



# North Dakota Senior Medicare Patrol Volunteer Handbook

*Protect ★ Detect ★ Report*



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This document was supported in part by a grant, number 90AM3065 from the Administration on Aging, Department of Health and Human Services.  
Created by Cathy Haarstad 2007

# Welcome to the North Dakota Senior Medicare Patrol

## Successful volunteers are:

- Curious
- Patient
- Outgoing
- Persistent
- Connected
- Willing to learn

**We believe that you have these qualities. Thank you for volunteering!**

Our office is located at the North Dakota Center for Persons with Disabilities on the campus of Minot State University. You can contact us at:

ND Senior Medicare Patrol  
ND Center for Persons with Disabilities  
500 University Avenue W.  
Minot, ND 58707  
**Toll Free** 1-800-233-1737  
**Phone** 701-858-3580  
**Fax:** 701-858-3483  
<http://www.ndcpd.org/smp>

When you call, ask for: Linda Madsen, Project Director or Heather Lee, Training and Volunteer Coordinator. Our goal is to:

1. Reach out to all seniors and seniors with disabilities who may be especially vulnerable
2. Provide them with the training and support they need to
3. Resist and report Medicare fraud so that
4. Valuable resources are not wasted but used to improve health care.

## **Introduction**

*To be successful as a volunteer in the Senior Medicare Patrol (SMP) project, you will need to know a little bit about ND SMP, Medicare, fraud, seniors and people with disabilities.*

## **Who Are the SMPs?**

The SMP programs recruit and teach senior volunteers and professionals such as doctors, nurses, accountants, investigators, law enforcement personnel, attorneys, teachers, and others to help Medicare and Medicaid beneficiaries become better health care consumers. Volunteers work in their communities and in local senior centers to help identify deceptive health care practices, such as overbilling, overcharging, or providing unnecessary or inappropriate services. Senior volunteers undergo several days of training, reviewing health care benefit statements and outlining steps individuals can take to protect themselves.

## **History of The Program**

In 1995, the Administration on Aging (AoA) became a partner in a government-led effort to fight fraud, error and abuse in the Medicare and Medicaid programs through the implementation of a ground-breaking demonstration project called Operation Restore Trust (ORT). ORT's purpose was to coordinate and target federal, state, local and private resources on those areas most plagued by abuse. Operation Restore Trust was announced at the 1995 White House Conference on Aging.

During its demonstration phase, ORT returned \$23 for every \$1 spent looking at the fastest growing areas of Medicare, including home health care, skilled nursing facilities, and providers of durable medical equipment. This comprehensive anti-fraud initiative began in five states--California, Florida, Illinois, New York and Texas. It has created a partnership in the Department of Health and Human Services between the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration), the Office of Inspector General, and the Administration on Aging which are working as a team to carry out ORT.

AoA became a key player in the fight against fraud through the enactment of P.L. 104-209, the Omnibus Consolidated Appropriations Act of 1997. Language in this legislation, offered by Senator Tom Harkin (D-IA), was adopted, directing the AoA to establish demonstration projects that utilize the skills and expertise of retired professionals in identifying and reporting error, fraud and abuse.

In May of 1997, the AoA first awarded funds to 12 agencies and organizations as part of an expanded ORT initiative. Based on the success of these activities, the SMP program has grown to 64 projects, including virtually every state and the District of Columbia, Puerto Rico, Guam, and the Virgin Islands.

It is difficult to accurately calculate the savings attributable to the **prevention** of errors, fraud and abuse by the more than 1.9 million seniors who have participated in group sessions or received one-on-one counseling from their local SMP volunteer. The Office of Inspector General's most recent outcomes tracking report of the SMP program indicate that since inception, the program has documented savings of more than \$104 million.

**It is possible to make a difference.**

Today, AoA provides the funding and support, NDCPD provides the resources and information and the SMP's experienced staff and trained volunteers serve as local experts and educational resources for consumers and partners concerned about errors, fraud and abuse.

The vision of the program is focused on supporting efforts of the SMPs to integrate their programs into the fabric of their states and communities. The SMP programs, AoA and The National Consumer Protection Technical Resource Center are working to create sustainable partnerships at every level of the health care system- national to local- in the battle to empower seniors to prevent and identify health care errors, fraud and abuse.

**North Dakota Senior Medicare Patrol (ND SMP)**

The Senior Medicare Patrol (SMP) Project was awarded to The North Dakota Center for Persons with Disabilities (NDCPD) at MSU in July 2006. Funded in part by the Administration on Aging, Department of Health and Human Services grant number 90AM3065.

**Mission Statement**

To assure that all ND seniors, including those in our most rural counties and those with disabilities, can review their Medicare bills to assure that no errors, fraudulent charges or abuse have occurred.

## **About North Dakota Center for Persons with Disabilities (NDCPD)**

### **Our mission:**

To provide leadership and innovation that advances the state-of-the-art and empowers people with disabilities to challenge expectations, achieve personal goals and be included in all aspects of community life.

NDCPD is a University Center of Excellence on Developmental Disabilities, Education, Research and Services. It is part of a network of similar programs at universities throughout the United States. University Centers of Excellence (UCE) such as the NDCPD serve the disability community by

- providing interdisciplinary training to students who are seeking professions in the human service arena,
- providing inservice training for professionals and others serving people with disabilities and their families,
- disseminating information about effective best practices regarding services for people with disabilities,
- and providing technical assistance to agencies and programs serving the disabilities community.

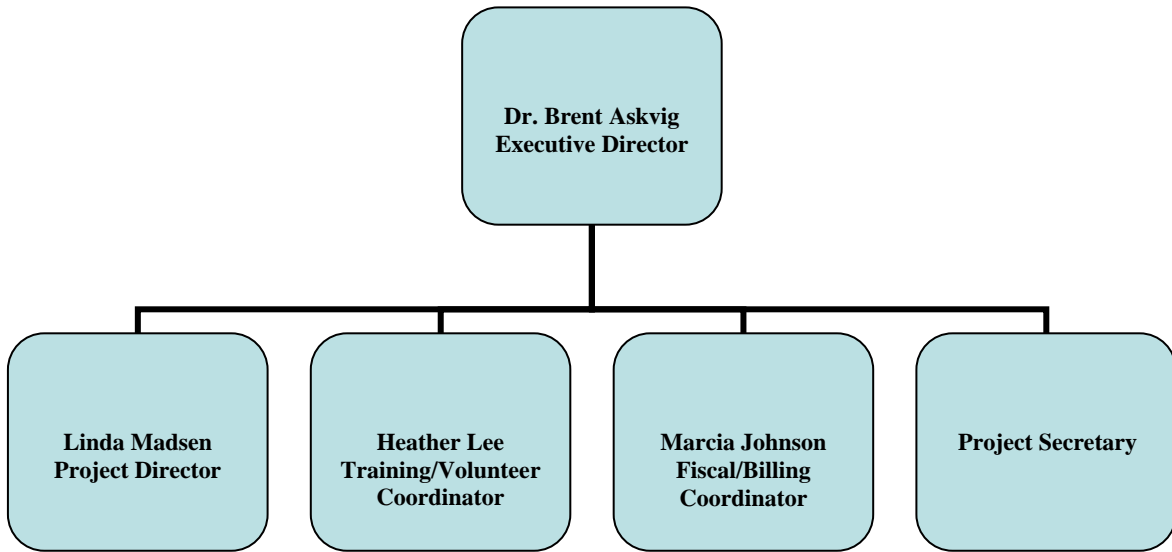
UCE's develop funding to carry out these functions by obtaining grants and contracts. These functions in turn become the 'core' of NDCPD's activities.

Our projects, activities, and programs are designed to increase the inclusion, integration, independence, and productivity of people who have disabilities in all aspects of community life. We serve a diverse population of consumers, service providers, families, and people in the private sector.

### **Vision Statement**

We believe that people with disabilities have the same rights as all citizens. We believe that people with disabilities who receive publicly funded services have the right to expect that those services appropriately promote their independence, productivity, integration and inclusion. Furthermore, we believe that the public expects that these services will be provided in an effective manner.

## Organizational Chart



For more information about the ND Center for Persons with Disabilities contact:

**Toll Free** 1-800-233-1737

**Phone** 701-858-3580

**Fax:** 701-858-3483

<http://www.ndcpd.org>

## **What is Medicare, fraud, seniors and people with disabilities?**

- Medicare is health insurance for people older than 65 and people with disabilities. Many people have no other form of health insurance. They rely on Medicare as their safety net in case of accident, injury or illness.
- Fraud happens when people try to cheat the Medicare system or the people who depend on that system. Fraud can include billing the government for services that were not provided or charging too much for services. Fraud also happens when an unauthorized person tries to access a senior's Medicare or Social Security number by pretending to be someone who works for Medicare.
- Fraud is costly. It can cheat people out of their life savings and add unnecessary expense to the system. Dollars lost to fraud cannot be used to improve health care.
- Fraud is big business. Fraud costs the Medicare program about 10% or, \$1 for every \$10 paid to a health care provider. Ten percent of the 200 billion dollars spent each year on Medicare is a lot of money. Whether fraud is accidental or deliberate it affects the people we love and robs them of important resources.
- Seniors, especially seniors with disabilities, are particularly vulnerable when it comes to fraud. Many seniors are respectful of authority figures. They can easily be taken in by anyone who assumes control. Other seniors are easily confused and may not notice or know what to do about duplicate bills. Finally, most seniors are easily discouraged when attempts to report fraud are discounted or ignored.

### **You can help make a difference!**

Let's learn a little bit about Medicare. The information in the next section has been put into a question and answer format to help you find and remember the facts you need to know to help seniors.

# Chapter One: What is Medicare?



Medicare is a government sponsored health insurance program for people age 65 and older and for people with disabilities. There are no *income* eligibility requirements. That means any senior can qualify. Medicare covers most of the medical services people may need.

## Who is eligible for Medicare?

### You are eligible for Medicare if you . . .

- Are a U.S. citizen; or
- You have your resident visa and have lived in the U.S. for 5 consecutive years; or
- You are 65 and older and have earned sufficient Social Security Quarters; or
- You have been getting disability benefits for at least 24 months; or
- You have kidney failure, End Stage Renal Disease (ESRD); or
- Are approved for Social Security Disability with a diagnosis of ALS (Lou Gehrig's disease)

## How do I enroll in Medicare?

### There are four ways to enroll in Medicare:

#### 1. Automatic enrollment

- Your Medicare card will be mailed to you automatically if:
- You have been receiving Social Security benefits before you turn 65; or
- You have a disability and have been receiving SSDI for at least 24 months.

#### 2. Initial Enrollment

- You can self-enroll during a 7-month period starting 3 months before your 65<sup>th</sup> birthday month, including your birthday month, and ending 3 months after.
- Enroll early to make sure coverage begins by the time you turn 65.
- To enroll contact the nearest Social Security Office.

#### 3. Special Enrollment

- When either you or your spouse are actively working at a company that has 20 or more employees, if you're 65 and older, or if you're a person with a disability and;
- You retire;
- You lose your health coverage;
- You have 8 months to enroll. Enroll early to avoid gaps in coverage.

#### 4. General Enrollment

- Enroll between January and March annually.
- Coverage will not start until July 1.
- You may have to pay a 10% Part B premium penalty for delayed enrollment.



#### Finding Your Local Social Security Office

To find your local Social Security office or to get answers to your questions, you have three easy options for contacting the Social Security Administration (SSA):

**Online:** Go to <http://www.socialsecurity.gov/onlineservices/> Enter your zip code and you will be able to obtain the office location, phone number, office hours, and other useful information.

**By toll-free telephone call:** Call 1-800-772-1213. Social Security operates this number from 7 a.m. to 7 p.m., Monday - Friday. If you have a touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays.

**By toll-free TTY telephone call:** Call 1-800-325-0778. This number, for people who are deaf or hard of hearing, is available between 7 a.m. and 7 p.m., Monday-Friday.

Callers should have their Social Security number available when calling.

#### What Does Medicare Cover in General?

Medicare consists of Multiple Parts. People can elect to enroll in all or part of Medicare. Most people obtain Part A and some Part B. When people speak of "traditional Medicare," they generally refer to the Part A and B programs.

	<b>Mandatory or Voluntary</b>	<b>Type of Benefit</b>
Part A	<b>Mandatory</b>	Hospital insurance, including skilled nursing, some home health, and hospice services
Part B	<b>Voluntary</b>	Physician and outpatient services, some home health care, durable medical equipment, and ambulance services
Part C	<b>Voluntary</b>	Alternative to receiving traditional Medicare. Beneficiaries enroll in a Medicare Advantage health plan
Part D	<b>Voluntary</b>	Prescription drug benefit

## What does each part cover?

<b>Part A</b>	<b>Part B</b>
<ul style="list-style-type: none"><li>• Inpatient hospital</li><li>• Inpatient skilled nursing facility</li><li>• Home health care</li><li>• Hospice care</li></ul>	<ul style="list-style-type: none"><li>• Doctor services</li><li>• Durable medical equipment</li><li>• Home health care</li><li>• X-rays, lab services</li><li>• Outpatient services</li></ul>

\*\*\*For specific coverage, please refer to the Medicare & You 2008 book.

### Medicare does not pay for:

- Dental care and dentures.
- Hearing aids and hearing exams.
- Routine eye care and eyeglasses.

### How do people with disabilities obtain these services if Medicare does not cover them?

Assistance may be available under Medicaid for people with disabilities if their income is low enough. Persons who receive both Medicare and Medicaid are known as "dual eligible's". For many people with disabilities, Medicaid provides a critical supplement to Medicare, filling in Medicare's gaps in coverage.

### What Are Your Costs?

**Even though Medicare is available no matter how much money you have, it is not totally free.**

**Part A:** You must pay a hospital deductible per visit.

**Part B:** Per year deductible plus a cost of a monthly premium which is based on yearly income.

- Medicare pays 80% of the Medicare-approved amount for doctor's services; you pay a coinsurance of 20%.

### To Help Seniors Cover Some of the Out of Pocket Costs Medicare:

- May suggest that you buy supplemental insurance to cover some of these costs.
- May assign your benefit to a Medicare Advantage Plan (i.e. HMO or PPO) to help reduce or control costs.
- May offer additional help to seniors living on a limited income (Medicaid).

## **What Coverage in Part A and B does the premium buy?**

### **Part A Coverage – no premium (free)**

**Part A covers everything medically necessary to your hospital stay: semi-private room, nursing services, medications, intensive care, etc.**

#### **Your Rights in the Hospital:**

- If you believe you are being discharged from the hospital too soon – get your discharge in writing.
- Appeal the decision through North Dakota Health Care Review, Inc. (NDHCRI) at 1-800-472-2902.

#### **Skilled Nursing Facility**

- A doctor must prescribe your plan of care in a SNF
- Must be hospitalized for at least 3 days
- Skilled care on a daily basis
- Must receive proper notice from facility when they believe coverage will end
- Days 1-20 covered
- Co-pay per day, days 21-100

#### **Home Health Care/hospice**

- Medicare will cover limited amount of Home Health care prescribed by a doctor.
- May include limited home health aide, e.g. bathing services.
- Hospice care is for patients certified by a physician as having six months or less to live.
- Pain medications and “comfort care” are now covered.

#### **What Can Your Doctors Charge? (Under Original Medicare)**

- To help lower your costs, use doctors who “take assignment”, which means they accept Medicare’s approved amount as payment in full.
- Medicare pays 80% of this amount.
- Many doctors take assignment. Those who don’t are allowed by law to charge up to 15% above Medicare’s approved amount.

**Case example:**

<b><u>Doctor takes assignment</u></b>		<b><u>Doctor doesn't take assignment</u></b>	
Bill	\$150	Bill	\$150
Medicare approves	\$100	Medicare approves	\$100
Medicare pays	\$ 80	Medicare pays	\$ 80
<u>You pay</u>	<u>\$ 20</u>	<u>You pay</u>	<u>\$ 35 (20% + 15%)</u>
Doctor gets	\$100	Doctor gets	\$115

If the doctor "opts out" of Medicare you must pay the full charge of \$150.



**Medicare Services Notices (MSN)** – These documents are automatically mailed to Medicare beneficiaries on a monthly basis. Each MSN details what services were provided and what they cost. They are not a bill but a document that lets beneficiaries know what Medicare covered. Reading the MSN carefully is one of the best ways of preventing Medicare Fraud or Abuse. To learn more about how to read an MSN look at the

tutorial that can be found

at: <http://www.ombudsman.state.ny.us/Restore/Tutmsn.htm>



**The Medicare Modernization Act (MMA) of 2003:** This recent legislation was passed to give seniors a way to better afford prescription medications.

- The plans are offered by private drug companies
- Seniors can choose which plan they want
- Seniors must make sure the drugs they need are covered by the plan they choose

**What is Part D?**

Medicare Part D provides coverage for a variety of prescription drugs. Any individual who receives coverage through the Medicare program is eligible for the Part D drug benefit.

Part D is a "voluntary" program. That means that an individual who receives Medicare benefits may choose not to enroll in a plan. However, eligible individuals who enroll late may have to pay a penalty added to their monthly Part D premiums. Medicare beneficiaries who also receive benefits through Medicaid will be automatically enrolled in a Medicare plan and will receive prescription drug coverage through Part D. They will also receive help paying for their Part D costs.

Prescription drug coverage depends on the drug plan in which a Medicare beneficiary chooses to enroll. Drug plans are allowed to design “formularies,” or lists of drugs that a plan will cover. The federal government has stated that it will not approve any drug plan unless its formulary includes coverage of certain drugs commonly prescribed to elderly and Medicare beneficiaries with disabilities. CMS has encouraged potential plan sponsors to include extensive formularies and has required coverage of all or substantially all drugs in 6 categories. These categories include: antidepressants, antipsychotic, anticonvulsants, HIV drugs, cancer medications, and immunosuppressant.

Over the counter drugs will not be covered under Medicare Part D. Detailed information about each private drug plan’s Part D coverage is available at your pharmacy.

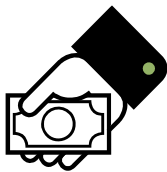
### **What Drugs Will Not Be Covered?**

Although plan providers have a great deal of freedom in choosing which drugs to cover, the law prohibits coverage of certain categories of drugs including, but not limited to:

- Drugs that can be paid for through Medicare Part A or Part B;
- Drugs used for weight loss, weight gain, or anorexia;
- Prescription vitamins except prenatal vitamins & fluoride preparations;
- Nonprescription drugs; Barbiturates; and Benzodiazepines.

Costs under Part D will vary according to your plan choice, medication needs, and income level. Many Medicare beneficiaries will have to pay a monthly premium for Part D coverage as well as a deductible and other out-of-pocket cost.

Each drug plan can create its own cost structure—within a certain framework created by the federal government. Medicare beneficiaries with lower incomes and few assets or who also have Medicaid coverage will receive assistance, also known as extra help, for their Part D plan costs.



### **Who provides the drug coverage?**

Unlike traditional Medicare, drug coverage through Medicare Part D will be offered by private drug plans approved by the federal government. These private plans will typically be operated by insurance companies or health maintenance organizations (HMOs). By October 15, 2005, Medicare beneficiaries will have access to information about the prescription drug plans that will be available in their area. Some plans are offered nationwide.

**To apply for extra help.** Call Social Security at 1-800-772-1213 or visit [www.socialsecurity.gov](http://www.socialsecurity.gov) on the web.

### **Things to Remember**

- Sign up for Medicare Part B right away to avoid premium penalties.
- To save money, use doctors and medical suppliers who take assignment.
- You have the right to all Medicare benefits, regardless of the plan you have.
- Report suspicious activities to ND Senior Medicare Patrol at 1-800-233-1737.

### **Can a person with a disability on Medicare and/or Medicaid be employed?**

Yes, under certain conditions. Until fairly recently, federal law made it extremely difficult for individuals with disabilities to be competitively employed and still retain vital Medicare or Medicaid benefits that often make work possible. To correct this flaw, Congress has added several "work incentives" to the Social Security Act that enables beneficiaries to:

- Receive education, training and rehabilitation to start a new line of work;
- Keep some or all SSDI or SSI cash benefits while working;
- Obtain or retain vital Medicaid coverage while working; and,
- Retain existing Medicare coverage while working.

For more information on how these incentives can enable beneficiaries to work, they can:

Read the publication, *Keeping Medicare and Medicaid When You Work, 2005: A Resource Guide for People with Disabilities, Their Families, and Their Advocates*, available from the Kaiser Family Foundation.

Or, call the Social Security Administration at 1-800-772-1213, or for the hearing impaired, 1-800-325-0778 (TTY/TTD).

**For More Information and Help:**

**North Dakota**

**State Health Insurance Counseling (SHIC) Program**

**Cindy Sheldon**

888-575-6611 or 701-328-2440

<http://www.state.nd.us/ndins/consumer/details.asp?ID=58>

**State Medicaid Office** 800-755-2604 or 701-328-2321

**Long-term Care Ombudsman** 800-451-8693 or 701-328-2310

**National**

**Social Security Administration** 1-800-772-1213

1-800-MEDICARE (1-800-633-4227)

[www.medicare.gov](http://www.medicare.gov)

[www.cahealthadvocates.org](http://www.cahealthadvocates.org)

[www.calmedicare.org](http://www.calmedicare.org)

Navigating Medicare and Medicaid: Resource Guides for People with Disabilities, Their Families, and Their Advocates <http://www.kff.org/medicare/med020705pkg.cfm>

## Chapter Two: What is Fraud & Abuse?



**Fraud and abuse are usually discovered when:**

1. A senior or person with a disability is suspicious about a claim.
2. A provider or supplier sees a pattern that does not look right.

**Someone has to report the problem to start an investigation!**

Spotting a potential problem does not mean that fraud has actually occurred. The legal standard to prove that fraud has occurred (the court has to prove the individual *intended* to cheat the government) is very high.

Most reported problems meet the standard for abuse. Medicare abuse happens when physicians, providers or suppliers mistakenly bill for items or services that should not be paid for by Medicare because they:

- **Are inconsistent with sound medical practice** (Example: prescribing a drug that is not recommended for a person with diabetes)
- **Fail to meet professionally recognized standards of care** (Example: charging a patient for more than the amount allowed by Medicare)
- **Are medically unnecessary** (Example: Telling a patient that they need physical therapy when a simple walking program would do)

Providers and suppliers that bill Medicare inappropriately have to pay back those amounts. Recovery actions can produce very large dollar savings for the Medicare program when abuse is discovered.

### Legal Definitions

**FRAUD:** The *intentional* deception or misrepresentation which an individual *knows* to be false or does not believe to be true, and makes knowing that the deception could result in some *unauthorized benefit* to himself/herself or some other person. The most frequent kind of fraud arises from a false statement or misrepresentation that is material to entitlement or payment under the Medicare program.

**ABUSE:** Incidents or practices of providers that are inconsistent with accepted sound medical, business, or fiscal practices. These practices may directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary.



*Good News!* The good news is that **you do not have to be a legal expert or decide if a problem is really fraud or abuse.** Your job is to inform consumers about what and how to report. Medicare will decide if any legal action is needed.

## What do I report? What are some examples of fraud or abuse?

### Examples of Fraud

- Billing for services or supplies that were not provided
- Altering claim forms to obtain a higher payment amount
- Asking for or accepting a kickback, bribe or rebate (for example, paying for a referral of patients)
- Billing Medicare for patients not professionally known by the provider (Example: A physician chats informally with someone from their house of worship about diabetes and then bills Medicare).
- Suppliers completing a Certification of Medical Necessity (CMN) for the physician
- Using another person's Medicare card to obtain medical care
- Repeatedly violating the participation agreement assignment or limiting charge

### Possible Outcomes of Fraud Review



If determined to be a billing error, processing error and/or other misunderstanding, appropriate action is taken:

- If the review shows a claim was paid properly, the beneficiary is informed
- Immediate suspension of payment by the Medicare fiscal agent
- If the review shows a billing or processing error, the claim is adjusted to reflect the correct information

If determined to be a case of actual fraud the case is referred to the Office of the Inspector General (OIG); the Medicare contractor develops the case prior to referral and will consider:

- Criminal and/or civil prosecution.
- Administrative sanctions (e.g., termination of participation agreement)
- Civil money penalties (Section 1128A of the Social Security Act allows penalties up to \$2,000 for each false or improper item claimed plus up to twice the amount falsely claimed)

- Exclusion from the Medicare program
- OIG may refer the case on to other law enforcement agencies, such as the FBI

If the OIG cannot accept the case or returns the case, the contractor is responsible for:

- Recouping any amounts that were paid incorrectly
- Education/written warnings

### Examples of Abuse

- Excessive charges for services or supplies
- Improper billing practices such as:
  - Exceeding the limiting charge set by Medicare
  - Billing Medicare at a higher rate than for non-Medicare patients
  - Submitting bills to Medicare instead of the beneficiary's primary insurer
- Breach (breaking or ignoring) of the Medicare agreements
- Claims for services that are not medically necessary



### Possible Outcomes of Abuse

- Recovery of amounts overpaid
- Education and/or warnings
- Referral to the Medical review unit
  - Post payment audits or review of claims
  - Prepayment review of certain practices; provider required to submit documentation prior to claim determination
- Referral to the Office of Inspector General if all else fails and abuse continues
  - Possible sanctions or exclusion from the Medicare program
  - Possible Civil Money Penalties up to \$10,000 for repeated violations



### Common Practices that are not Fraud:

Some common practices may look deceiving but are not fraud or abuse either. Here are some common situations that are not considered to be fraud under Medicare rules.

#### 1. The Medicare bill shows a service from someone the patient did not actually see.

- Laboratory
- Pathologist
- Anesthesiologist
- Radiologist

The radiologist may have read the X-ray in his office to check for shadows or conditions that a trained physician still might miss. The pathologist may have examined tissue

samples in the lab, even though the patient never saw it happen. These specialists often work behind the scenes and billing Medicare for their services is usually legitimate.

## 2. The beneficiary saw an employee of the physician even though the claim shows the service was provided by the physician

- Nurse practitioner
- Physician assistant
- Physical therapist

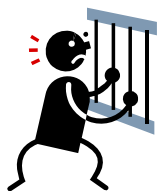
This may be a billing or processing error where the Medicare number has been miss-keyed. The only way to tell this is to contact the office that processed the claim so the original claim can be checked for an error. People are human and mistakes are common.

## 3. A hospital bill seems unusually high.

Some hospital bills are high and the charges may be legitimate. Hospitals cannot set their own rates for most services. They are required to bill using what is known as Diagnostically Related Groups (DRG). These groups of treatments and the corresponding costs are specified by the government based on what research shows is medically necessary for standard diagnosis. DRG have been established by physician review boards and the fixed costs do not usually affect what Medicare pays.

Hospital billing practices are also randomly checked for error by the North Dakota Health Care Review (NDHCR) agency. Medicare contracts with NDHCR to make sure hospitals are using the correct DRG. NDHCR employs nurses and doctors to check charts and billing amounts. This peer review system keeps everyone honest.

If a large hospital bill seems unreasonable because of some other circumstance contact the hospital billing department to report your concerns or clarify the disputed charges. Contact the intermediary if the overcharging seems extreme or unusual.



### Serious Penalties

- The False Claims Act provides for \$10,000 in penalties *per claim!* It also provides for triple damages and jail time.
- Kickbacks can result in a fine of up to \$25,000 and up to five years in prison.
- Civil monetary penalties can be assessed at \$10,000 *per claim.*
- Recently, the Racketeer Influenced and Corrupt Organization (RICO) Act has been used in Medicare Fraud cases—it provides for up to *twenty years* in prison.

## HIPAA

- Several years ago, Congress passed the Health Insurance Portability and Accountability Act or HIPAA.
- Most patients hear the term HIPAA when they are asked to sign forms that detail how a hospital or clinic will protect the privacy of their medical records.
- HIPAA legislation also created a new crime – HEALTH CARE FRAUD. Those convicted face up to ***ten years*** in prison or up to ***twenty years*** if someone is harmed or up to ***life*** in prison if someone is killed during the commission of the crime.
- Other HIPAA provisions provide expanded funding to Medicare Carrier Fraud Units, federal law enforcement agencies such as the FBI and OIG and the U.S. Attorney's Office.
- This money will be used to hire new agents and attorneys to investigate and prosecute health care fraud cases.
- HIPAA also makes it easier for federal agents to subpoena records and seize assets.

## Chapter Three: How to Prevent Fraud and Abuse in Medicare?

### You Can Help Prevent Fraud and Abuse!



- Let people know you're concerned about health care fraud.
- Educate beneficiaries and their families about the cost.
- Teach beneficiaries to take steps to prevent or detect fraud.
- Involve your community, health care providers in the anti-fraud effort.
- Develop a network in your community to share information on fraud scams.

### Help Save Medicare for Future Generations! For Beneficiaries:

- Review your explanation of Medicare Benefits carefully.
- Ask questions – ask your provider or your Medicare office:

**WHEN...you don't understand the charges billed**

**WHEN...you don't think you received the service**

**WHEN...you feel the service was unnecessary**

- Never give your Medicare number to anyone other than providers you know.
- Avoid offers of "free" medical tests/supplies in exchange for your Medicare card.
- Beware of advertising that promises Medicare will pay for certain care or devices.
- Never sign a blank form. Always read and keep a copy of any document you sign. Ask the provider to make a copy for you if needed.
- If you rent medical equipment, such as a walker, return the item to the medical equipment dealer when you are finished. Always get a receipt for the return.
- Beware of offers of special equipment, studies, checks or prevention. Rely on your doctor's advice to prescribe appropriate treatment for you.
- Treat your Medicare card like your credit card – never "loan" it to anyone.

- Contact your Medicare office immediately if you suspect fraud or abuse.

## **How to prevent Fraud and Abuse in Part D.**

### **Suggested Guidelines for selecting a Part D Plan**

These questions will help beneficiaries think about and compare drug plans.

1. How much would I pay for my monthly premium?
2. Does this plan include?
  - a. The drugs I need?
  - b. At the strength and dosage that I need?
3. How many days will be covered in each prescription (Example: 30, 60, 90 days)?
4. Does this plan's network include?
  - a. The pharmacies that I use in the community or;
  - b. The pharmacy available in my long-term care facility?
5. Does another pharmacy I might use offer a lower price for the same drugs?
6. Is mail-order is allowed or required?
  - a. The price differences or savings for mail order.
  - b. The number of days covered in each order. (Example: 30, 60, 90 days)
7. What tools are available to help manage the plan?
  - a. What are the prior authorization requirements?
  - b. Does the plan require that certain medication(s) be tried before others?
  - c. Does the plan require different co-pays for generic or brand named drugs?
    - i. How many of tiers or steps are to be followed?
    - ii. What are the co-payments/co-insurance per tier or step?
  - d. Does the plan offers therapeutic medication substitutions?
  - e. Are there are quantity limitations?
    - i. On the number of prescriptions I can order in a month.
    - ii. On the number of pills I can order in a prescription.
8. Does the plan offer supplemental benefits?
9. Does the plan have the Medicare approved seal?
10. Who is the plan sponsor? Have they been in the community for a year? Are they reliable?
11. What transition process is offered for temporary use of drugs not covered by plan?
12. What exception or appeals process does the plan have if my drugs are not covered?
13. Do I have other insurance that covers prescription drugs?
  - a. Through a Medicare HMO or other Medicare Advantage plan.
  - b. Through a retiree health plan.
  - c. Through a Medigap (Medicare supplemental) policy.
  - d. Individuals with coverage through the Veteran's Administration, TRICARE, Federal Health employee Benefit Plan, Railroad Retirement Board, Program All-Inclusive Care for the Elderly (PACE), or Indian Health Service.

Beneficiaries may or may not continue receiving prescription drug coverage through one of those plans if that coverage is as good as what is offered from Medicare prescription drug coverage. (A, B, & C yes; D no).

## **Part D Scams & Alerts**

As with any new program, this creates an opportunity for dishonest individuals to take advantage of Medicare beneficiaries. Some people may be contacted by telephone or by mail. Others may have salespeople showing up, claiming to be representatives from Medicare or Social Security. Examples of fraud schemes:

Virginia, an 85 year-old woman, soon found herself giving out bank account information so that she could qualify for a prescription drug benefit plan that she was told was “better than Medicare,” and that would help reduce the burdensome costs of her medications. After Virginia’s account was immediately debited \$299, it became clear that she was the victim of a con artist.

**Tip:** Medicare does not ask about bank account numbers.

## **Free Drug Coverage?**

A Medicare beneficiary receives a telephone call from a well established insurance company. The caller explains how the beneficiary can get into a new Medicare Prescription Drug program that offers the same prescription drugs at no cost to the beneficiary.

**Tip:** Most Medicare Part D participants pay a monthly premium. Be wary of companies offering “free” drug coverage.

## **MARKETING RULES FOR ALL PLANS OFFERING MEDICARE DRUG COVERAGE**

**Action:** The Centers for Medicare & Medicaid Services (CMS) has issued guidelines on marketing for companies offering prescription drug plans to Medicare beneficiaries. The guidelines will set standards that companies must follow in marketing their plans to the nation’s elderly and disabled. The standards reflect proven methods plus ongoing Medicare oversight to protect beneficiaries from unscrupulous or overzealous sales tactics, while enabling them to get information they can use to help make their decisions about this important new benefit.

### **The Marketing Guidelines Issued:**

- Protect beneficiaries' rights and privacy.
- Ensure that beneficiaries get accurate and consistent information about their plan.
- Help avoid unnecessary administrative burdens for plans that follow guidelines.
- Outline the roles of independent agents and brokers.
- Provide parameters where plans may "co-brand" with other organizations.
- Require plans to follow the federal "do not call" requirements for telemarketing.
- Providing details on what types of promotional activities plans may employ.
- Prohibit making door-to-door sales calls or sending unsolicited emails.
- Brokers or independent agents must adhere to state licensing requirements.
- Plans that employ marketing representatives must ensure representatives meet all state requirements, including state licensure and certification or registration.

CMS investigates any complaints made by beneficiaries and other organizations. CMS implements a monitoring system that will include beneficiary satisfaction surveys, a complaint tracking system and periodic site visits. The agency works closely with consumer protection groups and PDP organizations to educate consumers about what should be in service contracts and what red flags to look for. Beneficiaries who suspect a problem can contact CMS or call 1-800-MEDICARE.

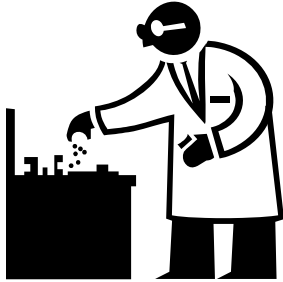
CMS takes appropriate action against plans found to be non-compliant, committing fraud or otherwise violating state or federal laws, which may include implementing corrective action plans, imposing sanctions that may close the plan to new enrollees, imposing civil monetary penalties or referring plans to the HHS Office of the Inspector General or to other federal or state law enforcement agencies.

### **What Consumers Should Know:**

**To protect against fraud or unwanted solicitations, consumers should be aware that:**

- They should not give out personal information (e.g., SSN, bank account numbers, credit card numbers, etc.) to plan marketing representatives, because plans are not allowed to request such personal information in their marketing activities.
- Plans cannot call outside of the calling hours allowed by the federal government and states. Federal rules do not allow telemarketers to call before 8 a.m. or after 9 p.m. State rules may vary.
- To stop repeated and unwanted sales calls, you simply need to say "stop". Plans are required to honor "do not call again" requests from beneficiaries. To register for the federal "do not call" list, go to [www.donotcall.gov](http://www.donotcall.gov).

- Additional information about drug plan options from an independent source, beneficiaries can go to [www.medicare.gov](http://www.medicare.gov) call 1-800-MEDICARE, or seek help from the local State Health Insurance Counseling (SHIC) Program or Area Agency on Aging to get personalized information about which drug plan may be best for them.



### Promotions and Provider/Roles

Many people with Medicare rely on their neighborhood pharmacists and other health care providers for information about their prescription drugs and coverage. Physicians, pharmacists and other health care professionals can provide objective information regarding specific plans, covered benefits, cost sharing, drugs on formularies and utilization management tools.

Under the final guidelines, these providers can make available plan marketing materials and they can display posters or other materials announcing the contractual relationship between the plan and provider. But providers cannot steer beneficiaries to a plan to further their own financial interests. Providers may, however, help a beneficiary choose the plan that best meets their needs. The guidance includes additional information regarding “Cans” and “Cannots” for providers that have contracted with PDPs.

CMS will provide information to various organizations that providers and pharmacists understand their role in helping beneficiaries find a plan that best suits their needs.

**“File and Use” Certification:** File and Use certification allows plans to submit and certify that certain types of materials meet CMS marketing guidelines. Under the File and Use certification, plans may be able to use CMS-provided “model language” for certain marketing materials, as long as the model language is not modified. Advertising activities are included under File and Use Certification and provide assurances that the information received is consistent across plans.

File and Use Eligibility allows plans that follow Medicare’s marketing guidelines to publish and distribute certain materials without prior approval. To qualify for File and Use Eligibility, plans have to meet a particular standard of performance and a standard for certain types of materials continually.

CMS will monitor the use of these certifications through retrospective sampling to ensure that plans are compliant with the guidelines. CMS will also analyze feed back from the public and the industry to ensure compliance. The guidelines may be viewed at: <http://www.cms.hhs.gov/pdps/PrtDPlnMrktngGdlns.asp>.

## Chapter 4: How to Detect Fraud and Abuse?

We need SMP volunteers who are warm, genuine and approachable! We hope that seniors or people with disabilities and caregivers will call or tell you about concerns or situations that might involve fraud or abuse. It will be helpful for you to know about the different types of schemes that have been reported in the past. We hope you will:



- Be aware of what has happened in the **past**
- Be alert and look for similar patterns in the **present**
- Be aware that new schemes and scams will emerge in the **future**.

**It's hard to believe but a scheme has been invented for each of the benefits available through Medicare!** Please read each section to learn a little bit about Medicare fraud and abuse so you will know what to look for in your work. We can't expect you to memorize all the scams but hope you will use this guide as a resource to help you stay alert and prevent victimization.

**What are the most common situations in which fraud or abuse are practiced?**

**Current Medicare Fraud Schemes:**



1. Nursing Facilities
2. Home Health Agencies
3. Durable Medical Equipment
4. Clinical Labs/Independent Labs
5. Physicians, Practitioner/Kickbacks
6. Hospitals
7. Ambulance
8. Mental Health Services
9. Managed Care Plans
10. Hospice Care
11. Medicare Modernization Act

# 1. Nursing Facilities:

## Why Nursing Homes?

- Beneficiaries are often not aware about items that are billed to Medicare under their Medicare number.
- Beneficiaries are often not able to participate in treatment decision-making
- No method of regulating sales representatives.
- Poor oversight of supply inventory or stockpiling of supplies.
- Staff not well-versed in scams defrauding Medicare.

### Fraud Schemes

- Providing medically unnecessary physical, occupational and speech therapies (PT, OT, ST). Therapies often supplied to large groups of patients but billed as if provided individually.  
*For example, a physical therapist spends 30 minutes with a group of 10 patients; Medicare is billed for 30 minutes of PT for each patient.*
- Billing social activities or life services as psychotherapy.  
*For example a dog is brought in from the local humane society and the activity is billed as psychotherapy to relieve depression.*
- Billing for medical supplies not provided to the patient. Where the patient is not under a Medicare Part A covered stay, facilities may bill for certain medical supplies under Part B. Numerous instances of billing for supplies not received by the beneficiary have been detected.
- Irrigation kits are often supplied to nursing facilities for ostomy patients in quantities far greater than needed.  
*In many cases, sterile kits are not medically necessary. Nursing homes may break kits down and add individual components to their central supply area.*
- Suppliers have billed Medicare for custom-fitted body jackets – the actual items supplied are plain, wrap-around corsets secured by Velcro straps.  
*Medicare is billed for custom-fitted, molded body jackets. Reimbursement was often several hundred dollars for an item that cost \$30.*



“Gang visits” – practitioners (such as optometrists, podiatrists, etc.) stopping by all or most patients in a facility without rendering any services but billing as if a service had been provided. Most of the patients do not have any prior symptom or condition warranting the practitioner’s service.

### Things to Look For

- Kits marked for individual patients used for other patients or held in extremely large supply in storage areas. This may be a sign that unnecessary supplies are being provided or that necessary supplies are being provided in a quantity much greater than required.
- Therapies (PT/OT/ST) being provided to groups of patients. These services *may* be billed to Medicare as if provided individually.
- Therapies (including psychotherapy) being provided to patients who cannot benefit from the services (especially patients with Alzheimer’s Disease or in a coma).
- ***Every patient*** has the same medical equipment (for example, the same brand and type of wheelchair, walker, etc.). It is highly unlikely that every patient needs or uses the same equipment. Moreover, the government may be paying twice for the equipment: Medicare pays on behalf of each patient, and the state factors the cost of durable medical equipment (DME) into the per diem rate that it establishes for the facility.
- Patient file access provided to persons who are not actual practitioners for specific patients.

## MEDICARE NURSING HOME BENEFITS AND RIGHTS

### Coverage Criteria

Medicare Part A (Hospital Insurance) pays for nursing home care in the following circumstances:

- The facility is a Medicare-certified skilled nursing facility (SNF);
- a physician has ordered daily skilled nursing or therapy services; and

- the patient has been hospitalized for at least three days within 30 days just prior to entering the nursing home for the same condition as that for which the patient needs SNF care.

Unfortunately, most services received in a skilled nursing facility do not meet Medicare's strict definition of the term "skilled". Most services are deemed "custodial" and are not covered by Medicare.

As long as all coverage criteria are met, Medicare covers up to 100 days of skilled nursing home care in each benefit period. Medicare pays in full for the first 20 days. For days 21-100, the patient is responsible for a daily co-payment (\$124.00 per day in 2007). Many Medicare Supplemental Insurance policies cover these co-payments. There is no Medicare coverage beyond 100 days in each benefit period regardless of a patient's continuing need for skilled care.

Even if criteria for Medicare coverage of the nursing home stay are not met, Medicare Part B (Medical Insurance) may pay for certain nursing home services such as x-rays, laboratory work, physicians' visit, and physical therapy.



### Skilled Services

Medicare defines skilled care as a nursing or rehabilitation therapy service that requires the special skills of technical or professional health personnel (registered nurses, licensed practical/vocational nurses, physical therapist, occupational therapist, speech pathologists, and audiologists).

Skilled nursing services include but are not limited to intravenous feeding; insertion, sterile irrigation and replacement of catheters; application of dressings involving prescription medications; and treatment of bedsores and other widespread skin disorders.

## 2. Home Health Agencies (HHA)

### Why Home Health Services?

- Beneficiaries have not, in the past, received explanation of benefits (EOB) forms/Medicare Summary Notices (MSNs) for home health services; there are no co-pays or deductibles. (*Effective 10/1/96, EOBs/MSNs are issued for all Medicare services.*)

### Fraud Schemes

- Billing for more visits than provided.
- Billing housekeeping services as skilled nursing or therapy services.



- Offering incentives, such as free groceries or transportation, to beneficiaries in exchange for their Medicare number or for switching to their agency.
- Offering cash or other benefits to physicians for referring patients and/or signing treatment plans for patients who do not meet the conditions for home health care.
  - Some registered nurses have provided care to their relatives and then billed it as home health care.
  - Providing home health aids to patients in assisted living facilities. Services provided by the aides should be provided by the assisted living facility.
  - Ordering large numbers of HHA supplies that the patient does not need.
- Billing for services to patients that do not meet the definition of homebound.

### Things to Look For

- Beneficiaries who are not homebound but who are receiving home health services.
- Review EOBs/MSNs to insure services billed coincide with services provided.
- All or most residents in assisted living facilities receiving home health care from the same HHA when more than one provider serves the area.

### Examples of Home Health Scams

- A home health agency pays an illegal fee or “kickback” to a physician in return for the physician’s certifying that the beneficiary needs skilled care provided by a home health agency. In many instances the beneficiary does not need skilled nursing care.



- A home health agency alters or fabricates its records to falsely indicate that a physician ordered or reordered the home health agency skilled care, or that a home health agency nurse or home health aide made visits that in fact were not made, or provided care in the patient’s home that in fact was not provided.

- A home health agency operator pays a fee to a residential care facility operator for patient referrals, which results in the agency providing “free” home health aide services in the residential care facility when the operator should be providing those same services at no additional cost to Medicare.
- A home health agency sends a home health aide to a beneficiary’s home many times a week to help with cooking, cleaning, shopping, and other household duties. In addition, a nurse visits once a week to take vital signs. These services are not covered if the beneficiary is capable of performing his or her own chores and *regularly* leaves the residence for shopping, walking, or to visit friends and relatives. Frequently the home health agency falsely indicates that the beneficiary is “home bound” in order to incorrectly obtain Medicare payment.

*The home bound rule becomes complicated when applied to people with disabilities. Some states have interpreted this rule so narrowly that people with disabilities were threatened with loss of vital services if they ever stepped outside or went to an event. In this case the capacity limitation that prevents a person from doing chores may not prevent them from going to a movie. It is important to rely on common sense and to consider the rule “regularly” against the context of the situation. When there is a question about a person’s ability to perform his or her chores that must be evaluated by a physician who is experienced with the needs of persons with disabilities and authorized by Medicare staff. It is not a decision that a casual observer can make.*

### **Common But Inappropriate Reasons for Denial of Home Health Care**

<b>REASON GIVEN:</b>	<b>ACTUAL RULE:</b>
The patient needs home care over a long period of time.	Medicare must pay for home health care for as long as it is medically necessary. There is no legal limit on how long a beneficiary can receive coverage.
The patient’s condition will not improve.	Medicare must pay for home health care if it prevents deterioration of the patient’s condition
The patient has a particular health condition.	Medicare must cover home health care based on the services the individual beneficiary needs, not on what type of disease or injury she/he has.
The patient has family members living in the home who could provide the care with or without training.	Medicare cannot deny payment on the basis that there is someone at home who could provide care, if that person is not willing to do so.

## What Home Health Services Does Medicare Cover?



If all of the required conditions for coverage are met, Medicare generally covers skilled nursing or rehabilitation services and, in certain circumstances, will also cover home health aid services. However, there are special rules as to the types of home health aid services and the amount of skilled nursing care and home health aid services for which Medicare will pay.

### Medicare Covered Home Health Services

- skilled nursing care
- physical therapy
- speech therapy
- occupational therapy
- medical social services
- home health aide services
- medical supplies (other than drugs and biologicals)
- durable medical equipment

### Home Health Aid Services

- Medicare will not cover home health aide services unless skilled care is also being provided. However, if Medicare is paying for skilled home health care, it will also cover certain personal and custodial care commonly referred to as home health aide care. Examples of covered home health aide services include assistance with bathing, dressing, exercising, getting in and out of bed, and toileting (i.e., help with using the bathroom or a bedpan).
- Even if skilled care is being provided, Medicare will not, in any circumstances, cover home-delivered meals, transportation, housekeeping or chore services.

### Skilled Nursing Care

- Skilled nursing services will trigger Medicare home health coverage only if they are prescribed by the patient's physician and required on an **intermittent basis**. A short-hand rule is "intermittent" generally means care that is provided less than seven days per week. However, there is no limit to the number of hours each day that care may be provided. "Intermittent" also generally indicates that the beneficiary is expected to need home health services at least once every 60 days.
- In certain limited circumstances, Medicare bends its definition of "intermittent" in order to trigger Medicare coverage of skilled nursing care. For example, Medicare will pay for skilled nursing care that is seven days per week but is needed for only two to three weeks and for less than eight hours each day, although technically the care does not meet the definition of intermittent.

## Home Health Aide Services

- Home health aide services will be covered only if they are needed and prescribed on an intermittent or part-time basis.
- Care that is provided less than eight hours each day is considered to be “part-time”. As long as care is provided less than eight hours each day there is no limit on the number of days each week that part-time services can be obtained. For example, home health aide services that are provided two hours each day, seven days a week, qualify as “part-time”.
- The definition of “intermittent” is the same as for skilled nursing services, discussed above. Generally, intermittent indicates care that is provided less than seven days per week and with no limit on the number of hours each day. For example, home health aide services that are provided three days per week, for nine hours each day, qualify as “intermittent”.
- NOTE: Although the terms “part-time” and “intermittent” each have their own definition, Medicare generally will cover only a total of 35 hours per week of nursing and home health aide services.

## 3. Durable Medical Equipment (DME)

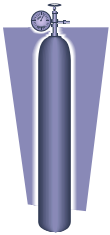
### Why Medical Equipment?

- There are no professional licensing requirements. All that’s needed in order to obtain a supplier number is a business license.
- In the past, Medicare contractors have not verified the existence or location of the suppliers.
- There is a high potential for quick profit.
- Suppliers have found it relatively easy to obtain beneficiaries’ Medicare numbers.

Unscrupulous suppliers use a variety of means to obtain Medicare numbers, knowing that having a supply of these numbers is an open door to obtain Medicare dollars fraudulently. Some of their methods:

- Calling beneficiaries under the guise of conducting a “health survey” – one of the questions is, “What is your Medicare number”?
- Offering beneficiaries a free “health screening” (e.g., blood pressure check, cholesterol test, etc.) and asking the same question.
- Paying beneficiaries for their Medicare number.
- Offering beneficiaries “free” services or supplies (e.g., milk, bread, clothing, etc.) in exchange for their Medicare number.
- Obtaining lists of Medicare numbers from nursing home by selling the administrators on “new” Medicare benefits to help their facility.

- Adult diapers have been billed as Female Urinary Collection Devices (FUCD). These diapers are not covered under Medicare. Suppliers misrepresented the item and patients' conditions in billing. Medicare paid nearly \$9 per FUCD; the diapers cost the suppliers \$0.26. Charges to Medicare have been as high as \$5,200 per month per patient.
- Lymphedema pumps are supplied to beneficiaries who did not meet medical necessity requirements; suppliers falsified claim forms and certificates of medical necessity (CMNs). Medicare was billed for high-priced pumps; pumps costing nearly \$3,000 less were actually supplied.
- Medicare has been billed for Nebulizer drugs which are used to relieve symptoms of emphysema and bronchitis. Claims review showed inappropriate quantities and combinations were billed. In fact, the suppliers were not even providing the drugs billed to Medicare.



- Oxygen concentrators have been provided to patients who have no need for oxygen. Because Medicare requires patients to be tested by an independent laboratory before paying for oxygen, suppliers have engaged in schemes with physicians and labs to falsify results.
- Hospitals have allowed DME companies to provide them with "discharge planners". These employees work in the hospital but their salaries are paid by, and they represent, the supplier. They make sure that patients receive every item imaginable (e.g., hospital beds, wheelchairs, walkers, etc.), whether they need them or not.
- Vendors offer "free" cases of milk supplements or groceries, and then bill Medicare for costly enteral/parenteral supplies.
- Some suppliers have ownership in or arrangements with labs which falsify tests to certify patients' need for home oxygen.

### Things to Look For

- Does it appear that the consumer required the supplies or equipment received?
- Beware of fraudulent attempts to obtain Medicare numbers (telemarketing, health screenings, medical surveys, offers of “free” items or cash).
- Did the supplier waive co-pays and deductibles in the absence of financial need?
- Be cautious of “free” services billed to Medicare or other insurers.
- Review EOBs/MSNs to insure services billed coincide with services provided.

### DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS



Medicare Part B covers durable medical equipment (DME), prosthetics, orthotics, and medical supplies when prescribed by a physician for use in the patient's home. A hospital or nursing facility providing skilled nursing or rehabilitative services is not considered a home.

DME includes wheelchairs, walkers, hospital beds, infusion pumps, canes, etc. Prosthetics and orthotics include devices such as artificial limbs, breast prosthesis, ostomy supplies, neck and leg braces, (but not elastic bandages). Medical supplies include surgical dressings and blood glucose strips.

Other covered items include oxygen and oxygen equipment, shoe inserts and therapeutic shoes for people with severe diabetic foot disease, and nutrition supplies for tube feeding patients who have a permanent impairment that prevents them from eating normally.

Home dialysis equipment and supplies are covered when necessary for patients with end stage renal disease (ESRD) who are being dialyzed at home under supervision of a Medicare approved dialysis facility.

For Medicare to allow coverage for any DME, prosthetics or orthotics, the item must meet the following requirement:

- Be medically necessary and meet Medicare guidelines for coverage.
- Be appropriate for use in the home.
- Serve primarily a medical purpose, that is, it cannot serve as merely a convenience item or be of use to persons who are not sick or injured.
- Be able to withstand repeated use. (This does not apply to medical supplies.)
- Be supplied by a Medicare certified vendor.



## **MEDICARE COVERAGE OF A POWER OPERATED VEHICLE (POV)**

A POV is an electric “scooter” type of wheelchair. It is usually controlled with a forward steering mechanism and is appropriate for use indoors.

Many POV manufacturers advertise that their product is covered by Medicare. But Medicare coverage is not automatic and a POV is not covered in every case.

### **Medicare Coverage**

Your doctor must determine that a POV is medically necessary for you and prescribe a POV for you.

**WARNING:** No supplier should try to sell you a POV that has not been prescribed by your physician first.

In order for Medicare to consider coverage of your POV, your medical condition must be such that you would be confined to a bed or a chair without the use of a wheelchair and you are unable to operate a manual wheelchair. This means that Medicare will not consider coverage of your POV if:

- You can walk, or
- You can use a manual wheelchair, or
- You need the POV for leisure activities only, or
- You would not need the POV for use in your home.

Also, you must be capable of safely operating the controls of the POV as well as having adequate trunk stability to ride safely and transfer in and out of it.

The doctor who orders the POV must be a specialist in Physical Medicine, Orthopedic Surgery, Neurology, or Rheumatology and will have to complete a Medicare form called a Certificate of Medical Necessity.

### **Medicare Prior Authorization**

If your doctor has ordered a POV and you believe that you may qualify for reimbursement from Medicare, you may want to request a Prior Authorization from CIGNA DMERC, PO Box 950 Nashville, TN. 37202-0950, Telephone: 1 (615) 782-4500.

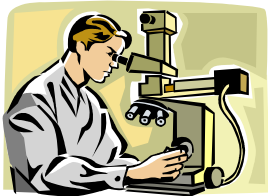
## Medicare Payment

Part B will **not** pay 100% of **any** POV. There will be a coinsurance amount. If your supplier does not accept Medicare assignment on the claim, there may be a balance beyond the coinsurance amount.

Your supplier should be able to give you details on the Medicare-allowed amount.

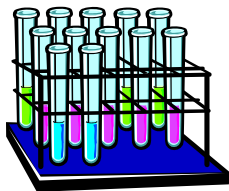
## 4. Clinical Labs/Independent Physiological Labs (IPLs)

### Why Laboratory Services?



- Beneficiaries have not received EOBs or MSNs. Medicare pays 100%.
- Physicians do not see what the laboratories bill to Medicare.
- For most lab tests, Medicare has not required labs to submit diagnosis or symptom information to support the need for the services. The following are some examples:
  - Labs have added tests not ordered by physician and billed them to Medicare.
  - Labs market their tests as panels to the physicians, but split certain tests out of the panels and bill them separately to Medicare.

For example, a physician will order a “Chem 14”, which the lab has identified as a panel containing 14 specific lab tests. The physician understands that the lab will bill the service as a 14-test automated panel. However, the lab bills Medicare for a 12-test panel and bills separately for two of the tests, increasing their Medicare payment.
  - Labs have billed for services not ordered or provided.



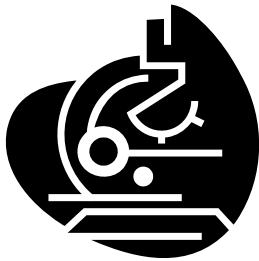
For example, in a 60-day period, one lab submitted to Medicare 717 claims for 416 beneficiaries (many of whom were already dead) and received \$330,000. One of the “referring” physicians listed on the claims had been dead for 2 years. In a random sample, nearly a third of the beneficiaries had never received services from the lab or did not know the referring physician listed on their claims.

- “Rolling labs” have gone to senior centers, shopping malls, etc, and offered “free” diagnostic tests. Patients are required to complete a registration form which includes their insurance billing number. The insurers are then billed for a variety of tests the beneficiary never received.

**Note: Many hospitals use mobile labs to provide services to rural areas. Beneficiaries should not be discouraged from using these facilities!**

### Things to Look For

- “Free” services billed to Medicare or other insurers.
- Dates of service on laboratory claims should generally be within 7-10 days of a practitioner visit. (Lab services must be ordered by a physician or other licensed practitioner.)
- Review EOBs or MSNs to insure services billed coincide with services provided.



### Independent Physiological Labs (IPLs)

IPLs are free-standing (not part of a facility or physician’s office) sites that perform non-invasive diagnostic tests, such as x-rays, oxygen tests, etc.

### Why IPLs?

- There are no professional licensing requirements. All that’s needed in order to obtain a provider number is a business license.
- In the past, Medicare contractors have not verified the existence of the lab’s equipment or of the lab itself.
- There is a huge potential for quick profit.
- IPLs have found it relatively easy to obtain beneficiaries’ Medicare numbers. The following are some examples:
  - Many IPLs have falsified results of oxygen tests to substantiate the need for oxygen. One test that is required is an oxygen saturation level taken while resting.

For example, several IPLs have been found to have offices located up one or two flights of stairs, thus requiring the patient to climb the stairs right before this test is performed. Many of these IPLs have been found to have ties to oxygen suppliers.

- Some IPLs have advertised “stroke prevention” testing. They perform a series of diagnostics tests, all or most of which are not medically necessary and/or proven effective for the purposes advertised.
- Some IPLs have performed sleep studies without a physician order. They are falsifying ordering physician information in order to receive Medicare payment.
- Some IPLs have billed for different services than were performed, and sometimes billing more than one carrier for the same services.

For instance, one IPL sent nurses to the homes of patients who required cardiac monitoring using an “event recorder”. The equipment was hooked up for approximately 20 to 30 minutes, then removed and taken with the nurse. This provider billed Medicare for *24-hour* attended monitoring for these patients. In addition, the lab billed the same claims for numerous patients to two separate Medicare carriers in an attempt to receive duplicate payment.

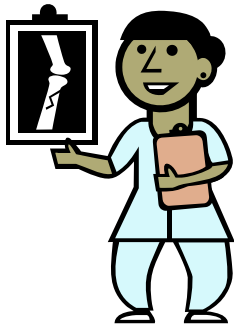
One national IPL billed Medicare for over \$5.9 million for Medical Resonance Imaging (MRI) services that were not provided. The provider used several different business names; none of which were viable businesses – the addresses provided on their applications were merely mail drops.

#### **Things to Look For**

- Advertisements for “free” diagnostic tests, including sleep studies, stroke prevention studies, oxygen tests, etc. All diagnostic tests should be ordered by the patient’s personal physician.
- Did the IPL waive co-pays and deductibles in the absence of financial need?
- Review EOBs/MSNs to insure services billed coincide with services provided.

## 5. Physicians, Practitioner/Kickbacks

(medical doctors, optometrists, chiropractors, podiatrists, physical therapists, etc.)



### Why Physician/Practitioner Services?

- People trust their medical caregivers.
- People are reluctant to question their physician because they are afraid of a negative impact on their care or that the physician will no longer treat them.

### Fraud Schemes



- Toe nail clipping (routine foot care) is only covered if there is some underlying medical condition warranting professional services. To obtain payment, some podiatrists or other physicians have misrepresented the diagnoses on the claim, indicating fungal infection when none exists. Another scam is to bill routine foot care as foot surgery.
- An optometrist always bills the comprehensive level of eye exam even when he/she performed the lower level exam.
- A chiropractor saw his patients two times per week but routinely billed for three services each week.
- An ophthalmologist falsified documentation for a test that is used to establish the need for cataract surgery. The doctor performed and billed Medicare for more than 100 unnecessary surgeries.
- A provider bills acupuncture (non-covered) as a covered service. In one instance, a physician billed acupuncture services as physical therapy. In another case, the physician misrepresented the acupuncture services as joint injections.

### Things to Look For

- Statements by beneficiaries that no physician was present at any time during the services or that he/she has never seen the physician/practitioner.
- Payments (in cash or kind) in return for providing the Medicare number or for visiting a clinic or office.
- Compare the physician statement provided at the time of the service to the services shown on the EOB/MSN.
- Review EOBs/MSNs to insure services billed coincide with services provided.

### What is a Kickback?



- A kickback is an arrangement between two people in which there is an offer to pay for Medicare business.
  - Kickbacks generate extra business for the participants, unneeded services for the patients, and they drain scarce tax dollars.
  - Health care providers engaging in kickback activities can be subject to criminal prosecution and exclusion from the Medicare and Medicaid programs.

### Examples

- Providing hospitals or nursing homes with discharge planners, home care coordinators, or home care liaisons in order to induce referrals.
- Paying a fee to a physician for each patient care plan certified by the physician on behalf of the home health agency.
- Providing “free” patient services, such as 24 hours nursing coverage, to board and care facilities in return for home health referrals.
- Paying a fee to a board and care operator or employee for each resident referred to a home health agency; in effect buying patients.

- Offering free services to beneficiaries, including meals and transportation, if they agree to switch home health providers.
- Paying beneficiaries \$50 each time they receive “treatment” at the clinic.

## 6. Hospitals

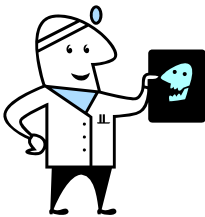
### Why Hospital Services?



- Patients are often not aware of all the services they are receiving.
- Medicare payment rules for hospital services are complex.
- Insufficient Medicare auditors to conduct extensive, detailed audits.

### Fraud Schemes

- For outpatient services, billing multiple view x-rays when only one view was taken.



- Misrepresentation of the discharge date in order to obtain inpatient and outpatient reimbursement. For example, one rehabilitation facility discharged their inpatients on paper but not in reality. The hospital received the DRG reimbursement for the inpatient stay and then also billed for outpatient services.
- Changing the patient’s condition (diagnosis code) on the claims form in order to change the DRG category and, therefore, increase the reimbursement.
- Some patients have been held in observation status for 3 or 4 days, rather than admitted as a hospital inpatient. Hospital observation services are reimbursed as a percentage of charges (through Part B), and the Medicare payment is usually higher than what the facility would have received through the DRG reimbursement.

### Things to Look For

- Review EOBs/MSNs to insure services billed coincide with services provided.
- Review hospital statements for “observation status” and determine if the patient was advised of their observation status in writing and any financial liability, and also advised that Medicare won’t pay for subsequent nursing home admission.
- Review EOBs/MSNs and statements from the hospital for duplicate billing of the inpatient deductible for hospital stays separated by a short period of time in the same or different hospitals.
- Review itemized statements from the hospital to assure that the patient has not been charged for items or services not provided.

## 7. Ambulance



### Why Ambulance Services?

- Beneficiaries, hospital discharge planners, nursing home staff, etc. do not understand Medicare Coverage.

### Fraud Schemes

- Billing for advanced life support services (ALS) when basic life support (BLS) was provided. Documentation is often falsified to indicate the patient needed oxygen which is a key indicator to establish medical necessity for ALS.
- Ambulance rides are provided to ambulatory dialysis patients to and from the dialysis center and billed as medically necessary transports. In one case, patients were filmed walking to the vehicle and riding in the front seat of the ambulance or were transported in a regular automobile. In addition, two or three patients were transported in the same vehicle, yet Medicare was billed for individual trips.
- Billing for more miles than traveled for transport.

- Falsification of documentation to substantiate the need for a transport from a hospital back to the patient's home. Medicare will only cover transport from hospital to home if the patient could not go by any other means (e.g., car, taxi).

### Things to Look For

- Ambulatory patients requiring regular medical services (such as renal dialysis) being transported by ambulance.
- Review EOBs/MSNs to insure services billed coincide with services provided.

**Note:** Please refer to the Medicare Handbook for ambulance coverage requirements and benefits.

## 8. Mental Health Services

*Partial Hospitalization Programs (PHPs)* are designed to keep patients with severe mental conditions from becoming hospitalized by providing intensive psychotherapy in a day outpatient setting.

*Community Mental Health Centers (CMHCs)* are outpatient mental health facilities that may be authorized to provide partial hospitalization services.



### Why Mental Health Services?

- Patients trust their therapist/counselor.
- The stigma of receiving mental health services may prevent some patients from questioning claims.

### Fraud Schemes

- Routine up-coding of psychotherapy sessions by the mental health provider (psychiatrist, clinical psychologist (CP), clinical social worker (SCW)). There are several variations to this scam, for example:
  - A psychiatrist conducts group sessions in a nursing or residential facility but bills for individual therapy.
  - A CP bills for 50 minute sessions but actually saw the patient for only 20-30 minutes.

- Some PHPs enroll patients who either cannot benefit from the therapy ( e.g. a person with significant cognitive limitations who does not understand symbolic communication) or who receive little more than social or recreational activities. Typically, the patients have not authorized the services and are not told that they are receiving psychotherapy.
- Trips to the store, cooking classes, listening to music and other recreational activities have been billed as psychotherapy.
- Non-licensed staff perform therapy sessions that have been billed as though provided by or under the direct supervision of a licensed practitioner.
- Billing for inpatient psychiatric treatment for weight reduction programs. Frequently, these programs include transportation to the facility. Clients are told their insurance will cover the costs of the program but are not made aware that the services will be billed as mental health services. The program usually ends when the insurance money runs out.
- “Coffee, cookies and conversation” – one CMHC advertised a social gathering to seniors in the community. The seniors went to CMHC, met the staff and subsequently received Medicare MSNs indicating they had received a psychotherapy session.

### **Things to Look For**

- Group therapy sessions where recreational activities are being provided.
- The presence of mental health providers with patients who are non-communicative or cannot benefit from psychotherapy (patients in a coma, patients in the late stages of Alzheimer’s, etc.).
- Review EOBs/MSNs to insure services billed coincide with services provided.

## 9. Managed Care Plans (MCPs)

### What is Managed Care?



- Managed care is a health care plan in which the provision of care is managed or controlled through a variety of cost-containment measures. The government health care programs save money by negotiating a flat fee to be paid for the total care of the patient. The fee set per patient is generally less than what the average cost of care was for the patients under fee-for-service coverage.
- The managed care plan (“MCP”) achieves its own cost savings through a variety of methods, including limiting the number of providers, reducing the type and amount of services offered, ordering in bulk at a discount rate, imposing pre-approval requirements on patient care, and/or encouraging preventative medicine.
- Patients usually have a restricted choice of providers who are under contract or employed by the HMO. In most plans, the patients must obtain the services from the participating providers and they may pay a small co-payment.
- Another model includes the Preferred Provider Organization or PPO, in which a group of health care providers contract with government insurers to provide care to enrolled members.

### Why Managed Care Plans?

- There has been a dramatic increase in the number of managed care plans in the past several years.
- Most managed care plans operate in a pre-payment environment; often, no claims are required to secure payment.
- Frequently, there are no claims; therefore, no EOBs or statements are sent to members.
- **Any of the schemes that have been described for the traditional fee-for-service” providers can be perpetrated in the managed care environment.**

## **Fraud Schemes**

- Some MCPs offer cash incentives to consumers to enroll in their plan.
- The contract practitioner or the MCP encourages beneficiaries to disenroll from the MCP in order to receive costly treatment or procedures. Beneficiaries are told they can re-enroll following completion of the course of treatment.
- Specialist, hospitals, (some plan physicians have accepted kickbacks in exchange for their referrals etc.)
- In order to limit or discourage services to plan members, some providers allot very limited office hours for MCP patients. These patients may not be able to schedule an appointment with the practitioner when they need it.
- Allegations of services not received; medical supplies, equipment not as ordered; or continued billing to the plan when the beneficiary no longer has or needs equipment.
- Failure to deliver services or under-utilization of services. Because many plans pay contract providers a monthly capitated rate, some practitioners have failed to provide needed care so as not to exceed their monthly plan payment.
- Balance billing patients for services received through the managed care plan.

### **Things to Look For**

- Beneficiary complains of having to wait several days or weeks to see the provider.
- An 800 number that is constantly busy.
- Beneficiaries who have received incentives for enrolling or disenrolling in managed care plans.
- Beneficiaries who have been denied medically necessary services.

Many physicians have expressed their concern about MCPs restricting their ability to treat the patients. A significant number of plans include a provision in their contracts with physicians that prohibit or gag physicians from fully informing patients about treatment limitations. Several states have passed legislation banning such gag provisions. Many beneficiaries have complained about being deprived of necessary services.

## 10. Hospice Care

### Why Hospice Care?

- Beneficiaries are not aware of items billed to Medicare when enrolled in a hospice.
- Hospice staff are well-versed in scams defrauding Medicare.

### Fraud Schemes

- Patients who do not meet the eligibility requirements for hospice (terminal illness with a 6-month or less life expectancy) have been enrolled by the hospice personnel.
- Some hospices have received duplicate payments, billing both Medicare and Medicaid.

### Things to Look For

- Beneficiaries who are not terminally ill but are enrolled in hospice.
- Beneficiaries that do not know they are entitled to respite care and care in a skilled nursing facility paid for by the hospice.

### Medicare Hospice Benefits

- Hospice care is designed for persons who are terminally ill with less than six months to live. The goal is to keep patients comfortable; not to provide cure-oriented treatment.
- Hospice benefits are provided under Part A. Medicare will pay for care by an approved hospice only if a doctor certifies that the patient has less than six months to live. Even if the patient does not actually die within six months, Medicare will continue to cover the hospice care; the patient must merely be expected to die within six months.
- If a patient chooses the hospice benefit over the standard Medicare benefit the traditional cure-oriented Medicare-covered services are replaced with hospice care. However, if a patient is receiving hospice care and needs treatment for a condition unrelated to the terminal illness, Medicare will pay for medical care for the unrelated injury or illness. For example, if a person with terminal cancer has the



hospice benefit and then breaks an arm, Medicare will still pay for treatment of the broken arm.

### **Covered Hospice Services**

- Medicare hospice services are provided primarily in the patient's home. Services covered under the hospice benefit are the same as those provided under the home health care benefit with the addition of homemaker and housekeeping services, patient and family counseling, and short-term in-patient care.
- The inpatient care benefit includes both respite care to provide relief for family caregivers, and procedures necessary for pain control and acute and chronic symptom management. Respite care can be provided only on an intermittent, non-routine and occasional basis, for not more than five days at a time.
- During the terminal illness, a Medicare beneficiary is entitled to four periods of hospice care: Two 90-day periods; a third, subsequent period of 30 days; and a final period of unlimited duration. The need for each period of hospice coverage must be certified by the attending physician or medical director of the hospice program. A beneficiary can elect to return to the standard Medicare benefit at any time. However, she/he will forfeit any remaining days in that hospice period. Any unused hospice periods remain intact.

### **Cost to the Beneficiary**

- If an individual elects hospice care, Medicare will cover everything except for a small co-payment for drugs and biologicals (5% of cost or \$5 per drug or biological, whichever is less); and for inpatient care (5% of the payment by Medicare for a respite care day, or a maximum of \$876 in 2004).

### **Responsibility of Medicare HMOs to the Terminally Ill**

- Medicare-contracting HMOs may not enroll beneficiaries who are already enrolled in the hospice benefit, and they do not have to provide or pay for hospice care for beneficiaries who become terminally ill after enrolling in the HMO. However, HMO enrollees who are terminally ill may elect to receive the hospice benefit. The beneficiary can choose to remain in the HMO to receive all non-hospice care, and Medicare will pay for the hospice care. The HMO is responsible for notifying terminally ill beneficiaries of the Medicare-certified hospice option and, at the beneficiary's request, for making a referral to one if the beneficiary so chooses.
- If a terminally ill Medicare beneficiary who is not in a hospice program wants to enroll in an HMO, the HMO is required to accept that enrollee.

## 11. Medicare Modernization Act (Part D of Medicare)

### Why Part D?

- This program is relatively new. When anything new is added to Medicare there is always the opportunity to confuse the public.

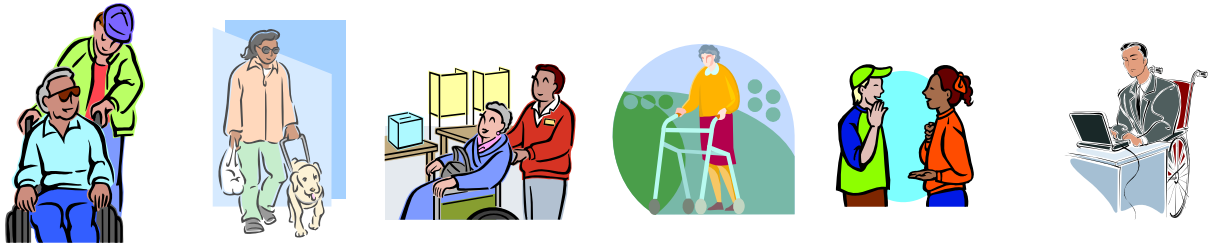
### Fraud Schemes

- There is an opportunity for “bait and switch” (i.e. a prescription drug program may offer a very generous initial drug package and then be able to change the formulary after a person has made a selection and is locked in for the year.)
- People may market programs that look similar to Medicare drug programs, but are not actually sanctioned by Medicare.

### Things to Look For

- Be wary of signing up for anything that does not signify Medicare approval.

## Chapter Five: How to Assist People with Disabilities?



People come in all shapes and sizes. We all have abilities and we all have limitations. As we age, the likelihood of some type of injury or disabling condition is more likely. Medicare beneficiaries fall into three important groups.

- 1. Seniors or people with developmental disabilities.** A developmental disability is a serious condition that was present at birth or developed some time before the person reached the age of 18 that has impacted their ability to carry out major life functions. People with developmental disabilities often require special services throughout life.

**Examples include:** People with intellectual, sensory or mobility challenges such as Down syndrome, autism, fetal alcohol syndrome, cerebral palsy, blindness, deafness, hearing or vision impairments or spina bifida.

- 2. Seniors with acquired disabilities.** An acquired disability is a serious condition that was acquired after the person became an adult (aged 18 and older) and that impacted their ability to carry out life functions. People with acquired disabilities also may require special services and lifelong support.

**Examples may also include:** People with behavioral, intellectual, sensory or mobility challenges such as significant anxiety or depression, mood disorders, traumatic brain injury, paralysis, kidney failure, blindness associated with diabetes, or intellectual disabilities acquired through substance abuse such as Methamphetamine use.

- 3. Seniors with age related disabilities.** Conditions that were acquired with age and may occur along side of or apart from other disability conditions.

**Examples include:** People with forgetfulness, arthritis, macular degeneration, dementia, hearing or vision loss, or other symptoms of the aging process. Seniors and people with age-related disabilities also require support to adjust to new limitations and obtain good health care or support.



**Good News!** You do not have to be an expert on disability to volunteer for the Senior Medicare Patrol. Let's learn a little bit about how to be helpful in teaching seniors or people with disabilities about Medicare, fraud and abuse.

**What do I need to know about seniors or people with disabilities to be an effective SMP volunteer?**

**How do I know if someone has a disability?** You may not! Some disabilities are apparent when you first meet a person and some are not. What you do need to know is that some disabilities make it difficult for people to:

- Get information
- Process or make sense of the information
- Respond to the information

You can learn how to communicate or share information with people whose disabilities makes it challenging for them to:

Behavior		Challenge
• See or hear clearly	➔	○ Sensory challenges
• Reach or move around easily or get where they need to go	➔	○ Mobility challenges
• Remember or make sense of information, apply information. Organize materials.	➔	○ Cognitive challenges
• Read, use math skills or write well	➔	○ Educational challenge
• Speak clearly. Make sense on the phone or in person	➔	○ Communication challenges

Regardless of whether the challenge is caused by arthritis, a stroke, a head injury or a genetic condition at birth, knowing what to do when a person has difficulty seeing, writing or speaking clearly is more important than knowing the name of a disability or a lot of facts about a condition.

## Read on to learn more!

**How do I speak respectfully about disabilities?** That is an important question. Unfortunately, people with disabilities often receive comments about their condition that are less than pleasant.

**For example:** How often have you heard people referred to as an imbecile, moron or idiot after they have made an error? These words are not complements.

Or how pleasant would it be to find yourself described as someone who is:

- Wheelchair-bound or confined to a wheelchair
- Disabled or handicapped
- Crippled
- Deaf & dumb
- Mute
- Blind as a bat



There may be nothing wrong with having a disability but none of us are lining up to get one. Especially when these types of statements are common! No wonder people with disabilities become sensitive about the words used to describe their condition.

**Senior Medicare Patrol volunteers are expected to learn and use *people-first* language on the job and in the community as a role model for others.**

## What is people-first language?

People-first language refers to individuals as people first. People are more than any condition they happen to have. They have a name and that comes first. Then any condition they may have is described in respectful terms. The guiding principal when using people-first language is to remember that individuals want to be seen as whole human beings. We do that by avoiding terms that:

1. Imply that a person as a whole is disabled (e.g. "disabled person");
2. Suggest that persons are their conditions (e.g. "epileptics");
3. Use exaggerated, negative overtones that awfulize a condition (e.g. "stroke victim");
4. Are viewed as a slur by people with disabilities (e.g. "cripple" or "retard").

When people with disabilities are viewed outside of people first language it is easy to conclude that they have neither the capacity nor the right to express their goals, preferences or concerns. We miss the fact that the person can still be a resourceful and contributing member of society.

The advantage of using people first language is that it shifts the focus away from the disability. This allows us to focus instead on an individuals name, strengths, abilities, skills and resources. When we do that we are more likely to take complaints from Medicare beneficiaries seriously. This can assist us in our work to undercover Medicare fraud. Some further examples of people first language are listed below.

<b>People first language</b>	<b>Non people first language</b>
John has a disability Mary has a learning challenge People who use wheelchairs Sue uses a wheelchair to get around Cathy is blind Fred is deaf Joe has a developmental disability	John is handicapped Mary has a mental condition The wheelchair people Sue is wheelchair bound Oh she can't see anything He's one of those deaf-mutes Joe is retarded



A person-first approach goes beyond the words we use and effects how we talk to people with disabilities. We talk directly to the individual first and not to the caregiver or family member they happen to be with that day. If the person needs assistance to communicate with you, they will indicate that so that you are then free to communicate with the helper. Even when that is the case, we still continue to address comments directly to the person each time. We demonstrate our good manners by letting people with disabilities speak for themselves as our equal!

This approach also means that we use good manners and respect people's privacy in our conversations when speaking about people with disabilities that we happen to know. Using good manners involves making other people feel comfortable. Most of us try hard to have good manners, but sometimes we lose the art when it comes to people with disabilities.

## **How often have we heard someone share private information about a person with a disability in a public setting by saying things like?**

- My aunt is autistic.
- He's thirty, but he functions like a 5-year-old.
- She doesn't have much "upstairs."

## **Would we share private information about family members who don't have disabilities?**

### **Would we ever say things such as?**

- My teenager still wets the bed.
- My husband takes Viagra.
- My wife has a big boil on her behind.

A family member of a person who has cancer does not say, "She's cancerous." So, why do we say, "He's disabled [or retarded, autistic, or whatever]."? Saying, "She has cancer," is more appropriate, as is, "He has a disability." The comments we make about other people with disabilities are overheard and used to judge the quality of the SMP. We want it said that the volunteers for that patrol are among the most respectful and professional in the state.

## **Making Accommodations for People with Disabilities**

### **How do I modify materials for people who have difficulty seeing?**

People with vision impairments often need materials to be modified. Favorite options include:

- No change to the materials – the person uses a magnifier
- Access to an electronic file – the document is sent to the person via email or on a CD. They use a screen reader to open & read the file.
- Large print – the material is printed using a large (e.g. 16 to 20) size font
- Braille – the material is printed in Braille

NDCPD will provide modified copies of SMP materials for ND seniors with disabilities on an as needed basis. It can take as long as two weeks to modify materials into large print or Braille, so ask in advance if you need a set. Remember, not everyone who is blind has learned to read Braille. Ask individuals what they prefer. Translations into large print or Braille are completed at:

**ND Vision Services**  
500 Stanford Road  
Grand Forks ND 58203  
701-795-2700

800-421-1181 - Toll Free  
Crystal Roy - Brailist,  
[croy@nd.gov](mailto:croy@nd.gov),  
701-795-2713

*ND Vision Services offers other important services for seniors with vision impairments. They can also be contacted to help arrange in-home mobility assessments, access talking books or large print materials or arrange other supports for seniors with vision challenges or vision changes. We think they are someone you should know.*

## **What if someone uses sign language?**



If a person is Deaf or hard of hearing and uses American Sign Language (ASL), you will need an interpreter to communicate. Some individuals who are Deaf prefer to use an interpreter they know in the community or have a family member who is willing to interpret. Ask them. Contact NDCPD to arrange for payment. If an interpreter is needed but a certified interpreter is not available we will contact one through Communication Services for the Deaf:

Because we need to schedule an interpreter at least two working days in advance, if the appointment is cancelled, please call at least 48 hours before the scheduled time. Be prepared to provide the following information:

- Date(s) and time(s) when the interpreter is needed
- Estimated completion time
- Specific location of the appointment
- Basic description of the situation or topic that will be interpreted
- The deaf consumer's name
- Their communication preference (oral, sign language, cued-speech, etc.)
- The name of the interpreter preferred by the deaf consumer, if known
- A contact person's name and phone number
- Billing information

## **Interpreters are contacted through:**

CSD of North Dakota  
(also Minnesota Relay)  
800 Holiday Drive, Suite 260  
Moorhead, MN 56560  
Toll Free Voice/TTY: (800) 467-5341  
Voice/TTY: (218) 291-1120  
Fax: (218) 291-1154

Contact CSD of North Dakota:  
P.O. Box 66  
Fargo, ND 58102  
(218) 291-1131 (V/TTY)  
(800) 467-5341 (V/TTY)  
(413) 604-2169 (fax)

## What if I can't understand someone's speech or I need to communicate with someone who is Deaf on the phone?



Relay North Dakota is a free service that provides full telephone accessibility to people who are deaf, hard-of-hearing, deaf-blind, and speech-disabled. This service allows hearing callers to communicate with text-telephone (TTY) users and vice versa through specially trained Communication Assistants (CAs). Calls can be made to anywhere in the world, 24 hours a day, 365 days a year with no restrictions on the number, length, or type of calls. All calls are strictly confidential and no records of any conversations are maintained. Anyone wishing to use Relay North Dakota simply dials the relay number to connect with a CA. The CA will dial the requested number and relay the conversation between the two callers.

**To obtain Relay Services for Individuals who are Deaf, Hard of Hearing, or with Speech Impairments call 1 - (800) 366-6889 (V), (800) 366-6888 (TTY); 711 (TTY) or (877) 366-3709 (Speech to Speech)**

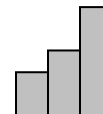
- VCO Direct answers all Voice Carryover (VCO) calls at the relay service.
- VCO Direct connects to Communication Assistants (CAs) with extensive training in VCO relay call procedures.
- The Voice Over feature works well for people who are deaf or late deafened adult, or have a hearing loss and like to use their own voice while talking on the phone. It also works well for people who are hard of hearing, or a person losing the ability to hear on the phone.

## What do I do if our materials seem too complex for a senior with a disability? What do I do if they appear confused or don't seem to understand?



**You can simplify material by using these strategies:**

- Get to the point in the first sentence.
  - Present text in blocks. This is called "chunking."
  - Present one idea at a time.
  - Use simple, basic English. Example: Say tell instead of notify.
  - Eliminate ~~extra~~ information that is not ~~really relevant~~ or important
  - Use large print (Size 16 font)
- Include simple pictures/icons ☺, or graphs
  - Break up long sentences. Use short ones.
  - Put some space between sentences
  - Use a direct not an indirect voice (see examples below)
  - Use a 5<sup>th</sup> grade reading level or below (see directions below)



Direct ✓	Indirect
If you are 65 years old . . . .	Those who are 65 years old . . .
You qualify for Medicare.	In the case of someone who qualifies . . .
You can hang up the phone.	It's not rude to hang up in these circumstances.



**Directions for checking the reading level of a document.**

You can check the reading level of any text by scanning or typing a paragraph of the information into a Microsoft Word document. After you have typed the paragraph, go to Tools and then Options and click on the Spelling and Grammar tab. A list of options will appear with boxes you can select. Check the readability statistics option. Then every time you spell check part or the entire document the reading level will be listed in a menu that appears at the end of the checking function.

**What else should I consider when sharing information with seniors or people with disabilities?**

**Climate control is an important source of support for many people with disabilities.** What is climate control? Controlling the climate involves making sure the area is comfortable for people who may be sensitive to light, sound, odors or space. This involves steps like:

- Not allowing others to smoke in the room/area
- Lowering the lights when using slides
- Not standing in front of a window (light source)
- Not using markers with a strong odor
- Not having peanuts in any snacks provided
- Taking frequent breaks
- Using a microphone
- Making sure people know where the restrooms are located

**Accessibility is also important to people with disabilities.** NDCPD will provide you with a checklist that you can use to make sure buildings you access for training purposes are fully accessible.

**How do I reach out to and find seniors with disabilities?**

Think about where people live, where they spend time outside of home and how they typically get information. Seniors with disabilities typically live:

- In their own homes or apartments
- In assisted living arrangements
- In nursing homes

**Seniors with disabilities spend time at:**

- Senior citizen centers
- Church activities
- Sport activities as a spectator
- Neighbors and relatives
- Grocery stores
- Clinics, hospitals and doctors
- Recreation centers
- Shopping malls
- Post office
- Restaurants
- Gas stations
- Commercial buildings

**Best practices in reaching out to people with disabilities include:**

- Making presentations to service groups
- Making presentations to disability support groups
- Providing seniors with information to use at home
- Scheduling 1-1 appointment with individuals
- Distributing public awareness materials
- Providing telephone support
- Sending updates through newsletters
- Holding online chats on fraud alert
- Hosting events with food, fun & information by partnering with others

**Information may be shared through:**

Radio ads, flyers, newsletters, PowerPoint, discussion, "how-to" kits, postcards, posters, booths, phone ads, simulations, TV interviews

We suggest that volunteers begin to become familiar with families and people with disabilities in their community or area, by completing some of the following activities and then by looking for opportunities to share information.

1. Mapping the community – find out which services exist and where.
2. Doing brief informational presentations to get the word out.
3. Doing an informal needs assessment to find out what information would be most helpful to seniors with disabilities.
4. Doing follow up checks and asking for individual referrals.
5. Doing more focused presentations at regular intervals for service agencies.
6. Maintaining a regular presence at disability and senior citizen events.
7. Developing a list of agencies and keeping each regularly supplied with brochures.
8. Visiting with senior caregivers or companions who are employed by the county.

## **What do I need to know about people with disabilities and Medicare fraud?**

North Dakota had about 102,591 people enrolled in Medicare (Part A and/or Part B) in 2005. That represents about 16% of the total state population. About 11,412 of those individuals or (11%) were under the age of 65 and represent people with disabilities on Medicare. About 91,843 individuals (88.9%) were seniors, some unknown percentage of whom also have disabilities. About 36,070 or roughly 42 percent of the total group met the qualifications for low income families. Eighty three percent of ND's on Medicare are receiving some type of long-term care. At least 22,262 people did not have any source of drug coverage in 2005. \*

\* *Information taken from the Kaiser Family State Health Facts website.*

This means that the majority of people on Medicare in ND are seniors, many of whom may have an acquired or age-related disability. These conditions may make individuals vulnerable to fraud in several ways.

## **Why are seniors and people with disabilities particularly vulnerable to fraud and abuse?**

Seniors and people with disabilities may be:

- More accessible to certain types of fraud because they live alone.
- More dependent on others to make important decisions about their money.
- More easily confused by the details and complexities of the system.
- Less sophisticated in their knowledge of money or financial planning.
- Socialized to respect authority figures or those who assume an air of authority.
- Isolated and prone to trust individuals who show them unexpected kindness.
- Less aware of the probable results of their decisions or actions.
- Having difficulty recognizing clues that point to another's hidden agenda.
- Reinforced by finding a bargain due to limited income.
- Finding it easier to go along with what happens than to question a situation.
- Socialized to believe that cutting someone off or hanging up is rude

**Watch a Scam Video:** Would you like to see how easy it is for unscrupulous people to take advantage of seniors? Go the website at <http://elder.law.stetson.edu/index.php> and view one of the videos showing common scams used to get personal information from people or get at their money. Then imagine the person also having a disability. You will quickly understand why people with disabilities are at risk.

Currently we have no data on how many people with disabilities are victims of Medicare fraud. We do know that disability or significant difficulties in getting information, making sense of information, or responding to information leave seniors and persons with disabilities more vulnerable to Medicare fraud or abuse.

This is where you come in as an SMP volunteer. You will have an opportunity to visit with seniors and people with disabilities who may encounter Medicare fraud and are at risk for being taken advantage of by others. The training materials we give you will be chunked into small, easy to remember segments. They begin with easy, familiar steps and gradually allow the person to do more on their own. These approaches use best practice strategies that are proven to work with people who have sensory, cognitive and mobility challenges.

## ACRONYMS/ABBREVIATIONS

<b>AAA</b>	Area Agency on Aging (State designation)
<b>AARP</b>	American Association of Retired Persons
<b>ALS</b>	Advanced Life Support (Ambulance)
<b>AoA</b>	Administration on Aging (Federal)
<b>ASC</b>	Ambulatory Surgical Center
<b>Bene</b>	Beneficiary
<b>BLS</b>	Basic Life Support (Ambulance)
<b>CMHC</b>	Community Mental Health Center
<b>CMN</b>	Certificate of Medical Necessity
<b>CMP</b>	Competitive Medical Plan
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CORF</b>	Comprehensive Outpatient Rehabilitation Facility
<b>CP</b>	Clinical Psychologist
<b>CPI</b>	Consumer Price Index
<b>CPT</b>	"Physicians' Current Procedural Terminology" (published yearly by the American Medical Association)
<b>CSW</b>	Clinical Social Worker
<b>DHS</b>	Department of Health Services (State)
<b>DHHS</b>	Department of Health and Human Services (Federal)
<b>DOI</b>	Department of Insurance (State)
<b>DME</b>	Durable Medical Equipment
<b>DMERC</b>	Durable Medical Equipment Regional Carrier
<b>DRG</b>	Diagnostic Related Groups
<b>EGHP</b>	Employer Group Health Plan
<b>EMC</b>	Electronic Media Claims
<b>EOB</b>	Explanation of Benefits
<b>EOMB</b>	Explanation of Medicare Benefits
<b>ESRD</b>	End-Stage Renal Disease
<b>FI</b>	Fiscal Intermediary
<b>FPL</b>	Federal Poverty Level
<b>FY</b>	Fiscal Year
<b>GAO</b>	General Accounting Office (Federal)
<b>HHA</b>	Home Health Agency
<b>HIC#</b>	Health Insurance Claim Number
<b>HICAP</b>	Health Insurance Counseling Advocacy Program
<b>HMO</b>	Health Maintenance Organization
<b>HPSA</b>	Health Professional Shortage Area
<b>ICF</b>	Intermediate Care Facility
<b>IPL</b>	Independent Physiological Lab
<b>I&amp;R</b>	Information and Referral
<b>LIS</b>	Low-Income Subsidy

**LTC**..... Long Term Care  
**MA** ..... Medicare Advantage  
**MA-DP**..... Medicare Advantage Drug Plan  
**MEDPARD** ..... Medicare Participating Physicians and Suppliers Directory  
**MFIS** ..... Medicare Fraud Information Specialist  
**MMA**..... Medicare Modernization Act of 2003  
**MSN** ..... Medicare Summary Notice  
**MSP**..... Medicare as Secondary Payer  
**MSP**..... Medicare Savings Program  
**NAIC** ..... National Association of Insurance Commissioners  
**OAA**..... Older Americans Act (Federal)  
**OIG** ..... Office of Inspector General  
**ORT**..... Operation Restore Trust  
**OT** ..... Occupational Therapy  
**Part A**..... Hospital Insurance (Medicare)  
**Part B**..... Medical Insurance (Medicare)  
**PDP** ..... Prescription Drug Plan  
**PHP** ..... Partial Hospitalization Program  
**PPO** ..... Preferred Provider Organization  
**PPS** ..... Prospective Payment System  
**PRO**..... Peer Review Organization  
**PSA** ..... Planning Service Area (part of AAA)  
**PT** ..... Physical Therapy  
**QIO** ..... Quality Improvement Organization  
**QMB**..... Qualified Medicare Beneficiary (State)  
**RHHI** ..... Regional Home Health Intermediary  
**RRB**..... Railroad Retirement Board  
**SEP** ..... Special Enrollment Period  
**SHIC** ..... State Health Insurance Counseling Program  
**SHIP** ..... State Health Insurance Assistance Programs  
**SNF** ..... Skilled Nursing Facility  
**SSA** ..... Social Security Administration (Federal)  
**SSI** ..... Supplemental Security Income (State)  
**SSN** ..... Social Security Number  
**SSP** ..... Supplemental Security Payment (State)  
**ST**..... Speech Therapy  
**UR**..... Utilization Review  
**TROOP** ..... True Out of Pocket costs  
**VA** ..... Veterans' Administration (Federal)

## BENEFICIARY DEFINITION OF TERMS

### (Medicare Part D Acronyms and Glossary of Terms)

**Activities of Daily Living (ADLs)** – Activities which include help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. Also see “Custodial Care”.

**Actual Charge** – The amount a physician or other health care provider bills a patient for a particular medical service or procedure. The actual charge may differ from the Medicare approved amount or amount approved by other insurance programs.

**Acute Hospital** – A hospital which provides care for persons who have a crisis, intense or severe illness or condition which requires urgent restorative care.

**Administration on Aging (AoA)** – An agency of the U.S. Department of Health and Human Services, that is a focal point and advocate agency for older persons and their concerns at the federal level. AoA works closely with its nationwide network of State and Area Agencies on Aging (AAA) to plan, coordinate, and develop community level systems of services that meet the unique needs of individual older persons and their caregivers.

**Allowed Amount** – See Approved Charge.

**Appeal** – Medicare beneficiaries have the right to request a review of a denied claim and if not satisfied with the review, to appeal to a higher review. See Medicare Appeal.

**Approved Charge** – The maximum fee that a third party (insurer) will use in reimbursing a provider for a given service. The Medicare “approved” charge is usually less than the customary, prevailing, or actual charge.

**Area Agencies on Aging (AAA)** – Local government agencies which grant or contract with public and private organizations to provide services for older persons within the area.

**Assignment** – The physician or supplier who accepts assignment under Medicare Part B agrees to be paid whatever amount Medicare determines to be allowable. If so, Medicare will pay 80 percent of the approved charge and the beneficiary pays 20 percent. The doctor cannot bill for any additional amount on the service for which assignment was accepted.

**Beneficiary** – Any person who receives benefits.

**Benefit Maximum** – The limit a health insurance policy will pay for a certain loss or covered service. The benefit can be expressed either as,

- 1) a length of time (for example, 60 days), or
- 2) a dollar amount (for example \$350 for a specific procedure or illness), or
- 3) a percentage of the Medicare approved amount.

The benefits may be paid to the policy holder or to a third party. This may refer to a specific illness, time frame, or the life of the policy.

**Benefit Period** – This is the period of time for which payments for benefits covered by an insurance policy are available. The availability of certain benefits may be limited over a specified time period.

**Benefit Period Under Medicare** – A Medicare benefit period begins upon entry to a qualified hospital and ends when the patient has been out of the hospital and not receiving Medicare benefits in a facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days, including the day of discharge.

**Biologicals** – Substances, such as whole blood, hemophilia clotting factors, tetanus, antitoxins vaccines, tumor chemotherapy agent, etc.

**Buy-In** – Program in which the state's Medicaid program pays the Medicare premiums, deductibles and co-payments for certain people who are low income eligible.

**Carrier** – A commercial health insurance company under contract with the Center for Medicare/Medicaid services (CMS) to handle claims processing for Medicare Part B, including the payment of claims for items and services provided in a given area.

**Catastrophic coverage:** Catastrophic coverage applies when drug costs are very high under Medicare Part D. It begins after a beneficiary has paid \$5,100 out of his own pocket for drugs in a year. At this stage, the plan pays most costs with no upper limit. Beneficiaries pay a small portion, such as five percent, or a small flat amount for each prescription.

**Center for Medicare/Medicaid Services (CMS)** – A branch of the U.S. Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

**Certificate of Medical Necessity (CMN)** – A document completed and signed by a physician to certify a patient's need for certain types of durable medical equipment (e.g., wheelchairs, walkers, etc.).

**Charges** – Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and from institution to institution.

**Chronic** – A lasting, lingering or prolonged illness.

**Claim** – A bill requesting that medical services be paid by Medicare or by some other insurance company.

**COBRA Legislation** – Legislation that requires that workers who end employment for specified reasons have the option of purchasing group health insurance for 18 months.

**Co-insurance** - Co-insurance is the term for splitting costs on a percentage basis under Medicare Part D. For example, in the standard plan designed by Congress, the beneficiary pays 25 percent of the drug cost and the plan pays 75 percent until the combined total reaches \$2,000. Some plans may have flat co-pays for each prescription instead of a percentage.

**Conditional Enrollment** – For persons who are not already enrolled in Medicare Part A and choose to enroll only if qualified for the State payment of deductible, they can apply for a conditional enrollment. If not qualified, enrollment will not occur. Also see Qualified Medicare Beneficiaries (QMBs).

**Consolidated Omnibus Budget Reconciliation Act (COBRA)** – Legislation that allows specific employees and their dependents to continue employer's group health plan coverage for a specified period of time.

**Coordination of Benefits** – Provisions and procedures used by insurers to avoid duplicate payments for losses insured under more than one policy. One of the insurers is usually the primary payer assuring that no more than 100% of the costs are covered. This does not usually apply to indemnity (cash payment) policies. Also see Medicare as Second Payer.

**Co-payment** – A specified dollar amount or percentage of covered expenses which the beneficiary is required to pay towards medical bills. Medicare Part A Hospital Insurance requires that a co-payment, or co-insurance, is paid by the beneficiary for certain covered services, the 21<sup>st</sup> through the 100<sup>th</sup> day of skilled nursing facility care. Medicare Part B pays 80% of "approved" charges and the beneficiary must pay the 20% coinsurance and the balance of the charges.

**Costs** – Expenses incurred in the provision of services or goods. Charges billed to an individual or third party may not necessarily be the same, as based on the costs.

Hospitals often charge more for a given service than it actually costs in order to recoup losses incurred from providing other services where costs exceed feasible charges.

**Cost-sharing** - The out of pocket contribution a beneficiary makes to their cost of care. This includes deductibles, premiums, co-insurance and co-payments.

**Coverage gap** - Coverage gap describes when the plan makes no contribution to drug costs and the beneficiary must pay 100 percent for drugs out of their pockets until they reach a pre-set maximum under Medicare Part D. Some people call this step "the doughnut hole," or "gap." Medicare beneficiaries still have access to discounts on the price of drugs, even within the "gap".

**Covered Services** – Medicare law permits payment only for services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury". Therefore, Medicare can pay for services only as long as they are medically necessary.

**Physicians' Current Procedural Terminology (CPT)** - yearly publication of the American Medical Association. A listing of the descriptive terms and the numeric identifying codes and modifiers for describing and reporting medical services and procedures performed by physicians. These codes are required on claims submitted for Medicare payment.

**Custodial Care** – Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. (These may also be referred to as Activities of Daily Living or ADLs.)

**Deductible** - Deductible is the term for the amount a beneficiary will pay before their insurance starts under Medicare Part D. In the standard Medicare plan, the deductible ends when the total paid for eligible drugs reaches \$250.

**Diagnostic Related Groups (DRGs)** – DRGs are used to determine the amount that Medicare reimburses hospitals for in-patient services. It is part of the Prospective Payment System. Categories of illnesses are divided into more than 470 groups, one of which is assigned to a Medicare patient being discharged from a hospital. The hospital is reimbursed a fixed amount based on the DRG code for the patient.

**Dual Eligible** - Medical benefits that are covered by Medicare and Medicaid, Medicare is the primary payer and Medicaid is the secondary payer.

**Duplication of Coverage** – Coverage of the same health services by more than one health insurance policy. Expenses for the covered services are only paid for by one

policy, meaning the policyholder has two (or more) policies but has only received benefits from one of them.

**Durable Medical Equipment (DME)** – Durable medical equipment, as defined by Medicare, is equipment which can:

- 1) withstand repeated use,
- 2) is primarily and customarily used to serve a medical purpose,
- 3) generally not useful to a person in the absence of illness or injury, and
- 4) is appropriate for use in the home.

Equipment used in the treatment of health conditions and impairments, such as oxygen, wheelchair.

**Durable Medicare Equipment Regional Carrier (DMERC)** – A commercial health insurance company under contract with CMS to handle claims processing for durable medical equipment. There are a total of two DMERC's, each serving a specific geographic area.

**Durable Power of Attorney for Health Care** – This legal document authorizes the person given the power to make decisions regarding the person's medical treatment only when the person giving the power becomes incompetent.

**Duration of Benefits** – Time period or maximum amount of dollars for which an insurance policy will pay benefits.

**Employer-Sponsored Plan** - An employer-sponsored group prescription drug plan can operate either as or under contract with a PDP or MA-PD plan, or can provide retirees with drug coverage as part of the normal retiree health plan.

**End Stage Renal Disease (ESRD)** – Medical condition in which a person's kidneys no longer function, requiring the individual to receive dialysis or a kidney transplant to sustain his or her life.

**Enrollment** – Procedure in which eligible persons can secure participation in the Medicare program and receive Medicare coverage. It is handled by the Social Security Administration through local Social Security offices.

**Enrollment Period** – Period during which individuals may enroll for an insurance policy, Medicare, or managed care plan.

**Explanation of Medicare Benefits (EOMB) Form** – The statement that Medicare sends the beneficiary to show what action was taken by the carrier in processing the Medicare claim. If payment is being issued to the Medicare beneficiary, a check will be attached.

**Federal Financial Participation (FFP)** - The process by which the federal government pays a portion of the costs of services provided to Medicaid recipients in the states. Each state receives its own percentage of the cost of covered services based on a specific formulary.

**Federal Poverty Level (FPL)** - A benchmark used to determine eligibility for various federal programs including Medicare and Medicaid. The current FPL is annual income below \$17,900 for an individual or \$24,000 if married and living with spouse. Even with income above this, individuals may be able to get extra help with drug coverage.

**Fee for Service** – Method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This is the usual method of billing by the majority of physicians.

**Fee Schedule** – A listing of accepted charges or established allowances for specified medical, dental or other procedures or services. It usually represents either a physician's or third party's standard of maximum charges for the listed procedures.

**Fiscal Intermediary (FI)** – Private health insurance company under contract with CMS to handle claims processing for Medicare Part A.

**Full-Benefit Dual-Eligible (FBDE)** - Persons eligible for both Medicare and Medicaid.

**Grace Period** – A specified period after a premium payment is due on an insurance policy or Medicare, in which the policy holder may make such payment, and during which the provisions of the policy continue.

**Health and Human Services, Department of** – An executive department of the federal government which has the ultimate authority for the Medicare and Medicaid programs.

**Health Insurance Claim Number (HICN)** - The identifying number on the Medicare card you will need to enroll in Part D and/or access beneficiary specific information on the Medicare Prescription Drug Plan Finder on-line tool.

**Health Insurance Counseling and Advocacy Program (HICAP)** - A statewide program funded through both state and federal dollars to assist elderly individuals with questions regarding their health insurance benefits and resources.

**Health Maintenance Organization (HMO)** – An organization that, for a prepaid fee, provides a comprehensive range of health maintenance and treatment services (including hospitalization, preventive care, diagnosis, and nursing). HMOs are sponsored by large employers, labor unions, medical schools, hospitals, medical clinics, and even insurance companies. Development of HMOs was spurred by the federal

government in the 1970's as a means to correct the structural inflationary problems with conventional health care payment systems.

**Home Health Agency (HHA)** – A home health agency is a public or private agency that specializes in giving skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

**Home Health Care** – Health care services provided in the home on a part-time basis for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis and is intended to help people recover or improve from an illness, not to provide unskilled services over along period of time.

**Hospice** – A hospice is a public agency or private organization that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families in the home.

**Illegal Sales Practices** – Sales techniques used by insurance agents selling health insurance to supplement Medicare in which they mislead older adults into buying unnecessary coverage or paying premiums for no coverage.

**Indemnity** – A specific amount paid for a specified occurrence.

**Initial Enrollment Period** – An individual's first opportunity to enroll in Medicare; the seven months surrounding a person's 65<sup>th</sup> birth month or 24<sup>th</sup> month of entitlement to disability benefits.

**Inpatient** – A patient who has been admitted at least overnight to a hospital or other health facility (which is, therefore, responsible for his room and board) for the purpose of receiving a diagnosis, treatment, or other health services.

**Institutionalization** – Admission of an individual to an institution, such as a nursing home; where he or she will reside for an extended period of time or indefinitely.

**Insured** – The individual or organization protected in case of loss or covered service under the terms of an insurance policy.

**Intermediary** – See Fiscal Intermediary.

**Intermediate Care Facility (ICF)** – An ICF provides health related care and services to individuals who do not require the degree of care or treatment given in an hospital or skilled nursing facility but who (because of their mental or physical condition) require

care and services which is greater than custodial care and can only be provided in an institutional setting.

**Length of Stay** – The time a patient stays in a hospital or other health facility.

**Lifetime Reserve** – Medicare Part A provides a 60 day, one time only benefit period beyond the 90<sup>th</sup> day of hospital coverage. This is not renewable and a co-payment is required.

**Long Term Care (LTC)** – The broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to chronic illness or condition and who are expected to need such services over a prolonged period of time. Long term care can consist of care in the home, by family members assisted with voluntary or employed help (such as provided by home health care agencies), adult day health care, or care in institutions.

**Long Term Care Insurance** – A policy designed to help alleviate some of the costs associated with long term care. Often, benefits are paid in the form of a fixed dollar amount (per day or per visit) for covered LTC expenses and may exclude or limit certain conditions from coverage.

**Low-Income Subsidy (LIS)** - Also known as extra help. A benefit through which the government pays for part or all of the Part D premiums for all Medicare Part D beneficiaries who have incomes that are below 150 percent of the federal poverty level (including all dual eligibles).

**Mammogram** – The X-ray of the breast to diagnose or screen for breast cancer.

**Medicaid** – Title XIX of the Social Security Act, federal assisted state administered program to finance health care services for persons with low-income of all ages. It is supported by Federal and State taxes.

**Medically Necessary** – Medical necessity must be established (via diagnostic and/or other information presented on the claim under consideration) before the carrier or insurer will make payment.

**Medicare** – Title XVIII of the Social Security Act, federal health insurance program for people 65 and older and some under 65 who are disabled. Medicare has two parts. Part A is Hospital Insurance and primarily provides coverage for inpatient care. Part B is Medical Insurance and provides limited coverage for outpatient care, physician services, diagnostic tests, supplies and ambulance services for the diagnosis and treatment of illness or injury.

**Medicare Advantage-Prescription Drug Plan (MA-PD)** - Managed Care based prescription drug plan. Current Medicare managed care plans must apply to be an MS-PD, or their beneficiaries will have to sign up with a PD or other MA-PD. The drug discount card will cease to exist on January 1, 2006.

**Medicare Appeal** – Procedure by which a beneficiary who disagrees with the amount of Medicare part B reimbursement can challenge the Medicare carrier within six months of the date of the MSN. If dissatisfied with the decision for an amount over \$100, beneficiary may request a Carrier Hearing. If the amount in question is over \$500, beneficiary may request a hearing by an Administrative Law Judge within 60 days. Medicare Part A appeals have different time limits and amount in controversy limits.

**Medicare Benefit Notice** – Form a Medicare beneficiary receives from the intermediary explaining the amount of Medicare reimbursement for a Part A claim.

**Medicare Modernization Act of 2003 (MMA)** - The federal law passed in which establishes the new Medicare Part D benefit and specifies many elements of the program including how dual eligible's are treated.

**Medicare Participating Physicians and Suppliers Directory (MEDPARD)** – Directory issued by a carrier listing all Medicare participating physicians (physicians who accept assignment) located in that carrier's area.

**Medicare Savings Programs (MSPs)** - Beneficiaries of these programs are known as "partial dual eligible's"; they have slightly higher incomes than people who are full dual eligible's, and Medicaid only pays for cost-sharing associated with Medicare. MSP beneficiaries are automatically deemed eligible for the low-income subsidy.

**Medicare Summary Notice (MSN)** – A newly designed format replacing the Explanation of Medicare Benefits form. The MSN shows what action was taken by the carrier or fiscal intermediary in processing the Medicare claim.

**Medicare as Secondary Payer (MSP)** – Situations, defined by law, in which payment may be made only after another source of medical benefits has either paid or denied payment of medical items and/or services.

**Medicare Supplemental Policy (also known as Medigap)** – Type of insurance policy with coverage specifically designed to pay the major benefit gaps in Medicare (deductibles and co-payment).

**Medigap Policy** – Insurance designed to supplement Medicare by "filling some of the gaps left by Medicare coverage".

**National Association of Insurance Commissioners (NAIC)** – The organization that prepares model provisions and guidelines for insurance companies and state legislatures.

**Network Long Term Care Pharmacy (NLTCP)** - MMA describes the requirements of a long term care pharmacy which contracts with a PDP or MA-PD and refers to them as NLTCP. Requirements include all of the traditional services of a long term care pharmacy including drug utilization review, special packaging, on-call and delivery services. Plans are under an “any willing provider” requirement with respect to the NLTCP, but must have at least one contract to service long term care residents.

**Nonparticipating Facility** – Health care facility which does not participate in the Medicare program and generally does not accept Medicare payment for services received in the facility.

**Notice of Continue Stay Denial** – A Medicare beneficiary may become liable for costs of hospital care after he/she is given a written Notice of Continued Stay denial. This notice of noncoverage states that in the hospital’s opinion and with the attending physician’s or QIO’s concurrence, the beneficiary no longer requires inpatient hospital care. Liability begins on the third day after the receipt of this notice from the hospital. Medicare beneficiaries can appeal written denials of coverage through an expedited appeal to the QIO or through the usual Medicare Part A Appeals procedure.

**Nursing Home** – Also convalescent hospital. A place where people reside who need some level of medical assistance and/or assistance with activities of daily living. A term used to cover a wide range of institutions including Skilled Nursing Facilities, Intermediate Care Facilities and Custodial Care Facilities. Not all nursing homes are Medicare approved/certified facilities.

**Nursing Home Policy** – Type of limited health insurance policy which generally pays indemnity benefits for medically necessary stays in nursing facilities (sometimes referred to as Long Term Care Policies).

**Occupational Therapy** – Activities designed to improve the useful functioning of physically and/or mentally disabled persons.

**Office of Inspector General (OIG)** – The agency within the U.S. department of Health and Human Services responsible for the investigation of suspected fraud and abuse and performing audits and inspections of HHS programs. The OIG has authority to levy certain sanctions and civil money penalties.

**Older Americans Act** – Federal legislation enacted in 1965 to provide money for programs and direction for a multitude of services designed to enrich the lives of senior citizens, for example, adequate housing, income, employment, nutrition and health care.

**Ombudsman** – A “citizen’s representative” who protects a person’s rights through advocacy, providing information and encouraging institutions or agencies to respect citizens’ rights.

**Open Enrollment** – A period when new subscribers may elect to enroll in a health insurance plan or managed care plan.

**Operation Restore Trust (ORT)** – The special HHS initiative establishing a two-year demonstration project (May 95-May 97) against fraud, waste and abuse in the Medicare and Medicaid programs. The project targeted areas of high spending growth (home health agencies, nursing homes and durable medical equipment) in the top five states in terms of beneficiary population and expenditures (California, Florida, Illinois, New York and Texas).

**Out-of-Pocket Expenses** – Costs borne directly by the patient without benefit of insurance; direct costs.

**Outlier Case** – Outlier cases are atypical cases which involve longer hospital stays or higher treatment costs. The Medicare beneficiary does not incur an obligation to pay the hospital because of the outlier case.

**Outpatient** – A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in organized programs, such as outpatient clinics.

**Part A** – See Medicare.

**Part B** – See Medicare.

**Part D** - The new prescription drug benefit component of the Medicare program. The prescription drug benefit began on Jan. 1, 2006.

**Part D Drugs** - A drug that is only available by prescription, approved by the Food and Drug Administration, used and sold in the United States and prescribed for medically acceptable conditions. Part D drugs include biological products, insulin, syringes, needles, gauze and alcohol swabs associated with the injection of insulin, and vaccines **not covered under Part B.**

Items excluded from the definition include: drugs for anorexia, weight loss or weight gain; drugs used to promote fertility; drugs used for cosmetic purposes or hair growth; drugs used for the symptomatic relief of coughs and colds; prescription vitamins and mineral products, except perinatal vitamins and fluoride preparations; nonprescription drugs; outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale; barbiturates; and benzodiazepines. Drugs that would be covered by Medicare Part A or Part B if the individual were enrolled are also excluded.

**Partial Hospitalization Program (PHP)** – A program designed to keep a patient with severe mental conditions from becoming hospitalized by providing intensive psychotherapy in a day outpatient setting.

**Participating Facility** – Health care facility which participates in the Medicare program and accepts Medicare payment for services received in the facility.

**Participating Physician/Supplier Agreement** – An agreement, by an individual physician or supplier, to always accept assignment on claims for Medicare-covered items and services. This agreement is valid for the calendar year and may be renewed annually.

**Personal Care** – Assistance provided to people who need help with bathing, cooking, dressing, eating, grooming or personal hygiene. These services are not routinely paid for by either Medicare or Medicaid.

**Personal Comfort Items** – For inpatients in a hospital, such items as a television, telephone, etc.

**Physical Therapy** – Services provided by specially trained and licensed physical therapists in order to relieve pain, restore maximum function, and prevent disability, injury or loss of a body part.

**Physician Payment Reform** – Physician Payment Reform, which began January 1, 1991, requires that all physicians and practitioners who accept Medicare, whether participating or not, use the Medicare approved amount to determine their actual charges, which can be set at no more than 115 percent above the Medicare approved amount. This legislation also established a national Physician Fee Schedule.

**Power of Attorney** – A legal document which gives a person (usually a spouse, other relative or friend) the power to act on behalf of another. The person giving the power must be competent, and does not lose the legal right to act on his own behalf.

**Preferred Provider Organization (PPO)** – Membership organizations that offer members a network of physicians and suppliers who accept assignment. They may also

offer additional benefits such as discounts on prescription drugs, transportation discounts and access to health education programs.

**Premium** – Dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or Medicare beneficiary in exchange for a designated amount of insurance or Medicare coverage.

**Prescription Drug Plan (PDP ) (or Part D plan)** - A private insurance plan that only offers coverage for prescription drugs under Medicare Part D.

**Primary Payer** – Provider of medical coverage first responsible for making payment on a Medicare claim.

**Prior Authorization** – Approval may be required before a medical service is provided. For procedures which require prior authorization, an insurer can deny coverage for services already provided or for proposed services which are deemed to not be medically necessary. It is generally the responsibility of the provider to obtain the authorization.

**Prospective Payment System (PPS)** – A standardized payment system implemented in 1983 by Medicare to help manage health care reimbursement whereby the incentive for hospitals to deliver unnecessary care is eliminated. Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay. In some cases, the Medicare payment will be more than the actual cost of providing services for that stay; in other cases the payment will be less than the hospital's actual cost. In special cases, the hospital may receive additional payment for unusually high costs. Also see Outlier Cases.

**Provider** – Someone who provides medical services or supplies, such as physician, hospital, X-ray Company, home health agency, or pharmacy.

**Quality Improvement Organization (QIO)** – Organization paid by the federal government focusing on case review and quality of care of Medicare patients in hospitals, skilled nursing facilities, ambulatory surgical centers and managed care plans. A patient has the right to appeal to a QIO if there is a question about care or length of stay.

**Qualified Medicare Beneficiaries (QMB)** – A federally required program where states must pay the Medicare deductibles and co-payments for Medicare beneficiaries who qualify based on income and resources.

**Railroad Retirement** – Persons who worked for a railroad company are entitled to their benefits at retirement (includes Medicare).

**Reasonable and Necessary Care** – The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

**Reconsideration** – The first step in the Medicare part A appeal process in which the beneficiary sends a written request to the intermediary showing his or her disagreement with the Part A payment allowed for a claim and asking that the payment decision be reviewed.

**Respite** – The in-home care of a chronically ill beneficiary intended to give the caregiver a rest. Can also be provided in a hospice or nursing home (as with hospice respite care).

**Retiree Drug Subsidy (RDS)** - The MMA establishes a 28% retiree drug subsidy. The subsidy payments reimburse plan sponsors for drug coverage they provide to retirees in lieu of Medicare drug coverage, encouraging them to continue offering the high quality coverage they have offered in the past.

**Review** – The first step in the Medicare Part B appeal process in which the beneficiary sends a written request to the carrier showing his or her disagreement with the Part B payment allowed for a claim and asking that the payment decision be reviewed.

**Secondary Payer** – A payer of medical benefits whose payments cannot be made until another, primary party has processed the claim and issued a claim determination.

**Senior Health Insurance Assistance Programs (SHIP)** – A state and federally funded program of peer to peer health insurance counseling for seniors. Usually operated out of the State Insurance Commissioner's Office or Department of Aging. In North Dakota these programs are known as SHIC.

**Skilled Nursing Care** – Care which can only be provided by or under the supervision of licensed nursing personnel. Skilled rehabilitation care must be provided or supervised by licensed therapy personnel. All care is under the general direction of a physician and necessary on a daily basis. Therapy that is needed only occasionally, such as twice a week, or where the skilled services that are needed do not require inpatient care, do not qualify as skilled level of care.

**Skilled Nursing Facility (SNF)** – A Medicare approved skilled nursing facility which is staffed and equipped to furnish skilled nursing care, skilled rehabilitation services and other important related health services for which Medicare pays benefits.

**Social Security** – A national insurance program that provides income to workers when they retire or are disabled and to dependent survivors when a worker dies. Retirement payments are based on worker’s earnings during employment.

**Social Security Administration (SSA)** – The federal agency responsible for determining Medicare eligibility and for the Medicare enrollment process.

**Special Enrollment Period (SEP)** - Applies to full benefit dual eligibles, specifically in long term care facilities, when a beneficiary moves out of a plan service area, in cases of involuntary loss, reduction, or non-notification of creditable coverage or other exceptional circumstances. It allows them to change drug benefit plans at any time, however the plan change does not begin until the beginning of the month following application to a new plan.

**Speech Therapy** – The study, examination, and treatment of defects and diseases of the voice, speech, spoken and written language.

**Spousal Impoverishment** – The community property and assets of a married nursing home patient may be divided according to CMS standards to protect the property and assets of the spouse.

**State Pharmaceutical Assistance Program (STAP)** - A state program that does not use federal funds (other than seed money), that wraps around the part D benefits and that has its cost-sharing assistance count toward a beneficiary’s true out-of-pocket payments for drugs.

**Supplemental Health Insurance** – See Medicare Supplemental Policy.

**Supplemental Security Income (SSI)** – A federal program that pays monthly checks to people in need who are 65 years or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide sufficient resources so that anyone who is 65 or blind or disabled can have a basic monthly income. Eligibility is based on income and assets.

**Supplier** – Persons or organizations, other than physicians or health care facilities, that furnish medical equipment or services, such as ambulance firms, laboratories, and equipment rental outlets.

**Third Party Liability** – A party other than the beneficiary who is responsible for payment of part or all of a specific Medicare claim. Medicare supplemental insurance (Medigap) coverage is one example.

**Title XVIII** – That portion of the Social Security Act which clearly defines the provisions of Medicare.

**Title XIX** – That portion of the Social Security Act which establishes that Social Security funds will be used to fund, on a federal/state cost sharing basis, a general medical assistance program, known as Medicaid.

**True Out of Pocket Costs (TROOP)** - TROOP stands for “true out-of-pocket” costs. The MMA and our regulations create a distinction between all beneficiary out-of-pocket expenditures and those that will be counted toward the annual Part D out-of-pocket threshold—the latter are known as “true” out-of-pocket (TROOP) expenditures. These are costs actually paid by the beneficiary, another person on behalf of the beneficiary, or a qualified State Pharmaceutical Assistance Program (SPAP) and not reimbursed by a third-party (such as a supplemental insurance plan sponsored by a former employer) that will count toward the TROOP threshold that determines the start of the catastrophic coverage. Most third-party assistance, such as that from employers and unions, does not count toward the TROOP threshold.

**TROOP Facilitator** - Computer data base that will track the out of pocket costs of Part D participants and provide information on which beneficiaries are enrolled in which PD or MA-PD.

**Unassigned Claim** – A claim submitted to a carrier, fiscal intermediary or health insurer by the person or on behalf of the person, who received a service, with payment made to that person rather than to the provider.

**Underwriting** – The process by which an insurer establishes and assumes risks according to insurability.

**Utilization Review Committee** – Committee in a health care facility which evaluates the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. This includes a current and retroactive review of the appropriateness of admissions, services ordered and provided length of stay, and discharge practices.

**Visit** – An encounter between a patient and a health care professional which requires either the patient to travel from his home to the professional's usual place of practice (an office visit), or for the doctor or other health care provider to see the patient in the hospital, skilled nursing facility, or in the patient's home. Doctors' services can be covered in any of these settings.

