

Chapter Seven

Medicare and Insurance Fraud for Benefits Counselors

1. Fraud Prevention and Benefits Counseling. The federal government is committed to protecting the integrity of the Medicare program from fraud and abuse. In an effort to reduce fraud, the Administration for Community Living (ACL) and the Centers for Medicare & Medicaid Services (CMS) partner with other federal agencies, Medicare contractors and providers, and various state agencies. As a Benefits Counselor, your knowledge of Medicare's fraud prevention activities will help protect clients against Medicare fraud and thereby help safeguard the program.
2. Benefit Counseling activities related to fraud include legal assistance (one-on-one counseling) and legal awareness. An example of legal assistance might be reviewing a monthly "Medicare Summary Notice" (MSN) with a client who is concerned that the items listed do not reflect actual care or services provided. An example of legal awareness might be monitoring local events for the aged and/or disabled and then disseminating information about any that seem misleading or fraudulent to clients.
3. Source of the Law. The Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act (HIPAA), in 1996 strengthened efforts to monitor and prevent fraud and abuse in the Medicare and Medicaid programs. The Medicare Integrity Program was created with different authorities for contracting fraud prevention activities under CMS, the Office of Inspector General, the U.S. Department of Health and Human Services (DHHS), the Administration on Aging, and the Social Security Administration. Some of the Area Agencies on Aging have programs that include a fraud component beyond the State Health Insurance Assistance Program (SHIP) subcontract. The Texas SHIP is the partnership known as the Health Information, Counseling and Assistance Program (HICAP). Coordination with other program areas in your agency will assure that you reach a greater number of persons.
4. The Older Americans Act amendments of 2006 and HIPAA, established the Senior Medicare Patrol. The Senior Medicare Patrol (SMP) is codified at 42 U.S.C. § 3032. SMP conducts group education sessions to educate audience members on spotting Medicare error(s), fraud and abuse. SMP conducts one-on-one counseling sessions with Medicare beneficiaries or their authorized representative and community education events. Media outreach is also used by SMP. These and other SMP activities and additional resources to combat fraud are described at <https://acl.gov/programs/protecting-rights-and-preventing-abuse/senior-medicare-patrol-smp>. A visit to that site allows one to click on the "Senior Medicare Patrol Resource Center" link under "Resources and Useful Links" to arrive at the "SMP locator." The SMP locator

shows that The Administration for Community Living (ACL) Office of Healthcare Information & Counseling manages the Senior Medicare Patrol (SMP) grants and that the Texas contact information is:

Jennifer Salazar
SMP Program Director
BBB Education Foundation
1333 W. Loop S., Suite 1200
Houston, TX 77027
Direct: 713-341-6184
Toll Free: 1-888-341-6187
Fax: 713-341-6192
<http://texassmp.org>
jsalazar@bbbhou.org

5 If you need help or have questions about reporting fraud, go the “Report Fraud,” portion of the SMP resources website at: <https://www.smpresource.org/Content/You-Can-Help/Report-Fraud.aspx>

6. SMPs are funded by the Health Care Fraud and Abuse Control (HCFAC) program for its antifraud activities. “In 2019 funding for the SMP program totaled approximately \$18 million. Approximately \$15.6 million of the total funding available was distributed to the state SMP projects to help beneficiaries prevent, detect, and report Medicare fraud, errors, and abuse.” See <https://acl.gov/programs/protecting-rights-and-preventing-abuse/senior-medicare-patrol-smp>. The funding for 2020 was projected to be \$18 million as well.

7. At the SMP website one can see that the SMP’s partners include the U. S. Department of Health & Human Services Office of the Inspector General, Centers for Medicare & Medicaid Services (CMS), state Medicaid fraud control units, and state attorneys general, among other partners.

8. In addition to addressing fraud prevention in Medicare, this chapter will focus on identifying how the state level HICAP partners, including the Area Agencies on Aging and Texas Legal Services Center (TLSC), act as resources in fraud and abuse prevention.

9. Definition of Medicare Fraud and Abuse. Medicare consumer publications define fraud as “intentional deception” or a misrepresentation that an individual knows to be false and knows could result in some benefit to himself or herself or to some other person. The consumer website for Medicare includes fraud-related publications that can be downloaded or ordered in quantities. The website address is www.medicare.gov.

10. Medicare antifraud activities also focus on abuse, defined as incidents or practices that are inconsistent with sound and accepted medical, business, or fiscal procedures. Medicare fraud/abuse may be committed by health providers; home health agencies, durable equipment suppliers, nursing homes or hospice care centers, or Medicare beneficiaries. Medicare contractors are similarly charged with educating

beneficiaries and providers to review medical bills with intent to detect possible fraud. While part of the focus is to correct errors in billing, certain activities are routinely monitored to identify patterns of fraud.

11. New fraud prevention efforts include identifying examples of situations where fraud may occur relative to specific Medicare benefits. Efforts are aimed at informing consumers how services sometimes are intentionally billed by providers to receive higher reimbursement. An example might be a provider billing for inpatient services when the care was provided on an outpatient basis. To help prevent Medicare abuse, consumers should be encouraged to learn what Medicare pays and does not pay.

12. The impact of fraud in Medicare or Medicare-related insurance products. At the highest level, the U.S. General Accounting Office has reported that billions of Medicare dollars are lost each year to fraud and abuse. To taxpayers it means higher costs, and to persons on Medicare it can often mean both financial hardship and loss of needed services. The scope and nature of healthcare fraud can be seen by viewing the information at <http://oig.hhs.gov/fraud/fugitives/index.asp>

13. Medicare Initiatives to Reduce Fraud and Abuse. CMS has at least four general methods of fighting Medicare fraud/abuse. These include prevention, investigation, coordination, and prosecution. Following are brief summaries of these CMS efforts and programs. CMS is also a partner with the SMP, of course.

14. Prevention – CMS efforts directed at consumers include:

A. Each fall CMS distributes the publication, Medicare & You, to all Medicare enrollees as a tool to educate consumers. The publication encourages reporting fraud/abuse and cross-references each Medicare subcontracting agency. The publication includes:

- (1) a statement indicating that errors occur and urging review of the monthly Medicare Summary Notice (MSN),
- (2) a description of the beneficiary's right to request an itemized statement from the provider,
- (3) promotion of the Medicare incentive program, and
- (4) the toll-free hotline number to the DHHS Inspector General to report complaints and information about fraud, waste, and abuse.

B. CMS also promotes the toll-free number to report fraud to the DHHS Inspector General. The number is 1-800-HHS-TIPS (1-800-447-8477).

C. An incentive program allows clients monetary awards.

D. People with Original Medicare are urged to use the MSN (Medical Summary Notice) (previously called the Explanation of Medicare Benefits, or EOMB) to review services provided to them by Medicare contractors during the three-month period to which the MSN relates. The MSN details any supplies or services that were provided to the individual and billed to Medicare. The MSN shows the beneficiary what Medicare services have been billed to Medicare, regarding the beneficiary, during the three-month period.

Beneficiaries can also view Medicare claims that providers and suppliers have submitted, by visiting www.MyMedicare.gov.

E. Although the MSN is used solely with Original Medicare, Medicare Advantage (MA) plans as subcontractors with Medicare are also required to help educate consumers about fraud and how to report it. Information for enrollees on combatting fraud can be found in the 2021 edition of Medicare & You. That booklet can be accessed (and downloaded) at <https://www.medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf>. The information at page 101 of Medicare & You 2021 includes pointers on guarding against identity theft. The Federal Trade Commission operates an ID Theft Hotline, at 1-877-438-4338. TTY users can call 1-866-653-4261.

15. CMS offers numerous additional consumer publications that address fraud patterns related to Medicare benefits, such as ambulance or home health services, including, “Protecting Yourself and Medicare from Fraud” and “4 Rs for Fighting Medicare Fraud”. These can be accessed (and downloaded) at www.cms.gov and going to the “Fraud Prevention Toolkit” CMS also asks that you report suspicious activities by calling 1-800-MEDICARE (1-800-633-4227).

16. Investigation – CMS enforcement efforts have targeted home health agencies, durable medical equipment suppliers, nursing homes, and hospice care centers. CMS estimates that 40 percent of Medicare and Medicaid claims fraud is related to these services. Consumers and Benefits Counselors are urged to know whom to call regarding specific medical bills and Medicare coverage. CMS fraud publications identify the state SHIP as a source for consumers to get help with questions about their medical bills. A quick review of the publication Medicare & You 2021, Pages 105-112, lists numerous resources with information about Medicare benefits. The Medicare & You booklet and the resources mentioned in it can be very helpful to beneficiaries in understanding the Medicare Summary Notice (MSN).

17. A blank MSN and guidance on how to read it, can be found at <https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/medicare-summary-notice-msn>. Even more detail on what entries are required and appropriate in an MSN is at <https://www.cms.gov/manuals/downloads/clm104c21.pdf>. That is the Medicare Claims Processing Manual, Chapter 21 – Medicare Summary Notices. Providers and contractors must be mindful of the requirements of the Medicare Claims Processing Manual.

18. The contractors that pay Medicare claims are also responsible for fraud prevention activities. As a result of Section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173), CMS has revised the allocation of contractor territories in the U.S. Section 911 of P.L. 108-173 became Section 1874A of the Social Security Act. Following enactment of P.L. 108-173 by the 108th Congress, Section 911 was codified (put into the United States Code) at 42 U.S.C. §1395kk-1.

Under this provision, CMS has entered into contracts with “Medicare Administrative Contractors.” The MACs carry out functions that “Medicare carriers” and “Medicare intermediaries” used to carry out. Some businesses that had been carriers and intermediaries now have contracts as Medicare Administrative Contractors (MACs).

In Texas, Novitas Solutions, Inc. is the Part A and Part B MAC. See:

<https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List#Texas>

The MAC for durable medical equipment (DME) for Texas is CGS Administrators, LLC. See:

<https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List#Texas>

The MAC for Home Health and Hospice for Texas is Palmetto Government Benefits Administrator. See:

<https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List#Texas>

19. A further result of Section 911 of P.L. 108-173 is the increased role of the Beneficiary Contact Center (BCC). In its “Functional Contractors Overview,” CMS described the role of the BCC thusly: Beneficiary Contact Center (BCC) The BCC is assuming the duties traditionally held by fiscal intermediaries and carriers. In the BCC environment, beneficiaries have a single Medicare point-of-contact, a 1-800-MEDICARE call center operated by CMS that that will connect them to a seamless network of customer service entities that can answer Medicare and related questions and resolve problems. See

<https://www.cms.gov/About-CMS/Agency-Information/ContactCMS>

20. Although the BCC can answer many questions about Medicare, CMS has a separate fraud hotline (1-800-HHS-TIPS). Before a report is filed: “...carefully review the facts, and have this information ready:

- Your name and Medicare Number (as listed on your red, white, and blue Medicare card)
- The name of the doctor, supplier, or facility that you think committed fraud. If possible, also include any identifying number you might have, like a provider or supplier number. If the fraud is related to a specific claim, you should have this information ready:
 - The service or item you’re questioning
 - The date the service or item was supposedly given or delivered
 - The payment amount approved and paid by Medicare
 - The date on your “Medicare Summary Notice”
 - The reason you think Medicare shouldn’t have paid
- Any other information you have showing why Medicare shouldn’t have paid for a service or item
- If the fraud isn’t related to a specific claim, you should have this information ready:
 - A description of the fraudulent activity
 - The place, date, and time the incident happened
 - Any other information or evidence you have showing why you think the incident is fraud”

You can find a sample Summary Notice here: <https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/medicare-summary-notice-msn>

The contact information is:

By Phone: 1-800-HHS-TIPS (1-800-447-8477)

By Fax: 1-800-223-8164 (no more than 45 pages please)
By E-Mail: HHSTips@oig.hhs.gov
By Mail: U.S. Department of Health and Human Services Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026

See <https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud>

21. On the website www.cms.gov, Benefits Counselors can find additional fraud-related information, including a Fraud Prevention Toolkit, an Overview How to Report Fraud, and State by State Fraud and Abuse Reporting Contacts. For Texas the listed contacts are: Health and Human Services Commission, 800-436-6184, <https://oig.hhsc.state.tx.us/>, and Office of the Attorney General, 512-463-2011, <https://www.texasattorneygeneral.gov/consumer-protection/health-care/health-care-fraud-and-abuse>.

Although, the Medicaid Fraud Control Unit (MCFU), entails Medicaid fraud; some instances of fraud harm both Medicare and Medicaid. CMS coordinates with the U.S. Office of Inspector General, in the federal Department of Health and Human Services (DHHS), and with the Administration on Aging, the Office of the Attorney General, and the FBI.

22. The Administration on Aging also coordinates related fraud activities to programs that address issues of elder abuse and outreach to vulnerable populations. Making presentations on elder abuse and providing information via posters, conferences, and culturally relevant programs reach target populations. Oftentimes these local programs are an opportunity for networking. A Benefits Counselor might increase their outreach on fraud by conducting presentations on how Medicare works for staff and volunteers of the local programs. Such outreach will likely result in greater legal assistance requests as clients begin to understand the importance of reviewing their MSNs.

23. Prosecution can result from timely and accurate reports of fraud, although criminal liability in the United States requires proof beyond a reasonable doubt. Reporting fraud can also (or instead) result in administrative recoupment of Medicare/Medicaid dollars, provider penalties, disqualification as a provider in these programs, or license revocation. As noted, criminal actions and fines can also be imposed. As mentioned above, criminal prosecution, to be successful, must result in proof beyond a reasonable doubt – the highest burden of proof. Civil fraud claims and administrative penalties do not require that high a level of proof. Prosecution of Medicare/Medicaid fraud falls to federal and state agencies such as the federal DHHS, Office of Inspector General, FBI, and at state level agencies like the Texas Attorney General’s Office and the Texas Department of Insurance.

24. The Office of the Attorney General (OAG) has a Civil Medicaid Fraud Unit. The group protects taxpayers by enforcing the Texas Medicaid Fraud Prevention Act (TMFPA), chapter 36 of the Texas Human Resources Code. The TMFPA permits private citizens to file lawsuits on behalf of the state against

those who violate the TMFPA. These private citizens are referred to as "relators" and they assist the state in identifying and pursuing fraudulent activity committed against the Medicaid program. Relators in successful matters receive a portion of the recovery. The OAG may also pursue cases on its own on behalf of the Medicaid program. In addition to actively litigating in state and federal courts, CMF works with relators, the criminal Medicaid Fraud Control Unit, the federal government, other state governments, and law enforcement to effectively conduct nationwide fraud recovery efforts. Through these efforts, the OAG has recovered over 1.4 Billion dollars on behalf of the Texas Medicaid system. See <https://www2.texasattorneygeneral.gov/cmfcivil-medicaid-fraud>. At that website, one also sees the contact information for the Civil Medicaid Fraud Unit – (800) 252-8011, or <https://www.texasattorneygeneral.gov/divisions/law-enforcement/medicaid-fraud-control-unit>

25. The Consumer Protection Division of the Office of the Texas Attorney General (OAG) has as a charge to prosecute those who cheat or deceive the elderly. OAG can file lawsuits under the Deceptive Trade Practices Act and also take legal action in cases referred by other state agencies such as the Texas Department of Protective and Regulatory Services and the Texas Department of Insurance.

26. OAG participates in crime prevention programs like the national TRIAD program. This program works in conjunction with a community-policing program that invites the involvement of the National Sheriffs' Association, the International Association of Chiefs of Police and the American Association for Retired Persons (AARP). Through these national sponsors, local programs unite seniors, their providers, and local police and sheriff's departments to combat fraud. The OAG takes legal action in cases referred by the Texas Health and Human Services, the state agency that inspects nursing homes and investigates alleged violations of state (HHS/DADS) and federal nursing home standards.

27. OAG also focuses efforts on investigation of advertising and sale of retirement-oriented investments, and financial and estate planning services. It also files lawsuits under the Deceptive Trade Practices Act for consumer fraud that targets Texas seniors or other vulnerable victims in telemarketing scams, mail fraud, and home and personal services or products.

28. The Texas Department of Insurance (TDI) is involved in Medicare fraud efforts because many persons on Medicare look to other health insurance to cover costs not paid by Medicare. There are several activities that TDI deems as practices that contribute to insurance fraud. Mirroring the federal partnerships, TDI coordinates enforcement of fraud practices with OAG, other state agencies, and law enforcement entities. TDI also investigates workers' compensation fraud. Reports of insurance fraud, including fraud against the workers' compensation program, can be made to TDI's toll-free insurance fraud hotline at 888-327-8818. Forms for reporting insurance fraud to TDI can be downloaded from <http://www.tdi.texas.gov/forms/form6.html>. The completed report can be emailed to FraudReport@tdi.texas.gov. Or, the printed report can be mailed to Texas Department of Insurance, Fraud

Unit, P.O. Box 149336, Mail Code 109-3A, Austin, TX 78714-9336. The overall website of the Texas Department of Insurance is at www.tdi.texas.gov.

29. Three TDI divisions play an active role in reducing insurance fraud. The Consumer Protection Division reviews consumer complaints about insurance companies or agents; reviews insurance ads; and educates consumers, the industry, and the general public. Consumer Protection also refers potential fraud cases to the Legal and Compliance Division and to the Fraud Unit. The Legal and Compliance Division is responsible for enforcement and disciplinary action against insurance companies and agents. The Fraud Unit investigates claim fraud committed by consumers and health care providers against insurance companies. It also has authority to investigate insurance agents converting premium payments to their own use, insurance company officials embezzling funds, and persons who are doing the business of insurance in Texas without the appropriate license are also subject to investigation and prosecution.

30. The TDI Fraud Unit is a law enforcement agency employing both commissioned and non-commissioned investigators. The unit employs peace officers pursuant to Article 1.10D, Texas Insurance Code and Article 2.12(28), Texas Code of Criminal Procedure. TDI received the authority to commission peace officers from the Texas Legislature in 1995. The Fraud Unit currently employs peace officers, investigators and criminal analysts.

31. TDI Fraud Unit investigators work on a variety of cases. TDI investigators cooperate with other law enforcement agencies and regularly conduct joint investigations with local police, sheriffs' departments, Texas district and county attorneys, the Texas Department of Public Safety (DPS), FBI, Internal Revenue Service, U.S. Postal Inspectors, and the U.S. Department of Labor. Upon completing an investigation, the investigator refers the case for indictment and prosecution directly to state or federal prosecuting attorneys. After the referral has been made, investigators continue to assist prosecutors and often serve as witnesses before grand juries and during trials. When asked, TDI will furnish attorneys as special prosecutors.

32. TDI has authority to punish fraud through license revocations, and cease-and-desist orders. The Fraud Unit and Legal and Compliance issue monthly reports on disciplinary actions taken against agents and individuals. This list is regularly issued as a press release by TDI and is available on the TDI website for downloading. The list identifies the name or company disciplined dollar amount of any penalties assessed, and the location in Texas where the crime was committed.

33. Fraudulent Insurance Practices – TDI defines any of the following activities as unfair practices in the sale of insurance products. Complaints can be referred to TDI using the consumer complaint form or by calling the Fraud toll-free number at TDI:

- Knowingly making any misleading statement that causes someone to drop a policy and buy a replacement from another company. This is called “twisting.”

- Using high-pressure tactics, including the use of force, fright, or threat to pressure someone into buying a policy.
- Obtaining sales leads through advertising that hides the fact that an agent or company may try to sell insurance. This is called “cold lead advertising.”
- Posing as a representative of Medicare or a government agency.
- Selling a Medigap policy that duplicates benefits or health insurance coverage someone already has. An agent is required to ask if the person has other health policies.
- Suggesting that someone falsify an application.
- Using misleading advertisements made to look like government mail by including eagles or similar graphics and official-sounding government bureaus on the return address.

34. Further protections relevant to specific insurance products. Both Medicare supplement policies (also known as Medigap policies) and long-term care policies have requirements that offer further protection against fraud. These requirements include “30-day free-look” for both Medigap and long-term care policies. This protection allows a client to review the actual policy once it is received and to return it for a complete premium refund if the buyer determines that the policy is not what was discussed or requested. TDI publications suggest that consumers verify the license and complaint history of both the company they are considering and the agent assisting them in purchasing a policy.

35. TDI has a publication and a video on insurance fraud. These resources offer examples of fraud related to various insurance products. They also include tips for individuals to guard against fraud.

36. How to Report Fraud to TDI. Although, there is a fraud insurance complaint telephone, Benefit Counselors, who believe that there is possible insurance fraud, should first call the toll-free Consumer Help Line at 1-800-252-3439. The caller will be able to review what next steps to take. Usually a recommendation will be made to file a written complaint with TDI. Once the case has been reviewed, if intentional fraud is suspected, the client will be advised on next steps to take or the case may be referred to the Fraud Division. It is through the review by Fraud and Legal & Compliance that patterns of fraud are identified and prepared for prosecution.

37. Benefits Counselors are encouraged to review print or electronic ads and refer misleading ads to TDI. TDI’s review might determine that an ad does not violate insurance rules but may be a violation of consumer deceptive trade practices and will make the appropriate referral to OAG.

38. The Texas Department of Health and Human Services is a regular funding source for national outreach activities aimed at reducing fraud and abuse. For Benefits Counselors, it is suggested that part of networking include review of existing and ongoing projects that contribute to fraud prevention. The overall website of the Texas Department of Health and Human Services is <https://hhs.texas.gov/>

39. The Texas Legal Hotline for Texans provides Benefits Counselors with expertise to also review whether a client's complaint is more appropriate as abuse, exploitation, or fraud related to public assistance programs. The Texas Legal Services Center (TLSC), which administers the Legal Hotline, is also a referral source for legal awareness activities related to fraud prevention. TLSC staff works in partnership with local Legal Aid Offices, Pro Bono programs and the State Bar of Texas. TLSC offers a separate toll-free line for use by Benefits Counselors. TLSC also collaborates with the State Long-Term Care Ombudsman Program related to nursing facility cases and training of staff and volunteers. TLSC is on the Web at www.tlsc.org.
40. Other state agencies that interact with fraud prevention and reporting. The following additional agencies are available and have a role in fraud reporting and investigation: The State Long-Term Care Ombudsman, on the Web at <https://apps.hhs.texas.gov/contact/mlo.cfm>, The Long-Term Care Ombudsman protects the rights interests of recipients of long-term care.
41. The Texas Department of Family and Protective Services investigates reports of abuse or exploitation of vulnerable persons including children, the elderly and individuals with disabilities. It is on the Web at <https://www.dfps.state.tx.us/>
42. Reporting fraud assistance and or awareness in the National Performance Report. Increasingly, the CMS is asking for reports related to fraud and abuse. It is important to document instances and remedies taken to reduce fraud. Congress has placed greater emphasis on fraud prevention and looks to benefits counseling to support efforts that safeguard the integrity of the Medicare and Medicaid programs.

Chapter Seven Questions

1. **Medicare fraud prevention is the responsibility of which agency?**
 - A. _____ Centers for Medicare and Medicaid Services
 - B. _____ Medicare contractors (carriers and fiscal intermediaries) and subcontractors (providers, including the State SHIP).
 - C. _____ Office of Inspector General, U.S. Department of Health & Human Services
 - D. _____ Social Security Administration
 - E. _____ A & C only.
 - F. _____ All of the above.

2. **A purpose of the Medicare Summary Notice is to directly involve Medicare beneficiaries in the prevention of Medicare fraud and abuse.**

True _____ False _____

3. **An example of fraud is when a provider knowingly bills for services provided that were not medically necessary.**

True _____ False _____

4. **A provider that routinely miscodes a service could be committing Medicare abuse without intentional fraud.**

True _____ False _____

5. **List the four items that must be contained in the annual handbook, "Medicare and You."**
 - A. _____
 - B. _____
 - C. _____
 - D. _____

6. **It is Medicare abuse when a provider changes medical records to justify a higher payment unintentionally.**

True _____ False _____

7. **It is Medicare fraud to knowingly falsify costs on Medicare cost reports.**

True _____ False _____

8. **It is Medicare fraud when someone by mistake bills Medicare for psychological services, not furnished.**
- True _____ False _____
9. **A client that calls HICAP, saying that they were asked for their Medicare card and charged a \$10 fee for getting a flu shot, should be instructed to:**
- A. _____ call the Medicare fraud hotline.
- B. _____ review their next Medicare Summary Notice to see what was billed and why.
- C. _____ turn in the name of the provider to the Medicare Administrative Contractor.
10. **The Medicare Summary Notice is a replacement of what previous form?**
- A. _____ the doctor or providers office receipts.
- B. _____ the billing statement to Medicare.
- C. _____ the Explanation of Medicare Benefits (EOMB) that was previously used by the Medicare.
11. **Medicare publications that focus on fraud, identify the state SHIP as a resource to help persons with questions about their Medicare bills.**
- True _____ False _____
12. **Based on the definition of fraud and abuse, indicate whether the following would be fraud or abuse.**
- A. _____ exceeding the Medicare limiting charge.
- B. _____ offering a discount or monthly award for referring Medicare patients to a supplier of durable equipment.
- C. _____ using another person's Medicare card to obtain medical services.
- D. _____ excessive charges for services or supplies.
- E. _____ submitting bills to Medicare when Medicare is not the primary insurer.
- F. _____ repeatedly violating the assignment agreement by balance billing clients for services.
13. **Whom would you first contact to resolve a question about a Medicare billing?**
- A. _____ The provider.

- B. _____ FEMA.
- C. _____ The U.S.D.A.
- D. _____ EPA.
14. **Number the order of steps from first to last, to resolve a complaint from a client that their doctor is committing fraud by repeated lab tests.**
- A. _____ Call the Medicare Administrative Contractor
- B. _____ Ask the client to bring the Medicare Summary Notice(s) that reflect the tests.
- C. _____ Ask the client to ask the provider, why it is necessary to repeat the lab test with such frequency?
15. **Many complaints referred to the SHIP may not be fraud, but simple misunderstanding or billing errors that can be resolved by reviewing the Medicare Summary Notice with a client.**
- True _____ False _____
16. **The Office of the Texas Attorney General would be a referral source of which of the following situations:**
- A. _____ Telemarketing fraud.
- B. _____ A new miracle drug that claims to heal arthritis.
- C. _____ Raising the cost of cooling fans during a heat wave.
- E. _____ Documented cases of nursing facility abuse.
- F. _____ A and B only.
- G. _____ All of the Above.
17. **If the Texas Attorney General's Office investigated and verified Medicaid fraud, it would not have the authority to prosecute but would instead refer the case to the federal level.**
- True _____ False _____
18. **The Texas Attorney General's Office works with which local entities to educate older Texans and other vulnerable groups about criminal and deceptive trade practices.**
- A. _____ Local chapters of the American Association for Retired Persons (AARP).

- B. _____ Enforcement groups including the police department, and sheriff offices.
- C. _____ Local Better Business Bureau offices
- E. _____ All of the Above.
- F. _____ A and B only.
- 19.. **The Texas Department of Insurance investigates suspected fraud cases related to Insurance.**
- True _____ False _____
20. **An insurance company can be held liable for the fraudulent actions of agents selling their product.**
- True _____ False _____
21. **The Texas Department of Insurance has the authority to impose which of the following:**
- A. _____ To revoke the license of an agent or insurance company.
- B. _____ To halt the sale of insurance products that are being sold in Texas without a license (cease and desist orders.)
- C. _____ To levy fines for non-compliance with state insurance rules and regulations.
- D. _____ All of the Above.
22. **Complaints about insurance benefits that are due to be paid by private insurance would be directed to the Texas Department of Insurance.**
- True _____ False _____
23. **“Twisting” is an insurance term that refers to fraud by obtaining sales leads through advertising that hides the fact that an agent or company may be selling insurance.**
- True _____ False _____

Chapter Seven Answer Key

1. F

2. T
3. T
4. T
5.
 - A. a statement indicating that errors occur and urging review of the Medicare Summary Notice (MSN),
 - B. a description of the beneficiary's right to request an itemized statement from the provider,
 - C. promotion of the Medicare incentive program, and
 - D. the toll-free hotline number to the DHHS Inspector General to report complaints and information about fraud, waste, and abuse.
6. T
7. T
8. F
9. B
10. C
11. T
12.
 - A. Abuse
 - B. Fraud
 - C. Fraud
 - D. Abuse
 - E. Abuse
 - F. Fraud
13. A. The provider
14.
 - A. 3
 - B. 2

C. 1

15. T

16. G

17. F

18. E

19. T

20. T

21. D

22. T

23. F