



Common Medicare Fraud Schemes:

- Ambulance
- COVID-19
- Durable Medical Equipment (DME)
- Genetic Testing
- Home Health Care
- Hospice
- Medical Identity Theft
- Medicare Marketing Violations and Enrollment
- Nursing Home Care
- Outpatient Mental Health Care
- Pharmacy and Prescription Drug

Also included:

- Medicare Fraud by The Numbers
- Medicare Statements Tip Sheet



Medicare Fraud by the Numbers

Tips for Protecting Yourself and Medicare

Medicare fraud is big business for criminals – Medicare loses billions of dollars each year due to fraud, errors, and abuse. Estimates place these losses at approximately \$60 billion annually, though the exact figure is impossible to measure.

Medicare fraud hurts us all. When thieves steal from Medicare, there is less money for the health care you really need. You pay for things you might never get. You can get hurt when you get tests, medicine, or care you don't need. Doctors, pharmacies, and medical suppliers can make mistakes and bad choices. Sometimes they straight-up steal from Medicare. Medicare is trying to crack down.

Operation Double Helix
35 individuals responsible
for an over \$2.1 billion
genetic testing scheme

Operation Rubber Stamp
Identified over \$1.5 billion in
fraudulent billing for durable
medical equipment (DME)

How You Can Help

Be the first line of defense in protecting your Medicare benefits.

- **Treat your Medicare card like a credit card.** Your Medicare number can be valuable to thieves who want to steal your medical identity or bill Medicare without even seeing you.
- **Don't take advice or offers of medical services** from people you don't know who call, come to your house, or approach you in public.
- **Read your Medicare Summary Notice or Explanation of Benefits.** Look for services or equipment you didn't receive, double charges, or things your doctor didn't order.
- **Ask questions and report problems.** Call the doctor or company and ask them about mistakes. Call the insurance company if you still have questions. Get help from your local SMP.
- **Volunteer.** No one cares more about keeping criminals out of Medicare than the people who need it. Become a part of your local SMP program. Help protect your friends and neighbors.

How Your Senior Medicare Patrol (SMP) Can Help

Your local SMP is ready to provide you with the information you need to **PROTECT** yourself from Medicare fraud, errors, and abuse; **DETECT** potential fraud, errors, and abuse; and **REPORT** your concerns. SMPs and their trained volunteers help educate and empower Medicare beneficiaries in the fight against health care fraud.

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To locate your state Senior Medicare Patrol (SMP):

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Ambulance fraud happens when Medicare is charged for services that are not medically necessary or do not meet other strict standards. Medicare Part B only covers medically necessary ambulance services certain strict criteria are met.

What Does Medicare Cover in Relation to Ambulance Services?

Medicare covers ground and air ambulance transportation when all of these criteria are met:

- The transportation is medically necessary.
- A wheelchair van or car could endanger the patient.
- It is the only means of transporting the patient safely.
- The ambulance and its crew meet certain standards.
 - At a minimum, ambulance vehicles must be equipped with a stretcher, emergency medical supplies, oxygen equipment, emergency warning lights and sirens, and telecommunications equipment, as required by state or local law.
- The destination is the nearest appropriate facility that can treat the beneficiary's condition.
 - Covered: Transport to hospitals, skilled nursing facilities (SNFs), dialysis facilities for End-Stage Renal Disease (ESRD) beneficiaries who require dialysis, and return trips to a beneficiary's home when necessary.
 - Noncovered: Transport from home to doctor appointments, community mental health centers, psychiatric facilities (outside of a hospital), or independent labs not connected with a hospital or SNF.

Examples of Fraud Schemes

- Falsification of documentation to provide the appearance of medical necessity when medical necessity did not exist.
- Billing for more miles than traveled for transport.
- Billing nonemergency trips as emergency trips.
- Billing a ride in a taxi or wheelchair van as an emergency transport.
- Billing the beneficiary instead of Medicare, even though the provider participates in Medicare and the trip met Medicare's coverage criteria.

What Can You Do to Stop Ambulance Fraud?

- Review your Medicare Summary Notice (MSN) and/or Explanation of Benefits (EOB) and look for the following:
 - The services listed match what you actually received.
 - The mileage billed isn't more than the distance traveled.
 - That you weren't billed for emergency transport if there wasn't an emergency.
- Be on the lookout for upcoding on transport claims from basic life support (BLS) to advanced life support (ALS).
 - ALS vehicles must be staffed by at least two people, who each must be certified as an EMT-Intermediate or an EMT-Paramedic by the state or local authority where the services are being furnished to perform one or more ALS services.
- If you find billing errors or have concerns, contact your Senior Medicare Patrol at www.smpresource.org or 1-877-808-2468.
- For Medicare coverage questions, contact your local State Health Insurance Assistance Program (SHIP) at www.SHIPTAcenter.org or 1-877-839-2675.



Other Ambulance Resources

- Senior Medicare Patrol National Resource Center (SMPNRC): <https://www.smpresource.org/Content/Medicare-Fraud/Fraud-Schemes/Ambulance-Fraud.aspx>
- Centers for Medicare & Medicaid Services (CMS): <https://www.medicare.gov/coverage/ambulance-services>

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COVID-19 Consumer Tip Sheet

Tips for Protecting Yourself and Medicare

Scams related to the coronavirus, also known as COVID-19, are rapidly increasing as the public health emergency develops. Scammers are targeting older adults and those with serious long-term health conditions who appear to have a higher risk for serious illness from COVID-19.

Fraudsters are attempting to bill Medicare for sham tests or treatments related to the coronavirus and are targeting individuals to illegally obtain money or Medicare numbers.

Scammers rapidly alter their tactics and adapt their schemes to the changing landscape, and we anticipate that they will leverage the COVID-19 vaccine to prey on unsuspecting beneficiaries. Be vigilant and protect yourself from potential fraud concerning COVID-19 vaccines and treatments.

COVID-19 Vaccine Schemes

- You will not need to pay anything out-of-pocket to get the vaccine during this public health emergency.
- Medicare will not contact you to confirm your Medicare number/personal information over the phone.
- Medicare has not issued a COVID-19 Medicare card and anyone contacting you about this is attempting to steal your information.
- No one from a vaccine distribution site or health care payer, like a private insurance company, will call you asking for your Medicare number, Social Security number, or your credit card or bank account information to sign you up to get the vaccine.
- You cannot buy a vaccine card, make your own, or fill in blank vaccination record cards with false information. It is considered an unauthorized use of an official government agency's logo/ seal. This is a crime.

COVID-19 Testing Schemes

- Be cautious of any COVID-19 testing site that requires your financial or medical information in order to receive a free test.
- Be mindful of advertisements for COVID-19 testing or treatments on social media platforms. If you make an appointment for a COVID-19 test online, make sure the location is an approved testing site.
 - We encourage the public to check official government websites for a list of approved COVID-19 testing sites.
- Be careful! Scammers are selling fake and unauthorized at-home COVID-19 test kits in exchange for your personal or medical information. Make sure to purchase FDA approved COVID-19 test kits from legitimate providers.



What Does Medicare Cover in Relation to COVID-19?

- Medicare Part B (Medical Insurance) covers COVID-19 tests when ordered by your doctor or health care provider on or after February 4, 2020.
- The administration of the COVID-19 vaccine will be billed through Original Medicare, even if you are on a Medicare Advantage plan. The vaccine is free to everyone.
- Medicare covers all medically necessary hospitalizations, including extra days in the hospital for patients who had to stay longer under COVID-19 quarantine.
- Medicare also expanded coverage of telehealth services to enable beneficiaries to access a wider range of services from their providers without having to travel to a facility.
 - This includes access to doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers.
 - During this emergency, there are also more options for the ways your providers can talk with you under this provision.

What Can You Do to Stop COVID-19 Fraud?

- Do not give out your Medicare number to anyone other than your doctor, health care provider, or other trusted representative.
- Protect your Medicare number and treat your Medicare card like a credit card. Never provide your Medicare number to anyone who contacts you through unsolicited calls, texts, or emails.
- Be cautious of anyone who comes to your door offering free coronavirus testing, treatment, or supplies.
- Don't click on links from sources you don't know, which could put your computer or device at risk. Make sure the anti-malware and anti-virus software on your computer are up to date.
- Don't post on social media that you are getting tested for or receiving a vaccination for COVID-19. Posting content that includes your date of birth, health care details, or other personally identifiable information can put you at risk as these details can be used to steal your identity.
- Be cautious when purchasing medical supplies from unverified sources, including online advertisements and email/phone solicitations.
- Be cautious of COVID-19 survey scams that offer money or gifts in exchange for personal, medical, or financial information.
- Do your homework before making a donation to a charity or crowdfunding site due to a public health emergency. Be particularly wary of any charities requesting donations by cash, by gift card, or wire transfer.

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Supported by a grant (No. 90MPRC0001) from the Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS).

Durable Medical Equipment Fraud

Tips for Protecting Yourself and Your Medicare

Medicare Part B covers medically necessary durable medical equipment, or “DME,” that is prescribed by your doctor, can withstand repeated use, serves a medical purpose, and can be used in the home. Medicare only covers DME if you get it from a supplier enrolled in the Medicare program. Medicare Part B pays 80% of the approved amount and you pay the other 20%.

What Does Medicare Cover in Relation to DME, Orthotics, and Prosthetics?

- DME that Medicare covers includes, but is not limited, to:
 - Blood sugar monitors and test strips, canes, continuous positive airway pressure (CPAP) devices, crutches, hospital beds, infusion pumps and supplies, oxygen equipment and accessories, patient lifts, walkers, wheelchairs, and scooters
- Prefabricated orthotics that Medicare covers include, but are not limited, to:
 - Shoulder, knee, back, wrist, and ankle braces
- Prosthetic devices that Medicare covers include, but are not limited, to:
 - Breast prostheses (including a surgical bra), one pair of conventional eyeglasses or contact lenses provided after a cataract operation, ostomy bags and certain related supplies, some surgically implanted prosthetic devices (including cochlear implants), and urological supplies

Examples of Durable Medical Equipment Fraud Schemes

- Suppliers who offer “free” equipment but bill Medicare.
- Suppliers who want you to use their doctors (not yours), who then prescribe unnecessary medical equipment.
- Suppliers or doctors who provide medical equipment or supplies you never requested.
- Suppliers or doctors who charge for items you never received.
- Suppliers who bill for people who have passed away.
- Suppliers who request your Medicare number at a presentation, during a sales pitch, or in an unsolicited phone call.
- Beneficiaries who willingly allow their Medicare number to be used in exchange for money, gifts, or unnecessary equipment and supplies.
- Suppliers who deliver an off-the-shelf product but bill Medicare for a more costly product.



What Can You Do to Stop Durable Medical Equipment Fraud?

- Be sure your doctor has assessed your condition and orders the equipment or supplies.
- Never sign a blank form from your health care provider or equipment supplier.
- Always read your Medicare Summary Notice (MSN) or Explanation of Benefits (EOB). Look for charges for equipment you do not need, never requested, or did not receive.
- If you rent and return medical equipment, always get a dated receipt.
- Protect your Medicare, Medicaid, and Social Security cards like credit cards.
- Do not accept products or services from strangers who call or knock on your door.
- Do not give out your Medicare number at a presentation or during a sales pitch.
- Do not accept money, gifts, or unnecessary equipment and supplies from a supplier in exchange for your Medicare number.

Example Medicare Charges for DME

Any Medicare code that starts with an “L” indicates that it is an orthotic, which is a type of DME. Here are some examples:

- **L0625-L0651:** Lumbar Orthosis ~ *Back brace*
- **L1810-L1860:** Knee Orthosis ~ *Knee brace*
- **L1900-L1990:** Ankle-foot Orthosis ~ *Ankle brace*
- **L3650-L3678:** Shoulder Orthosis ~ *Shoulder brace*
- **L3763-L3931:** Wrist Orthosis ~ *Wrist brace*



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Genetic Testing Fraud Sweeps Nation

Across the nation genetic testing company representatives are offering “free” genetic tests to Medicare beneficiaries. These tests can also be referred to as DNA screenings, cancer screenings, and hereditary testing, to name a few. The representatives go to senior centers, senior housing, health fairs, and even parking lots to convince people to let them take a cheek swab for testing. They advertise on TV and online. They promise that the results will help recipients avoid diseases or find the right medications. All they ask for in return is the person’s Medicare number.

While this may sound harmless, in reality it is dangerous. These companies can steal people’s medical identity and falsely bill Medicare, draining the system of needed funds. Tests ordered under these circumstances are medically unnecessary and could lead to confusion about someone’s health condition.

Because confusion exists regarding Medicare’s coverage for genetic tests for cancer and other conditions, the Office of Inspector General (OIG) released a [fraud alert](#) on the topic. It advises the public to be suspicious of anyone who offers “free” genetic testing and then requests their Medicare number.

The OIG’s fraud alert also states that a physician that a person knows and trusts should approve any requests for genetic testing. In fact, federal regulations state that diagnostic tests must be ordered by the physician who is treating the beneficiary – in other words, the person’s own doctor. A doctor who has never met or examined a patient, often hired by a genetic testing company, should not be signing off on any tests. That’s a red flag.

The SMP recommends that beneficiaries should:

- Refuse to give out their personal information or accept screening services, including a cheek swab, from someone at a community event, a local fair, a farmer’s market, a parking lot, and/or any other large event.
- Go to their own doctor to assess their condition, not a doctor on the phone they’ve never met from a company they don’t know.
- Always read their Medicare Summary Notice (MSN) or Explanation of Benefits (EOB). The words “gene analysis” or “molecular pathology” as service codes may indicate questionable genetic testing.
- Refuse the delivery of any genetic testing kit that was not ordered by their physician.
- Be suspicious of anyone who offers free genetic testing and then requests their Medicare number. If their personal information is compromised, it may be used in other fraud schemes.
- Contact their local SMP for help. SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse.

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Cardiovascular Genetic Testing Fraud

Tips for Protecting Yourself and Medicare

Genetic testing scams quickly emerged in 2019 targeting cancer screening and pharmacogenetics (medication metabolism). The latest growing genetic testing fraud trend focuses on cardiovascular genetic testing. Scammers are offering Medicare beneficiaries cheek swabs for genetic testing to obtain their Medicare information for fraudulent billing purposes or possibly medical identity theft.

What is Cardiovascular Genetic Testing Fraud?

Cardiovascular genetic testing fraud occurs when Medicare is billed for a cardio type of test or screening that was not medically necessary and/or was not ordered by a beneficiary's treating physician.

What are Examples of Cardiovascular Genetic Testing Fraud?

- Here are several ways cardiovascular genetic testing is advertised:
 - * Cardio/cardiac genetic screening/test
 - * Comprehensive cardiovascular panel
 - * Cardiovascular disease genetic kit
 - * Cardiovascular genetic screening/test
 - * Comprehensive cardiomyopathy NSG
 - * Hereditary cardiovascular profile
- A company offering you "free" or "at no cost to you" testing without a treating physician's order and then billing Medicare.
- A company using "telemedicine" to offer testing to you over the phone and arranging for an unrelated physician or "teledoc" to order the tests.
- Billing Medicare (usually thousands of dollars) for a broad range of cardiac genetic tests that you did not request or possibly even receive.
- A company calls you stating your doctor or cardiologist requested that you have the testing done and they will send you a testing kit.

What Happens if Medicare Denies the Cardiovascular Genetic Test Claims?

You could be responsible for the entire cost of the test. The average is \$9,000 to \$11,000.

Medicare Billing Codes

There are numerous Current Procedural Terminology (CPT) codes that have been associated with cardiovascular genetic testing complaints as noted by SMP. The codes are in the 81400 - 81500 CPT series associated with Gene Analysis & Molecular Pathology. You can review your MSN for these codes.

When is Cardiovascular Genetic Testing Covered by Medicare?

- When the test is medically reasonable and necessary.
 - ✓ Federal regulations define medical necessity as *“services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”*
- When it is ordered by a treating physician.
 - ✓ Federal regulations define a treating physician as *“the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary’s specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.”*
- When a treating physician orders the test as a diagnostic service and uses the results to manage the patient’s condition.

What Can You Do to Stop Cardiovascular Genetic Testing Fraud?

- Be sure your doctor has assessed your condition. Although Medicare covers many genetic tests to detect heart disease, it is not a test to predict or screen for cardiovascular disease.
- Do not give out your personal information to someone calling claiming your cardiologist has requested the testing.
- Do not give out your personal information or accept screening services from someone at a community event, a local fair, a farmers’ market, a parking lot, or any other event.
- Always read your Medicare Summary Notice (MSN) or Explanation of Benefits (EOB). The words “gene analysis,” “molecular pathology,” or “laboratory” may indicate questionable genetic testing has occurred.
- If you received a cardiovascular genetic testing kit or test that was not medically necessary, report your concerns about billing errors or possible fraud and abuse to your local SMP.

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Home Health Care Fraud

Tips for Protecting Yourself and Medicare

Medicare Coverage For Home Health Care

Medicare Parts A and B cover intermittent or short-term home health services. These services must be provided by a Medicare-approved home health agency that works with your doctor to manage your care. To be eligible for Medicare coverage:

- Your doctor must determine it's medically necessary for you to receive skilled care services at home. Skilled care services at home could include part-time or "intermittent" nurse and nurse aide visits (personal, hands-on care) and rehabilitation services, which include speech-language pathology, physical and occupational therapy, and medical social services.
- Your condition must be expected to improve in a reasonable amount of time or your condition requires skilled therapy to maintain your current condition or prevent or slow, further deterioration.
- You must be considered "homebound." This means you are unable to leave your home without assistance, it requires considerable and major effort, or it is considered dangerous due to your current health condition. You may leave home for medical care and some short or infrequent outings (for example, worship services) as long as you meet these conditions.

What are Examples of Home Health Care Fraud?

- Medicare was charged for:
 - Home health services when you did not meet Medicare's "homebound" criteria
 - Services that were not deemed medically necessary by your doctor
 - Home health services like skilled nursing care and/or therapy services that were not provided
- You were:
 - Enrolled in home health services by a doctor you do not know
 - Offered things such as "free" groceries or a "free" ride from a home health agency in exchange for your Medicare number or to switch to a different home health agency
 - Charged a copayment for home health services
 - Asked to sign forms verifying that home health services were provided even though you did not receive any services
- Someone came to your home and provided housekeeping or medication services, but you see on your Medicare Summary Notice (MSN) or Explanation of Benefits (EOB) that Medicare was billed for a covered service like skilled nursing or other therapy instead.
- You accept cash or gifts in exchange for going along with a home health scam.

What Can You Do to Stop Home Health Care Fraud?

- Read your MSN or EOB to compare the services Medicare was charged with what you received.
- Be sure you work with your doctor to enroll you in any home health services you may need and to determine medical necessity for these services.
- Do not accept gifts (such as money, gift cards, or groceries) in return for home health services.
- Do not sign up for housekeeping or medication services from someone who comes to your door claiming they can provide home health services. These services are only covered by Medicare if you are also receiving therapy services.
- Do not sign forms that you do not understand for home health services.
- Report charges on your MSN or EOB for services or visits you did not receive.
- Report charges on your MSN or EOB for services that are different than what you received.

Differences Between Home Health Care and Nursing Home Care

Medicare coverage for home health does not include round-the-clock nursing care or some services considered custodial in nature. Home health aides can, however, provide some personal care services, including help with bathing, dressing, hygiene, and feeding, as long as the patient also needs intermittent skilled nursing or therapy. These personal care services are not automatically covered just because you receive home health care services. A doctor must certify your need for them. Talk to your doctor about what services are necessary and right for you.

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Hospice Care and Medicare Fraud

Tips for Protecting Yourself and Medicare

Hospice is an important benefit for the Medicare population.

Hospice fraud threatens this benefit for all beneficiaries. Scammers are getting beneficiaries to agree to hospice care even though they do not qualify for the benefit.

What is Medicare Hospice Fraud?

Hospice fraud occurs when Medicare Part A is falsely billed for any level of hospice care or service.

What are Examples of Hospice Fraud?

- Falsely certifying and providing services to beneficiaries who are not terminally ill – that is, with a life expectancy of six months or less if the disease runs its normal course
- Enrolling in hospice without the knowledge or permission of the patient or family
- Falsely certifying or failing to obtain physician certification on plans of care
- Paying gifts or incentives to referral sources (such as physicians and nursing homes)
- Billing for a higher level of care than was needed or provided or for services not received
- Targeting assisted living facility and/or nursing home residents whose life expectancy exceeds six months
- Using high-pressure and unsolicited marketing tactics of hospice services
- Providing inadequate or incomplete services, including, for example, no skilled visits in the last week of life
- Providing/offering gifts or incentives, including noncovered benefits such as homemaker, housekeeping, or delivery services to encourage beneficiaries to elect hospice even though they may not be terminally ill
- Embezzling, abusing, or neglecting beneficiaries or medication theft by a hospice worker
- Keeping a beneficiary on hospice care for long periods of time without medical justification
- Providing less care on the weekends and disregarding a beneficiary's care plan

What Can You Do to Stop Hospice Fraud?

- Be sure your doctor has assessed your condition.
- Be sure your doctor has certified that you are terminally ill and expected to live six months or less if the disease runs its normal course.
- Never accept gifts (such as money, gift cards, or groceries) in return for hospice services and be wary of “too-good-to-be-true” offers.
- Report quality-of-care complaints to your local SMP and the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) (qioprogram.org/file-complaint).

How are Fraudsters Benefiting from Hospice Fraud?

General inpatient care and continuous home care pay significantly more than routine home care. Falsely signing someone up for hospice and then providing routine home care at a continuous home care rate could be very lucrative for a fraudster.

What Medicare Paid for Hospice Care in 2021

Routine Home Care	General Inpatient care	Continuous Home Care
\$199.25 per day for days 1-60 \$157.49 per day for days 61+	\$1,045.66 per day	\$1,432.41 per day

Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements 2021, 147 Fed. Reg. 42528 Page 16, 17 (August 4, 2021)

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Medicare Marketing Violations

Tips for Protecting Yourself and Medicare

Unlike Original Medicare, Medicare Advantage (MA, Part C) and Medicare Prescription Drug Plans (Part D) are administered, marketed, and sold by private insurance companies. The Centers for Medicare & Medicaid Services (CMS) has guidelines for marketing Part C and Part D insurance that protect Medicare beneficiaries from manipulative and deceptive sales and enrollment tactics.

Please note, these guidelines primarily focus on activities and materials related to agents, brokers, and direct plan communication, as opposed to television and radio commercials or advertising.

Plan sponsors and their representatives, including agents and brokers, must follow these guidelines when marketing to beneficiaries. Marketing is seen as equivalent to “steering” beneficiaries toward a plan.

What are Examples of Medicare Marketing Violations?

- Receiving an unsolicited phone call from a plan with whom they have no prior relationship or from which they disenrolled
- An agent or broker representing themselves as though they come from or were sent by Medicare, Social Security, or Medicaid
- Receiving an unsolicited home visit – i.e., “door-to-door cold call”
- Receiving information such as leaflets, flyers, door hangers, etc. on their car or at their residence from a company with whom they did not have an appointment
- An agent initiating a discussion about other insurance products, such as life insurance or annuities, during a visit or meeting about a Part C or Part D Medicare product
- An agent returning uninvited to a residence after missing an earlier appointment
- Requiring attendees to provide contact information as a prerequisite for attending a marketing event
- Marketing event attendees are later called without permission
- Prospective enrollees are called to confirm receipt of mailed information
- An agent signing a beneficiary up for a plan that is supposed to cover specific prescriptions or services but the beneficiary learning later that those prescriptions or services were actually not covered by the plan because they received a bill

What Can Plans and Agents Do?

- Call a beneficiary who has expressly given advanced permission
- Offer nominal gifts valued at \$15 or less (or \$75 in total, per person, annually) to beneficiaries, provided the gift is given regardless of whether a beneficiary enrolls in the plan
- Include information about rewards and incentives programs in their marketing materials
- Provide refreshments and light snacks, but not meals, at marketing/sales events
- Make unsolicited contact with potential enrollees using conventional mail and other print media (e.g., advertisements) and by email provided it contains an opt-out function
- Conduct marketing/sales activities in common areas of health care settings (i.e., waiting rooms, common entryways, vestibules, cafeterias, or community, recreational, or conference rooms)

What Can't Plans and Agents Do?

- Conduct marketing or sales activities at an educational event
- Require participants to provide contact information to attend an event
- Sell door-to-door or leave information like leaflets, flyers, door hangers, etc. on someone's car or at their residence (unless the beneficiary is a "no show" for a prescheduled appointment)
- State that they are approved, endorsed, or authorized by Medicare; are calling on behalf of Medicare; or that Medicare asked them to call or see the beneficiary
- Send unsolicited text messages, make unsolicited phone calls, or leave voicemail messages for potential enrollees
- Approach beneficiaries in public common areas (i.e., parking lots, hallways, lobbies, or sidewalks)
- Provide information that is inaccurate or misleading
- Offer health screenings or other activities that may be perceived as, or used for, "cherry-picking"

What About Medigap Policies?

Marketing of Medigap, or supplemental insurance, policies is regulated by each state's department of insurance restrictions, which may or may not be as strict as federal rules that govern the marketing of Part C or Part D plans.

How the Senior Medicare Patrol (SMP) Can Help

The local SMP is ready to provide beneficiaries and others with the information they need to **PROTECT** themselves from Medicare fraud, errors, and abuse; **DETECT** potential fraud, errors, and abuse; and **REPORT** concerns. SMPs and their trained volunteers help educate and empower Medicare beneficiaries in the fight against health care fraud. The SMP can help with questions, concerns, or complaints about potential fraud and abuse issues. It also can provide information and educational presentations.

To locate the state Senior Medicare Patrol (SMP):

Visit www.smpresource.org or call 1-877-808-2468.

Medical Identity Theft Tip Sheet

Tips for Protecting Yourself and Your Medicare

Medical identity (ID) theft occurs when someone steals personal information – such as your name and Medicare number (this also includes any Medicare Advantage, Medigap or supplemental, prescription drug, or other health ID numbers) – and uses the information to bill your insurance for supplies or services you did not receive. Typical examples are medical treatment, medical equipment, prescription drugs, and surgery. Not only can this affect your finances, but this can also endanger your care.

When you fall prey to consumer scams and give out your Medicare number, your Medicare number is considered to be “compromised” as a result of medical identity theft. If this happens, it is recommended to request a new Medicare number from the Centers for Medicare & Medicaid Services (CMS) by calling 1-800 Medicare to prevent any further abuse.

When to Contact Your Local Senior Medicare Patrol (SMP)

- You gave out your Medicare number:
 - Over the phone or internet to someone offering genetic testing, coronavirus testing or supplies, back or knee braces, etc.
 - At a fair or other gathering as a check-in or to receive “free” services
 - In response to a television or radio commercial, postcard, or Facebook/print ad
 - To receive more information or to sign in at a Medicare Open Enrollment event
 - To someone offering to deliver milk or other groceries to you
 - To someone claiming Medicare will cover housekeeping services
- You were contacted by your doctor to cancel appointments since, unbeknownst to you, you were signed up for hospice care.
- You received boxes of braces, testing kits, or other medical supplies in the mail that you did not request.
- You were contacted by a debt collection company for a provider bill you do not owe.
- Your Medicare and/or Medicare Advantage plan denies or limits your coverage or benefits because of a medical condition you do not have or says you already received a product or service when you did not.

What Can You Do to Stop Medical Identity Theft?

Medical identity theft can take many forms and is used in many different tactics and schemes. Be cautious if anyone asks you for personal or medical information over the phone, door to door, through email, or at a health fair. Here's how to protect yourself:

- Never give out your Medicare number to anyone other than your doctor, health care provider, or other trusted representative.
- Protect your Medicare number by protecting your Medicare card as you would a credit card.
- Never give out your Medicare number to anyone who contacts you through unsolicited calls, texts, or emails.
- Understand that Medicare and Social Security already have your Medicare and Social Security number so if someone calls, emails, or texts claiming they need it, don't give it to them. Instead, find the organization's contact information on your own (don't use caller ID) and call or email them directly to discuss the situation.
- Be cautious of anyone who comes to your door offering "free" testing, treatments, or supplies for genetic diseases, cancer, or the coronavirus.
- Do not click on links from sources you don't know, as this could put your computer or device at risk. Make sure the anti-malware and anti-virus software on your computer are up to date.
- Be cautious when purchasing medical supplies from unverified or unknown sources, including online advertisements and email/phone solicitations.

Other Identity Theft Resources

Compromised Medicare Number	Compromised Social Security Number
1-800-Medicare (633-4227)	www.identitytheft.gov

How Can Your Senior Medicare Patrol (SMP) Help?

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Nursing Home Care Fraud

Tips for Protecting Yourself and Medicare

Medicare Coverage for Nursing Home Care

Medicare doesn't generally pay for long-term nursing home care. Medicare Part A covers medically necessary, short-term care in a skilled nursing facility (SNF) under certain conditions. Part A covers a semiprivate room, medical supplies used in the facility, meals, and other items.

To be eligible for nursing home coverage, Medicare requires you to meet certain criteria such as, but not limited, to:

- You have a qualifying inpatient hospital stay of at least three days before entering the SNF.
- You stay at a Medicare-certified SNF.
- Your doctor orders and you receive inpatient skilled nursing or rehabilitation services on a daily basis. The daily skilled care you need can only be provided in a SNF on an inpatient basis because it is not available on an outpatient basis in the beneficiary's area or transportation to the closest facility would be an excessive physical hardship, less economical, or less efficient.
- You are enrolled in Part A with days left in your benefit period. (*Note: If you are unsure of how many days you have left in your benefit period, call 1-800-Medicare.*)
- You need treatment for a medical condition treated in the hospital or for conditions, such as bed sores, you develop in the SNF.

What are Examples of Medicare Nursing Home Care Fraud?

- Medicare was charged for:
 - Services that were not deemed medically necessary by your doctor
 - Therapy services or visits that were billed to Medicare but were not provided
 - More expensive services than what you were provided
 - More therapy than what you were provided
 - Skilled nursing services for dates after you were released from the SNF
- You are forced to remain in a SNF until your Part A benefits have expired even though your condition has improved and you wish to change to home health care services.

What Can You Do to Stop Nursing Home Care Fraud?

- Read your Medicare Summary Notice (MSN) or Explanation of Benefits (EOB) to compare the services Medicare was charged with what you received.
- Be sure you work with your doctor to enroll you in any SNF therapy services you may need and to determine medical necessity for these services.
- Do not accept gifts (such as money, gift cards, or groceries) in return for choosing a nursing home in which to receive skilled nursing.
- Do not sign forms that you do not understand, including a Medicare Outpatient Observation Notice (MOON), an Advance Beneficiary Notice (ABN), or any form that is blank.
- Report charges on your MSN or EOB for services or visits you did not receive.
- Report charges on your MSN or EOB for services that are different than what you received.
- Report quality-of-care complaints to your local SMP and the Beneficiary Family Centered Care Quality Improvement Organization (BFCC-QIO).

Differences Between Home Health/Skilled Care and Nursing Home Care

Medicare coverage for home health does not include round-the-clock nursing care or some services considered custodial in nature. Home health aides can, however, provide some personal care services, including help with bathing, dressing, hygiene, and feeding, as long as the patient also needs intermittent skilled nursing or therapy. These personal care services are not automatically covered just because you receive home health care services. A doctor must certify your need for them. Talk to your doctor about what services are necessary and right for you.

How Your Senior Medicare Patrol (SMP) Can Help

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Outpatient Mental Health Care

Tips for Protecting Yourself and Medicare

Medicare covers a wide range of outpatient mental health benefits.

These services are provided in settings including a health care provider's office (or telehealth portal in some circumstances), hospital outpatient department, or community mental health center.

What Does Medicare Cover in Relation to Outpatient Mental Health Care?

Medicare Part B (Medical Insurance) helps pay for outpatient mental health services, including:

- One depression screening per year. The screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals.
- Individual and group psychotherapy with a doctor or other licensed mental health professional (such as psychiatrist, clinical psychologist, nurse practitioner, or clinical social worker) allowed by the state where services are being received.
- Family counseling if the main purpose is to help with your treatment.
- Testing to find out if you are getting the services you need and if your treatment is helping.
- Psychiatric evaluation, medication management, and diagnostic tests.
- Treatment of opioid use disorder.
- Treatment of inappropriate alcohol and drug use.

What Can You Do to Stop Outpatient Mental Health Care Fraud?

- Review your Medicare Summary Notice (MSN) and/or Explanation of Benefits (EOB) and report the following concerns:
 - Services listed do not match what you actually received.
 - Medicare was billed for individual treatment when group services were received.
 - Diagnostic tests, medical equipment, or prescriptions you did not receive were added on. An example would be excessive labs or unnecessary urine analysis.
 - Medicare was billed for in-person visits or expensive facility care when only telehealth services were provided.
 - Medicare was billed for more hours of mental health services than what you received.
- Do not give out your Medicare number or other personal information in response to unsolicited offers to receive mental health treatment.

Examples of Outpatient Mental Health Care Fraud

- You and/or Medicare are billed for psychiatric treatment services you did not receive.
- Adult daycare services are billed as individual or group psychotherapy. Examples include:
 - Beneficiaries are picked up by a bus or van. Medicare does not cover transportation to and from mental health services.
 - Beneficiaries are taken out to eat or for a recreational outing with no other services received.
 - Beneficiaries are allowed to watch TV or play games all day.
 - Support groups bring people together to talk and socialize.
- Call-in refills for mental health prescriptions are billed as psychiatric evaluations and/or complex office visits.
- Unrelated services (such as genetic tests and back braces) you do not need or want are billed in conjunction with your mental health treatment.
- Medicare is billed for residential sober home, substance use disorder treatment facility, or partial hospitalization services when only outpatient counseling was received.
- You are offered money or gifts in exchange for your Medicare and/or Medicaid number, which is then used to bill for mental health services you did not or do not plan to receive.
- Mental health services provided by a medical assistant, massage therapist, or other unqualified individual are billed as though you were seen by a licensed mental health professional.



How Your Senior Medicare Patrol (SMP) Can Help

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Pharmacy/Prescription Drug Fraud

Tips for Protecting Yourself and Medicare

Pharmacy and prescription drug fraud is a consistent trend in Medicare. Due to the lucrative nature of prescription drug diversion and pharmacy scams, criminals continue to exploit Medicare Part D.

What is Medicare Pharmacy/Prescription Drug Fraud?

Although there are many types of prescription drug schemes, pharmacy fraud primarily occurs when Medicare is billed for a medication that was not received or a beneficiary is intentionally given a different prescription drug than prescribed.

What are Examples of Pharmacy/Prescription Drug Fraud?

- Billing Medicare for prescription drugs (including refills) that were never picked up, delivered, or even prescribed.
- Billing Medicare for prescription drugs (occasionally controlled substances such as opioids) that were prescribed by a health care provider you have never seen.
- Billing Medicare for medication amounts beyond the quantity you were prescribed.
- Billing Medicare for a different prescription drug (often more expensive) than the one you were originally prescribed or issuing you a drug that is not approved by the U.S. Food and Drug Administration (FDA).
- A pharmacy that intentionally provides less medication than prescribed.
- A pharmacy that issues expired drugs.
- A pharmacy that provides and bills for an expensive compounded medication, including topical pain creams, when a traditional or less expensive prescription was ordered by your provider.
- A company offering you “free” or “discount” prescription drugs without a treating physician’s order and then billing Medicare.
- A pharmacy offering gift cards or other compensation so you switch your prescriptions over to a specific pharmacy.
- A pharmacy automatically refilling a prescription you no longer need. You do not pick up the prescription but the pharmacy still bills Medicare.
- An individual offering to pay you for the use of your Medicare number to bill for prescription drugs or offering you cash or other compensation to pick up prescriptions on your behalf.

What Can You Do to Stop Pharmacy/Prescription Drug Fraud?

- Be sure your doctor has assessed your condition before prescribing you any medication.
- Do not give out your Medicare number or other personal information to unknown individuals requesting it for prescription drug services. Be suspicious of all unsolicited calls and offers for “free” or “discount” prescription drugs.
- Always read your Medicare Summary Notice (MSN) or Explanation of Benefits (EOB) to watch for the names of unknown providers and billing of prescriptions and other services you did not receive.
- If you notice a charge to your Medicare drug plan for prescriptions you did not receive (or for different drugs than the ones you were prescribed), report your concerns about possible fraud, errors, or abuse to your local SMP.

Pharmacy/Prescription Drug Fraud and Medical Identity Theft

Be especially wary if someone requests your Medicare number (and/or possibly driver's license) to evaluate your prescription history at a health fair, senior center, assisted living facility, mall, farmers market, home show, parking lot outside retail stores, or a privately sponsored wellness event. These venues are high risk for medical identity theft.

Medical identity theft occurs when someone steals or uses your Medicare number to submit fraudulent claims to Medicare without your authorization. Medical identity theft may disrupt your medical care and/or result in financial harm.

How are Fraudsters Benefiting from Pharmacy/Prescription Drug Fraud?

Criminals, ranging from health care providers to drug trafficking organizations, continue to commit prescription drug fraud because it is profitable. Unfortunately, there is a strong illegal market for prescription drugs – including controlled drugs such as opioids and expensive prescriptions such as autoimmune medications like Xeljanz. Some prescription drugs are targeted because they can be combined with recreational and illegal drugs to enhance a high or hallucinogenic effect.

How Your Senior Medicare Patrol (SMP) Can Help

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U.S. Department of Health and Human Services (DHHS).

Medicare Statements

Tips for Protecting Yourself and Medicare

What is a Medicare Summary Notice (MSN)?

Beneficiaries enrolled in Original Medicare (Parts A and B) receive Medicare Summary Notices or MSNs. Medicare only mails MSNs every three months, but you can view your MSNs 24 hours a day by visiting Medicare's Medicare.gov website which allows beneficiaries in Original Medicare to log into (or create) a secure Medicare account to view their most recent MSNs, track claims made on their behalf, and check payment status. Creating a free, secure account with Medicare allows you to review all bills processed within the past 36 months.

What is an Explanation of Benefits (EOB)?

Beneficiaries enrolled in Medicare Advantage (Part C) plans or Medicare Prescription Drug Plans (Part D) receive Explanations of Benefits or EOBs. EOBs are mailed monthly if services are received, however, beneficiaries can check with their plan to see if they have an online service for accessing claims made on their behalf and payment status.

What do MSNs and EOBs Explain?

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

Using Your MSN or EOB to Detect Fraud, Errors, and Abuse

- Review your Medicare statements as soon as they arrive to ensure all of the services listed were actually received. Reviewing your MSN or EOB is one of the best ways that you can help detect potential errors, fraud, and abuse.
- Keep a record of medical visits, tests, receipts for services, and equipment you have received. A My Health Care Tracker, which you can get from the SMP, can help you keep a record.
- Compare your MSN or EOB to your receipts and records to your My Health Care Tracker. If you notice any mistakes, or have questions, call your provider or plan with your questions. If you still have questions or need further help, contact your local SMP!

What Information Should You Look for on Your MSN or EOB?

Plan	Coverage	Statement	Information to Look for
Medicare Part A (Hospital Insurance)	Inpatient hospital, skilled nursing facility, home health, and hospice care (the MSNs for each of these is a bit different)	MSN (quarterly or online at Medicare.gov)	<ul style="list-style-type: none"> • Date of Service • Provider Name and Address • Benefit Days Used • Claim Approved? (Yes or No) • Non-Covered Charges • Amount Medicare Paid • Maximum You (Beneficiary) May Be Billed • Notes for Claim • Appeals Information • QMB Status
Medicare Part B (Medical Insurance)	Outpatient services (doctor visits, lab tests, medical equipment, ambulance, immunizations, screenings, and more)	MSN (quarterly or online at Medicare.gov)	<ul style="list-style-type: none"> • Date of Service • Provider Name and Address • Service Provided & Billing Code (or Quantity & Service Provided) • Service Approved? (Yes or No) • Amount Provider Charged • Medicare-Approved Amount • Amount Medicare Paid • Maximum You (Beneficiary) May Be Billed • Notes for Claim • Appeals Information • QMB Status
Medicare Part C (Medicare Advantage)	Medicare-covered benefits and others, according to the beneficiary's Medicare Advantage plan	Explanation of Benefits (EOB) from the Medicare Advantage plan (monthly, if benefits are used)	The beneficiary's MA plan provides an Explanation of Benefits statement that describes what the plan has covered.
Medicare Part D (Prescription Insurance)	Prescription drugs	Explanation of Benefits (EOB) from the drug plan (monthly, if benefits are used)	<ul style="list-style-type: none"> • Year-to-date costs in the drug plan • Total out-of-pocket and drug costs • Current coverage information (deductible, coverage gap, etc.) • Summary of claims since last EOB • Any updates to the plan's formulary
Supplemental Insurance (Medigap)	Benefits covered by private insurers	Explanation of Benefits (EOB) from Medigap company	<ul style="list-style-type: none"> • Total charges • What Medicare paid • What Medigap paid

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