MEDICARE CLAIMS PROCESSING

SECTION C

Medicare Claims Processing

All providers, participating and nonparticipating, are required by law to file Medicare claims for covered services, and to each provider you must supply correct information including:

- Your Medicare claim number.
- All health coverages, including Medicare A & B (to determine primary or secondary payer).
- Your name exactly as it apears on your Medicare card (no nicknames).
- Notify Social Security of any changes in address, phone number, and ask that changes be made in the Master File (which will also change the information in your Medicare file).
- Update providers' files with changes in address, phone number, etc.

Medicare is authorized to ask service providers for important medical or personal information about you, **but only with your permission.** This information is given to Medicare intermediaries, carriers, the medical review board, and providers in order to administer Medicare claims.

You **may refuse** to give permission to **release** the requested information, but-**you must give information about . . .**

- work injuries
- auto injuries
- other liability related insurance claims

Keep in mind, withholding information may result in slow or no payment. You have the right to obtain information about their claims.

Medicare Part A Claims

How are Part A claims Processed?
Medicare participating facilities submit the claim to Medicare. Since the facility accepts assignment, Medicare pays the facility directly.

When Should You Pay the Facility?
You should wait until you know that Medicare and any other insurance has paid before you pay anything. **You must inform the facility of your intention to wait.**

Usually, facilities file all private insurance claims as well as Medicare claims and receive reimbursement directly from the insurer. You may request an itemized bill from the facility, but this will not reflect Medicare's payment, only what was paid.

You will receive a **Medicare Summary Notice (MSN)** from Medicare. This form describes days used, and the deductible, and/or the co-payments that you owe. The MSN is usually received within 60-90 days after hospitalization. Wait on **both** the Medicare Summary Notice, **and** the hospital bill before paying.

Can the Service Provider Bill You for More Money?
For Medicare covered services, the facility **cannot** bill you for the difference between Medicare's payment and the facility's actual costs. The facility may bill you only for Medicare covered services that are counted toward the deductible, any co-payment, and any Medicare non-covered services provided.

Who is the Intermediary?
The intermediary is the organization that processes Part A claims. Hospital and skilled nursing facility claims are processed in Indiana by **National Government Services** (formally AdminaStar Federal)**.** Home health care and hospice claims are processed by regional intermediaries. Indiana's regional intermediary is **Palmetto Government Services**.

Medicare Part B Claims

When Are Part B Claims Processed by the Part A Intermediary?
This occurs when the individual receives Part B services in a Part A facility. In these instances, services are reimbursed according to Part B coverage through the Part A intermediary. This usually means that you must meet the Part B deductible, and coinsurance.

Railroad Retirees and Medicare
For Part B claims, **Railroad Retirees** should deal with **United Health Care**. Regional carriers are listed in the *Railroad Medicare Handbook*. The phone number will also be listed on the beneficiary's Medicare Summary Notice, and in the SHIP Telephone Reference.

When Services Occur Outside Indiana
Medicare claims must be submitted to the Medicare carrier or intermediary **in the state where the individual received the service**. If you have residences in more than one state, take special note of where the service was performed, because there is an **exception** to this rule. Durable Medical Equipment claims are filed by the supplier with regional carriers in the state of your permanent residence (the address where you spend six {6} months of the year). The Social Security Administration can supply the name of each state's Medicare carrier. Carriers are listed in the back of the *Medicare and You Handbook*.

Medicare Summary Notice

The **Medicare Summary Notice (MSN)** is an easy to read statement that clearly details your insurance claim information. You will normally receive your MSN from the carrier. **These notices are sent on a quarterly basis (every three months),** unless you are due a payment check from Medicare. In that case the MSN will be sent as your claims are processed. Individual MSNs can be accessed on-line at any time.

The MSN lists the details of services you received and the amount you may be billed. It is important to compare the MSN to bills received from providers to determine which have been processed and paid, and which have not.

- When it is determined that some medical bills have not been processed, request that the service provider **resubmit** the bills to Medicare.
- **Denied** payments may indicate that the service provider may have used an incorrect code. You should call the provider and ask them to double check the coding and **resubmit** the claim.
- If the deductible has not been met, it is subtracted from the Medicare approved amount. Medicare's 80% payment is then calculated.

Non-Participating Providers

When a provider does not accept assignment, you will be sent a check from Medicare to pay the provider. The **check will be attached to the bottom of the MSN**. These MSN are sent out as the claims are processed. Be careful to not file MSN attachments without understanding their purpose. Many beneficiaries do not notice the check and file it away without cashing it.

- **Deposit** the check, then **write a personal check** to the provider. This creates a way to track payments.
- Keep a copy of the MSN until the bill is completely settled.
- Send only **copies** of the MSN or other papers.

Submitting Claims

Assigned and non-assigned providers must submit claims within **12 months** of providing the service to you. Non-assigned providers may request a three (3) month extension. Medicare will usually deny payments on late claims. In these cases you are not responsible for paying the amount Medicare would have paid if the claim was filed on time, nor for paying any coinsurance.

If you have already paid money on these claims, Medicare will instruct the provider to **refund** the money. **Nonparticipating** providers on unassigned claims will be asked by Medicare to refund money paid by you, **but they are not required** to offer a refund. If a provider refused to submit a claim, or if you have a problem with delayed payments, contact:

1-800-Medicare (1-800-633-4227).
If you must submit a claim yourself, send all information to:
Medicare Part B Claims, P.O. Box 6160, Indianapolis, IN 46204-6160

Important Points of the MSN

- There are separate MSNs for Medicare Part A and Medicare Part B. (See copies of MSN brochures.)

- A claim is paid unless there is a message in the **Notes** section that says it was not or if the **Non-Covered Charges** column contains amounts other than zero (0).

- The Notes section contains valuable information that will explain how the claim was processed.

- The MSN provides the right to appeal the payment or claim denial. A beneficiary simply circles the item on the MSN he/she disagrees with, signs the form, and returns it to National Government Services for review. It is only necessary to return the form if the beneficiary disputes a denied claim or other problem.

- Deductible and coinsurance amounts are not shown separately. The two (2) amounts are added together and shown in the deductible and coinsurance column. The Notes section identifies the amount of the deductible met and still to be met.

- The dates of service do not appear at the top of the claim information. These dates are shown several lines down below the words “referred by.” They refer to the date the service was received, not the date the patient was referred for service.

- The logo in the upper left hand corner of the MSN refers to the Centers for Medicare and Medicaid Services (CMS). CMS is the government agency responsible for the Medicare and Medicaid programs. The logo shows both Medicare and Medicaid, but that does **not** mean that a beneficiary has both.

Below is a sample of an MSN for Part A and information on how to read it.

1. **Date:** Date MSN was sent.
2. **Customer Service Information:** Who to contact with questions about the MSN. Provide your Medicare number (3), the date of the MSN (1), and the date of the service you have a question about (7).

3. **Medicare Number:** The number on your Medicare card.

4. **Name and Address:** If incorrect, contact the company listed in (2), and the Social Security Administration immediately.

5. **Be Informed:** Messages about ways to protect yourself and Medicare from fraud and abuse.

6. **Part A Hospital Insurance - Inpatient Claims:** Type of service. See the back of MSN for additional information. (**Please Note:** For outpatient services, this section is called "**Part B Medical Insurance - Outpatient Facility Claims.**")

7. **Claim Number:** Number that identifies this specific claim.

8. **Provider's Name and Address:** Facility's name and billing address. The referring doctor's name will also be shown. The address shown is the billing address, which may be different from where you receive the service(s).

9. **Dates of Service:** Dates service were provided. You may use these dates to compare with the dates shown on your hospital bill.

10. **Benefit Days Used:** Shows the number of days used in the benefit period. See the back of your MSN for an explanation of benefit periods. (**Please Note:** For outpatient services, this column is called "**Amount Charged.**")

11. **Non-Covered Charges:** Shows the charges for services denied or excluded by the Medicare program for which you may be billed.

12. **Deductible and Coinsurance:** The amount applied to your deductible and coinsurance.

13. **12. You May Be Billed:** The total amount the provider may bill you, including deductibles, coinsurance, and non-covered charges. Medicare supplement (Medigap) policies may pay all or part of this amount.

14. **See Notes Section:** If letter appears, refer to (#15) for explanation.

15. **Notes Section:** Explains letters in (13) for more detailed information about your claim.

16. **Deductible Information:** How much of your deductible you have met for the benefit period.

17. **General Information:** Important Medicare news and information.

18. **Appeals Information:** How and when to request an appeal.

Below is a sample of an MSN for Part B and information on how to read it.

1. **Date:** Date MSN was sent.
2. **Customer Service Information:** Who to contact with questions about the MSN. Provide your Medicare number (3), the date of the MSN (1), and the date of the service you have a question about (7).
3. **Medicare Number:** The number on your Medicare card.

4. **Name and Address:** If incorrect, contact the company listed in (2), and the Social Security Administration immediately.

5. **Be Informed:** Messages about ways to protect yourself and Medicare from fraud and abuse.

6. **Part B Medical Insurance - Assigned Claims:** Type of service. See the back of MSN for information about assignment. (**Please Note:** For unassigned services, this section is called "**Part B Medical Insurance - Unassigned Claims.**")

7. **Claim Number:** Number that identifies this specific claim.

8. **Provider's Name and Address:** Doctor (may show clinic, group, and/or referring doctor) or provider's name and billing address. The referring doctor's name may also be shown if the service was ordered or referred by another doctor. The address shown is the billing address, which may be different from where you received the services.

9. **Dates of Service:** Date service or supply was received. You may use these dates to compare with the dates shown on the bill you receive from your doctor.

10. **Amount Charged:** Amount the provider billed Medicare.

11. **Medicare Approved:** Amount Medicare approves for this service or supply.

12. **Medicare Paid Provider:** Amount Medicare paid to the provider. (**Please Note:** For unassigned services, this column is called "**Medicare Paid You.**")

13. **You May Be Billed:** The total amount the provider may bill you, including deductibles, coinsurance, and non-covered charges. Medicare supplement (Medigap) policies may pay all or part of this amount.

14. **See Notes Section:** If letter appears, refer to (16) for explanation.

15. **Services Provided:** Brief description of the service or supply received.

16. **Notes Section:** Explains letters in (14) for more detailed information about your claim.

17. **Deductible Information:** How much of your yearly deductible you have met.

18. **General Information:** Important Medicare news and information.

19. **Appeals Information:** How and when to request an appeal.

Assigned Claims

Providers **take assignment** and **accept Medicare's approved amount** as total payment for the service. You may be billed for:

- Deductible
- Co-Insurance
- Services which are not covered by Medicare
- Non-covered services for which the person signed a waiver listing service and cost prior to receiving the service

Non-Assigned Claims

Providers **do not** take assignment, and **do not accept Medicare's approved amount** as total payment for the service. You may be billed for:

- Deductible
- Co-Insurance
- Services which are not covered by Medicare
- Non-covered services for which the person signed a waiver listing service and cost prior to receiving the service
- Charges in excess of the Medicare approved amount, (not in excess of the 115% Limiting Charge.

If a provider will not refund charges in excess of the Limiting Charge or continues to attempt to collect the excess charges, the beneficiary should report this to the **Medicare Fraud and Abuse Division at: 1-800-Medicare (1-800-633-4227).**

Medicare Billing

Billing for Medicare Part A, Part B, and Managed Care Plans is all processed differently. Questions about bills and claims should be directed to Medicare, the Medicare carrier, Managed Care Plan, and/or the provider, depending on the services, claims and bills in question.

Part A Claims

When the beneficiary goes into the hospital:

1. The hospital bills Medicare for all covered charges.
2. The Medicare Intermediary sends payment directly to the hospital and sends a Medicare Summary Notice to the patient.
3. The hospital bills the patient for the Part A deductible and applicable co-payments if in over 60 days, and for any other services not covered by Medicare.

Part B Claims

When the beneficiary goes to a physician or other service provider that **accepts Medicare assignment** for Medicare Part B covered services:

1. The physician or provider bills Medicare directly.
2. The Medicare carrier pays 80% of the approved charge directly to the provider minus the Part B deductible and sends the beneficiary a Medicare Summary Notice.
3. The patient is then responsible for paying the 20% coinsurance to the provider and any amount applied towards the Part B deductible.

When the beneficiary goes to a physician or other service provider that **does not accept Medicare assignment** for Medicare Part B covered services:

1. The physician or provider bills Medicare directly.
2. Medicare sends a check for 80% of the approved charge with the MSN directly to the patient.
3. The patient should deposit the Medicare check and then must pay the provider Medicare's portion of the bill, the 20% coinsurance, any amounts to be applied toward the annual deductible, and any excess charges up to the Limiting Charge.

Medicare Supplement Policies

Federal and state law mandates that companies selling Medigap policies must participate in **Medigap Cross Over**. Many Medigap companies have a contract with the Medicare carrier and arrange to have Medicare send all claims directly to the Medigap company. This is called **All Claims Cross Over**.

Medigap Cross Over	All Claims Cross Over
Initiated by the beneficiary.	Initiated by the Medigap company.
Service covers all participating and nonparticipating providers.	Service is only for Medicare participating providers.
Payment is sent directly to the participating physician or supplier.	Payment may be to the beneficiary or to the provider.
Federal and state law mandates that companies selling Medigap must participate in Medigap Cross Over.	Companies do not have to offer this service, nor do beneficiaries have to take and buy this service.

How Does Someone Initiate Medigap Cross Over?

A beneficiary should:

- Ask the Medicare participating physician or supplier to submit a completed claim form to Medicare; sign the completed form in two (2) places, giving both Medicare and the insurance company his/her permission to send payment directly to the provider.
- Provide necessary Medigap policy information to the provider to be included on the NGS claim form #1500 in box 9.

Medicare will:

- Process Medicare's part of the claim and forward the claim information to the Medigap company. The Medigap company is required by law to accept the claims information from Medicare. Medigap companies pay a user fee to receive these claims.

The Medigap company will:

- Pay its portion of the claim directly to the participating physician or supplier.

Managed Care Plans

Managed Care Plans provide covered services for Parts A and B. The beneficiary may have co-payments, as specified in the Managed Care agreement. There is no bill processing as is described above. Beneficiaries should contact their plan for more information on that company's billing process.

Beneficiaries should never send original copies of bills in question

When Medicare Is Not The Primary Payer

Medicare is the secondary payer after claims have been processed through the primary insurance company for the following:

Employer Group Insurance

Medicare is secondary for persons that are 65 years old or older who have an employer group health plan through **current employment** or the **current employment of a spouse**. This law applies when the employer has 20 employees or more.

- For Medicare covered services not included under the employer's plan, Medicare would be a primary payer.
- When the employer group plan is an HMO, and the person goes to a provider outside the HMO network, Medicare will pay as the primary payer for the first few claims. Medicare will send a letter stating that Medicare will no longer pay for out-of-network providers.
- For people who are disabled, Medicare is the secondary payer if he/she accepts a group health plan and:
  1. Is under 65 years old and has Medicare due to a disability
  2. Is covered under a group health plan because of current employment or the current employment of a family member of any age.
  3. The employer has 100 or more employees.

End Stage Renal Disease Patients

Medicare is secondary for persons with ESRD that have an active employer group health plan or are on COBRA.

Veterans Administration

See the *Navigation Guide for Supplemental and Other Insurance*.

Federal Black Lung Program

See the *Medicare and Other Health Benefits* booklet.

Liability Settlements

Medicare will be the secondary payer whenever an injury has occurred which is covered and paid by a liability or no-fault insurance. This will occur in the following cases:

- **Automobile Insurance** Submit automobile accident related claims to the insurance company before submitting them to Medicare.
- **Liability Insurance** (homeowner, malpractice, etc.) These claims may be submitted to Medicare for a conditional payment after three (3) months. After a liability settlement is reached, Medicare will recover the conditional payment from the settlement amount.
- **Worker's Compensation** Medicare will be billed first if the claim is contested and the person is waiting for the Worker's Compensation Board decision. The bill should include a statement that the claim is being contested.

Patients must inform the provider when the injury or illness for which they are seeking medical attention is the result of a **work related incident**, an **auto accident**, or an injury involving **liability** or **homeowner insurance**. This type of insurance would then be the primary payer.

Medicare beneficiaries and their providers must accurately complete the section of the Medicare claim form that deals with other health insurance.

Medicare has the right to be a secondary insurance payer due to **subrogation laws**. Subrogation prevents people from receiving double insurance payments and making a profit on an injury. A beneficiary that receives a monetary settlement could receive demands from Medicare to return payments that Medicare had previously made. To prevent this, Medicare beneficiaries should inform Medicare whenever there is any kind of liability insurance involved.

What Medicare Pays When Medicare Is the Secondary Payer?

Medicare does **not act like a supplement** to the primary insurance. This means **Medicare will not always pay the remaining amount after the primary insurance has paid**. If the primary insurance payment is less than Medicare's approved amount, Medicare may pay the difference. If the primary payment is equal to or more than the Medicare approved amount, Medicare will pay nothing.

Medicare does not act like a supplement to the primary insurance. Medicare deductibles must be met before Medicare will pay. This is true whether Medicare is the primary or secondary payer. National Government Services has a special department called the Medicare Secondary Payer Unit. Questions should be addressed there by calling: 1-800-633-4227.

Who Files the Claim When Medicare is the Secondary Payer?
Facilities that provide the services will usually file with the primary insurance and also with Medicare when Medicare is the secondary payer. Doctors or suppliers have a choice of whether or not to file the claim with the primary insurance company when Medicare is a secondary payer.

When the doctor files a claim with the primary insurance and receives payment from them, then the doctor must also file the claim with Medicare.

When you file the claim with the primary insurance company and receives the payment from the company, then you can do either of these:

1. Take all paperwork to the doctor including the insurance company's payment information and request the doctor file the claim with Medicare.

2. File your own claim with Medicare, using form #1490-F. This form can be obtained from the Social Security Administration, or Medicare, (**1-800-633-4227)**

When filing claims with Medicare when Medicare is secondary, you must include a copy of the primary insurance company's benefit statement, whether it is the provider or the beneficiary filing the form.

Private Insurance Claims

Medigap policies **coordinate** benefits with Medicare. Some Medicare supplement policies pay for excess charges above the Medicare approved amount, usually up to the Limiting Charge. They may also pay for specific Medicare non-covered services.

Check the policy to know what it will pay.

Most private insurance companies want a copy of the Part B Medicare MSN before it will reimburse for the claim. Some also require a bill from the provider and its own insurance claim form. Some may have cross over service with Medicare. Check with the company for information about its services and requirements regarding claims. The typical filing process is as follows:

- The provider files the claim with Medicare. The beneficiary should wait to receive the MSN.
- The beneficiary attaches a copy of the MSN to the insurance company's claim form. He/she should also attach the actual bill if the insurance company requires it.
- The beneficiary mails all items in the envelope supplied by the insurance company (if there are any) to insure prompt processing.
- A beneficiary should **never** send his/her only copy of the MSN or other forms.

See *SHIP's Claims Record Form* in the *Navigation Guide 4 Section R Forms*.

Privacy and Medicare

The purpose of the Privacy Act of 1974 is to provide safeguards for you against an invasion of privacy by Federal agencies. Guidelines for releasing Medicare information have been established for you living or deceased. There are **two (2) ways** to release Medicare information that include the following:

Direct Consent (or Verbal Permission) to Release Information
Direct consent from you will enable the Customer Service Representative (CSR) at National Government Services (formally AdminaStar Federal) to release your information including payment if the CSR receives verbal consent over the phone from you.

Written Consent (or Authorized Permission) to Release Information
Written consent from you will enable the CSR to release information including payment if the caller can verify certain information asked by the CSR and has a consent form on file at the Medicare office. Also, if the caller is a Representative Payee for you or if the caller has Power of Attorney on file at the Medicare office they can receive information about you.

Without Verbal or Written Consent to Release Information
No consent from you will limit the amount of information a CSR can give to a third party caller. Only the following four (4) types for information can be offered:

- If and when Medicare received a claim.
- When the claim was processed (not how).
- When you will receive your MSN.
- General Medicare and coverage questions.

Medicare can send the third party a consent form. There are separate consent forms for Part A, Part B and Durable Medical Equipment. Once the form is filled out, signed, and returned to the Medicare office, Medicare can release information for the Medicare beneficiary on the form only or Medicare can send a copy of the MSN directly to you. Most of the information will be on the notice.

For questions or to have a consent form mailed out, call 1-800-633-4227.

Medicare: Fraud and Abuse

Most Medicare payment errors are due to simple mistakes, and not the providers trying to take advantage of system. Unfortunately there are those who do try to abuse or defraud Medicare. National Government Services (formally AdminaStar Federal) has fraud and abuse divisions where beneficiaries can report the following:

- Providers performing unnecessary or inappropriate services.
- Providers billing Medicare for services the person did not receive.
- Providers who refuse to file claims to Medicare.
- The use of someone else's Medicare claim number to receive services or supplies.

To contact National Government Services use the contact information on your MSN.

Detection Tips

You should be suspicious if the provider tells you that:

- The equipment or service is free; he only needs your Medicare number for his records. NOTE: For clinical laboratory tests, there is no co-payment and a provider may in good faith state that the test is free, since there is no cost to the person with Medicare.
- Medicare wants you to have the item or service.
- They know how to get Medicare to pay for it.
- The more tests they provide the cheaper they are.

Be suspicious of providers that:

- Charge co-payments on clinical laboratory tests, and on Medicare covered Preventive Services such as PAP smears, prostate specific antigen (PSA) tests, or flu and pneumonia shots.
- Routinely waive co-payments on any services, other than those previously mentioned, without checking your ability to pay.
- Advertise "free" consultations to people with Medicare.
- Claim they represent Medicare.
- Use pressure or scare tactics to sell you high priced medical services or diagnostic tests.

- Bill Medicare for services you did not receive.
- Use telemarketing and door-to-door selling as marketing tools.

Prevention Tips

To help prevent Medicare fraud, you should report suspected instances of fraud. Whenever you receive a payment notice from Medicare, review it for errors. The payment notice shows what Medicare was billed for, what Medicare paid and what you owe. Make sure Medicare was not billed for health care services or medical supplies and equipment you did not receive.

The following is a list of tips to prevent fraud:

- Don't ever give out your Medicare Health Insurance Claim Number (on your Medicare card) except to your physician or other Medicare provider.
- Don't allow anyone, except appropriate medical professionals, to review your medical records or recommend services.
- Don't contact your physician to request a service that you do not need.
- Do be careful in accepting Medicare services that are represented as being free.
- Do be cautious when you are offered free testing or screening in exchange for your Medicare card number.
- Do be cautious of any provider who maintains they have been endorsed by the Federal government or by Medicare.
- Do avoid a provider of health care items or services who tells you that the item or service is not usually covered, but they know how to bill Medicare to get it paid.

The carrier or intermediary need to be notified of the possible fraud or abuse, the date it occurred, and the names and addresses of the provider and beneficiary involved.

Always report suspected Medicare Fraud and Abuse.

Medicare: Fraud and Abuse

INDIANA

SMP Overview

The SMP (formerly Senior Medicare Patrol) program was established in May of 1997 and is primarily funded by the Administration on Aging. The program consists of fifty-seven innovative community-based projected located in every state, the District of Columbia, Guam, U.S. Virgin Islands and Puerto Rico. The SMP projects utilize the skills and expertise of retired professionals, such as doctors, nurses, teachers, lawyers, accountants, and others to work in their communities, educating and empowering beneficiaries to take an active role in the detection and prevention of health care fraud and abuse, with a focus on the Medicare and Medicaid programs.

The Indiana SMP Project partners with the State Health Insurance Assistance Program (SHIP) to provide new counselor/volunteer training and Updates training for Certification. The Indiana SMP Project is located in the Indiana Association of Area Agencies on Aging (IAAAA) office and works with the 16 Area Agencies on Aging promoting community awareness of health care errors, fraud and abuse.

SMP's work together with SHIP Counselors to educate beneficiaries and others of ways to protect their personal information, detect fraudulent scams, and report suspicious behavior.

By helping beneficiaries read and understand the Medicare Summary Notice and encouraging them to report errors, you are taking an active part in protecting them and others against fraudulent, wasteful, and abusive health care practices.

Most Medicare payment errors are due to simple mistakes, and not the providers trying to take advantage of the system. Unfortunately there are those who do try to abuse and defraud Medicare.

National Government Services has fraud and abuse divisions where beneficiaries can report the following:

- Providers performing unnecessary or inappropriate services.
- Providers billing Medicare for services the person did not receive.
- Providers who refuse to file claims to Medicare.
- The use of someone else's Medicare claim number to receive services or supplies.

To contact national Government Services use the contact information on your MSN in the Customer Service Information box.

What is Medicare Fraud?

Under the False Claims Act, it is a ***criminal offense*** to present a false or fraudulent claim for medical services if the individual ***knew*** that the claim was false or fraudulent. The most frequent kind of fraud arises from a false statement or misrepresentation that is material to entitlement or payment under the Medicare program.

What is Medicare Abuse?

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

Detection Tips

You should be suspicious if the provider tells you that:

- The equipment or service is free; he only needs your Medicare number for his records. NOTE: For clinical laboratory tests, there is no co-payment and a provider may in good faith state that the test is free, since there is no cost to the person with Medicare.
- Medicare wants you to have the item or service.
- They know how to get Medicare to pay for it.
- The more tests they provide the cheaper they are.

Be suspicious of providers that:

- Charge co-payments on clinical laboratory tests, and on Medicare covered Preventive Services such as PAP smears, prostate specific antigen (PSA) tests, or flu and pneumonia shots.

- Routinely waive co-payments on any services, other than those previously mentioned, without checking your ability to pay.

- Advertise “free” consultations to people with Medicare.

- Claim they represent Medicare.

- Use pressure or scare tactics to sell you high priced medical services or diagnostic tests.

- Bill Medicare for services you did not receive.

- Use telemarketing and door-to-door selling as marketing tools.

What is Medicaid Fraud?

Medicaid fraud occurs when a health care provider, such as a doctor, dentist, pharmacist, hospital, nursing home or other health care service:

- Bills Medicaid for services that the Medicaid patient does not receive;

- Bills excessively for services; or

- Bills for services not necessary.

What next?

Ask beneficiaries if they have recorded medical information in a journal. (If not, suggest they request one from SHIP/SMP.)

Before calling to question or report problems, have the following information available:

- Name and Medicare or Medicaid number
- Name of company or doctor
- Date of service
- Description of the problem
- Suggest they **call the provider or plan first**, or assist them with the call.
- Suggest they **call the local Area Agency on Aging at: 1-800-986-3505**, or assist them with the call.
- Suggest they **call 1800 MEDICARE (1-800-633-4227)** or assist them with the call.
- Suggest they **call the Office of Inspector General Hotline 1-800-HHS-TIPS (1-800-447-8477)** or asst them with the call.

Contacts for SMP Complaints

Medicare Part A, B and Home Health and Hospice Services

TrustSolutions, LLC
Donna Casey
6755 W. Washington St
Milwaukee, Wisconsin 53214
(414) 459-6085
(414) 459-2857 (fax)
Donna.casey@trustsolutionsllc.com

Medicare Durable Medical Equipment

TriCenturion
Vicky Quinonez
7909 Parklane Rd., Suite 190
Columbia, SC, 29223
(803) 264-8144
(803) 264-7505 (fax)
Vicky.quinonezl@tricenturion.com

Medicare Part D

SafeGuard Services
MEDIC North-Medicare Drug Integrity Contractor
Doug Quave
(717) 975-4040
(717) 975-4442 (Fax)
1-877-772-3379 Toll Free hotline
Douglas.quave@eds.com

Medicaid Fraud

Medicaid Fraud Control Unit
A llen K. Pope - Director, MFCU
Medicaid Fraud Control Unit of Indiana
Office of Attorney General
8005 Castleway Dr.
Indianapolis, IN 46250-1946
(317) 915-5303
(317) 232-6523 (Fax)
apope@atg.state.in.us

Report ID Theft To: Any one of the nationwide consumer reporting companies to place a fraud alert on your credit report

1) **Equifax:** 1-800-525-6285 or www.equifax.com

2) **Experian:** 1-888-397-3742 or www.experian.com

3) **TransUnion:** 1-800-680-7289 or www.transunion.com

4) **Federal Trade Commission:** 1-800-438-4338 or www.consumer.gov/idtheft

Forms

- See SMPS reporting Forms in the Navigation Guide 4 Section R Forms
- Group Session Post Survey – to be completed after a presentation
- SMP Simple Inquiry – included on SHIP client contact form
- SMP Complex Issue Form – For more complicated issues

For more information about the SMP projects contact: The National Consumer Protection Technical Resource Center

www.smpresource.org
1-877-808-2468