

# **SMP COMPLEX ISSUES AND REFERRALS MANUAL**

**May 2013**





# SMP COMPLEX ISSUES AND REFERRALS TRAINING MANUAL

**Funded by:**

The U.S. Administration for Community Living  
Administration on Aging  
Washington, DC

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Waterloo, IA

*May 2013*





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## About the SMP Resource Center

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

### Direct Services Provided to SMPs:

- Promotes SMP networking and the sharing of best practices.
- Provides education and information about health care fraud, error, and abuse.
- Develops new products and tools for the national SMP network.
- Trains SMPs in the use of the SMP national tracking and reporting system.
- Provides technical assistance to SMPs both one-on-one and in group settings

### National SMP Website: [www.smpresource.org](http://www.smpresource.org)

Our website provides education to the public on health care fraud and consumer protection. Visitors can also find their state’s SMP program (see the “Locate an SMP in your area” search tool).



### Nationwide Toll-free Number: 877-808-2468

Available Monday through Friday, 9:00 a.m. – 5:30 p.m. Eastern Time. Callers receive information about the SMP program and are connected to the SMP in their state if they need individual assistance.

### Additional Contact Information:

- **Email:** [info@smpresource.org](mailto:info@smpresource.org)
- **Mailing Address:** SMP Resource Center, Hawkeye Valley Area Agency on Aging, 2101 Kimball Ave., Ste. 320, P.O. Box 388, Waterloo, Iowa 50704-0388

## Acknowledgments

This manual was made possible by grant number 90NP0001 from the U.S. Administration on Aging (AoA), Administration for Community Living (ACL), Department of Health and Human Services, and was prepared by the National Consumer Protection Technical Resource Center, more commonly known as The Senior Medicare Patrol (SMP) Resource Center. The contents were developed collaboratively by SMP stakeholders, AoA, SMP Resource Center, The Centers for Medicare & Medicaid (CMS), and others.

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This manual was first published in November 2011. Special thanks also go to the following additional individuals, who provided guidance and/or content review for the original version or subsequent versions:

**ACL:** Barbara Dieker, Director of the Office of Elder Rights, Rebecca Kinney, SMP Program Manager, Josh Hodges, Program Analyst, and Amy Wiatr-Rodriguez, Aging Services Program Specialist.

**SMPs:** Theresa Brownson (DC), Charles Clarkson (NJ), Karol Dermon (NH), Anne Fredrickson (OH), LaNelle Godsey (TN), Barbara McGinity (TX), Vera Watson (NM), and Erin Weir (IL).

**CMS:** Reviewed or contributed to the section on marketing and/or reviewed and approved CMS content: Valeria Allen, Paul Collura, Marnie Dorsey, Helaine Fingold, Deanna Greene, Danielle Lucas, Camille Brown, Carolyn Mill, and Gloria Parker. Additional content about types of fraud was provided by the following CMS contractors: Jeannie Aydelotte (formerly with Health Integrity), Adele Culpepper (Health Integrity), Amy Miller-Bowman (formerly with IntegriGuard), Annia Ortlely (Health Integrity), and Molly Rhoutzhan (Health Integrity).

**Others:** Thanks also go to Hilary Dalin, formerly with the National Council on Aging, and Vicki Gottlich, formerly with the Center for Medicare Advocacy, Inc., whose “Okay/Not Okay” concept of teaching Medicare marketing guidelines informed Chapter 4. Technical assistance regarding Medicare appeals and coordination of benefits was provided by Center consultant, Mike Klug. Some information about observation status was provided by the South Dakota SMP. Information on fraud and abuse laws was excerpted from The Office of Inspector General publication, “A Roadmap for New Physicians; Avoiding Medicare and Medicaid Fraud.”

## Introduction

In SMP Foundations, you learned to identify Medicare fraud, error, and abuse. In this manual, you will learn what action to take when presented with complaints of suspected Medicare fraud, error, or abuse. SMP complex issues involve complaints from Medicare beneficiaries, their caregivers, or professionals in the care of older adults. These complaints may also involve consumer protection concerns that often co-occur with suspected Medicare fraud or abuse, such as identity theft or scams aimed at preying upon the personal finances and property of older adults.

Additionally, there are often other problems that may come to the SMP's attention, such as health care quality-of-care concerns, the need for Medicare benefits counseling, and the need for information and assistance in the field of aging. Sometimes, complaints are brought to the attention of the SMP that are outside the scope of the program to address.

This manual will assist you in putting beneficiaries and caregivers in touch with the appropriate organization or organizations that can help. In this way, SMPs remain in their role without ignoring important beneficiary needs.

## Purpose

The purpose of this manual is to guide SMP staff and volunteers in the process of managing complex issues and, when necessary, conducting referrals to the appropriate entity for further action.

## Suggested Prior Training and Experience

### SMP Foundations Training

- Provides SMP staff and volunteers with a foundation of knowledge in three main content areas: the SMP program, Medicare basics and Medicare fraud and abuse.
- [www.smpresource.org](http://www.smpresource.org) > Resources for SMPs > Training > Volunteer Training > [SMP Foundations Training](#).
- This manual assumes that SMP staff and volunteers who will handle SMP complex issues and referrals are qualified in the content of SMP Foundations and have a copy of the most current SMP Foundations manual.

### SMP Counselor Training

- Provides SMPs with the necessary skills and resources to handle one-on-one counseling sessions and simple inquiries consistently across the country. [www.smpresource.org](http://www.smpresource.org) > Resources for SMPs > Training > Volunteer Training > [SMP Counselor Training](#).

*Suggested Prior Training and Experience, SMP Counselor Training, continued*

- This manual assumes that SMP staff and volunteers who will handle SMP complex issues and referrals are qualified in the content of the SMP Counselor training and have a copy of the most current SMP Counselor manual.

### SMART FACTS

SMP staff and volunteers who manage SMP complex issues and make referrals of suspected Medicare fraud, error, or abuse are expected to understand and use SMART FACTS, the SMP tracking and reporting online database. Comprehensive SMART FACTS instruction is outside the scope of this manual, though some references to SMART FACTS and SMART FACTS reminders will be included.

- It is possible to assist in managing complex issues using paper forms without knowledge of the SMART FACTS database. However, it is not possible to conduct referrals of suspected Medicare fraud and abuse without using SMART FACTS.
- Volunteers who are involved with complex issues but not referrals will need to work closely with an SMP staff member who does use SMART FACTS and knows how to make a referral of suspected Medicare fraud or abuse. This approach will require highly coordinated teamwork.

For more information about SMP Foundations and SMART FACTS, visit [www.smpresource.org](http://www.smpresource.org) or call the SMP Resource Center (also known as the National Consumer Protection Technical Resource Center) at 877-808-2468.

### Formatting

The two formatting techniques below are used for the indicated purposes throughout this manual.

### Key Concept

This color of box will contain items considered key concepts and tips.

**NOTE:** *This type of indication will include important information on the topic above it.*



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## SMP Unique Role

As you learned in SMP Foundations, there are many entities involved in addressing Medicare fraud, error, and abuse, and also many organizations available to help beneficiaries. The role of the SMP is to act as a messenger between a beneficiary (or caregiver) and the appropriate organizations that can address the suspected fraud, error, or abuse. SMPs not only assist beneficiaries in reporting complaints of suspected fraud, error, and abuse, but they also can act as complaint managers, supporting and assisting beneficiaries through the resolution of complaints. Such complaints not only affect Medicare but also beneficiaries personally.

As **messengers**, SMPs report suspected fraud, error, and abuse to government organizations that can intervene and stop it at the source. SMPs also relay relevant information from government organizations back to the complainant.

As **complaint managers**, SMPs help beneficiaries understand and resolve the personal consequences that arise when they are the victim of an error or are inadvertently caught up in fraud or abuse, which not only harms the health care system but possibly also their personal finances and medical records.



Sometimes, SMPs receive complaints from a beneficiary or their caregiver who identified a scam attempt but did not fall prey to it and thus prevented potential Medicare fraud. In these instances, SMPs act as **public educators**, alerting the appropriate authorities at the state, regional, and local level so they can take further preventative action. Managing complaints of this type are also within the role of the SMP.

## Definition of an SMP Complex Issue

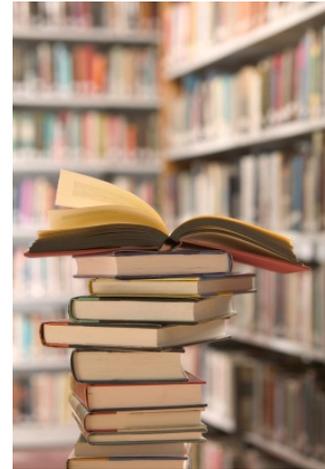
Complaints of Medicare fraud, error, and abuse, consumer scams that seek Medicare and Social Security numbers, and health care fraud aimed at Medicare beneficiaries are deemed “complex issues” in the SMP program.

The definition of a **complex issue** is:

“Complex issues are inquiries that generally require the SMP staff or volunteer to obtain beneficiary personal identifying information and detailed information related to the issue, complaint, or allegation in order to conduct further investigation or referral.”

The definition of an SMP complex issues **complaint** is:

“Allegations of health care fraud, errors, and abuse.”  
As mentioned earlier, complaints can also involve associated consumer fraud or attempted scams aimed at stealing a Medicare beneficiary’s identity.



A **complainant** is a Medicare beneficiary, caregiver or other person who submits a complex issues complaint to the SMP.

Complex issues are usually time-consuming to address. They cannot be resolved in a single phone call or conversation. They require research, gathering information and documentation from the beneficiary or caregiver, and consulting training manuals (such as this one). Many result in a referral to external organizations for further investigation. A significant amount of subject-matter knowledge on the part of staff or volunteers is often necessary to address complex issues.

## Definition of a Referral

When the term “referral” is used in conjunction with complex issues, it means that the SMP is reporting a complaint to outside entities on behalf of the beneficiary, caregiver, or other complainant. This is distinctly different from the use of the term in other contexts, where a client is given the contact information for appropriate organizations and expected to make contact on their own behalf.

### Key Concept

In the SMP taxonomy and for purposes of this manual, “referrals” are made on behalf of the client by the SMP.

## Understanding What is Not a Complex Issue

Not every complaint brought to an SMP can be considered a complex issue. For example, someone may call complaining that Medicare is too complicated. A complaint? Yes. An SMP complex issue? No. SMPs services follow a continuum. The bulk of SMP activities fall into the category of outreach and education. As a result of this education, SMPs may receive many questions and concerns from beneficiaries and caregivers, including incidents of suspected fraud, error, and abuse. Not all concerns brought to the SMP are considered complex issues.

### Simple Inquiries

SMPs receive inquiries that can be resolved quickly with a simple answer in one phone call or in-person conversation. These are called “simple inquiries” in the SMP taxonomy.

### One-on-One Counseling Sessions

SMPs also provide individual education to beneficiaries or their caregivers in “one-on-one counseling” sessions for the purpose of educating them about how to prevent, detect, and report Medicare fraud. During these sessions, there may be a great deal of dialogue between the SMP representative and the beneficiary or caregiver. For various reasons, such as language barriers, cultural differences, sensory impairments, etc., a one-on-one counseling session may become time consuming. Earlier you learned that complex issues are time-consuming to resolve. Some one-on-one counseling sessions may also be time-consuming, however. The time element by itself does not determine the difference between the two.



Not every beneficiary complaint will meet the definition of a complaint or a complex issue. Perhaps a beneficiary thinks she has spotted fraud, but in the course of the conversation, the SMP staff member or volunteer is able to easily discern that the problem is really a matter of the beneficiary not understanding how Medicare works. Let's face it: Medicare can be very confusing! This problem is solved in one conversation and did not require research or follow-up. Though it may have been time consuming and did involve a beneficiary complaint, the matter was resolved by providing education and would thus be considered a one-on-one counseling session.

## Key Concept

Instructions for conducting simple inquiries and one-on-one counseling sessions are provided in the SMP Resource Center's [SMP Counselor Training Manual](#). A flow chart from the *SMP Counselor Training Manual*, which explains how to make the distinction between simple inquiries, one-on-one counseling sessions, and complex issues, is in Appendix A.

### Q & A After Group Education Sessions

Another major function of the SMP is to provide group education sessions about preventing, detecting, and reporting Medicare and Medicaid fraud, error, and abuse. It is quite common for participants to bring up examples of problems they have heard about or experienced during these group education sessions. Question-and-answer periods that are part of a group education session are not considered the management of complex issues. When a potential problem is raised during a group session, it is the role of the presenter to make sure someone can follow up with the participant later to manage the complex issue.



This final example raises an important point: Though handling simple inquiries, conducting one-on-one counseling, or answering questions as part of a presentation to a group are all considered to be separate activities from managing complex issues, these activities may result in the identification of complex issues that will be addressed separately by a trained SMP staff member or volunteer.

## What is Not an SMP Issue?

Just as not all complaints or time-consuming interactions are SMP complex issues, situations may present themselves that are complex by nature but are not within the primary scope of SMP work. Let's review the SMP program intended clientele and mission.

### Who does the SMP program serve?

Medicare beneficiaries, their families, and caregivers

### What does the SMP program do?

Empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education

For more information, review the SMP Counselor Manual, Chapter 1, and also the flow chart in Appendix A. Following are issues that may be brought to the SMP's attention but are not considered within the primary scope of the SMP program to manage at the level of a complex issue.

## Benefits Counseling

Helping beneficiaries choose the right Medicare plan during enrollment periods is the function of the State Health Insurance Information Program (SHIP). It can certainly be a complex task (and time consuming!), but this activity would not be considered SMP work and thus not an SMP complex issue. See the "Medicare Benefits Complaints" section in Chapter 5 for information on how to contact your state's SHIP program.

## Quality of Care Complaints

Though we are naturally concerned about reports of poor quality of care and these reports certainly need to be addressed, it is not the role of the SMP to manage such complaints. Quality-of-care complaints should be addressed by the government agency that has oversight over the provider or service in question. Quality of care may be an additional concern for someone complaining about fraud, error, or abuse, but if the complaint is solely about quality of care, the person should be directed to contact the appropriate organization with the authority to respond. See Chapter 5 for more information on organizations that receive quality-of-care complaints.

*What is Not an SMP Issue, continued*

## Medicare Appeals

Some beneficiaries served by the SMP may need to file an appeal as a result of a denied claim. Like quality-of-care concerns, the need to appeal a claim may occur in addition to a complaint of fraud, error, or abuse. The SMP role is to explain to the beneficiary or caregiver where they can learn more about the appeals process. It is not the SMP role to actually manage the appeal. For more detailed information about how appeals questions may come up in the course of conducting SMP work, see Chapters 2 and 5.

## Information and Assistance

There will be other examples in addition to the three outlined above where beneficiaries are experiencing overlapping problems – some within the scope of SMP work and some not. The Eldercare Locator, a service of the U.S. Administration on Aging, provides national Information & Assistance services. Most states also have Aging & Disability Resource Centers that can provide statewide Information and Assistance service.

- Visit the Eldercare Locator, [www.elderlocator.gov](http://www.elderlocator.gov), or 1-800-677-1116.
- For more information about ADRCs, visit AoA's website, [www.aoa.gov](http://www.aoa.gov).

### Key Concept

To be considered an SMP complex issue; there must be a complaint of potential health care fraud, error, or abuse or an associated consumer protection concern that needs further research, SMP follow-up, and often even the intervention of a government organization.



# SMP Complex Issues and Referrals Training Manual

## CHAPTER 2: When You Suspect Medicare Error

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## Overview

The first crucial step in responding to a complaint from a beneficiary is determining whether or not the problem is an innocent error. You may not always know, but it is important to remember that proving fraud requires the legal process (“innocent until proven guilty”). It is also important to consider the patient/provider relationship and, when possible, to give the provider the benefit of the doubt. Medicare is complicated, and what may seem like an error to the beneficiary may simply be the result of a misunderstanding about their benefits.

This is where knowledge of Medicare coverage is essential. You will need to review Chapter 2 of the SMP Foundations manual and, if necessary, seek assistance from Medicare coverage experts (such as your SHIP or 1-800-Medicare) to determine if the bill or statement is correct according to Medicare coverage guidelines. It is also recommended that you become familiar with the [Medicare & You handbook](#), published by the Centers for Medicare & Medicaid Services (CMS) each year.

## Gathering Enough Information

The complex issues form within SMART FACTS is designed to guide you through the interview process with the complainant, who may be a beneficiary, a caregiver, or other complainant. Instructions in the use of this form are provided in the SMART FACTS manual and recorded training, all available at [www.smpresource.org](http://www.smpresource.org). To summarize, there is a lot of information to collect from the complainant about confusing or suspicious charges appearing on the Medicare Summary Notice, Explanation of Benefits, or a bill from the provider for their co-pay or deductible. Start by gathering the following information, at a minimum:

- Beneficiary and/or Complainant Information
  - Start with the basics: name, Medicare number, and contact information (including mailing address). The more complicated the case, the more information you will need.
  - Your SMP may have additional intake guidelines governing the amount and type of information you must request from a complainant.
- Type of Service
  - Ask what type of service has been billed and is being questioned



### *Gathering Enough Information, continued*

- Type of Coverage
  - Ask whether this beneficiary has Original Medicare (Part A and B) or is enrolled in a Medicare Advantage Plan (Part C). If the service is a prescription drug, determine whether or not the beneficiary has Part D coverage.
  - Is the beneficiary dually enrolled in Medicare and Medicaid?
  - Do they have a Medicare Supplement (Medigap)?
- Service Provider Information
  - Who is the provider?
  - Does the provider participate in Medicare?
  - Does the provider accept assignment?
  - Has the complainant contacted the provider and voiced their concerns directly?
    - If the answer is “yes,” find out how the provider responded
    - If the answer is “no,” ask why
- Appeal Status
  - Find out if an appeal has already been filed, and if so, ask what the complainant knows about the status of the appeal
- Advance Beneficiary Notice (ABN)
  - This 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 Page 14 for more information on ABNs)
    - Did the beneficiary sign one of these?
    - If so, was it blank?

### **Determine Who Will Take the Next Step**

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. The SMP is not expected to manage the resolution of every suspected error on health care statements when beneficiaries are capable of taking basic preliminary steps on their own behalf. SMPs are expected to work with a beneficiary or other complainant to the best of their ability in order to resolve an issue. Some complainants may simply 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 request the SMP to make contacts on their behalf.

### *Gathering Enough Information, Determine Who Will Take the Next Step, continued*

Some good rules of thumb to follow are these:

- ✓ If innocent error is suspected, counsel the complainant to contact the health care provider, 1-800-Medicare, and/or their Medicare Plan to work it out. Ask them to call you back if the response is inadequate.
- ✓ An inadequate response from a health care provider or Medicare Plan may point to a pattern, leading to suspected abuse or fraud.
- ✓ If the complaint is part of a pattern being seen by your SMP or the national SMP network, you will usually become involved from the beginning. It may look like an error when considered individually, but when understood in the context of the larger health care environment, can become an instance of suspected abuse or fraud. One common example is the shipment of unnecessary diabetes supplies or “arthritis kits.”

### **Release of Information?**

If you need to contact a beneficiary’s health care provider on his or her behalf, keep in mind that the provider may request a release of information. However, releases of information are not required to make a referral of suspected fraud or abuse. **It is important to tell the complainant that they may be contacted by a CMS or law enforcement representative if their complaint leads to an investigation of suspected fraud.** The SMP program does not investigate suspected fraud and abuse, but it does forward such complaints to the proper authorities.

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 and have them sign the release of information.

### **Proper Handling of Sensitive Information**

If you will be handling a beneficiary’s sensitive, personal identifying information or other confidential information, keep in mind the privacy recommendations within 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 also. 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. In addition, you should check with your agency and follow any internal information handling policies.

## Working Directly with Providers

If the complainant did not contact the provider directly, encourage them to do so and get back to you. If they are unwilling or unable to contact the provider, offer to make that contact on their behalf. A responsive provider will work with beneficiary or caregiver to correct errors or better explain their charges.

Checklist for working with providers:

- ✓ Is it a billing error that the provider can correct with Medicare, another payer, or the beneficiary?
  - If so, attempt to resolve at the provider level.
  - If your attempts fail, take further action, as described later in this manual.
- ✓ Has the beneficiary already been sent to collections?
  - If so, review the section about collections in this chapter and proceed accordingly.
- ✓ Is the provider unwilling to bill Medicare for a covered service or to bill according to Medicare rules?
  - If so, proceed to the referrals process (Chapter 3). Providers are required to comply with the Medicare Participating Physician or Supplier Agreement. If they do not, this can be reported as suspected fraud or abuse.
- ✓ Does the provider's behavior seem particularly egregious and far outside the realm of possible error?
  - If so, seek outside guidance first, rather than contacting the provider.
    - Review the subsequent chapters of this manual to learn who you should contact, depending upon the situation.
- ✓ Have you received other complaints of errors about this provider?
  - If so, there may be an abusive pattern, not an accidental error
    - Review the subsequent chapters of this manual for guidance about how to refer the complaint to an outside agency.



## Working Directly with Medicare

Sometimes the beneficiary lacks the full picture about a claim made on their behalf to Medicare. For example, perhaps the beneficiary has received a bill for a co-payment from their provider, which generated their concern, but has not yet received a Medicare Summary Notice (if they are in Original Medicare) or Explanation of Benefits (if they have Part C or Part D) explaining the portion billed to Medicare. As you know, the vast majority of Medicare Summary Notices are sent quarterly. However in some high-fraud areas, The Centers for Medicare & Medicaid Services (CMS) provide them monthly. Part C and Part D recipients receive Explanations of Benefits (EOBs) in varying intervals, depending upon the plan.

### SMP Unique ID with 1-800-Medicare

1-800-Medicare can provide claims information for beneficiaries enrolled in Original Medicare. If the beneficiary is unable or unwilling to contact 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, your SMP Unique ID will enable you to gather the necessary information about the beneficiary's benefits and recent claims information on their behalf. You are not required to obtain a release of information to speak with 1-800-Medicare using your SMP Unique ID. Instructions for using your SMP Unique ID with 1-800-Medicare are found in Appendix B. You will notice that use of this ID is restricted to approved SMP staff and volunteers who manage SMP complex issues. SMP Unique ID Users are selected by the SMP director.

### MyMedicare.gov

Use of MyMedicare.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, language barriers, etc. Sometimes a beneficiary or caregiver will authorize an SMP staff member or volunteer to access MyMedicare.gov on behalf of a beneficiary. However, there are ethical and logistical concerns that pose barriers for the SMP program. Because of this, using the SMP Unique ID is a better solution for researching complex issues brought to the SMP.

### Private Medicare Plans

When beneficiaries are enrolled in private Medicare plans (Part C and/or Part D), requests for claims information should be made directly to their plan.

## Following Up With the Complainant

All of this information gathering will take time, often requiring many phone calls. There are multiple avenues available to beneficiaries who come forward with Medicare complaints. The information you gather will help you determine the next step, including whether or not to make a referral of suspected fraud or abuse. Complaints are often multi-faceted, requiring more than one course of action. Some actions will be taken directly by you, if they are within the mission of the SMP program (see Chapter 1), whereas other actions will be taken by the beneficiary, the provider, or another organization, if they are outside of the SMP mission.

As you learned in Chapter 1, SMPs act as **complaint managers**, in addition to referring suspected fraud, error, and abuse. In this role, SMPs help beneficiaries navigate the Medicare system, make use of other available service organizations, and help them understand and resolve the personal consequences that arise as a result of billing errors.



## Appeals

Complex issues involving potential error may involve a claim denied by Medicare. Upon review, you or the beneficiary may disagree with Medicare's decision.

Keep in mind the following considerations:

1. Follow up with the provider to make sure the claim made to Medicare correctly reflects the service provided (you or the beneficiary can take this step, depending upon the beneficiary's capacity).
2. If payment for charges submitted to Medicare were denied, the beneficiary has the right to appeal.
3. The appeals process is explained to beneficiaries on their MSN, if they are in Original Medicare. Beneficiaries in Part C or Part D can obtain appeals information from their plan. For more information on the appeals process, visit <http://www.medicare.gov>.
4. Filing appeals is 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 State Health Insurance Assistance Programs (SHIPs) and legal services providers are considered the primary experts and client advocates regarding the appeals process.
  - To find the SHIP in your state, visit the SHIP Resource Center website, [www.shiptalk.org](http://www.shiptalk.org).
  - To find the legal services provider in your state, visit the National Legal Resource Center's website: <http://www.nlrc.aoa.gov>.

*Following Up With the Complainant, Appeals, continued*

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

### **Coordination of Benefits Contractor**

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. The beneficiary may have forgotten to notify Medicare about their other coverage or there may have been a mistake made at some level within the Medicare claims processing system. This can result in either duplicate payments by Medicare or denial of payment.

If a beneficiary has other health coverage besides Medicare, and many do, CMS' Coordination of Benefits (COB) Contractor may need to be contacted, either by the beneficiary, their caregiver, or the SMP complex issues and referrals representative. The COB contractor determines who should pay the claim first, Medicare or another payer, such as

- Medicaid
- Veterans Benefits
- Group Health Plan
- No-Fault or Liability insurance
- Workers Compensation
- COBRA
- Etc.

CMS states that the "purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries" ([www.cms.gov](http://www.cms.gov) > Medicare > COB - General Information).

#### **To Contact the COB:**

- Call 1-800-999-1118
- TTY users should call 1-800-318-8782
- Have the following available:
  - Medicare number
  - Address
  - Medicare effective date(s)
  - Social Security Number (or other piece of identifying information)
  - Whether the beneficiary has Medicare Part A and/or Part B coverage

*Following Up With the Complainant, continued*

## **Advance Beneficiary Notice (ABN)**

As mentioned earlier, an ABN is a notice that a provider or supplier may have asked a beneficiary with Original Medicare to sign, stating that Medicare may not pay for certain services. It provides the beneficiary an opportunity to choose whether or not to accept services that may not be covered by Medicare. In determining the appropriateness of charges to a beneficiary, you need to know if they signed an ABN. The ABN explains to beneficiaries that they will have to pay if Medicare doesn't.

There are many rules governing the use of ABNs. When the situation involves error or misunderstanding of Medicare rules, it can often be resolved at the beneficiary/provider level, with SMP intervention, if needed. SMPs and beneficiaries should understand the following key points if a beneficiary has signed a legitimate ABN:

- ✓ The beneficiary may be responsible for all or part of the entire claim.
- ✓ If the beneficiary checks (on the ABN) that they want the service, the particular option they select is important. Beneficiaries must select from three options on the ABN which convey the following concepts:
  - a. Beneficiary accepts the service, but DOES want the provider to bill Medicare
  - b. Beneficiary accepts the service and does NOT want the provider to bill Medicare
  - c. Beneficiary declines the service altogether.
- ✓ When a beneficiary signs an ABN, accepting service, the provider is allowed to immediately begin collecting payment and can even request payment up front.
- ✓ If Medicare ultimately covers all or part of the charges, the beneficiary is owed a timely refund for the portion they had already paid after signing the ABN.
- ✓ Review the [Medicare & You handbook](#) and CMS online resources for more information about ABNs.

### **Key Concept**

Suspected fraud regarding the use of ABNs and how to refer such cases is covered in Chapter 3. See the section on Provider Fraud and Abuse and the Civil Monetary Penalties Law.

*Following Up With the Complainant, continued*

### **When Beneficiaries Face Collections**

When claims are denied or disputed, it is possible beneficiaries may be sent to collections if they are unwilling or unable to pay the associated out of pocket expenses. It is not expected or desired that the SMP assist the beneficiary with the details of the collections process, but it is useful to know some basic information in order to answer their questions about suggested next steps and available resources.

You can suggest that the beneficiary contact the provider, or get the beneficiary's 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 that doesn't work, and the beneficiary is still sent to collections, they 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; for example, when the beneficiary had never seen that provider or when a provider is billing for a specific 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 they are 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 (see Chapter 1). Depending upon the nature of your agency, it may be most appropriate to have them talk with someone else in your agency whose area of expertise is connecting clients with other services or service organizations.

### **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](http://www.nclc.org) (click on “Issues,” then “Debt Collection”).

## Documenting Results

Your SMP program should get credit for the cost avoidances, savings to the beneficiary, and recoveries to Medicare, Medicaid, or a Medigap plan that result from your interventions. As described in Chapter 1 of SMP Foundations, SMPs report their outcomes every year to the HHS Office of Inspector General (OIG), Office of Evaluation and Inspections. SMART FACTS is the reporting mechanism. The OIG report of SMP outcomes is published every year and is reviewed by Congress and HHS leadership.



The ability to get credit for cost avoidances, savings, and recoveries is one way to ensure the continued support of Congress for the SMP program. This will require that you obtain documentation. Often, the beneficiary is your only source of this information, so please work with them to gather the necessary documentation and post it in SMART FACTS. Just as the beneficiary provided you with a copy of the documents showing the original error, inform them that they will also need to provide you with documentation showing corrections or reimbursements. This allows you to 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.

### Key Concept

**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.

**Follow the national SMP policies** for the safe, confidential, and secure transport and storage of documents. You can ask your SMP director or coordinator of volunteers for guidance.

**The SMP Resource Center** provides training and resources explaining the type of documentation required to prove savings and recoveries. Information is available on the "OIG Reports" page of [www.smpresource.org](http://www.smpresource.org), in the SMART FACTS manual, and in Chapter 3 of this manual.

## Recommended Resources

### Publications

- Appendix of this Manual
- [SMP Foundations manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org)
- [SMART FACTS manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org)
- [Medicare & You Handbook](#): Call 1-800-Medicare or visit [www.mymedicare.gov](http://www.mymedicare.gov) to order a new copy each year.
- [Medicare and Other Health Benefits: Your Guide to Who Pays First](#) (CMS)

### Online Resources

- SMP Resource Center: [SMART FACTS training](#)
- Administration for Community Living, Administration on Aging, [SMP Volunteer Risk and Program Management Policies](#) (Information Technology).
- CMS: [www.mymedicare.gov](http://www.mymedicare.gov)
- SMP Resource Center: [www.smpresource.org](http://www.smpresource.org)
- CMS: [Advance Beneficiary Notice of Noncoverage](#) booklet
- Center for Medicare Advocacy: [www.medicareadvocacy.org](http://www.medicareadvocacy.org)
- [National Consumer Law Center](#): Click on “Issues,” then “Debt Collection”





## **SMP Complex Issues and Referrals Training Manual**

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## Suspected Fraud or Abuse?

It is important to remember that complex issues received by SMPs should be considered *suspected* fraud or abuse. It will take an investigation by the appropriate entities to make a legal determination.

This chapter will provide you with more in depth knowledge of health care fraud and abuse – the definitions, laws, examples, and investigative entities – and, if your research rules out error or if the complaint was not resolvable at the provider level, you will learn how to refer the complaint as suspected health care fraud or abuse to the proper entities for further investigation.

### Medicare Fraud Defined

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

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

### Medicare Abuse Defined

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

Medicare abuse is further defined as incidents or practices by providers that are inconsistent with accepted sound medical, business, or fiscal practices. These practices may directly or indirectly result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care or that are medically unnecessary.

CMS further defines abuse as “billing Medicare for services that are not covered or are not correctly coded.”

*Suspected Fraud or Abuse, continued*

### Intentionality

SMPs aren't often in the position to determine "intentionality," which is a significant dividing line between fraud and abuse. Fraud assumes "criminal intent." The determination of intentionality will be made by the investigative entities who receive SMP referrals. It is still important to know the differences, since both terms are commonly used. The response of investigative entities and the consequences for providers are based upon the determination they make regarding the provider's intentions. Also, SMP referrals protocols are based upon an SMP deciding whether or not a case is suspected fraud or suspected abuse.

### Patterns of "Error" can be Fraud or Abuse

A pattern of error by a particular provider 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. If a pattern does emerge, however, a referral should be made for further investigation. Following up with the provider regarding each individual error may not address the underlying problem. SMPs are not in a position to address underlying problems at the provider level but the investigative entities who receive your referral are in that position. They may determine that the matter can be addressed through provider education, or, based on the investigative tools at their disposal; they may make a determination of fraud or abuse and take corrective action, legal action, or prosecute.

### SMP Referrals Partnerships

The Administration for Community Living (ACL), Administration on Aging (AoA) and the SMP Resource Center have worked to develop and maintain national referrals partnerships with both CMS and the Office of Inspector General (OIG) hotline. SMPs also maintain these partnerships by referring suspected fraud and abuse, following the guidelines ACL has arranged with these national partners. Many SMPs have also developed successful partnerships with their state or regional CMS and OIG offices.

**NOTE:** *Though state and regional partnerships are outside the scope of this manual, they have proven to be very helpful for those SMPs with such partnerships, not only for referrals but as a source of education and technical assistance.*

### Centers for Medicare & Medicaid Services (CMS)

ACL and CMS have worked to establish a formal relationship between SMPs and CMS. Though beneficiaries can also report suspected fraud and abuse to CMS using 1-800-Medicare or to the Office of Inspector General using 1-800-HHS-TIPS, some beneficiaries will still turn to the SMP. Not all beneficiaries will be able to use the other complaint mechanisms effectively and may even be referred to the SMP by 1-800-Medicare. For example, 1-800-Medicare may think the beneficiary would benefit from SMP program assistance in further developing and referring their complaint. SMPs have the knowledge necessary to prepare a high-quality referral. Also, beneficiaries may need the SMP program's help in connecting with needed community resources.

The SMP program has national referrals partnership with these CMS entities:

- **1-800-Medicare**

SMPs representatives who manage complex issues and referrals have access to an SMP Unique ID with 1-800-Medicare. Using this Unique ID, SMPs refer suspected Medicare Part A and B **abuse** to 1-800-Medicare.

- **The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)**

SMPs refer suspected Medicare Part C and D **services abuse** to the NBI MEDIC, which we will shorten to simply "MEDIC" in remaining references. The MEDIC receives SMP referrals via SMART FACTS.

- **CMS Regional Office (RO) Department of Insurance (DOI) Liaisons**

SMPs refer suspected Part C and Part D marketing violations to CMS regional offices. Part C and Part D marketing violations are addressed in the following chapter.

### OIG Hotline

Under the guidance of ACL, the SMP network entered into a partnership with the OIG Hotline in May 2011. Under this partnership, which has now expanded from a pilot project to a nationwide system, SMPs refer suspected Medicare **fraud** (but not abuse) to the Office of Inspector General (OIG) Hotline. All referrals for the OIG Hotline are routed to the OIG by ACL headquarters. This process involves law enforcement (the OIG) as soon as possible once the SMP has learned about a case of suspected fraud. In addition, the OIG Hotline is tracking Senior Medicare Patrol as a distinct referral source. The 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."

*SMP Referrals Partnerships, OIG Hotline, continued*

## Key Concept

The appendices provide a **flow chart** overview of SMP Referrals protocols (Appendix D).

The SMART FACTS manual, Chapters 5 and 6, explain how to enter complex issues and referrals into SMART FACTS.

### **CMS or the OIG (via ACL): How Do I Decide?**

CMS is concerned about both fraud and abuse in the Medicare system. However, when abuse is determined and administrative action is needed to address it, such as an order to return funds to Medicare, re-education, or a warning, CMS takes that action. When CMS suspects fraud and/or criminal intent, they will turn cases over to the OIG and other law enforcement entities.

The OIG is concerned primarily with fraud and criminal activity in the Medicare system. When legal action involving the justice system is needed, the OIG will become involved, working with other law enforcement entities, as needed. When the OIG suspects error or abuse, they will turn cases over to CMS.

When in doubt, make a referral of suspected fraud to the OIG, via ACL. **SMPs should refer cases to CMS OR the OIG, not to both entities.** This is a change from previous years to eliminate duplicate referrals. Since the OIG and CMS collaborate to address the problem of health care fraud, they have mechanisms in place for referring cases to each other. If the OIG needs more information on a case of suspected fraud or if they choose not to open a case they will turn it over to CMS.

## Key Concept

Not sure if a complaint is suspected fraud or suspected abuse? When in doubt, refer it to the OIG Hotline, via ACL.

See Appendix C for instructions on how to make a referral to the OIG.

## Fraud and Abuse: Laws and Examples

Chapter 3 of SMP Foundations described basic fraud and abuse and provided many examples. Here, we will go into even greater depth to supplement what you already know and to assist you in making the appropriate referrals decisions. The information in this section about fraud and abuse laws was based on the Office of Inspector General publication “[A Roadmap for New Physicians; Avoiding Medicare and Medicaid Fraud.](#)”

### Provider Fraud and Abuse

As explained in the OIG’s “A Roadmap for New Physicians; Avoiding Medicare and Medicaid Fraud:”

“Most physicians strive to work ethically, render high-quality medical care to their patients, and submit proper claims for payment. Society places enormous trust in physicians, and rightly so. Trust is at the core of the physician-patient relationship. When our health is at its most vulnerable, we rely on physicians to use their expert medical training to put us on the road to a healthy recovery.

The Federal Government also places enormous trust in physicians. Medicare, Medicaid, and other Federal health care programs rely on physicians’ medical judgment to treat beneficiaries with appropriate services. When reimbursing physicians and hospitals for services provided to program beneficiaries, the Federal Government relies on physicians to submit accurate and truthful claims information.”



Experience has shown, however, that some fraud and abuse is perpetrated by unethical health care service providers (not just imposters, beneficiaries, or insurance companies).

There are five major fraud and abuse laws that apply to providers:

- False Claims Act
- Exclusion Statute
- Anti-Kickback Statute (AKS)
- Civil Monetary Penalties Law
- Physician Self-Referral Law

### False Claims Act

Under the False Claims Act, it is illegal to submit claims for payment to Medicare or Medicaid that the provider knows or should know to be false or fraudulent.

- Incorrect reporting of diagnoses to maximize payments
  - Example: 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 6-months-or-less life expectancy.
- Incorrect reporting of procedures to maximize payments, such as “upcoding”
  - Example: 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 bill 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
  - Includes billing Medicare for appointments that a patient failed to keep.
- 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.
- Altering claims forms, electronic claims records, medical documentation, etc., to obtain a higher payment amount



### *Fraud and Abuse: Laws and Examples, Provider Fraud and Abuse, continued*

- 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 based on “gang visits”
  - Example: A physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients.
- Billing non-covered or non-chargeable services as covered items
  - For example, 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 not medically necessary
- 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
  - See Exclusion Statute below.



### **To whom should you refer False Claims Act violations?**

CMS?

- ✓ **Yes** If **Abuse** is suspected (violation was not knowing or intentional)
- ✓ **No**, if you suspect fraud

OIG Hotline (via ACL)?

- ✓ **Yes**, if you suspect **fraud**
- ✓ **No**, if you suspect abuse

Not sure?

- ✓ OIG Hotline (via ACL)

*Fraud and Abuse: Laws and Examples, Provider Fraud and Abuse, continued*

### Exclusion Statute

The 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.

According to the OIG, individuals and entities will be excluded for the two following categories of crimes:

- **“Mandatory** exclusions: ...for the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, ...State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.
- **Permissive** exclusions: ...misdemeanor convictions related to health care fraud...the unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; engaging in unlawful kickback arrangements; and defaulting on health education loan or scholarship obligations; and controlling a sanctioned entity as an owner, officer, or managing employee.”

The OIG maintains an online database of excluded providers. Visit [www.oig.hhs.gov](http://www.oig.hhs.gov) and select “Exclusions.” If a complaint involves a provider on the excluded list, refer the case to the OIG.

#### To whom should you refer Exclusion Statute violations?

CMS?

✓ **No**

OIG Hotline, via ACL?

✓ **Yes**

*Fraud and Abuse: Laws and Examples, Provider Fraud and Abuse, continued*

### Anti-Kickback Statute (AKS)

In some industries, it is acceptable to reward those who refer business to you. However, in federal health care programs, paying for referrals is a crime. You may remember learning about kickbacks in Chapter 3 of SMP Foundations.

The statute covers the payers of kickbacks (those who offer or pay remuneration) as well as the recipients of kickbacks (those who solicit or receive remuneration). Each party's intent is a key element of their liability under the AKS. Examples include:

- Soliciting, offering, or receiving a kickback, bribe, or rebate
  - Paying for referral of patients
    - Such as in exchange for ordering diagnostic tests and other services.
    - Such as 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. According to the OIG's Roadmap for New Physicians, “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 or Medicaid patients for utilizing the provider's business.
  - Routinely waiving co-pays.
    - Waiving co-pays cannot be advertised, done routinely or used as an inducement.

**NOTE:** *Physicians may waive co-pays 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.*



*Fraud and Abuse: Laws and Examples, Provider Fraud and Abuse, continued*

### To whom should you refer Anti-Kickback Statute violations?

CMS?

- ✓ **Yes** If **Abuse** is suspected (violation was not knowing or intentional)
- ✓ **No**, if you suspect fraud

OIG Hotline, via ACL?

- ✓ **Yes**, if you suspect **fraud**
- ✓ **No**, if you suspect abuse

Not sure?

- ✓ OIG Hotline, via ACL

### Civil Monetary Penalties Law

There are other ethical violations for which the OIG may seek penalties, authorized by the Civil Monetary Penalties Law, which should be referred. Examples of violations to the Civil Monetary Penalties Law that SMPs might hear about include the following:

- 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.
- Violating the [Medicare Participating Physician or Supplier Agreement](#) (CMS Publication 460):
  - As explained in Chapter 2 of SMP Foundations, Physicians and Suppliers who accept **assignment** can only charge the Medicare approved amount for the services they provide beneficiaries. Physicians or Suppliers who do not accept assignment can charge up to 15% above Medicare's approved amount.
    - Participating Physicians and Suppliers are thus required to bill Medicare for services and to bill according to the terms of their agreement. If they do not, it is fraud or abuse.  
**NOTE:** *This rule does not apply to Physicians or Suppliers who have **opted out** of Medicare.*
  - Physicians should not have beneficiaries sign blank ABNs (ABNs were also discussed in Chapter 2 of this manual).

### *Fraud and Abuse: Laws and Examples, Provider Fraud and Abuse, continued*

- Violating the durable medical equipment (DME) supplier marketing guidelines, which prohibit unsolicited direct contact with beneficiaries. Marketing of Medicare-covered items can only take place under one or more of the following three circumstances:
  - The beneficiary has given written permission to be contacted.
  - The supplier is contacting the beneficiary about an item already provided.
  - The supplier has furnished one Medicare-covered item within the previous 15 months.
- Providing false or misleading information
- Misrepresentations regarding:
  - Dates and/or descriptions of services furnished.
  - Identity of beneficiary.
  - Identity of individual who furnished services (for example, using another prescriber's Drug Enforcement Agency (DEA) number or prescription pad).
- Script mills
  - Prescriptions written that are not medically necessary, often in mass quantities, and often for individuals that are not patients of a provider.
- Prescribing based on illegal inducements rather than the clinical needs of the patient.
- Medical identity theft: stealing a beneficiary's personal information (name, Social Security number, or Medicare number) to obtain medical care, buy drugs, or submit fake billings to Medicare.

### **To whom should you refer Civil Monetary Penalty violations?**

CMS?

- ✓ **Yes** If **Abuse** is suspected (violation was not knowing or intentional)
- ✓ **No**, if you suspect fraud

OIG Hotline, via ACL?

- ✓ **Yes**, if you suspect **fraud**
- ✓ **No**, if you suspect abuse

Not sure?

- ✓ OIG Hotline, via ACL

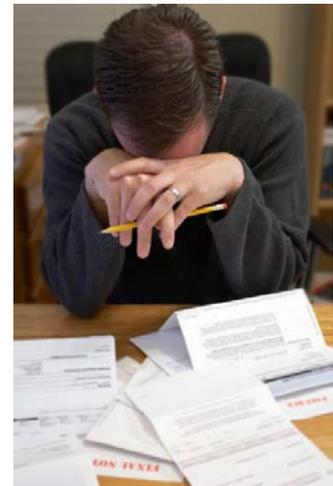
*Fraud and Abuse: Laws and Examples, Provider Fraud and Abuse, continued*

### Physician Self-Referral Law (Stark Law)

According to the OIG, “The Physician Self-Referral Law, commonly referred to as the ‘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.”

For example, it is a Stark Law violation when a physician refers a patient to one of the following services despite having a financial relationship with the designated service:

- Clinical laboratory services
- Physical therapy, occupational therapy, and outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment (DME) and supplies
- Parenteral nutrients (through the veins), enteral nutrients (through a tube), and their associated equipment and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services



Stark violations are not very transparent and will be difficult for beneficiaries or SMPs to detect. There are also “safe harbors,” allowing some types of financial relationships, so it even requires a lot of research on the part of the OIG to determine if there’s a violation. However, if you or a complainant suspects a Stark Law violation, it should always be referred for further investigation.

#### To whom should you refer Stark Law violations?

CMS?

✓ **No**

OIG Hotline, via ACL?

✓ **Yes**

## Fraud and Abuse by Pharmacies

The following examples of fraud and abuse are relevant to pharmacists, who must also abide by the same laws outlined above that apply to providers. Refer the following violations conducted by retail, mail order, and long-term care pharmacies:

- Prescription Issues
  - Prescription drug switching; not only is switching medications for financial gain unethical and dangerous, it is fraudulent.
  - 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.
  - Dispensing a generic drug but charging the beneficiary for a brand-name drug.
- 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



*Fraud and Abuse: Laws and Examples, Fraud and Abuse by Pharmacies, continued*

- Inappropriate billing practices
  - Billing for brand names when generics are dispensed.
  - Billing for covered drugs when non-covered drugs are dispensed.
  - Billing for non-existent prescriptions.
  - Billing for prescriptions that are never picked up.
  - Charging the retail price rather than the negotiated price.
  - Bait-and-switch pricing: 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.*

### To whom should you refer complaints about Pharmacists?

CMS?

- ✓ **Yes** if **Abuse** is suspected (violation was not knowing or intentional)
- ✓ **No**, if you suspect fraud

OIG Hotline, via ACL?

- ✓ **Yes**, if you suspect **fraud**
- ✓ **No**, if you suspect abuse

Not sure?

- ✓ OIG Hotline, via ACL

### Fraud and Abuse by Plan Sponsors and Benefit Managers

Plan sponsors and benefit managers must also abide by the same laws outlined above that apply to providers. Below are examples of suspected fraud or abuse by Plan Sponsors and Benefit Managers.

- Inappropriate enrollment/disenrollment
  - For example, enrolling beneficiaries who do not meet criteria into a Special Needs Plan (SNP).
    - (Motivation? To artificially inflate a plan's risk score.)

*Fraud and Abuse: Laws and Examples, Fraud and Abuse by Plan Sponsors and Benefit Managers, continued*

- Disenrolling chronically ill beneficiaries.
  - (Motivation? They are costing the plan so much in benefits that the cost doesn't outweigh the payback on the beneficiaries' increased risk scores.)
- Inaccurate data submission – for example, falsifying information in order to justify coverage.
- Adverse selection (also known as “Cherry Picking”)
  - Selecting or denying beneficiaries based on their illness profile or other discriminating factors, such as:
    - Retaining only healthy members.
    - Excluding beneficiaries with certain profiles.
- Inappropriate formulary decisions
  - Making decisions on which costs take priority over criteria such as clinical efficacy and appropriateness.
  - Inappropriate relationships with formulary committee members in order to have a manufacturer's products included on a plan's formulary.
- Fictitious employees or members
- Payments for deceased members
- Denial of necessary covered medical care
- Bonus pools or withholding fees based on service utilization
  - Bonus pools are when a plan offers bonuses to providers if their beneficiaries do not use a lot of services.
  - Withholding fees is the opposite of a bonus pool: It is when a plan withholds payment to providers who make necessary referrals, thus costing the plan more money because of increased service utilization.
- Misrepresentation of the plan's:
  - Physician-to-patient ratio
  - Physician qualifications



*Fraud and Abuse: Laws and Examples, Fraud and Abuse by Plan Sponsors and Benefit Managers, continued*

- Misrepresentation of the plan's:
  - Access to care
  - Service area
  - Providers available
- Inappropriate financial incentives paid to facilities or beneficiaries to obtain enrollments
  - Financial incentives for steering a beneficiary toward a certain plan or drug, or for formulary placement.

### To whom should you refer complaint about Plan Sponsors and Benefit Managers?

CMS?

✓ **Yes.**

- The MEDIC addresses suspected Plan Sponsor and Benefit Manager fraud and abuse
  - **Note:** The CMS Regional Office Department of Insurance Liaisons address Part C and Part D marketing violations (see Chapter 4)

OIG Hotline, via ACL?

- ✓ **No**, if you suspect fraud
- ✓ **No**, if you suspect abuse

### Beneficiary Participation in Fraud

It is fraudulent for beneficiaries to collude with providers (or scam artists posing as providers) to falsely bill Medicare and it needs to be referred. Such beneficiaries are unlikely to contact the SMP, however. SMPs are more likely, however, to be contacted by or hear about beneficiaries who are unaware of the federal health care fraud and abuse laws and are unknowingly participating in a scheme. The role of the SMP to conduct outreach and education is critical in both preventing and detecting fraud that involves the participation of a beneficiary.

Beneficiaries should be made aware that participating in schemes to defraud Medicare is illegal, if they aren't already aware. Remind them: *"If it sounds too good to be true, it probably is!"* Many beneficiaries educated this way by SMPs have been instrumental in identifying fraud schemes.

*Fraud and Abuse: Laws and Examples, Beneficiary Participation in Fraud, continued*

Examples of beneficiary participation in fraud include:

- Using another person's Medicare card to obtain medical care (medical identity theft in addition to Medicare fraud)
- Accepting money, gifts, or services in exchange for their Medicare number
  - "Cappers" (also known as "recruiters") will solicit beneficiaries for their Medicare numbers in exchange for cash, gifts, and "free" services, such as transportation.
  - Some beneficiaries have been known to act as cappers 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.



**To whom should you refer complaints about beneficiaries participating in fraud?**

Refer to CMS?

✓ **No**

OIG Hotline, via ACL?

✓ **Yes**

## Key Concept

Medicare numbers that have been misused are considered "compromised." They go on a list and subsequent health care claims using those numbers may be scrutinized before payment is made.

## Referrals and Follow-Up

### Use of SMART FACTS

SMP staff and volunteers who conduct referrals will need access to SMART FACTS. The use of SMART FACTS is integral to effectively managing SMP complex issues. The SMART FACTS manual was updated and provided in bulk quantities to SMPs in early 2013. Chapters 5 and 6 address complex issues and referrals. If you do not have a manual, contact your SMP project director to inquire. An electronic copy of the manual and other training materials are also available at [www.smpresource.org](http://www.smpresource.org). Go to the SMART FACTS training page.

### Continue Information Gathering

When you determine a referral is necessary, you may need to gather additional information. This will require more data entry, using the Complex Issues Form in SMART FACTS. It will also require that you obtain a signed Release of Information (ROI), if you haven't done so already, because you will be sharing sensitive, personal identifying information about a beneficiary with outside sources (review Chapter 2 for more information about ROIs). If the beneficiary wishes to be anonymous, you can still enter the case in SMART FACTS as a complex issue as long as the complaint itself qualifies as a complex issue. Though anonymous referrals are not as optimal for investigative entities, they may still be worthwhile if you have the name of the provider. Additionally, entering the complaint in SMART FACTS will allow you to document a pattern, if one should emerge.

In addition to the type of information explained in Chapter 2, the content of the complaint should:

- Contain all known information about the provider
- Be clear
- Avoid most acronyms (CMS, SMP, OIG, etc. are commonly understood, however.)
- Be non-judgmental
- Be factual
- Include supporting facts and available documentation, such as the Medicare Summary Notice (MSN), Explanation of Benefits (EOB), Plan Sponsor statements, notes from discussions with the complainant, provider, etc.



*Referrals and Follow-Up, continued*

### **CMS Response to SMP Referrals**

Upon receipt of referrals, CMS further develops the cases with the assistance of contractors. Their job is to ensure that Medicare Trust Fund dollars are not inappropriately paid out and that any mistaken payments are recouped. To accomplish this, they:

- Gather additional information from the complainant, if necessary
- Analyze Medicare claims data to identify patterns of fraudulent and abusive billing
- Review medical records
- Review and correct Medicare claims
- Refer selected cases to federal law enforcement or other entities involved in Medicare fraud and abuse investigation, who can investigate and prosecute, if necessary

### **OIG Hotline Response to SMP Referrals**

Upon receipt of fraud referrals, the OIG Hotline reviews the information they have received to determine the best next steps. These next steps may include opening a case for further investigation, referring the case to OIG regional offices, and/or passing the complaint to CMS. Because of the nature of the OIG investigation process, the OIG cannot follow up with complainants on the status or the disposition of any case until it has been closed. This is done to protect the integrity of the investigation.

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 to disclose any information on the status of a case.



*Referrals and Follow-Up, continued*

### Appropriate Expectations

It can be months or years before a complaint is entirely resolved. 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. In addition, the SMP program may or may not be alerted to the final resolution, depending upon the entity responsible for that resolution and the SMP program's relationship to that entity. Make sure your complainant clearly understands the SMP role. 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.

### Documenting Results

Your referrals may result in recoveries to Medicare and also savings to beneficiaries. As described in Chapter 2 of this manual, SMPs report their outcomes every year to the HHS Office of Inspector General (OIG) through SMART FACTS. OIG then publishes the report, which is read by Congress and HHS leadership.



Getting credit on the OIG Report for recoveries and savings is dependent upon your ability to obtain documentation. Beneficiaries and caregivers are a primary source of information. Just as the beneficiary provided you with a copy of the documents showing the original error, they will need to provide you with documentation showing corrections or reimbursements.

ACL's partnership with the OIG Hotline may yield financial outcomes for the national SMP program in the coming years. This effort is currently underway, since the OIG Hotline is documenting the SMP program as a referral source in order to track SMP complaints from start to finish. At the writing of this manual, however, that effort is still in its early stages and SMPs must continue to seek documentation elsewhere, when available.

1-800-Medicare is not able to provide SMPs written verification of the outcomes of referrals. 1-800-Medicare is only able to provide verbal information about claims and changes to claims. Since 1-800-Medicare is not a source of documentation for SMP Outcomes 16 – 17D, that documentation will need to come from other sources, when available (such as beneficiaries). The MEDIC may provide SMPs with follow-up information, however, in response to complaints of Part C and Part D fraud. The MEDIC typically provides follow-up information within SMART FACTS and/or in a letter.

### *Documenting Results, continued*

Here are some examples of documentation that meet OIG Report standards:

- Copy of a cancelled check or a reimbursement check
- Corrected hospital billing statement
- Letter from provider or supplier, explaining the amount of the savings or recovery.
- Letter or other evidence from a CMS program integrity contractor, CMS claims processing contractor, or an investigative agency
- Statement within SMART FACTS by the MEDIC, explaining the outcome of the case, such as the identification of a specific overpayment.

### **Key Concept**

ACL understands that the value of the SMP program goes beyond the ability to document recoveries, savings, and cost avoidance. Documentation may be difficult or impossible to obtain. SMPs must also rely on outside entities to obtain this documentation, putting the ability to get credit for these monetary outcomes outside SMP control. The SMP program is, in large part, a prevention model and prevention is difficult to measure. However, when working with complex issues, it is still important to at least seek documentation. At the writing of this manual, the SMP program is still being partly measured on financial outcomes related to complex issues and referrals.

## Recommended Resources

### Publications

- Appendix of this Manual
- [SMP Foundations manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org).
- [SMART FACTS manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org).
- [Medicare & You Handbook](#): Call 1-800-Medicare or visit [www.mymedicare.gov](http://www.mymedicare.gov) to order a new copy each year.

*Recommended Resources, continued*

### Online Resources

- U.S. Department of Health and Human Services and U.S Department of Justice: [www.stopmedicarefraud.gov](http://www.stopmedicarefraud.gov)
- CMS: [www.mymedicare.gov](http://www.mymedicare.gov)
- OIG: [www.oig.hhs.gov](http://www.oig.hhs.gov)
  - OIG Fraud Alert: Telemarketing by Durable Medical Equipment Suppliers:  
<http://oig.hhs.gov/fraud/docs/alertsandbulletins/telemarketingdme.pdf>
- SMP Resource Center: [www.smpresource.org](http://www.smpresource.org)
  - [Complex Issues and Referrals Training](#)
  - [Fact Sheets](#)
  - [SMART FACTS training](#)



## **SMP Complex Issues and Referrals Training Manual**

### **CHAPTER 4: When You Suspect Part C or Part D Marketing Violations**

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## Overview

Unlike Medicare Part A and Part B (Original Medicare), Medicare Part C and Part D are administered, marketed, and sold by private insurance companies. CMS has developed guidelines for the marketing of Part C and Part D insurance. The purpose of these marketing guidelines is to protect Medicare beneficiaries from manipulative and deceptive sales and enrollment tactics. Marketing products and services is a natural and expected activity in the private sector. Because Medicare Part C and Part D are funded by the government, Medicare Part C and Part D marketing behavior is governed by federal rules (regulation or statute) to protect both the Medicare Trust Fund and Medicare beneficiaries.

## Know the Difference between Marketing and Education

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 more than 100 pages of guidance on the subject.

### CMS Definitions:

- **Education** is informing a beneficiary in an unbiased way about Original Medicare, Medicare Advantage plans, Part D plans, and Medicare Advantage plan products.
- **Marketing** is steering, or attempting to steer, a potential enrollee towards a plan or limited number of plans, or promoting a plan or a number of plans.

The way an event is conducted and advertised is crucial to determining whether or not a violation of the CMS marketing rules has occurred. Many activities allowed at marketing events are prohibited at education events. For example, though both types of events involve the provision of information in group settings, educational events must only be held in a public venue, whereas marketing events can also be held at an in-home or one-on-one setting.



*Know the Difference between Marketing and Education, continued*

In summary:

- **Education Events** are clearly advertised to beneficiaries as such. Educational events may be hosted either by the plan sponsor or by an outside entity and are held in a public venue. Educational events may not include any sales activities such as the distribution of marketing materials or the distribution or collection of plan applications.
- 
- **Marketing/Sales Events** are clearly advertised to beneficiaries as such. 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.

### Key Concept

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

### Okay or Not Okay?

To help you understand specific marketing and education behaviors and to determine what is or is not okay, the following chart outlines some of the common acceptable (okay) and unacceptable (not okay) practices that may be seen by beneficiaries.

To review the complete set of CMS Marketing Guidelines (100+ pages), visit [www.cms.gov/ManagedCareMarketing/](http://www.cms.gov/ManagedCareMarketing/).

**NOTE:** *The chart that follows is also available as a handout in Appendix E.*

Okay	NOT Okay
<b>Advertising</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Advertising sales/marketing events (in any form of media) must explain:                             <ul style="list-style-type: none"> <li>○ “A sales person will be present with information and applications”</li> <li>○ “For accommodation of persons with special needs at sales meetings call &lt;insert phone and TTY number&gt;”</li> </ul> </li> <li>✓ Educational events are advertised as such.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ An advertisement for an event does not state its purpose – marketing or education.</li> <li>∅ Communications resemble government mailings.</li> <li>∅ Sending unsolicited e-mails, text messages or voicemails to a beneficiary.</li> </ul>
<b>Co-Branding (provider logo and plan logo appearing together on materials)</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ When multiple providers participate in a plan, co-branded materials contain a disclaimer saying there are other participating providers, explaining how to find them.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Co-branding without the required disclaimer when there are multiple providers under a plan.</li> </ul>
<b>Direct Mail</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ 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.</li> <li>✓ A plan may send items such as postcards, self-mailers, and reply cards.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ A plan violates a beneficiary’s request to opt-out of receiving communications.</li> </ul>

Okay	NOT Okay
<b>Enrollment Activities</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Plan salesperson is knowledgeable about Medicare and, during a marketing activity, objectively discusses whether or not the plan meets that potential enrollees individual needs.</li> <li>✓ 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.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Plan salesperson removes a beneficiary from Original Medicare and enrolls them in Medicare Part C without their knowledge.</li> <li>∅ Plan salesperson fails to demonstrate or provide adequate Medicare expertise and enrolls a beneficiary in a plan that is inappropriate for them.</li> <li>∅ Plan salesperson falsely states that their doctor accepts the plan.</li> <li>∅ 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.</li> <li>∅ Plan salesperson “cherry-picks” (selecting or denying beneficiaries based on their illness profile).</li> <li>∅ Plan salesperson enrolls or attempts to enroll a dually-eligible beneficiary in their plan, regardless of its appropriateness for that beneficiary.</li> </ul>
<b>Events (Marketing and Education)</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Provision of a <b>light snack</b> 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.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Provision of a <b>meal</b> 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. Beware of snacks bundled into a meal -- NOT okay.</li> </ul>

Okay	NOT Okay
<b>Events (Marketing and Education), continued...</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Provision of a meal valued at \$15 or less at an event that is for general Medicare education purposes where no marketing occurs.</li> <li>✓ Marketing Events taking place at a kiosk or in a recreational vehicle (RV)</li> <li>✓ Providing a beneficiary with one or more salesperson business cards at an educational event and responding to questions if asked, as long as business cards are free of marketing or benefit information.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Provision of a meal to prospective beneficiaries at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed. These would be considered marketing events and only light snacks are allowed.</li> <li>∅ The plan salesperson cannot market in the same building where an education event is taking place (or just took place). This would be considered back-to-back education and marketing, which is prohibited.</li> <li>∅ Collecting beneficiary contact information at an education event. Examples of violations:             <ul style="list-style-type: none"> <li>○ Asking all participants to provide personal identifying information as part of a general "sign in" sheet</li> <li>○ Asking for contact information to participate in a drawing for a prize</li> </ul> </li> <li>∅ Agents or brokers may NOT require a face-to-face meeting to provide plan details.</li> <li>∅ Displaying business cards or attaching them to educational materials.</li> <li>∅ Agents or brokers may NOT request Social Security numbers, bank, or credit card info at education or marketing events.</li> <li>∅ Agents or brokers may NOT hold an educational event in a private home or other one-on-one setting.</li> <li>∅ Agents or brokers may NOT solicit individual appointments under the premise that the appointment is only for educational purposes.</li> </ul>

Okay	NOT Okay
<b>Health Care Settings</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Physicians can provide brochures or other educational materials about all the plans in which they participate.                             <p style="margin-left: 20px;"><i>NOTE: Providers should remain unbiased. Also, they are not required to seek out materials from plans.</i></p> </li> <li>✓ Plan salesperson conducts sales presentations and distributes and accepts enrollment applications in a common area.                             <ul style="list-style-type: none"> <li>○ Common areas are: hospital or nursing home cafeterias, community, recreational and conference rooms</li> </ul> </li> <li>✓ Patients are not misled or pressured into participating.</li> <li>✓ Conduct the following in long-term care facilities                             <ul style="list-style-type: none"> <li>○ Display posters</li> <li>○ Include materials in admission packets</li> <li>○ Provide to residents that meet Special Needs Plan criteria a brochure for each Special Needs Plan with which the facility contracts</li> </ul> </li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ A physician cannot reject brochures or other educational materials from some of the plans in which they participate, while accepting brochures or other educational materials from others.</li> <li>∅ Conducting sales presentations, distributing and accepting enrollment applications where patients receive care. Restricted areas include:                             <ul style="list-style-type: none"> <li>○ Waiting rooms</li> <li>○ Pharmacy counter areas</li> <li>○ Exam rooms</li> <li>○ Hospital patient rooms</li> </ul> </li> </ul>

Okay	NOT Okay
<b>Home Visits</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ A beneficiary requests a home visit from a plan salesperson. This includes visit in long-term care facilities</li> <li>✓ 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.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ A salesperson's initial contact is an unsolicited home visit – i.e. "door-to-door cold call" sales tactic.</li> <li>∅ Agents or brokers may NOT represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid.</li> <li>∅ Agents and brokers may not leave information such as leaflets, flyers, door hangers, etc. on someone's car or at their residence (unless the beneficiary is a "no show" for a pre-scheduled appointment).</li> </ul>
<b>Insurance Agent and Broker Credentials</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Plan salesperson has a demonstrated knowledge of Medicare, including passing a test.</li> <li>✓ Agent or Broker is licensed in their state and follows state appointment rules.</li> <li>✓ Plan customer service representatives are not licensed.</li> <li>✓ Plan terminates agents and brokers who violate regulations or laws, notifying the state licensure body. The bad behavior of individual agents or brokers does not automatically result in a plan losing the right to sell Medicare products, as long as they respond appropriately.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Plan salesperson has not passed test and/or demonstrates lack of adequate Medicare knowledge.</li> <li>∅ Unlicensed agents and brokers selling Medicare products and breaking state appointment rules.</li> <li>∅ Customer service representatives fulfilling roles that belong to licensed agents or brokers.</li> <li>∅ Plans failing to report termination of agents or brokers to state licensure body.</li> <li>∅ Agents or brokers must never represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid.</li> </ul>

Okay	NOT Okay
<b>Promotional Activities/Gifts</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Offering promotional activities or items that are of “nominal” value. <i>Nominal value</i> 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.</li> <li>✓ Offering promotional activities or items to both current and potential enrollees.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Offering promotional items or activities over the course of a year that have an aggregated value of more than \$50 per person.</li> <li>∅ Offering items that are considered a health benefit for free as a promotion (e.g., a free checkup).</li> </ul>
<b>“Scope of Sales”</b>	
<b>– Defining the Content of a Sales or Enrollment Contact</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ 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.</li> <li>✓ A beneficiary changes their mind about the scope of sale during an appointment. (For example, asking about other insurance products). The salesperson documents this change of scope and provides the requested information.</li> <li>✓ 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 sale.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ 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.</li> <li>∅ Misrepresenting a product as an approved Part C or Part D plan when it is actually a Medigap policy or non-Medicare drug plan.</li> <li>∅ A beneficiary changes their mind about the scope of sale and the salesperson conducts marketing and/or enrollment activities without documenting the change in the scope.</li> <li>∅ Requiring a face-to-face appointment to provide plan information.</li> <li>∅ Returning uninvited to an earlier “no show.”</li> <li>∅ Using high pressure sales tactics.</li> </ul>

Okay	NOT Okay
<b>Telephone Calls (“Outbound” calls to beneficiaries)</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ A beneficiary has reviewed advertising or attended an educational event and gives permission to be contacted by the plan.</li> <li>✓ 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 (Refer to §70.6 on unsolicited contact).</li> <li>✓ An unsolicited outbound call may be made to beneficiaries currently enrolled in a Part C or Part D plan to conduct “normal business.” <ul style="list-style-type: none"> <li>○ For example, a beneficiary on “Extra Help” who needs to be re-assigned can be called</li> <li>○ Initiating a phone call to confirm an appointment</li> <li>○ Contacting members to discuss educational events</li> <li>○ Contacting former members after the disenrollment date to conduct disenrollment survey</li> <li>○ Returning beneficiary phone calls</li> </ul> </li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ 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.</li> <li>∅ Agents or brokers may NOT represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid.</li> <li>∅ 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. <ul style="list-style-type: none"> <li>○ Contacting beneficiaries to ensure receipt of mailed information</li> <li>○ Making calls to beneficiaries that resulted from a referral</li> <li>○ Making calls to former members who have disenrolled or to current members who are in the process of disenrolling</li> <li>○ Making calls without permission to beneficiaries who attended an event</li> </ul> </li> </ul>

## Referrals of Suspected Violations by Plans, Agents, or Brokers

CMS Regional Offices (RO) have staff dedicated to working with each state's Department of Insurance (DOI). These staff members are known as the CMS RO DOI liaisons. They handle complaints of suspected compliance and enforcement violations, including but not limited to the marketing violations described in the previous section. CMS and the SMP Resource Center have formed a partnership allowing SMPs to refer suspected marketing violations directly to CMS RO DOI liaisons. Refer to the SMART FACTS manual, Chapter 6, for instructions on the appropriate procedures.

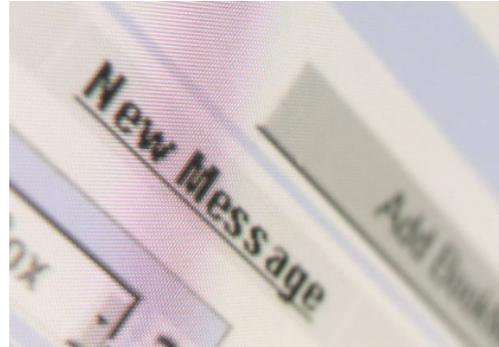
Though all suspected marketing violations should be referred to the CMS RO DOI liaisons for your state, egregious insurance agent violations should also be referred to the State Department of Insurance.

### Complaints Referred to CMS RO DOI Liaisons

- Part C and Part D marketing violations by agents, brokers, or plans, as outlined earlier in this chapter
- Agents, brokers, or plans conducting business after they have been asked to cease and desist
- Misleading advertising. For example:
  - Materials that look like they are being sent from an official government source
  - Materials that imply private fee-for-service plans function as Medicare supplement plans
- Offering inducements to enroll
- Enrollment complaints
  - Enrollment of beneficiaries in a plan without beneficiary consent
  - Disenrolling (removing) a beneficiary from Original Medicare without their knowledge
  - Falsely telling a beneficiary that their physician or hospital accepts the plan

*Referrals of Suspected Violations by Plans, Agents or Brokers, Complaints Referred to CMS RO DOI Liaisons, continued*

- Phishing Scams
  - Unsolicited emails purporting to be a valid Part C or Part D plan or service.
  - These e-mails often entice an individual to visit a fraudulent website and provide sensitive personal information.
- Marketing insurance products that do not exist



### **Complaints Referred to BOTH the CMS RO DOI Liaisons AND the State Department of Insurance**

Though CMS RO DOI Liaisons will also alert the state's department of insurance to the issues brought to their attention by the SMP, SMPs should refer egregious agent/broker behavior directly to their state department of insurance concurrently with the referral to CMS. This will ensure that both entities will know and be able to respond to your referral as quickly as possible.

To find your state department of insurance, you can use the interactive map on the National Association of Insurance Commissioner's website: [www.naic.org](http://www.naic.org)

### **Key Concept**

The SMART FACTS manual, Chapter 6, explains how to refer cases to the CMS RO DOI Liaisons

A flow chart summarizing all types of referrals, including referrals of Part C and Part D marketing violations, as well as egregious agent/broker behavior, is Appendix D of this manual.

## Recommended Resources

### Publications

- Appendix of this Manual
- [SMP Foundations manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org)
- [SMART FACTS manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org)
- [Medicare & You Handbook](#): Call 1-800-Medicare or visit [www.mymedicare.gov](http://www.mymedicare.gov) to order a new copy each year.

### Online Resources

- U.S. Department of Health and Human Services and U.S Department of Justice: [www.stopmedicarefraud.gov](http://www.stopmedicarefraud.gov)
- CMS: [www.mymedicare.gov](http://www.mymedicare.gov)
- CMS Managed Care Marketing Guidelines: [www.cms.gov/ManagedCareMarketing/](http://www.cms.gov/ManagedCareMarketing/).
- OIG: [www.oig.hhs.gov](http://www.oig.hhs.gov)
- SMP Resource Center: [www.smpresource.org](http://www.smpresource.org)
  - [Complex Issues and Referrals Training](#)
  - [Fact Sheets](#)
  - [SMART FACTS training](#)



## SMP Complex Issues and Referrals Training Manual

### CHAPTER 5: Medicaid and Other Health Care Complaints

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## When Medicaid is Involved

Though the SMP program mission is to serve Medicare beneficiaries and their caregivers, many Medicare beneficiaries are dually enrolled in Medicare and Medicaid. As you learned in SMP Foundations, Chapter 2, these beneficiaries are called “dual-eligibles.” When there are improper Medicare payments on a claim for a dually-enrolled beneficiary through fraud, error, or abuse, the integrity of the Medicaid program is also compromised.

### Recognizing Medicaid Fraud, Error, and Abuse in Long-Term Care

The Medicaid program is vulnerable for the same reasons that the Medicare program is vulnerable and may be committed by both providers and beneficiaries. The laws governing Medicare fraud and abuse that were outlined in Chapter 3 also apply to Medicaid.

Many beneficiaries receiving long-term care services are dual-eligibles. Below are some examples of typical fraud, error, and abuse seen in long-term care facilities, according to the [National Association of Medicaid Fraud Control Units](#):



- ✓ **Billing for services not provided** - A provider bills for services not performed, such as blood tests or x-rays that were not taken, full denture plates when only partial ones were supplied, or a nursing home or hospital that continues to bill for services rendered to a patient who is no longer at the facility either because of a death or transfer.
- ✓ **Double billing** - A provider bills both Medicaid and a private insurance company (or recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.
- ✓ **Billing for phantom visits** - A provider falsely bills the Medicaid program for patient visits that never take place.
- ✓ **Kickbacks** - A nursing home owner or operator requires another provider, such as a laboratory, ambulance company, or pharmacy, to pay the owner or operator a certain portion of the money received for rendering services to patients in the nursing home. This practice usually results in unnecessary services being performed to generate additional income to pay the kickbacks.

*When Medicaid is Involved, continued*

### Reporting Medicaid Provider Fraud

Medicaid provider fraud should be reported to the OIG, via ACL, and also your state's Medicaid Fraud Control Unit (MFCU). This acronym is commonly pronounced "moo-foo-coo." Your state's MFCU investigates and prosecutes health care providers that defraud the Medicaid program. The unit is also charged with collecting any overpayments it identifies in carrying out its activities. "Although recipients also commit Medicaid fraud," as stated by the National Association of Medicaid Fraud Control Units, "the jurisdiction of the Medicaid Fraud Control Units (MFCUs) is limited to investigating and prosecuting Medicaid provider fraud." All providers who receive Medicaid reimbursement are subject to scrutiny by the state MFCU.

Following is a list of common types of providers who have been subject to investigation:

- Dentists
- Durable medical equipment companies
- Home health care agencies
- Hospitals
- Medical transportation companies
- Mental health professionals
- Nursing homes
- Pharmacies
- Physicians



Visit [www.namfcu.net/states](http://www.namfcu.net/states) and use the interactive map to locate the MFCU in your state. See Appendix C for instructions on how to refer to the OIG via ACL.

### Reporting Medicaid Error and Beneficiary Fraud

When a Medicaid beneficiary perpetrates Medicaid fraud, it should be reported to the OIG, via ACL, and also the state Medicaid agency. You will also need to contact the state Medicaid agency regarding suspected billing errors. The CMS website provides instructions on how to report suspected fraud ([www.cms.gov](http://www.cms.gov) > Medicaid > How to Report Fraud > How to Report Suspected Fraud). They provide a document titled [State Fraud and Abuse Contact Report](#) that lists each state's Medicaid agency, including the contact information.

## Other Common Health Care Complaints

Many common health care complaints co-occur with suspected fraud, error, and abuse. You should document them on the SMART FACTS Complex Issues Form along with the details of the suspected fraud, error, or abuse. It is considered an SMP best practice to direct the complainant to the appropriate source of help but not necessarily manage the process of addressing these other types of complaints.

If a complaint does not meet the criteria for Medicare or Medicaid fraud, error, or abuse outlined earlier in this manual but is related to another type of health care complaint, it is not an SMP complex issue. It will be a one-on-counseling session or a simple inquiry. Refer to the SMP Counselor Manual for assistance in determining the appropriate procedures.

### Medicare Part C and Part D Plan Customer Service Complaints

Customer service complaints about Medicare Part C and Part D should be made directly to the plan sponsors. Examples include:

- Routine enrollment, disenrollment, and premium issues
- TrOOP (True Out of Pocket Cost) calculations
  - If the plan makes a mistake processing claims and miscalculates a beneficiary's out of pocket costs, it is up to the plan to correct that error.
- Formulary issues
  - Example: A beneficiary's plan will only pay for a certain drug if it is generic, but the beneficiary's doctor insists that the beneficiary must take the brand name drug because the generic is not effective in her case. The beneficiary can then apply to the plan for a formulary exception.
- Request for a plan to review its denial of a claim (appeal)
- Grievances with plan sponsors
  - For example, a plan's customer service representative was rude to a beneficiary, or
  - The plan did not inform a beneficiary about its decision regarding his appeal.
- Beneficiaries' requests for reimbursement from plan sponsors

*Other Common Health Care Complaints, Medicare Part C and Part D, continued*

If customer service issues persist and accumulate, they become compliance issues, which are the purview of the CMS Regional Offices. After the customer service channels have been tried and failed, the case does become an SMP complex issue. When plans are unresponsive to customer service complaints, make a referral to the CMS RO DOI Liaisons (see Chapter 4).

### **Referrals to your State Department of Insurance**

In addition to those egregious Part C and Part D agent/broker complaints discussed in Chapter 4, there are two insurance sales complaints common to the SMP network that should be taken directly to your state department of insurance:

- **Medigap Complaints:**

Though “Medigap” (Medicare Supplement) policies are sold by private companies, they are not a Part C or Part D product and are not handled under the SMP unique referral relationship with CMS RO DOI Liaisons or the MEDIC. 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.

- For example, in Texas, agents can sell Medigap policies door-to-door. To determine whether or not a sales practice for a Medigap policy is allowable in your state, contact your state’s department of insurance.
- To find your state department of insurance, you can use the interactive map on the National Association of Insurance Commissioner’s website: [www.naic.org](http://www.naic.org)

- **Lead Generators (such as postcard solicitation)**

“Lead Generators” are ways of developing contact lists for insurance solicitation. When a Part C or Part D product is not 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 should be referred to them.

*Other Common Health Care Complaints, Referrals to Your State Dept of Insurance, continued*

- Example: Many SMPs have been contacted over the years about postcards sent by an organization called the National Processing Center. These cards have confused some beneficiaries because they can appear to be from Medicare or indicate pending changes in Medicare coverage. However, they contain a disclaimer in small print: “Not affiliated with Medicare or any government agency.”
  - Unless your state prohibits these cards, they are legal.
  - Educate beneficiaries about what to expect: Beneficiaries who complete and return the cards will be placed on lists used for insurance solicitation.

### Medicare Benefits Complaints

The following circumstances are not considered fraud, error, or abuse. Like the majority of customer service complaints, they are not considered SMP complex issues by themselves, but may be an aspect of a complaint within the SMP scope.

- Medicare coverage or policy concerns
  - Send the client to their insurance provider, 1-800-Medicare, or to the SHIP for more information about Medicare coverage options.
    - The contact information for each state’s SHIP program can be found on the SHIP Resource Center website: [www.shiptalk.org](http://www.shiptalk.org).
  - Observation status complaints
    - Definition: A doctor may order “observation services” to help decide whether a patient needs to be admitted to the hospital. That time doesn’t count toward the three-day inpatient hospital stay needed for Medicare to cover subsequent skilled nursing facility care.
    - This is an advocacy issue of concern to SMPs, since many beneficiaries are unaware of the consequences. Observation status claims do not constitute fraud, however, and the SMP role would be educational.
    - Message: Beneficiaries should always ask their doctor if Medicare will cover their skilled nursing facility care.



*Other Common Health Care Complaints, Medicare Benefits Complaints, continued*

- Medicare appeals or reconsideration requests
  - As explained in Chapter 2 of this manual, appeals can be a factor in SMP complex issues regarding errors.
    - Filing appeals on behalf of a beneficiary is not within the scope of the SMP program, however
  - If the sole nature of a complaint is the desire for information on how to appeal, the complaint is not an SMP complex issue.
- Excessive prices for health care services;
  - Complaints about the cost of health care (other than costs due to error or false claims) are outside of the scope of the SMP program.
  - If necessary, educate the beneficiary about co-pays, deductibles, assignment, and participation in Medicare, or send them to another knowledgeable source, such as SHIP. Under some circumstances, the beneficiary may want to appeal.
- Low-income eligibility questions and concerns;
  - The beneficiary should contact the state agency responsible for determining eligibility (see Chapter 2 of SMP Foundations for more information about programs that help people with limited income and resources).

### Quality of Care Complaints

Complaints alleging malpractice or poor quality of care may or may not involve a fraudulent situation. Quality of care or malpractice concerns are handled by the following organizations:

- **Quality Improvement Organizations (QIOs)** conduct reviews of complaints filed by Medicare beneficiaries about the quality of medical services that he/she received. QIOs have authority to investigate quality of care complaints for almost all settings in which Medicare covers services and supplies, including hospitals, skilled nursing facilities, physician's offices, hospices, home health agencies, and emergency rooms. QIOs investigate these complaints, gather facts from all parties involved, and recommend action to help providers and suppliers improve quality of care.

### *Other Common Complaints, Quality of Care Complaints, continued*

- The contact information for each state's QIO is on the American Health Quality Association's website: [www.ahqa.org](http://www.ahqa.org). Here's the link to their QIO locator: [www.ahqa.org/pub/connections/162\\_694\\_2450.cfm](http://www.ahqa.org/pub/connections/162_694_2450.cfm).
- For more information, visit the CMS QIO webpage about QIOs: [www.cms.gov/qualityimprovementorgs/](http://www.cms.gov/qualityimprovementorgs/).
- **State Certification Boards** handle complaints about providers they certify. The list below, though not exhaustive, covers several types that also have a national organization offering a directory:
  - State Board of Medical Examiners  
If the complaint is against a physician. The Federation of State Medical Boards (FSMB) has an online directory: [www.fsmb.org/directory\\_smb.html](http://www.fsmb.org/directory_smb.html).
  - State Chiropractic Board  
If the complaint is against a chiropractor. The Federation of Chiropractic Licensing Boards (FCLB) has an online directory: [www.fclb.org/ChiropracticBoards/tabid/439/Default.aspx](http://www.fclb.org/ChiropracticBoards/tabid/439/Default.aspx).
  - State Nursing Board  
If the complaint is against a nurse. The National Council of State Boards of Nursing, NCSBN, has a search tool on its website to locate the board in your state: [www.ncsbn.org/contactboardofnursing.htm](http://www.ncsbn.org/contactboardofnursing.htm).
  - State Board of Pharmacy  
If the complaint is against a pharmacist. The National Association of Boards of Pharmacy (NABP) has an online directory: [www.nabp.net/boards-of-pharmacy/](http://www.nabp.net/boards-of-pharmacy/).
- **State Long-Term Care Ombudsman Program** handle complaints about quality of care in long-term care facilities should be directed to your Long-Term Care Ombudsman, the advocates for residents of nursing homes, board and care homes and assisted living facilities. Though the ombudsman can assist you with complaints, you must have client permission to share their concerns on their behalf. To find the ombudsman in your state, visit the interactive map on the National Long-Term Care Ombudsman website: [www.ltombudsman.org](http://www.ltombudsman.org).

## Documenting Results

Your assistance with complaints involving Medicaid may result in recoveries or savings to Medicaid and also to beneficiaries, both of which are captured on the OIG Report. Like Medicare recoveries, they require the same type of supportive documentation to validate the recoveries or savings that were explained in Chapter 2 and Chapter 3.



### Key Concept

If your primary assistance to a beneficiary is with “other common health care complaints” and no complex issue is involved, refer to the process flow chart in Appendix A, which is from the SMP Counselor manual.

## Recommended Resources

### Publications

- Appendix of this Manual
- [SMP Foundations manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org).
- [SMART FACTS manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org).
- [Medicare & You Handbook](#): Call 1-800-Medicare or visit [www.mymedicare.gov](http://www.mymedicare.gov) to order a new copy each year.
- [SMP Counselor manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org).

### Additional Online Resources

- U.S. Department of Health and Human Services and U.S Department of Justice: [www.stopmedicarefraud.gov](http://www.stopmedicarefraud.gov)
- CMS: [www.mymedicare.gov](http://www.mymedicare.gov)
- OIG: [www.oig.hhs.gov](http://www.oig.hhs.gov)
- SMP Resource Center: [www.smpresource.org](http://www.smpresource.org)
  - [Complex Issues and Referrals Training](#)
  - [Fact Sheets](#)
  - [SMART FACTS training](#)



## **SMP Complex Issues and Referrals Training Manual**

### **CHAPTER 6: Consumer Protection Issues and Remedies**

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### Overview

Though consumer protection is not the primary service provided by SMPs, consumer protection concerns often arise as secondary issues for SMP clients. Consumer scams are also a common vehicle used against Medicare beneficiaries to obtain Medicare numbers and Social Security numbers, both of which can enable criminals to commit health care fraud. Because of this, some SMP complex issues will involve consumer protection concerns. This chapter will describe those common scams and provide information about the organizations to which you should make referrals.

### Micro-Level and Macro-Level Complex Issues

Due to the success of your SMP's outreach efforts, you may receive complaints from savvy Medicare beneficiaries or caregivers who knew better than to fall for a scam. They may contact the SMP, knowing the SMP has the ability to warn others. You may also be contacted by Medicare beneficiaries or caregivers who fell victim to the scam and then later realized it was a mistake.



SMP complex issues involving consumer fraud fall into two categories:

**Micro-Level:** Scams addressed by assisting individual beneficiaries who became victims

- Enter a complex issue in SMART FACTS for each individual victim and refer it to the appropriate entities

**Macro-Level:** Scams addressed at the national, state, and local levels by alerting authorities and warning the public to beware.

- Enter the scam itself into SMART FACTS as a complex issue and refer it to the appropriate entities
  - Enter a separate complex issue for each individual victim of the scam (each is a micro-level complex issue)
  - The individual complaints from beneficiaries who did not fall prey to the scam will be entered into SMART FACTS as simple inquiries or one-on-one counseling sessions (for more information, see the next page and also Appendix A).

## Telemarketing, Door-to-Door Sales, and Mail Solicitation

Older adults are frequent targets of solicitation through telemarketing, door-to-door sales, and the U.S. Mail. As with Medicare fraud, the proper authorities will need to determine whether or not these solicitations are abusive or illegal. The SMP response to complaints from Medicare beneficiaries about solicitation will vary according to the nature of the issue and the capacity of the beneficiary.

### When Solicitation Involves Medicare

How to handle certain types of solicitation involving Medicare has already been covered in previous chapters. For example, if a suspicious solicitation involves a durable medical equipment supplier, refer to Chapter Three for detailed instructions. You may need to make a referral to the OIG. If a suspicious solicitation involves Medicare Part C or Part D, refer to Chapter Four for instructions. You may need to make a referral to CMS. In Chapter Five, mailings known as “lead generators” were already discussed.



What should you do if suspicious telemarketing, door-to-door solicitation, or a mailing involves the Medicare program or services, but does not meet the criteria for referrals outlined in previous chapters? One common example is when beneficiaries receive calls from individuals claiming to be from Medicare, requesting the beneficiaries' Medicare numbers. We know Medicare doesn't make those calls. Scam artists have also preyed upon the public's confusion over health care reform, claiming to need Medicare numbers, social security numbers and even banking information as a result of this legislation. If the beneficiary gave out their Medicare number, their Medicare number may be compromised. This is suspected medical identity theft. See Chapter 3 for referrals guidance.

When beneficiaries refuse to share their Medicare numbers with callers seeking Medicare numbers, these suspected scams are considered a macro-level complex issue. Enter the case into SMART FACTS under the name of the suspected scam, not the name of the beneficiary or beneficiaries (who were wise and did not fall prey). Use the checklists in SMART FACTS to indicate that telemarketing was involved. **The data will be used at the national level to respond to requests for scams and trends seen by SMPs.**

*Telemarketing, Door-to-Door Sales, and Mail Solicitation, continued*

## **Local Law Enforcement**

Local law enforcement should be alerted to all fraudulent activity, including suspicious solicitation through telemarketing, door-to-door sales, and the mail. Preferably, the beneficiary or caregiver should contact law enforcement on their own behalf. If the beneficiary or caregiver is unable to do so, the SMP may alert law enforcement, depending upon the circumstances, keeping legal, ethical, and confidentiality concerns in mind.



## **State Attorneys General**

SMPs should contact the state attorney general's office to report consumer scams happening in their state, particularly those involving solicitation through telemarketing, door-to-door sales, and the mail. The state attorneys general have law enforcement authority. They serve as counselors to their legislatures and state agencies and also as the "People's Lawyer" for all citizens. The state attorneys general act as public advocates in the area of consumer protections, handle serious state-wide criminal prosecutions, institute civil suits on behalf of the state, and operate victim compensation programs.

To find the attorney general's office in your state, visit the National Association of Attorney's General (NAAG) website, [www.naag.org](http://www.naag.org)

## **Federal Trade Commission**

The Federal Trade Commission (FTC) is a national partner with the SMP program. The FTC is the nation's consumer protection agency and collects complaints about companies, business practices, and identity theft. The FTC pursues vigorous and effective law enforcement and advances consumers' interests by sharing its expertise with federal and state legislatures and U.S. and international government agencies.

**Federal Trade  
Commission**



Though the FTC does not manage individual complaints, it is worthwhile to report suspected consumer fraud using its online complaint form.

*Telemarketing, Door-to-Door Sales, and Mail Solicitation, Federal Trade Commission, continued*

Filing a complaint helps the FTC detect patterns of wrong-doing, and leads to investigations and prosecutions. The FTC enters all complaints it receives into their *Consumer Sentinel*, a secure online database that is used by thousands of civil and criminal law enforcement authorities worldwide.

It is preferable for the beneficiary to file their own complaint with the FTC, though some SMP clients may not be able to, and may need assistance.

Complaints can be filed with the FTC online or by telephone:

- Online complaint form: [www.ftc.gov](http://www.ftc.gov), then click on “Complaint Assistant.”
- Toll-free helpline: 1-877-FTC-HELP (1-877-382-4357)

### Identity Theft

Because of the close ties between Medicare numbers and Social Security numbers, identity theft, medical identity theft and Medicare fraud are inextricably linked. According to the Federal Trade Commission’s *Guidebook for Assisting Identity Theft Victims*, “Each year millions of Americans discover that a criminal has fraudulently used their personal information to obtain goods and services and that they have become victims of identity theft. Under federal law, identity theft occurs when someone uses or attempts to use the sensitive personal information of another person to commit fraud.” The guidebook goes on to explain that “a wide range of personal information” may be abused, including the following:

- Social Security number
- Driver’s license number
- Bank account number
- Credit card number
- Name
- Medical records
- Address
- Date of birth
- Phone number
- Biometric data (e.g. fingerprints)



*Telemarketing, Door-to-Door Sales, and Mail Solicitation, Federal Trade Commission, continued*

### How can you spot identity theft?

The Federal Trade Commission (FTC) lists these warning signs:

- Accounts you didn't open and debts on your accounts that you can't explain
- Fraudulent or inaccurate information on your credit reports, including accounts and personal information, like your Social Security number, address(es), name or initials, and employers
- Failing to receive bills or other mail. Follow up with creditors if your bills don't arrive on time. A missing bill could mean an identity thief has taken over your account and changed your billing address to cover his tracks
- Receiving credit cards that you didn't apply for
- Being denied credit, or being offered less favorable credit terms, like a high interest rate, for no apparent reason
- Getting calls or letters from debt collectors or businesses about merchandise or services you didn't buy

### Remedies for Identity Theft Victims

The FTC recommends that the following steps be taken:

1. File a complaint with the police
2. File a complaint with the FTC
  - The FTC does not resolve individual complaints, but filing a complaint with the FTC alerts criminal and civil law enforcement nationwide
  - The FTC has a complete guide for identity theft victims. It can be ordered, viewed online, or printed from their website. Here's the direct link: <http://www.idtheft.gov/probono/index.html>
3. Report it to the bank, seeking assistance from their fraud department
4. Report it to the applicable credit card companies, seeking assistance from their fraud department
5. Victims should place a fraud alert on their credit reports (and review them), using any of the following services:
  - **TransUnion:** 1-800-680-7289; [www.transunion.com](http://www.transunion.com)
  - **Equifax:** 1-800-525-6285; [www.equifax.com](http://www.equifax.com)
  - **Experian:** 1-888-EXPERIAN (397-3742); [www.experian.com](http://www.experian.com)

*Telemarketing, Door-to-Door Sales, and Mail Solicitation, Federal Trade Commission, continued*

### **National Do Not Call Registry**

The National Do Not Call Registry is managed by the Federal Trade Commission and is a free service that allows consumers to avoid receiving telemarketing calls. Most telemarketers should not call numbers that have been on the registry for 31 days. If they do, a complaint should be filed with the registry. The registry does not cover calls from political organizations, charities, telephone surveyors, or companies with which a consumer has an existing business relationship. Telephone numbers on the registry will only be removed when they are disconnected and reassigned, or when the consumer chooses to remove a number from the registry.



To register, call 1-888-382-1222, or register online at [www.donotcall.gov](http://www.donotcall.gov).

### **U.S. Postal Inspection Service**

The U.S. Postal Inspection Service investigates any crime in which the U.S. mail is used to further a scheme -- whether it originated in the mail, by telephone, or on the Internet. The use of the U.S. mail is what makes it mail fraud.

#### **Government Look-Alike Mail**

One type of mail fraud targeted toward older adults and often brought to the attention of SMPs is mail that appears to have come from the government. Characteristics to look for include messages such as "Important Notice," "Official Business," or "Open Immediately" hand-stamped or printed on the envelopes. The U.S. Postal Service instructs citizens to read the contents carefully. It should become clear that the mailing really came from a private organization, not a government entity. Keep the mailing. The U.S. Postal Inspection Service will want to see it.



*Telemarketing, Door-to-Door Sales, and Mail Solicitation, U.S. Postal Inspection Service, continued*

### **To Report Suspected Mail Fraud**

- Call your local post office for guidance, or
- Submit a complaint online:  
<https://postalinspectors.uspis.gov/forms/MailFraudComplaint.aspx>

You may be asked to send the suspicious mailing to the postal inspector, care of your local postmaster.

## **Key Concept**

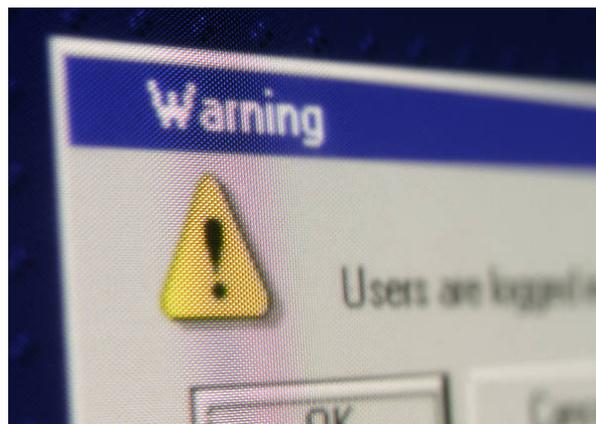
Mailings known as “lead generators” are sometimes mistaken for mail fraud. As explained in Chapter 5, some may at first appear to be official government mail, but contain a disclaimer in fine print. Unless your state prohibits them, they are legal.

Reminder: avoid jumping to the conclusion that something is fraud; report suspected fraud the proper authorities, who will make the final determination.

## **Internet Crime**

Anyone who uses a computer is likely to have encountered Internet crime. Receiving spam e-mail has become a daily occurrence for most computer users. Just like the telephone, the mail, and door-to-door solicitations are used by scam artists as an avenue for theft, so is our most modern of communication tools, the Internet.

If a suspicious email is marketing a Part C or Part D Plan, see Chapter 4.



*Internet Crime, continued*

## **Internet Crime Complaint Center (IC3)**

According to the Internet Crime Complaint Center (IC3) a partnership between multiple law enforcement entities and operated by the Federal Bureau of Investigations (FBI), Internet crime is defined as any illegal activity involving one or more components of the Internet, such as websites, chat rooms, and/or e-mail. Internet crime involves the use of the Internet to communicate false or fraudulent representations to consumers.

The Internet Crime Complaint Center (IC3) has a website that provides a wealth of information about Internet Crime Schemes. Familiar examples include:

- E-mail spam
- The Nigerian Letter
- “You have won the lottery” e-mails
- Phishing – unsolicited e-mails that entice an individual to visit a fraudulent website and provide sensitive personal information

To report incidents of Internet crime, visit the Internet Crime Complaint Center’s website: [www.ic3.gov](http://www.ic3.gov).

## **Suspicious or Unethical Business Practices**

### **Medical Discount Plans**

According to the FTC, what sounds like affordable health insurance may be a medical discount plan instead. Medical discount plans can be a way for some people to save money on their health care costs, but discount plans aren’t health insurance. Some medical discount plans provide legitimate discounts; others take peoples’ money and offer very little in return. Many plans give outdated lists of names and facilities or don’t include local providers. Some offers are just plain scams.

- To help you determine the legitimacy of an offer, visit the FTC website’s online fact sheet: [www.ftc.gov/bcp/edu/microsites/medicaldiscountscams/index.shtm](http://www.ftc.gov/bcp/edu/microsites/medicaldiscountscams/index.shtm).

*Suspicious or Unethical Business Practices, continued*

## Prescription Drug Discount Cards

The FTC places prescription drug discount cards in the same category as medical discount plans. Though widely available, these cards are a controversial subject among SMPs. The question of their legality and benefit arises often. The answer to the question “Are they legal?” is “Yes.” The answer to the question “Are they beneficial?” is “It depends.” The general consensus is to proceed with caution. Beneficiaries who choose to use a prescription drug discount card should research it thoroughly. Below is a list of common pros and cons raised about the prescription drug discount cards.

Pros	Cons
<ul style="list-style-type: none"> <li>✓ Can save a beneficiary money on prescriptions while they are in the Part D donut hole, particularly if they don't expect to get out of the donut hole</li> <li>✓ Some are offered by trusted organizations at no cost to the recipient</li> </ul>	<ul style="list-style-type: none"> <li>✓ Can delay getting out of the Part D donut hole</li> <li>✓ Some companies use questionable marketing tactics, raising concerns about their ethics and legitimacy</li> <li>✓ Some are scams</li> <li>✓ The rules pertaining to the cards can be confusing</li> <li>✓ Some have fees</li> <li>✓ They may not offer a true benefit, for example, they may not be accepted at the beneficiary's pharmacy</li> </ul>

For tips about making an informed prescription drug discount card decision, see the FTC online newsletter topic titled “Misleading Medical Discount Packages:”

<http://www.ftc.gov/bcp/edu/microsites/phonefraud/seniors.shtml>

## Better Business Bureau

You may be suspicious about a given business or provider, yet unsure whether or not your suspicions are warranted. The Better Business Bureau (BBB) has a national website that is an excellent source of information to research private businesses and charities. You can find the BBB office in your area, research a particular business or charity, or file a complaint online.

*Suspicious or Unethical Business Practices, Better Business Bureau, continued*

### Researching a Business or Charity

- Go to [www.bbb.org](http://www.bbb.org);
  - Search for the contact information of the BBB nearest you, by using the search by postal code feature, or
  - Click on “USA Site” to search the national database
- If you selected “USA Site” because you wanted to research a business or charity:
  - Select “For Consumers”
  - Select “Check out a Business or Charity”
  - Follow the online instructions to learn more about a specific entity and learn:
    - Whether there have been complaints filed against them
    - Whether or not these complaints were founded
    - Whether or not the business or charity is registered with the BBB
    - What rating they have been given by the BBB
    - Procedures for filing a complaint, if you wish to do so



Complaints about unethical business practices can also be brought to the attention of your state Attorney General’s Office (described earlier).

### State-Based Consumer Protection Services

Each state has agencies dedicated to consumer protection, including but not limited to the state attorney general. Examples include banking authorities, utility commissions, and security administrators. The website [www.usa.gov](http://www.usa.gov) has a directory of consumer protection agencies in each state.

## Key Concept

A flow chart illustrating ALL categories of complaints outlined in this manual and where they should be referred is available in Appendix D of this manual.

## Recommended Resources

### Publications

- [SMP Foundations manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org)
- [SMART FACTS manual](#): Available in print from your SMP program or electronically at [www.smpresource.org](http://www.smpresource.org)

### Additional Online Resources

- CMS Regional Office Locator: <http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/index.html?redirect=/regionaloffices/>
- DME Supplier Telemarketing Frequently Asked Questions (CMS): [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DME\\_Telemarketing\\_FA\\_Qs.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DME_Telemarketing_FA_Qs.pdf)
- Financial Fraud Enforcement Task Force: [www.stopfraud.gov](http://www.stopfraud.gov)
- FTC Do Not Call registry fact sheet: <http://www.ftc.gov/bcp/edu/pubs/consumer/alerts/alt107.shtm>
- Office of the Inspector General: <http://oig.hhs.gov>





## **SMP Complex Issues and Referrals Training Manual**

### **CHAPTER 7: Case Studies; Applying What You Have Learned**

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## Case Studies

The following case studies are edited examples of actual SMP cases within the major categories of SMP complex issues and referrals addressed in this manual. All the names in these scenarios are fictional.

The entire breadth and depth of SMP complex issues and referrals cannot be captured by a few case studies, however these case studies provide you with some concrete examples of how to apply the knowledge you have gained. You will also notice that many examples involve more than one major category, such as both Medicare Part D and Medicaid or both Consumer Fraud and a complaint that is not an SMP complex issue. You will find this to be common in your work at the SMP.



It should be noted again that all complex issues should be entered into SMART FACTS according to the instructions in Chapters 5 and 6 of the SMART FACTS manual. SMART FACTS instruction is outside the scope of this manual; however some specific SMART FACTS references will be found below, due to the nature of the examples. The absence of reference to SMART FACTS data entry is not meant to imply that data entry isn't necessary.

### Key Concept

The flow chart in Appendix D, which illustrates all categories of complaints and appropriate referrals outlined in this manual, will assist you with these case studies.

## Complex Issue Involving Suspected Error

**Scenario:** A beneficiary named Gloria who is enrolled in Original Medicare reviewed her MSN and called the SMP to report very high charges for a recent hospital stay. Also, there were two charges for MRIs and she only remembered having one MRI. She thinks the hospital might be trying to rip off Medicare. She has not yet talked to the hospital.

### What is the Problem?

- **May Not be a problem:** Complaints of excessive prices are a Medicare benefits issue, rather than suspected fraud, error and abuse (see Chapter 5).
- **May be a problem:** Billing for two MRIs could be a billing error on the part of the hospital for the two MRIs, since it would be unusual for two MRIs to be performed during one hospital stay.

### What is the SMP Response?

1. To address Gloria's concerns that the overall hospital charges were too high, educate her about Medicare's method of paying inpatient hospital claims. You can send her to either the SHIP program or 1-800-Medicare for a detailed explanation of Medicare coverage policy.
  - For example, Medicare benefits experts can explain that hospital inpatient claims are paid under the Diagnosis Related Group (DRG) system and charges on a hospital claim do not necessarily reflect what Medicare actually allows or pays.
2. To address Gloria's report that she only received one MRI yet two MRIs were billed, recommend that she contact the hospital to discuss the potential double billing for her MRI.
  - Ask Gloria to follow up with you regarding their response.
  - If there was an error, request from her a copy of the original MSN and the corrected MSN for annual outcomes reporting to the OIG.
3. Offer to contact the hospital billing department if Gloria is unable or unwilling to make the contact herself. Take the following steps:
  - Contact the hospital on Gloria's behalf. If they request a release of information before speaking with you, follow-up with Gloria.
  - Clarify whether or not only one MRI was performed and, if so, ask them to remove the duplicate MRI charge.
  - Follow up with Gloria to explain the results of your work and arrange for her to provide you with a copy of her corrected MSN, if indeed only one MRI was performed.

**NOTE:** *As long as the hospital billing department is cooperative, this case remains in the category of suspected error.*

## Complex Issue Involving Part A

**Scenario:** A nurse for a skilled nursing facility called the SMP to report hospice care fraud on the part of her employer. She knew that the facility director was altering patient records to falsely indicate they needed a hospice level of care in order to obtain higher reimbursement from Medicare. The nurse did not want her employer to know about her report to the SMP but was willing to be identified to investigators.

### What is the Problem?

This situation reflects multiple violations of the law, both under the False Claims Act and the Civil Monetary Penalties Law, including altering patient records to achieve higher payment, incorrect reporting of diagnoses, and submitting claims the provider knew to be fraudulent.

### What is the SMP Response?

This is a clear-cut case of an immediate referral to the OIG, via ACL. You should not contact the provider, due to the egregious nature of the case.

1. Explain your SMP role to the nurse: SMPs make referrals to CMS and the OIG, but are unable to provide any information on the status of the case until it has been resolved.
  - o Referred cases, particularly egregious ones, can take years to resolve.
2. Inform her that she may be contacted by an investigator as a result of your referral.
  - o Tell her also that investigators will not inform you about progress on her case. You will only be informed when it is fully resolved.
3. In this scenario, the nurse was willing to be named as the complainant.
  - o If she had wished to remain anonymous, you would have submitted an anonymous referral, entering the facility name in the yellow “First Name” field and “anonymous” in the yellow “Last Name” field in SMART FACTS. Anonymous referrals do not carry the same weight with investigators, so it is fortunate that she was willing to give her name.

**NOTE:** See the SMART FACTS manual, Chapter 5, for complex issue data entry instructions. See the SMART FACTS manual, Chapter 6, for instructions in documenting a referral in SMART FACTS. See Appendix C for instructions regarding referrals to the OIG Hotline via ACL.

## **Complex Issue Involving Part B**

**Scenario One:** A beneficiary in Original Medicare named Kim was prescribed a power wheelchair. The durable medical equipment (DME) supplier took measurements and ordered the wheelchair. When it arrived, Kim found that it did not fit her and she was unable to use it. Either the measurements were taken incorrectly or the chair was not ordered according to the measurements. Kim called the DME supplier to complain and request help, but was forced to leave repeated messages. Because the DME supplier did not return her phone calls, she called the SMP. She does not have a copy of her MSN yet and is not signed up with [www.mymedicare.gov](http://www.mymedicare.gov) to review her claims in real time. Incidentally, the SMP recognized the name of the DME supplier, since they had been frequently complained about both within the state and within the national SMP network.

### **What is the Problem?**

The supplier neglected to respond to Kim's complaint directly. Medicare has been billed for her power wheelchair, which does not meet her needs. Not only does unusable equipment waste Medicare dollars, Kim now has a power wheelchair that she cannot use. Because Medicare only pays for one in a beneficiary's lifetime, Kim cannot go to a different supplier for an appropriate power wheelchair without paying out of pocket. The SMP knows that this supplier is frequently complained about by beneficiaries and other SMPs. In summary:

- The DME supplier is not addressing the problem directly with the beneficiary, which is its obligation.
- DME suppliers must ensure a proper fit the first time.
- Medicare will only pay for one power wheelchair in a beneficiary's lifetime.

### **What is the SMP Response?**

1. Use your SMP Unique ID with 1-800-Medicare to research whether or not the supplier has already billed Medicare for the power wheelchair.
2. Attempt to contact the DME supplier on Kim's behalf, to see if they will remedy the situation after talking with you.
  - Though Kim said she had tried and failed to work with the provider, this step gives the provider the benefit of the doubt and allows you to double check the information you were given by the beneficiary.
  - If the supplier responds with a willingness to remedy the situation, request a timeline from them and follow-up with Kim to ensure she receives immediate assistance and a timely replacement power wheelchair.

### *Example of a Complex Issue Involving Part B, What is the SMP Response, continued*

3. If the DME supplier is unresponsive, refer the case to the OIG through ACL as a case of suspected fraud, particularly since a pattern of “error” has been noticed with this particular provider.
4. Request instruction from CMS about how to remedy Kim’s medical need for a power wheelchair during the investigative process. Your SMP Unique ID with 1-800-Medicare is one good CMS resource available to you for this purpose.
5. Follow up with Kim.
  - Explain any guidance you received about how to remedy her need for a power wheelchair.
  - If the provider remained unresponsive through this process, suggest she consider filing a complaint with the Better Business Bureau.
  - Check in with Kim periodically until her need for a properly fitting wheelchair has been met.

**Scenario Two:** A beneficiary named Mr. River contacted the SMP because he was getting charged a \$147 deductible at XYZ Pharmacy for his diabetes supplies, even though his supplemental plan (Medigap Plan F) should have been charged the deductible. This pharmacy is a Part B provider and did accept Medicare payment. Mr. River called the pharmacy to explain that his supplement covers the deductible, but they disagreed with him and said he still needed to pay them directly. He paid, but went to a different pharmacy for his diabetes supplies the next time. The second pharmacy did bill his Medigap Plan and did not charge Mr. River the deductible. He called the SMP because he thought XYZ Pharmacy was engaged in fraud and he wanted to report it. This was the second complaint of the same nature against that pharmacy received by the SMP in recent months.

### **What is the Problem?**

The pharmacy was not honoring the additional coverage made available to Mr. River through his supplemental (Medigap) plan. The pharmacy needs to bill the Medigap Plan and owes Mr. River a refund of \$147. The pharmacy appears to not understand the terms of the Medigap Plan F.

### **What is the SMP Response?**

If the SMP representative managing this case does not already know the coverage available through Medigap Plan F, the SMP representative can research the issue online, ask the SHIP program, or use her SMP Unique ID with 1-800-Medicare to inquire. Upon verifying that XYZ Pharmacy indeed should not have charged Mr. River the cost of the deductible, but should instead have billed his Medigap Plan, the SMP representative should take the following steps:

### *Example of a Complex Issue Involving Part B, What is the SMP Response, continued*

1. Contact XYZ Pharmacy and explain the problems being reported by Medicare beneficiaries who should not be charged a deductible for their diabetes supplies. Explain that the Medigap Plan should be billed and the beneficiaries should be reimbursed.
2. If the pharmacy disagrees and will not remedy the situation, refer the case to 1-800-Medicare using the SMP Unique ID (see Appendix B) as suspected Medicare abuse.
3. Follow-up with Mr. River until he receives his reimbursement. Request proof of the reimbursement so that SMP can claim dollars on Outcome 17C of the OIG Report (for savings to a beneficiary).
  - See the SMART FACTS manual, Chapter 6, for more information on acceptable documentation. See also training provided by the OIG on the SMP Resource Center's website, [www.smpresource.org](http://www.smpresource.org).

## Complex Issue Involving Part C

**Scenario:** An anonymous senior housing coordinator contacted the SMP to report that residents at a senior apartment complex were being visited by Medicare Advantage plan insurance agents. The senior housing residents had not requested these visits but let the agents into their apartments because the agents said they had been sent by the doctor who sees most of the residents in the housing complex. The agents proceeded to enroll the residents in a Medicare Advantage plan and also attempted to sell life insurance. The agents knew a great deal about the residents, including their Medicare number and their personal health information. The anonymous complainant knew the name and address of the residents' doctor and the Medicare Advantage plan being marketed.

One of the residents at this senior apartment complex later contacted the SMP and reported that she was pressured by her doctor into enrolling in the plan but discovered later that it didn't meet her needs. She said the doctor had invited the plan representatives into his office, where patients were told they needed to enroll for the Medicare Advantage plan because it was better. The resident reporting this activity had enrolled, discovering later that the Medicare Advantage plan didn't meet her needs. She realized, in retrospect, that the situation didn't "feel right."

### What is the Problem?

There are multiple violations represented in this scenario:

- It appears that the doctor colluded with the plan to violate CMS marketing guidelines, also violating patient confidentiality.

### *Example of a Complex Issue Involving Part C, What is the Problem, continued*

- Possible kickbacks from the plan to the provider can be suspected.
- The Medicare Advantage plan agents violated multiple aspects of the CMS marketing guidelines.
- At least one resident was enrolled in a plan that didn't meet her needs.

## What is the SMP Response?

This scenario involves two separate (though related) complex issues.

### **Complex Issue #1:** Anonymous complaint from the senior housing coordinator

1. Inform the senior housing coordinator of the SMP referrals process. Offer to work with her to inform residents in her building about the SMP program, being respectful of her desire to be discreet about the actual incidences of fraud in order to remain anonymous.
2. Enter an anonymous complex issue into SMART FACTS.
  - Enter the senior housing facility name in the yellow "First Name" field, which will help you easily identify this anonymous complaint compared to other anonymous complaints.
  - Use the term "anonymous" in the yellow "Last Name" field, which will allow you sort alphabetically for your anonymous complaints.
3. Make a referral to the OIG via ACL for suspected kickbacks and collusion on the part of the doctor (see Appendix C for procedures).
4. Make a referral to your CMS RO DOI Liaison for the plan marketing violations
5. Make a referral to the state department of insurance, due to the egregious agent behavior.

### **Complex Issue #2:** Complaint from the individual resident of the senior apartment complex

1. Inform the resident about the SMP referrals process.
2. Conduct a referral to the OIG, via ACL, for suspected kickbacks and collusion, explaining that the incident happened at the same senior housing residence involving the same doctor as your other case (complex issue #1 above). It is important to point out the links between related cases in your case notes.

*Example of a Complex Issue Involving Part C, What is the SMP Response, continued*

3. Make a referral to the CMS RO DOI Liaison, due to the marketing violations and the senior housing resident's need for help with the inappropriate disenrollment from Original Medicare.
4. Explain your SMP role to the beneficiary:
  - SMPs make the referrals, but are unable to provide any information on the status of the case until it has been resolved.
  - Referred cases, particularly egregious ones, can take years to resolve.
  - The CMS RO DOI Liaison will assist her in returning to Original Medicare.
5. Inform her that she may be contacted by an investigator as a result of your referral.
6. Though the provider's violation of confidentiality in this case could warrant quality complaints, the egregious nature of this issue dictates that you should leave it in the hands of investigators rather than conducting further referrals to quality improvement organizations or state certification boards, unless you are told otherwise by ACL when you make your referral. You do not want to compromise an investigation.

### Complex Issue Involving Part D

**Scenario One:** A beneficiary named Carmela was called by an ABC Health Care insurance sales agent who informed her that he was working with low income people to help them get some new benefits they are entitled to, called "Extra Help." Carmela told the agent she was not interested. However, the next day the agent showed up at her door. He said he was from Medicare, so Carmela let him in. After talking awhile, the agent handed her an ABC Health Care folder. The agent told her that not only would his plan cover her prescriptions, her doctor was also part of the ABC Health Care provider network. She told him that she still didn't want to change plans because she didn't want to risk having to change doctors. She was interested in the Extra Help program he described, however.

A week later, Carmela went to her pharmacy to pick up her prescription drugs and found that she had been switched to a different plan. The prescriptions she was on were not covered under the new plan. She tried to contact the ABC Health Care sales agent who had visited her, but the telephone number he provided was out of service. She then contacted the SMP program, having received the SMP brochure at a senior center presentation. She told the SMP that she never agreed to enroll in ABC Health Care. She thought she was only signing up for Extra Help.

*Example of a Complex Issue Involving Part D, continued*

### **What is the Problem?**

- Insurance agents cannot represent themselves as being “from Medicare.”
- Insurance plans cannot make cold calls to beneficiaries.
- Insurance plans cannot solicit door to door and cannot visit a beneficiary in their home without an approved scope of sale.
- Extra Help applications are handled through the Social Security Administration, not insurance sales agents (see Chapter 2 of SMP Foundations volunteer training).
- The salesman misrepresented himself by marketing “Extra Help” and using it to secure Carmela’s Medicare number, resulting in her being disenrolled from the plan of her choice and enrolled in a plan that did not meet her needs.
- Carmela’s health and financial well-being were negatively impacted due to the loss of coverage for her prescriptions and subsequent out-of-pocket expenses.

### **What is the SMP Response?**

1. Inform Carmela about the SMP referrals process and that she may or may not be contacted by an investigator.
2. Refer this case to the CMS RO DOI Liaison also, due to the marketing violations and inappropriate disenrollment from her plan and enrollment in another plan against her wishes.
3. Make a referral to the state department of insurance, due to the egregious agent behavior.
4. Explain your SMP role to the beneficiary:
  - SMPs make referrals of suspected fraud but are unable to provide any information on the status of the case until it has been resolved.
  - Referred cases, particularly egregious ones, can take years to resolve.
5. Explain that the CMS RO DOI Liaison will assist her in returning to the plan of her choice.
  - Explain to Carmela that she can work with her pharmacist to arrange temporary coverage for prescriptions while her enrollment request is being processed by a Medicare representative.

### *Example of a Complex Issue Involving Part D, What is the SMP Response, continued*

6. Check back with either Carmela or the CMS RO DOI Liaison within two weeks to make sure Carmela is re-enrolled in her original Part C and Part D Plan.
7. Educate Carmela about the other appropriate consumer protection and public benefits organizations that can help her, offering assistance in working with them if needed:
  - Send Carmela to the Social Security Administration to complete a legitimate Extra Help application. Tell her the SHIP program can also help.
  - Inform Carmela of the role of the Better Business Bureau and the procedures for filing a complaint, if she wishes to do so.

**Scenario Two:** A beneficiary named Mr. Lin called to complain that for the third time that year his pharmacy did not dispense the proper number of pills in his prescription. All three times he was dispensed fewer pills than he was supposed to receive. Each time, he complained to the pharmacy and they corrected the problem. Still, he thinks it is suspicious that the problem keeps occurring.

### **What is the Problem?**

It is difficult to know whether or not the pharmacy is purposefully engaging in pill-shortening. Since this is the only complaint your SMP has received about this pharmacy, you can give the pharmacy the benefit of the doubt regarding their intentions and refer this as suspected abuse rather than suspected fraud. The pharmacy's practices are potentially resulting payment for services that do not meet professional standards (pill shorting), but the pharmacy may not be knowingly or intentionally shorting their customers on pills. Still, there is a pattern, with Mr. Lin having experienced the problem three times, and Mr. Lin's efforts to stop the pattern have had no effect.

### **What is the SMP Response?**

1. Explain the SMP role to Mr. Lin and inform him that you will refer his complaint to the MEDIC, a CMS contractor, who may or may not contact him regarding his complaint.
2. Conduct a referral to the MEDIC for suspected Part D services abuse.
3. Review SMART FACTS periodically for case resolution information from the MEDIC.

## Complex Issue Involving Medicaid

**Scenario:** A long-term Medicaid recipient named Mr. Jones contacted the SMP for assistance because he had received a notice from a collection agency to pay more than \$10,000 to the hospital that took care of him for complications after a stroke. His stroke had occurred two years ago and he didn't understand why he would be billed, since he was on Medicaid. In addition to the notice from the collection agency, the hospital sent him a letter saying they were going to sue him for the services. Mr. Jones was very distraught and overwhelmed.

### What is the Problem?

- Medicaid recipients should not be responsible to pay their entire hospital bill, so the hospital was in error for trying to obtain complete payment from him.
- Mr. Jones should not have been sent to collections for a bill that was not his responsibility.
- There seems to have been a breakdown in the payment process between the hospital and the state Medicaid office.

### What is the SMP Response?

1. Determine whether or not Mr. Jones can take action on his own behalf. In this example, Mr. Jones is overwhelmed and he elected to have the SMP intervene. He has already made many calls and doesn't feel like anyone is listening to him.
2. Gather information. Begin with the Medicaid office to verify that he did have Medicaid at the time of service. If he did, determine why they did not pay Mr. Jones' claim.
  - In this example, the Medicaid case worker said the hospital never completed and returned the paperwork required by Medicaid to reimburse the hospital.
  - Also, the Medicaid office was able to determine that Mr. Jones' share of the hospital cost was \$1,500.
  - Ask the case worker for information about who at the hospital should be contacted to complete the appropriate steps.
3. Contact the hospital and request that they remedy the situation. Provide them with the instructions you received from Mr. Jones' Medicaid case worker. Remedies taken by the hospital should include:
  - Submitting a proper claim to Medicaid
  - Cancelling the involvement of a collection agency
  - Sending Mr. Jones a letter removing the threat to sue

*Example of a Complex Issue Medicaid, What is the SMP Response, continued*

4. Follow up with Mr. Jones to inform him of your progress. Ask him to contact you when the problem has been resolved so that you can close the case. Request copies of the revised letters and bills that he receives so that you can document cost avoidance for the OIG Report.
5. Maintain contact with Mr. Jones to stay abreast of progress and to ensure that the problem gets resolved.
6. If the hospital neglects to complete the needed paperwork and remedy the situation, make a referral of suspected Medicaid abuse to the Medicaid Fraud Control Unit.

### **Complex Issue Involving Consumer Fraud: Solicitation Involving Medicare**

**Scenario:** Your SMP received a report from a local senior center that scam artists posing as Medicare officials are calling Medicare beneficiaries requesting personal information, such as Social Security numbers, Medicare numbers, or bank account numbers. The callers tell Medicare beneficiaries they need this information in order to provide rebate checks, which were made possible due to health care reform. So far, none of the beneficiaries who have called you gave out their personal information to these callers.

#### **What is the Problem?**

- Medicare officials do not make cold calls to seniors, nor do they request Medicare numbers.

**NOTE:** *Under rare circumstances, contractors hired by CMS to conduct research may call a beneficiary as part of a study. Beneficiaries selected for studies receive letters in advance, however. Keep in mind also that Medicare Advantage Plans can call their existing members to discuss their benefits (these would not be considered cold calls).*

- Health care reform resulted in the provision of rebate checks to beneficiaries enrolled in Medicare Part D who had reached the coverage gap (also called the “donut hole”). However, beneficiaries reaching the coverage gap automatically received their rebate checks without having to take any action.
- Scam artists try various scare tactics designed to prey upon the public’s confusion over health care reform, with this particular tactic being only one of many.

*Example of a Complex Issue Involving Consumer Fraud: Solicitation Involving Medicare, What is the Problem, continued*

- This is a macro-level complex issue involving attempts to use Medicare or health care reform as a ruse to defraud consumers and steal their Medicare, Social Security, or financial information.

### What is the SMP Response?

1. Enter the scam into SMART FACTS as a macro-level complex issue, using the name of the scam in the yellow “First Name” and “Last Name” fields. In this example, you do not have information about any individual beneficiaries who were scammed, so you do not have any separate, micro-level complex issues associated with this scam to report.
  - Explain all of the details of the scam in the “describe the primary nature of the issue” field, which serve as your case notes.
  - Select the “telemarketing” options in the SMART FACTS complex issues checklists.
  - Enter the individual calls as simple inquiries, unless the callers needed SMP counseling. If an individual caller’s needs went beyond reporting the scam into needing SMP education, enter that call as a one-on-one counseling session.
2. Report the scam to the proper consumer protection authorities:
  - Local law enforcement
  - Your state attorney general’s office
3. Work with the staff at your SMP who conduct public education so that Medicare beneficiaries and caregivers in your state can be warned.

## Complaints that Do Not Involve SMP Complex Issues and Referrals

**Scenario One:** A beneficiary named Edward called the SMP in June, very upset because his doctor of 18 years is no longer a covered provider through his Medicare Advantage plan. Everything has been fine for three years and this has come up “out of the blue.” He has multiple complicated health problems and doesn’t believe another doctor could possibly understand him. He can’t afford to pay for his expensive care out of pocket.

He read that the SMP program addresses Medicare fraud and he thinks it is fraud that he is being forced to leave his doctor.

*Examples of Complaints That Do Not Involve SMP Complex Issues and Referrals, continued*

### What is the Problem?

- Client dissatisfaction with his Medicare coverage
- Client wants to make a change, but the open enrollment period is months away

### What is the SMP Response?

1. Listen empathetically to his complaint. This is a best practice when assisting any beneficiary and is particularly important given the disposition of this caller.
  - Refer to the SMP Counselor manual, Chapter 3, for tips on effective counseling skills.
2. Maintain a professional, neutral approach, without getting drawn into issues outside of your control. Gently convey that you empathize with him and then explain that Medicare coverage or policy guidelines are not within the authority of the SMP to change. Reassure him that you will do what you can to point him in the direction of a solution.
  - Provide him with the SHIP contact information to receive Medicare coverage guidance.
  - Suggest that he contact his Medicare Advantage plan to receive a list of covered physicians.
  - Suggest he talk with his doctor about his concerns and to find out what coverage his doctor does accept.
3. Enter this conversation in SMART FACTS as a one-on-one counseling session. It would not be considered a complex issue.
  - Responding to the complaint was achieved in one phone call.
  - The beneficiary was provided with education.
  - Further research and follow-up were not required.

**NOTE:** *For more information about the difference between one-on-one counseling and complex issues, see Appendix A of this manual and also the SMP Counselor Manual.*

*Examples of Complaints That Do Not Involve SMP Complex Issues and Referrals, continued*

**Scenario Two:** A caregiver calls with concerns about his parent. His parent has been receiving Medicare home health services, but the home health agency seems unable to send sufficient staff to the parent's home. He says the home health staff frequently does not show up when scheduled. When the caregiver calls to ask what happened, an excuse is made and the company asks to reschedule. The company is often unable to reschedule in time to provide therapy according to the doctor's prescription, however. The caregiver feels his parent's health needs are going unmet. The company is not charging for missed visits, since the caregiver has not received any bills and charges for these visits are not appearing on his parent's MSNs.

### What is the Problem?

- Poor quality of care
- Poor customer service

### What is the SMP Response?

1. Listen empathetically to his complaint.
2. Explain the SMP role and respond that the problem seems to be poor quality of care and poor customer service rather than fraud, based on the information provided.
3. Suggest other appropriate avenues for this caregiver to take in order to remedy the situation:
  - Seek a different home health agency
  - Contact the prescribing physician to report the poor quality of care
  - If the beneficiary is dual-eligible (on both Medicare and Medicaid), report the problem to the Medicaid office
  - File a complaint with the state Quality Improvement Organization (QIO)
4. Document the conversation as a one-on-one counseling session.

## Key Concept

As explained in Chapter 1, Information and Assistance services, such as through the ADRC or Eldercare Locator, are excellent resources for beneficiaries or caregivers whose needs are outside the scope of the SMP.

## **Closing**

Strategies used by unscrupulous individuals involved in health care fraud are vast and ever-changing. It is not possible to outline every kind of scenario in this manual. Because the methods used to prevent, detect, and report fraud, error, and abuse evolve over time, this manual will be updated periodically. In addition to mastering the concepts in this manual, you can keep your skills current by taking part in the ongoing training offered by your state SMP, the Administration on Aging (AoA), and the SMP Resource Center.



# **SMP Complex Issues and Referrals Training Manual**

## **Appendices**

**Appendix A:** Types of SMP Questions

*Also Appendix A of the SMP Counselor Manual*

**Appendix B:** SMP Unique ID User Guide

**Appendix C:** SMP Referrals to the OIG Hotline

**Appendix D:** Flow Chart – SMP Complex Issues and Referrals

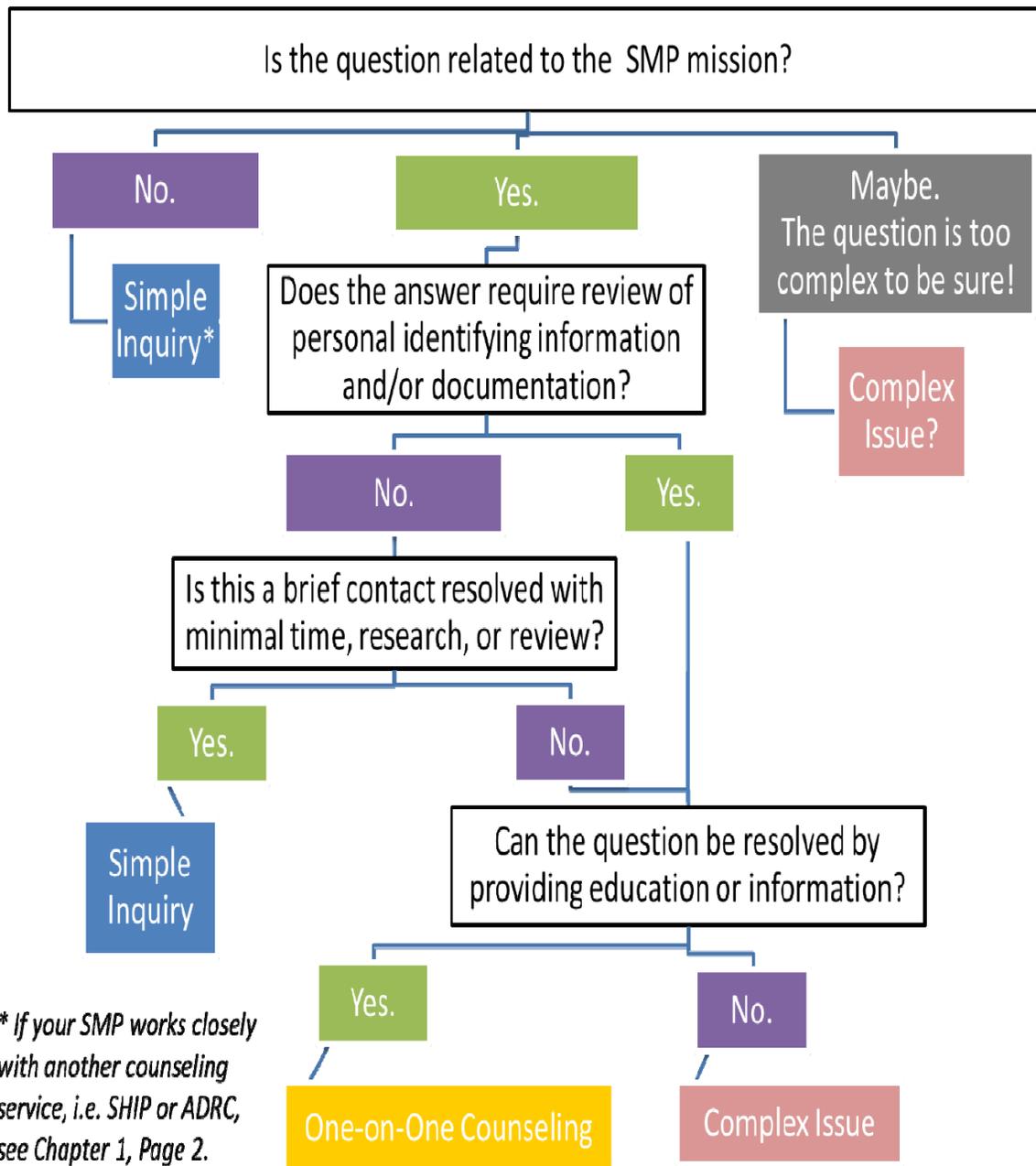
**Appendix E:** Handout: Can They Do That? Medicare Part C and Part D Plan Marketing Rules

**Appendix F:** Glossary of Terms



## Appendix A: Types of SMP Questions Flow Chart

Use the chart below to determine if a question is a simple inquiry, a one-on-one counseling session, or a complex issue. Details are provided on the following pages. See Chapter 1 for additional information.





*Appendix A: Types of SMP Questions Flow Chart, continued...*

**Is the question related to the SMP mission?**

“The SMP mission”

- The mission of the Senior Medicare Patrol (SMP) program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, error, and abuse through outreach, counseling, and education.
- The SMP mission involves educating beneficiaries about the SMP program, outreach and education events, volunteer opportunities, and/or potential Medicare fraud, error or abuse.

<b>No.</b>	If a question is NOT related to the SMP mission, it’s a simple inquiry.
<b>Yes.</b>	If a question IS related to the SMP mission, it could be a simple inquiry, a one-on-one counseling session, or a complex issue. Additional factors must be considered before making a decision.
<b>Maybe.</b>	If the question is too complex to be sure, send it to the person at your SMP who handles complex issues so that they can decide.

**Does the answer require review of personal identifying information and/or documentation?**

“Personal identifying information and documentation”

- |                                                                                                                                                                         |                                                                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Medicare card and/or number</li> <li>• Social Security card and/or number</li> <li>• MSNs (Medicare Summary Notice)</li> </ul> | <ul style="list-style-type: none"> <li>• EOBs (Explanation of Benefits)</li> <li>• Information about a medical condition</li> <li>• Financial account information</li> <li>• Etc.</li> </ul> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

<b>No.</b>	If this type of review is NOT needed, it could be any of the three types of questions. See the next step in the flow chart.
<b>Yes.</b>	If this type of review IS needed, the question can no longer be a simple inquiry. See the next step in the flow chart to decide if it’s a one-on-one counseling session or complex issue.

Appendix A: Types of SMP Questions Flow Chart, continued...

**Is this a brief contact, resolved with minimal time, research, or review?**

“Brief”

- The question can be answered in less than 15 minutes (not counting time needed to address communication barriers such as hearing impairment, language issues, side conversations, beneficiary venting, etc.).

“Minimal time, research, or review”

- For simple inquiries and one-on-one counseling sessions, additional “research or review” may be needed by the SMP in order to **answer the question**.
- For complex issues, additional research, review, and/or follow-up are needed by the SMP to **resolve a problem**.

Yes.	If this is a brief contact which can be resolved with minimal time, research, or review, it's a simple inquiry!
No.	If it's not, it could be either a one-on-one counseling session or complex issue. See the next step in the flow chart to decide.

**Can the question be resolved by providing education or information?**

“Education or information”

- Simple inquiries and one-on-one counseling sessions are outreach and education activities of the SMP program. The purpose of these types of sessions is to educate and inform.
- Any question which requires additional actions beyond providing education or information should be sent to the person at your SMP who handles complex issues.

Yes.	If the question can be resolved by providing education or information, it's a one-on-one counseling session!
No.	If additional action is needed, it's a complex issue!

# Appendix B: SMP Unique ID User Guide

## SMP 1-800-Medicare Unique ID

### USER GUIDE



### What is the benefit of the SMP Unique ID?

The SMP Unique ID allows you to make a referral of suspected Medicare Part A or Part B abuse. This SMP Unique ID also allows you to speak with 1-800-Medicare customer service representatives (CSRs) on behalf of a beneficiary. Without an SMP Unique ID, the beneficiary must be present during conversations with 1-800-Medicare. SMPs often work with beneficiaries who need the SMP to call 1-800-Medicare on their behalf. The reasons vary, but may include having difficulty with the complexities of Medicare, incapacity, sensory impairment, or geographic isolation, to name a few. You do not need to obtain a signed client release of information in order to speak with 1-800-Medicare on behalf of a beneficiary using your SMP Unique ID.

### Appropriate Use of ID:

SMP staff and volunteers who manage SMP complex issues should use this service to research complex issues and to refer suspected Medicare Part A or Part B abuse. Some complex issues involve errors, rather than fraud or abuse. The SMP Unique ID is particularly beneficial for assisting beneficiaries in resolving claims errors but it may also be needed to research claims involving suspected fraud or abuse.

### Types of claims you can research:

Claims involving original Medicare can be researched using this ID. Claims involving Part C or Part D must be researched directly through the Plan. See the attached handout from 1-800-Medicare that explains the information 1-800-Medicare Customer Service Representatives (CSRs) can provide regarding claims involving Original Medicare.

### How to use your Unique ID

1. Have the following information ready to provide to the CSRs. It will be needed for every call:
  - Beneficiary name (as it appears on their Medicare card)

- Beneficiary Medicare #
- Beneficiary date of birth

*These additional pieces of information may be needed also:*

- Beneficiary address
- Parts A & B effective dates (or whether or not they have Part B)

2. Dial **1-855-767-5463** (1-855-SMP-LINE)
  - This number is reserved specifically for SMPs
    - notice that this number is not *1-800-Medicare*
  - You will be greeted with *“Thank you for calling the Senior Medicare Patrol Hotline. Please enter your SMP number.”*
3. Enter your SMP Unique ID on your telephone keypad
4. Select from the following menu:
  - For general questions, press 1
  - For a hospital stay, press 2 (for a Part A agent)
  - For doctors services, press 3 (for a Part B agent)
  - For medical supplies, press 4 (for a DME agent)

### Frequently Asked Questions:

**Q:** “I already have a SHIP Unique ID. Do I still need an SMP Unique ID?”

**A:** Yes. CMS and AoA are tracking use of this Unique ID for outcome measurement and quality assurance purposes. Please continue to use your SHIP Unique ID for SHIP work, but be sure to use your SMP Unique ID for SMP work.

**Q:** I need to refer a complaint of fraud. Can I use my Unique ID for that?

**A:** No. SMP referrals of suspected Part A or Part B fraud are made to the OIG Hotline, via ACL. SMP Referrals of suspected Part C or Part D fraud or abuse have other protocols. Refer to Appendix D of the SMP Complex Issues and Referrals manual for an overview.

**Q:** Can I get copies of corrected MSNs with my SMP Unique ID?

**A:** No. CMS will only provide corrected MSNs to the beneficiary.

***For more information, contact the SMP Resource Center at 1-877-808-2468.***

1-800 MEDICARE CSRs **CAN** Perform the Following Activities

The appropriate Customer Service Representative (CSR) level for each topic is also listed below. Higher/different levels of CSRs do NOT have access to different (or more) information than the CSR tier shown below.

Subject/Topic	Notes	CSR Level
<b>Claims Inquiries (Denials)</b>	The beneficiary or SMP should check the MSN to understand what type of service is in question (i.e., Part A, Part B, DME). Claim Tier 1 CSRs can provide information on the reasons for the denial, details on suspended or rejected claims, and status of appeals.	Claim Tier 1 CSRs  <i>Note:</i> Claim CSRs are specific to the line of business (i.e., Part A, Part B, DME)
<b>Claims Inquiries (General)</b>	General Medicare Tier 1 CSRs can handle simple claims inquiries (i.e., indicate whether a claim was approved or denied, provide information on the amount paid, and determine crossover). This information is also available on the 1-800 MEDICARE IVR (Interactive Voice Response) and on mymedicare.gov	General Medicare Tier 1 CSR
<b>Competitive Bidding (Durable Medical Equipment)</b>	Specialized Competitive Bidding CSRs are able to provide information on the program, locate competitive bidding suppliers in the specific competitive bidding areas, and file complaints with the CBIC (Competitive Bidding Implementation Contractor) on various categories. This information is also available on www.medicare.gov	Specialized Competitive Bidding CSR  <i>Note:</i> A specialized group of agents have been identified to handle questions regarding Competitive Bidding. To reach the specialized group of agents, dial 1-800 MEDICARE from within a Competitive Bid area code to hear a special prompt at the beginning of the IVR.
<b>Complex Inquiries</b>	Certain inquiries will need to be referred to the claims processing contractor for further action. Examples would include reissuing checks and claims adjustments. (Note: though CSRs also handle fraud referrals, AoA requests that SMPs follow SMP-specific protocols for referring suspected Medicare fraud to CMS Contractors and the OIG).	Claim Tier 1 CSRs  <i>Note:</i> The CSRs will refer complex inquiries to the claims processing contractors (i.e., MACs) through the desktop. This is not a live transfer. The claims processing contractor takes the appropriate actions offline.

Subject/Topic	Notes	CSR Level
<b>LIS Eligibility Information</b>	LIS eligibility status is available on the web (i.e., Plan Finder, mymedicare.gov) and in the 1-800 MEDICARE IVR to SMPs and beneficiaries	General Medicare Tier 1 CSR
<b>Medicare Secondary Payer</b> <i>(Simple Terminations – when a person retires or terminates group health insurance that pays before Medicare)</i>	1-800 MEDICARE is only permitted to perform “simple terminations.” If the record is incorrect or needs to be deleted, the caller will be referred to COBC (Coordination Of Benefits Contractor).	Claims Part A, Part B, or DME Tier 1 CSRs
<b>Part D Enrollment Status</b>	Enrollment status is available on the web (i.e., Plan Finder, mymedicare.gov) and in the 1-800 MEDICARE IVR to SMPs and beneficiaries	General Medicare Tier 1 CSR
<b>Part D Premium Withhold</b>	General Medicare Tier 1 CSRs can verify if the beneficiary is in premium withhold status and can verify the amount of the Part D (and/or Part C) premium. General Medicare Tier 1 CSRs can file a complaint if the beneficiary is experiencing ongoing premium withhold problems.	General Medicare Tier 1 CSR

1-800 MEDICARE CSRs **CANNOT** Perform the Following Activities

*The appropriate Customer Service Representative level for each topic is also listed below. Higher/different levels of CSRs do NOT have access to different (or more) information than the CSR tier shown below.*

Subject/Topic	Notes
<b>Medicare Reconsiderations &amp; Appeals</b>	All appeal requests must be submitted in writing. Appeal rights and where to send the reconsiderations request are on the back of the MSN.
<b>Medicare Secondary Payer (i.e., Worker’s Compensation, Liability, Disability)</b>	1-800 MEDICARE can only provide status of the beneficiary’s record. If changes are required or updates needed, the caller should contact the Medicare Secondary Payer or Contractor or Coordination Of Benefits Contractor for specific resolution.  <i>Note: If an attorney requires the “Payment Summary” form for settlements, these are available on <a href="http://www.mymedicare.gov">www.mymedicare.gov</a></i>
<b>Retroactive Enrollments/Disenrollments</b>	1-800 MEDICARE is only permitted to perform <b>prospective</b> enrollments. If the caller requires a retroactive enrollment, the CSR will transfer the caller to an Internal Support Group CSR to file a complaint.  Retroactive enrollments are handled by the CMS Regional Office staff.

## SMP Referrals to the OIG Hotline via ACL

Under the guidance of ACL/AoA, the SMP network entered into a partnership with the OIG Hotline in May 2011. This partnership resulted in a pilot, which was expanded nationwide in the spring of 2013. Under this partnership, SMPs refer suspected Medicare and Medicaid services fraud to the Office of Inspector General (OIG) Hotline **via ACL**. ACL will triage SMP referrals of suspected fraud intended for the OIG Hotline.

This appendix is intended to provide the logistical steps required to conduct a referral. It will not replicate the decision-making guidance provided within the chapters of the manual.

### Step-by-Step Referral Procedures

1. Enter the complaint into SMART FACTS, following the data entry procedures in the SMART FACTS manual, Chapter 5.
2. Mark in SMART FACTS that the referral was sent to ACL by:
  - a. Marking **Referral** and **Contact ACL/AoA** on the SMP Activity Log. For example:

**SMP Follow Up Actions**

1 Date of Action  
 Mar 28 2013

Follow Up Action Taken (check all that apply)

- Referral** (always check this box if your action includes a referral on this date)
- Contact beneficiary
- Contact 1-800-Medicare
- Contact ACL/AoA**
- Contact CMS Contractor
- Contact CMS Regional Office
- Contact OIG

- b. AND mark **OIG Hotline** on the **Other Referrals** tab, as shown in the example below:

Select which **law enforcement** or **regulatory entities** you referred you

- Attorney General
- CMS Regional Office
- FBI
- Local law enforcement
- Medicaid Fraud Control Unit (MFCU)
- OIG Hotline**
- OIG - state office
- State Insurance Commissioner
- State Practitioner Licensing Board

3. Send an email to [smp@acl.hhs.gov](mailto:smp@acl.hhs.gov), alerting ACL that a referral of suspected fraud is waiting in SMART FACTS:
  - a. **Email Do's:**
    - i. **DO** tell them your **state**
    - ii. **DO** tell them the **case number** (so they can find your case)
  - b. **Email Don'ts:**
    - i. Do Not share any personal identifying information about the complainant in the email.
    - ii. Do Not share any personal identifying information about the person/provider who the complaint is against in the email.

### What Happens Next?

ACL will review your referral and forward it to the OIG Hotline, unless they deem it was not an appropriate OIG referral. If they have feedback or questions for you, they will contact you. When the case has been resolved, ACL will enter resolution information into SMART FACTS. This information will be entered in ACL fields contained on the 4<sup>th</sup> tab of the Complex Issues Form in SMART FACTS.

### FAQs

**Q: Will I be told the outcome of my referral so I can follow-up with the complainant?**

**A:** ACL is expecting to be informed by the OIG of the eventual outcome, however it may take years. You should inform the complainant that you have forwarded their complaint to the proper authorities but you may not know the outcome for a very long time, even years. You should also inform the complainant that they may be contacted by investigators if their complaint leads to an investigation. ACL will update SMPs on the resolution of their referrals when information becomes available to them. In the meantime, ask your complainant to contact you if they learn the outcome before you do.

**Q: How can I claim dollars for OIG Report outcomes 16, 17A, or 17B if I may not be told the outcome of my referral?**

**A:** Though they cannot promise immediate results, ACL is working on obtaining financial outcome data as the result of SMP referrals to the OIG. The OIG is documenting SMP as the referral source. Because this is a relatively new process and because cases that are investigated can take years to resolve, financial outcomes may not be measureable for several years. In the meantime, ask your complainant to provide you with documentation they receive, such as corrected MSNs, reimbursements, etc. that are related to their complaint, if applicable.

## Appendix D: SMP Complex Issues and Referrals Flow Chart

Error?	<ul style="list-style-type: none"> <li>• <b>Review claims</b></li> <li>• From beneficiary or 1-800-Medicare</li> <li>• <b>Resolve with Provider</b></li> <li>• Unless your research unveils suspected fraud/abuse</li> </ul>
Part A or Part B Abuse?	<ul style="list-style-type: none"> <li>• <b>1-800-Medicare</b></li> <li>• Use SMP Unique ID</li> </ul>
Part C or Part D Services Abuse?	<ul style="list-style-type: none"> <li>• <b>CMS Contractor (MEDIC)</b></li> </ul>
Parts A, B, C, and D Services Fraud?	<ul style="list-style-type: none"> <li>• <b>OIG (through ACL)</b></li> <li>• Email case number and your state to <a href="mailto:smp@acl.hhs.gov">smp@acl.hhs.gov</a> - ACL will forward to OIG</li> <li>• Exception: Fraud by Part C and D Plan Sponsors and Benefit Managers does <u>not</u> go to OIG; goes to <b>MEDIC</b></li> </ul>
Part C or Part D Marketing Violation?	<ul style="list-style-type: none"> <li>• <b>CMS Regional Office Department of Insurance Liaisons</b></li> <li>• <b>State Department of Insurance</b> (egregious agent or broker behavior)</li> </ul>
Medicaid Fraud or Abuse?	<ul style="list-style-type: none"> <li>• <b>State Medicaid Agency</b> (beneficiary perpetrated)</li> <li>• <b>Medicaid Fraud Control Unit</b> (provider perpetrated)</li> <li>• <b>OIG (through ACL)</b></li> <li>• Fraud referrals only. Email case number and your state to <a href="mailto:smp@acl.hhs.gov">smp@acl.hhs.gov</a> - ACL will forward to OIG</li> </ul>
Medigap Fraud or Abuse?	<ul style="list-style-type: none"> <li>• <b>State Department of Insurance</b> (such as complaints about a Medigap plan, agent behavior, lead generators, etc.)</li> </ul>
Consumer Protection Issue?	<ul style="list-style-type: none"> <li>• <b>State Attorney General, Federal Trade Commission (FTC), others as appropriate</b></li> <li>• See Chapter 6 for more</li> </ul>



## Appendix E: Can They Do That?

### Medicare Part C and Part D Plan Marketing Rules

The following chart outlines some of the common acceptable (**Okay**) and unacceptable (**Not Okay**) Part C and Part D Plan marketing practices that may be seen by beneficiaries.

The below chart is by no means exhaustive. To review the complete set of CMS Marketing Guidelines (100+ pages), visit <http://www.cms.gov/ManagedCareMarketing/>

Okay	NOT Okay
<b>Advertising</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Advertising sales/marketing events (in any form of media) must explain:                             <ul style="list-style-type: none"> <li>○ “A sales person will be present with information and applications”</li> <li>○ “For accommodation of persons with special needs at sales meetings call &lt;insert phone and TTY number&gt;”</li> </ul> </li> <li>✓ Educational events are advertised as such.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ An advertisement for an event does not state its purpose – marketing or education.</li> <li>∅ Communications resemble government mailings.</li> <li>∅ Sending unsolicited e-mails, text messages or voicemails to a beneficiary.</li> </ul>
<b>Co-Branding (provider logo and plan logo appearing together on materials)</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ When multiple providers participate in a plan, co-branded materials contain a disclaimer saying there are other participating providers, explaining how to find them.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Co-branding without the required disclaimer when there are multiple providers under a plan.</li> </ul>

Okay	NOT Okay
<b>Direct Mail</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ 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.</li> <li>✓ A plan may send items such as postcards, self-mailers, and reply cards.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ A plan violates a beneficiary's request to opt-out of receiving communications.</li> </ul>
<b>Enrollment Activities</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Plan salesperson is knowledgeable about Medicare and, during a marketing activity, objectively discusses whether or not the plan meets that potential enrollees individual needs.</li> <li>✓ 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.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Plan salesperson removes a beneficiary from Original Medicare and enrolls them in Medicare Part C without their knowledge.</li> <li>∅ Plan salesperson fails to demonstrate or provide adequate Medicare expertise and enrolls a beneficiary in a plan that is inappropriate for them.</li> <li>∅ Plan salesperson falsely states that their doctor accepts the plan.</li> <li>∅ 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.</li> <li>∅ Plan salesperson "cherry-picks" (selecting or denying beneficiaries based on their illness profile).</li> </ul>

Okay	NOT Okay
<b>Enrollment Activities, continued</b>	
	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Plan salesperson enrolls or attempts to enroll a dually-eligible beneficiary in their plan, regardless of its appropriateness for that beneficiary.</li> </ul>
<b>Events (Marketing and Education)</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Provision of a <b>light snack</b> 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.</li> <li>✓ Provision of a meal valued at \$15 or less at an event that is for general Medicare education purposes where no marketing occurs.</li> <li>✓ Marketing Events taking place at a kiosk or in a recreational vehicle (RV).</li> <li>✓ Providing a beneficiary with one or more salesperson business cards at an educational event and responding to questions if asked, as long as business cards are free of marketing or benefit information.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Provision of a <b>meal</b> 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. Beware of snacks bundled into a meal -- NOT okay.</li> <li>∅ Provision of a meal to prospective beneficiaries at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed. These would be considered marketing events and only light snacks are allowed.</li> <li>∅ The plan salesperson cannot market in the same building where an education event is taking place (or just took place). This would be considered back-to-back education and marketing, which is prohibited.</li> </ul>

Okay	NOT Okay
<b>Events (Marketing and Education), continued...</b>	
	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Collecting beneficiary contact information at an education event. Examples of violations:                             <ul style="list-style-type: none"> <li>○ Asking all participants to provide personal identifying information as part of a general “sign in” sheet</li> <li>○ Asking for contact information to participate in a drawing for a prize</li> </ul> </li> <li>∅ Agents or brokers may NOT require a face-to-face meeting to provide plan details.</li> <li>∅ Displaying business cards or attaching them to educational materials.</li> <li>∅ Agents or brokers may NOT request Social Security numbers, bank, or credit card info at education or marketing events.</li> <li>∅ Agents or brokers may NOT hold an educational event in a private home or other one-on-one setting.</li> <li>∅ Agents or brokers may NOT solicit individual appointments under the premise that the appointment is only for educational purposes.</li> </ul>

Okay	NOT Okay
<b>Health Care Settings</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Physicians can provide brochures or other educational materials about all the plans in which they participate.</li> </ul> <p><b>NOTE:</b> <i>Providers should remain unbiased. Also, they are not required to seek out materials from plans.</i></p> <ul style="list-style-type: none"> <li>✓ Plan salesperson conducts sales presentations and distributes and accepts enrollment applications in a common area.                             <ul style="list-style-type: none"> <li>○ Common areas are: hospital or nursing home cafeterias, community, recreational and conference rooms</li> </ul> </li> <li>✓ Patients are not misled or pressured into participating.</li> <li>✓ Conduct the following in long-term care facilities                             <ul style="list-style-type: none"> <li>○ Display posters</li> <li>○ Include materials in admission packets</li> <li>○ Provide to residents that meet Special Needs Plan criteria a brochure for each Special Needs Plan with which the facility contracts</li> </ul> </li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ A physician cannot reject brochures or other educational materials from some of the plans in which they participate, while accepting brochures or other educational materials from others.</li> <li>∅ Conducting sales presentations, distributing and accepting enrollment applications where patients receive care. Restricted areas include:                             <ul style="list-style-type: none"> <li>○ Waiting rooms</li> <li>○ Pharmacy counter areas</li> <li>○ Exam rooms</li> <li>○ Hospital patient rooms</li> </ul> </li> </ul>

Okay	NOT Okay
<b>Home Visits</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ A beneficiary requests a home visit from a plan salesperson. This includes visit in long-term care facilities</li> <li>✓ 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.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ A salesperson's initial contact is an unsolicited home visit – i.e. "door-to-door cold call" sales tactic.</li> <li>∅ Agents or brokers may NOT represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid.</li> <li>∅ Agents and brokers may not leave information such as leaflets, flyers, door hangers, etc. on someone's car or at their residence (unless the beneficiary is a "no show" for a pre-scheduled appointment).</li> </ul>
<b>Insurance Agent and Broker Credentials</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Plan salesperson has a demonstrated knowledge of Medicare, including passing a test.</li> <li>✓ Agent or Broker is licensed in their state and follows state appointment rules.</li> <li>✓ Plan customer service representatives are not licensed.</li> <li>✓ Plan terminates agents and brokers who violate regulations or laws, notifying the state licensure body. The bad behavior of individual agents or brokers does not automatically result in a plan losing the right to sell Medicare products, as long as they respond appropriately.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Plan salesperson has not passed test and/or demonstrates lack of adequate Medicare knowledge.</li> <li>∅ Unlicensed agents and brokers selling Medicare products and breaking state appointment rules.</li> <li>∅ Customer service representatives fulfilling roles that belong to licensed agents or brokers.</li> <li>∅ Plans failing to report termination of agents or brokers to state licensure body.</li> <li>∅ Agents or brokers must never represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid.</li> </ul>

Okay	NOT Okay
<b>Promotional Activities/Gifts</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ Offering promotional activities or items that are of “nominal” value. <i>Nominal value</i> 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.</li> <li>✓ Offering promotional activities or items to both current and potential enrollees.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ Offering promotional items or activities over the course of a year that have an aggregated value of more than \$50 per person.</li> <li>∅ Offering items that are considered a health benefit for free as a promotion (e.g., a free checkup).</li> </ul>
<b>“Scope of Sales”</b>	
<b>– Defining the Content of a Sales or Enrollment Contact</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ 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.</li> <li>✓ A beneficiary changes their mind about the scope of sale during an appointment. (For example, asking about other insurance products). The salesperson documents this change of scope and provides the requested information.</li> <li>✓ 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 sale.</li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ 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.</li> <li>∅ Misrepresenting a product as an approved Part C or Part D plan when it is actually a Medigap policy or non-Medicare drug plan.</li> <li>∅ A beneficiary changes their mind about the scope of sale and the salesperson conducts marketing and/or enrollment activities without documenting the change in the scope.</li> <li>∅ Requiring a face-to-face appointment to provide plan information.</li> <li>∅ Returning uninvited to an earlier “no show.”</li> <li>∅ Using high pressure sales tactics.</li> </ul>

Okay	NOT Okay
<b>Telephone Calls (“Outbound” calls to beneficiaries)</b>	
<p><b>Okay:</b></p> <ul style="list-style-type: none"> <li>✓ A beneficiary has reviewed advertising or attended an educational event and gives permission to be contacted by the plan.</li> <li>✓ 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 (Refer to §70.6 on unsolicited contact).</li> <li>✓ An unsolicited outbound call may be made to beneficiaries currently enrolled in a Part C or Part D plan to conduct “normal business.” <ul style="list-style-type: none"> <li>○ For example, a beneficiary on “Extra Help” who needs to be re-assigned can be called</li> <li>○ Initiating a phone call to confirm an appointment</li> <li>○ Contacting members to discuss educational events</li> <li>○ Contacting former members after the disenrollment date to conduct disenrollment survey</li> <li>○ Returning beneficiary phone calls</li> </ul> </li> </ul>	<p><b>Not Okay:</b></p> <ul style="list-style-type: none"> <li>∅ 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.</li> <li>∅ Agents or brokers may NOT represent themselves as though they come from or were sent by Medicare, Social Security, or Medicaid.</li> <li>∅ 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. <ul style="list-style-type: none"> <li>○ Contacting beneficiaries to ensure receipt of mailed information</li> <li>○ Making calls to beneficiaries that resulted from a referral</li> <li>○ Making calls to former members who have disenrolled or to current members who are in the process of disenrolling</li> <li>○ Making calls without permission to beneficiaries who attended an event</li> </ul> </li> </ul>

## Appendix F: Glossary of Terms

### Terms

#### **1-800-Medicare**

Toll-free number for beneficiaries who have questions about their Medicare benefits and claims. SMPs have a unique ID allowing them to receive claims information on behalf of beneficiaries they are helping.

#### **Assignment**

An agreement by providers to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill beneficiaries for any more than the Medicare deductible and co-insurance.

#### **Cappers**

Cappers (also known as “recruiters”) will solicit beneficiaries for their Medicare numbers in exchange for cash, gifts, and “free” services, such as transportation.

#### **Centers for Medicare & Medicaid Services (CMS)**

The federal agency responsible for the Medicare and Medicaid programs.

#### **CMS Regional Office Department of Insurance Liaisons (CMS RO DOI Liaisons)**

CMS RO DOI liaisons handle CMS marketing rule violations for Medicare Part C and Part D.

#### **Complainant**

A Medicare beneficiary, caregiver, or other person who submits a complex issues complaint to the SMP.

#### **Complaints**

Allegations of fraud, error, and abuse.

#### **Complex Issue**

Complaints of Medicare fraud, error, and abuse, consumer scams that seek Medicare and Social Security numbers, and health care fraud aimed at Medicare beneficiaries often become “complex issues” in the SMP program. The OIG Report definition of complex issues further explains that complex issues are inquiries that generally require the SMP staff or volunteer to obtain beneficiary personal identifying information and detailed information related to the issue, complaint, or allegation in order to conduct further investigation or referral.

#### **Do Not Call Registry**

A free service that gives consumers the choice to avoid receiving telemarketing calls. It is managed by the Federal Trade Commission (FTC).

#### **Dual-Eligibles**

Individuals receiving both Medicare and Medicaid services.

*Terms, continued...*

**Durable Medical Equipment (DME)**

Certain medical equipment that is ordered by a doctor for use in the home. Examples are walkers, wheelchairs, hospital beds, and oxygen equipment and supplies. DME is paid for under both Medicare Part B and Part A for home health services.

**Explanation of Benefits (EOB)**

A statement sent by a health insurance company to covered individuals explaining what medical treatment and/or services were paid for on their behalf.

**Exploding Charges**

Illegal practice of billing separately for services already included in a bundle.

**Federal Trade Commission (FTC)**

The federal agency whose goal is to protect consumers by preventing fraud, deception, and unfair business practices in the marketplace.

**Kickback**

In the federal health care programs, a kickback is illegal and refers to a reward offered in exchange for a referral of health care business.

**Lead Generators**

Ways of developing contact lists for insurance solicitation. Example: postcard solicitation.

**Medicaid**

A joint federal and state program that pays medical costs for some people with low incomes and limited resources.

**Medical Identity Theft**

Refers to illegally obtaining and using someone's personal health information, either to bill for medical services or to receive medical services using the stolen medical identity.

**Medicare**

The federal health insurance program for people 65 years old or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant, sometimes shortened to ESRD).

**Medicare Advantage (also known as Part C)**

Health plan options run by Medicare-approved private insurance companies. Medicare Advantage plans are a way to get the benefits and services covered under Part A and Part B of Original Medicare. Most Medicare Advantage plans also cover Medicare prescription drug coverage (Part D).

*Terms, continued...*

**Medicare Drug Integrity Contractor (MEDIC)**

MEDICs are responsible for benefit integrity, medical review, data analysis, and related provider education and beneficiary outreach for the Part D (prescription drug) and Part C (Medicare Advantage) programs within Medicare.

**Medicare Summary Notice - MSN**

A notice sent quarterly to beneficiaries after doctors or providers have filed claims for Part A or Part B services in the Original Medicare plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what beneficiaries must pay, if anything. MSNs also provide Medicare appeals information. A paperless version is available at [www.mymedicare.gov](http://www.mymedicare.gov).

**Medigap**

Medicare Supplement policies, sold by private companies, that help pay some for the health care costs that Medicare doesn't cover.

**Observation Status**

Term used to define a beneficiary's hospital stay under a doctor's orders for "observation services," which help the doctor determine if the patient needs to be admitted. The time doesn't count toward the three-day inpatient hospital stay needed for Medicare to cover subsequent skilled nursing facility care and often results in unexpected out-of-pocket expenses for beneficiaries.

**Office of Inspector General (OIG) Hotline**

The OIG Hotline accepts tips from all sources about potential fraud, waste, abuse, and mismanagement in Department of Health and Human Services programs.

**Part A**

Medicare hospital insurance. It also helps cover skilled nursing facility, hospice, and home health care.

**Part B**

Medicare coverage for doctor and other health care provider services, outpatient care, durable medical equipment, and home health care.

**Part C**

Also known as Medicare Advantage (see above).

**Part D**

Medicare Prescription Drug Program.

*Terms, continued...*

### **Quality Improvement Organizations (QIOs)**

QIOs conduct reviews of complaints filed by Medicare beneficiaries about the quality of medical services received.

### **Referral**

In the context of “SMP Complex Issues and Referrals,” this term describes the SMP reporting a complaint to outside entities on behalf of the beneficiary, caregiver, or other complainant.

### **State Health Insurance Assistance Programs (SHIPs)**

SHIPs are state programs funded by the Centers for Medicare & Medicaid Services to provide free local health insurance counseling to people with Medicare. They are sometimes referred to by different names and acronyms (e.g., SHIBA, SHIK, GeorgiaCares).

### **SMART FACTS**

SMART FACTS is the web-based electronic tool for SMP management, tracking, and reporting of program outcomes to AoA and to the Office of Inspector General (OIG). SMART FACTS is also used to conduct electronic referrals of suspect fraud and abuse to CMS.

### **Senior Medicare Patrol (SMP)**

SMP programs are located in all 50 states, Puerto Rico, Guam and the Virgin Islands to help Medicare and Medicaid beneficiaries prevent, detect, and report health care fraud.

### **The Eldercare Locator**

A service of the U.S. Administration on Aging that provides national information and assistance/referral services. Visit the Eldercare Locator website: [www.eldercare.gov](http://www.eldercare.gov) or call 1-800-677-1116.

### **Upcoding**

Incorrect reporting of procedures to maximize payments.

### **U.S. Administration for Community Living (ACL)**

Agency created by the Department of Health and Human Services in 2012 to bring together the efforts and achievements of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability. SMPs and the SMP Resource Center are funded by ACL.

### **U.S. Administration on Aging (AoA)**

AoA oversees the national SMP program. AoA also works closely with its nationwide network of State and Area Agencies on Aging to plan, coordinate, and develop community-level systems of services that meet the unique needs of individual older person and their caregivers.

## **Acronyms and Abbreviations**

<b>AAA</b> .....	Area Agency on Aging
<b>ACL</b> .....	Administration for Community Living
<b>ADRC</b> .....	Aging and Disability Resource Center
<b>AoA</b> .....	Administration on Aging
<b>CMS</b> .....	Centers for Medicare & Medicaid Services
<b>DME</b> .....	Durable Medical Equipment
<b>DOI</b> .....	Department of Insurance
<b>EOB</b> .....	Explanation of Benefits
<b>HHS</b> .....	Department of Health and Human Services
<b>I&amp;A</b> .....	Information and Assistance
<b>MEDIC</b> .....	Medicare Drug Integrity Contractor
<b>MFCU</b> .....	Medicare Fraud Control Unit
<b>MSN</b> .....	Medicare Summary Notice
<b>OIG</b> .....	Office of Inspector General (Federal)
<b>SHIP</b> .....	State Health Insurance Assistance Program
<b>QIO</b> .....	Quality Improvement Organization



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