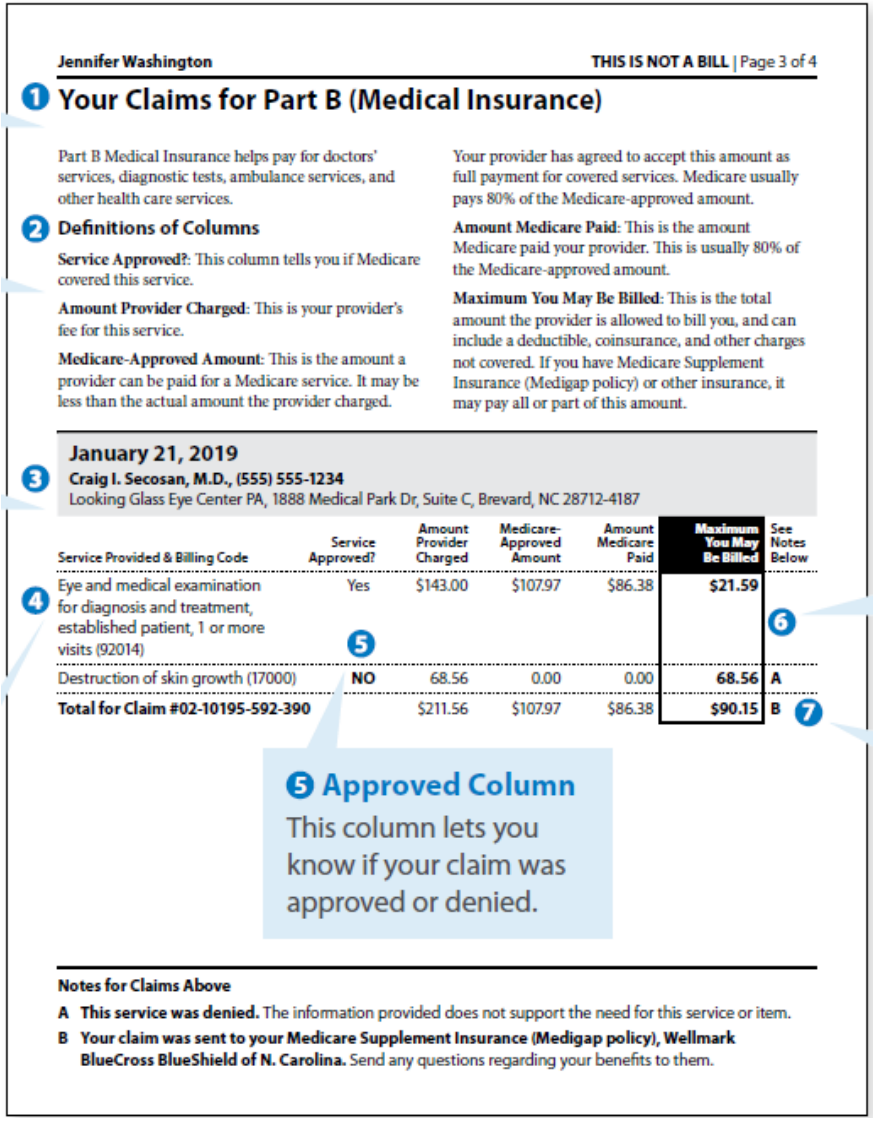
You may get a reward if you meet all of these conditions:

- The suspected Medicare fraud you report must be investigated and validated by Medicare contractors
- The reported fraud must be formally referred to the Office of Inspector General (OIG) for further investigation
- You aren't an excluded individual
- The person or organization you're reporting isn't already under investigation by law enforcement
- Your report leads directly to the recovery of at least $100 of Medicare money

Learning Activity

Jennifer has concerns and wants to discuss her MSN with you.

What are some things that might indicate fraud?



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

1 Your Claims for Part B (Medical Insurance)

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

2 Definitions of Columns

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

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

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

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

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

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

3 January 21, 2019
Craig I. Secosan, M.D., (555) 555-1234
Looking Glass Eye Center PA, 1888 Medical Park Dr, Suite C, Brevard, NC 28712-4187

4 Service Provided & Billing Code	5 Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	6 Maximum You May Be Billed	See Notes Below
Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (92014)	Yes	$143.00	$107.97	$86.38	**$21.59**	
Destruction of skin growth (17000)	**NO**	68.56	0.00	0.00	**68.56**	**A**
Total for Claim #02-10195-592-390		$211.56	$107.97	$86.38	**$90.15**	**B** 7

5 Approved Column
This column lets you know if your claim was approved or denied.

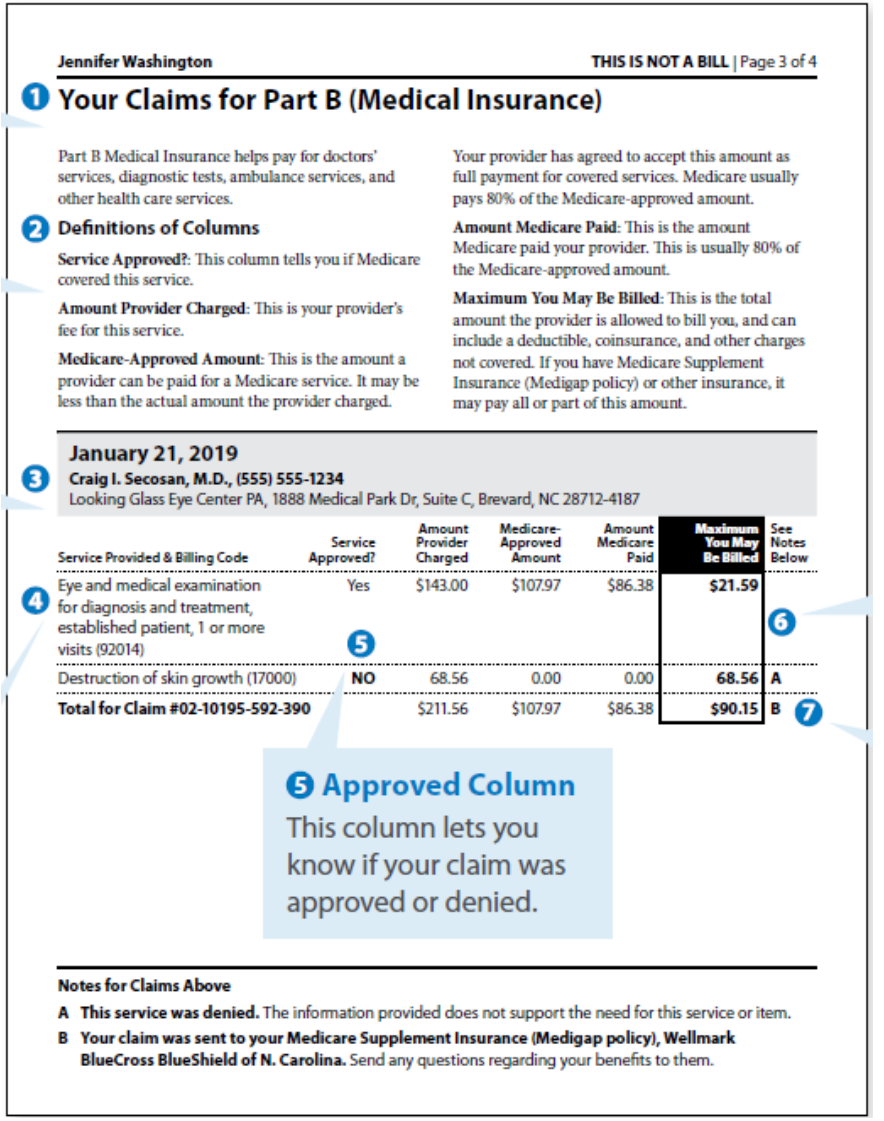
Notes for Claims Above

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

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

Learning Activity (continued)

1. Does she know the provider/facility?
2. Did she get these services?
3. Is the date of service correct?
4. Do any services appear twice when they shouldn't?



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

1 Your Claims for Part B (Medical Insurance)

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

2 Definitions of Columns

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

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

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

January 21, 2019 3
Craig I. Secosan, M.D., (555) 555-1234
Looking Glass Eye Center PA, 1888 Medical Park Dr, Suite C, Brevard, NC 28712-4187

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
4 Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (92014)	Yes	$143.00	$107.97	$86.38	$21.59	6
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Protecting Personal Information

- Your Medicare card has a Medicare Number that's unique to you; not your Social Security Number
- Only share information with people you trust:
  - Doctors, other health care providers, and plans approved by Medicare
  - Insurers who pay benefits on your behalf
  - Trusted people in the community who work with Medicare
- If you aren't sure if a provider is approved by Medicare or someone calls you and asks for your Medicare Number call, 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048

Identity Theft

- Identity theft is when someone else uses your personal information, like your Social Security Number to:
  - Open new accounts, like credit cards
  - File for a tax refund
  - Make purchases

- If you think someone is using your information:
  - Call your local police department
  - Visit identitytheft.gov
  - Call the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338; TTY: 1-866-653-4261
  - Visit ftc.gov/idtheft for more information about identity theft or to file a compliant online

Medical Identity Theft

- Medical identity theft is a special type of identity theft where someone uses your Medicare or Medicaid Number to submit fraudulent claims to Medicare, Medicaid, or other insurers without your permission
- Medical identity theft can result in:
  - False or missed diagnoses
  - Treatment for conditions you don't have
  - Incorrect lab results
  - Bills for services you didn't get
  - Denied services or prescriptions
  - Inaccurate medical history records

View OIG's Public Service Announcement about medical identity theft

Reporting Suspected Medicaid Fraud

- Medicaid Fraud Control Unit (MFCU) investigates and prosecutes:
  - Medicaid fraud
  - Patient abuse and neglect in health care facilities
- OIG certifies and annually re-certifies each MFCU; call to report fraud at 1-800-447-8477; TTY: 1-800-377-4950
- State Medical Assistance (Medicaid) office; see state listing for Medicaid at CMS.gov/apps/contacts

Key Points to Remember

- ✓ Differences between fraud, waste, and abuse depend on circumstances, intent, and knowledge
- ✓ Improper payments are often mistakes
- ✓ CMS fights fraud, waste, and abuse with support from Program Integrity Contractors and partnerships with organizations
- ✓ Fraud schemes can change frequently; check online resources for the most up-to-date information
- ✓ You can fight fraud, waste, and abuse by recording details about your visits, reviewing statements, reporting suspicious activity, and remembering to protect your information

Examples of Successful Fraud Takedowns

- Justice.gov/opa/pr/florida-man-charged-covid-relief-fraud-health-care-fraud-and-money-laundering
- Justice.gov/opa/pr/four-detroit-area-physicians-found-guilty-health-care-fraud-charges-role-over-150-million
- Justice.gov/opa/pr/national-health-care-fraud-and-opioid-takedown-results-charges-against-345-defendants
- Justice.gov/opa/pr/justice-department-takes-action-against-covid-19-fraud

Medicare and Medicaid Fraud & Abuse Resource Guide

Centers for Medicare & Medicaid Services (CMS)	▪ Call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048. ▪ CMS.gov ▪ Medicare.gov/fraud
Social Security	▪ Call 1-800-772-1213. TTY: 1-800-325-0778 ▪ socialsecurity.gov
Senior Medicare Patrol Program	▪ Call 1-877-808-2468 ▪ smpresource.org
National Health Care Anti-Fraud Association	▪ NHCAA.org
PPI MEDIC and I-MEDIC Parts C&D Fraud Investigations Contractor	▪ Call 1-877-7SAFERX (1-877-772-3379). ▪ I-MEDICComplaints@qlarant.com ▪ I-MEDIC_OIG_Hotline@qlarant.com

Medicare and Medicaid Fraud & Abuse Resource Guide (continued)

U.S. Department of Health & Human Services Office of the Inspector General	▪ Call 1-800-HHS-TIPS; (1-800-447-8477); TTY: 1-800-377-4950 ▪ OIG.hhs.gov/fraud/report-fraud
Medicaid Fraud Education	CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html

Medicare and Medicaid Fraud & Abuse Resource Guide (continued 2)

1. “Protecting Yourself & Medicare From Fraud” (CMS Product No. 10111)	Medicare.gov/Pubs/pdf/10111-Protecting-Yourself-and-Medicare.pdf
2. “Medicare Fraud: Guard Your Card” (CMS Video)	youtube.com/watch?v=vScAG7rtPe8&list=PLaV7m2-zFKpiuxlWwMfKHNUrQ2Mxhay4b
3. “4Rs for Fighting Fraud” (CMS Product No. 11610)	Medicare.gov/Pubs/pdf/11610-4R-for-Fighting-Fraud.pdf
4. “Medicare & You: Preventing Medicare Fraud” (CMS Video)	youtube.com/watch?v=zKZuVdL-GC0
5. “Medicare Fraud: Coronavirus Scams (CMS Video)	youtube.com/watch?v=N_iI1IkTQZo

To access other helpful products:

- View or download at Medicare.gov/publications.
- Order multiple copies (partners only) at Productordering.cms.hhs.gov.

You must register your organization.

Acronyms

BFCC-QIO Beneficiary and Family-Centered Care Quality Improvement Organization

CBA Competitive Bidding Area

CBP Competitive Bidding Program

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

COVID-19 Novel Coronavirus 2019

CPI Center for Program Integrity

DME Durable Medical Equipment

DOJ Department of Justice

EOB Explanation of Benefits

FBI Federal Bureau of Investigations

FFS Fee-for-Service

FY Fiscal Year

HEAT Health Care Fraud Prevention and Enforcement Action Team

HFPP Health Care Fraud Prevention Partnership

HHS Health and Human Services

IRS Internal Revenue Service

IVR Interactive Voice Response

MEDIC Medicare Drug Integrity Contractor

MFCU Medicaid Fraud Control Unit

MICs Medicaid Integrity Contractors

MSN Medicare Summary Notice

NTP National Training Program

Acronyms (continued)

OIG Office of Inspector General

PDP Medicare Prescription Drug Plan

PERM Payment Error Rate Measurement

PPI Plan Program Integrity

QIO Quality Improvement Organization

RAC Recovery Audit Contractor

SHIP State Health Insurance Assistance Program

SMP Senior Medicare Patrol

TTY Teletypewriter

UPIC Unified Program Integrity Contractor

ZPIC Zone Program Integrity Contractor

CMS National Training Program (NTP)

To view all available NTP training materials, or to subscribe to our email list, visit CMSnationaltrainingprogram.cms.gov.

Stay connected.

Contact us at training@cms.hhs.gov.