

Fraud Schemes & Genetic Testing



Jean Stone

*Program Integrity Senior Specialist,
Division of Stakeholder
Engagement and Outreach,
Data Sharing & Partnership Group.
Center for Program Integrity*

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Agenda

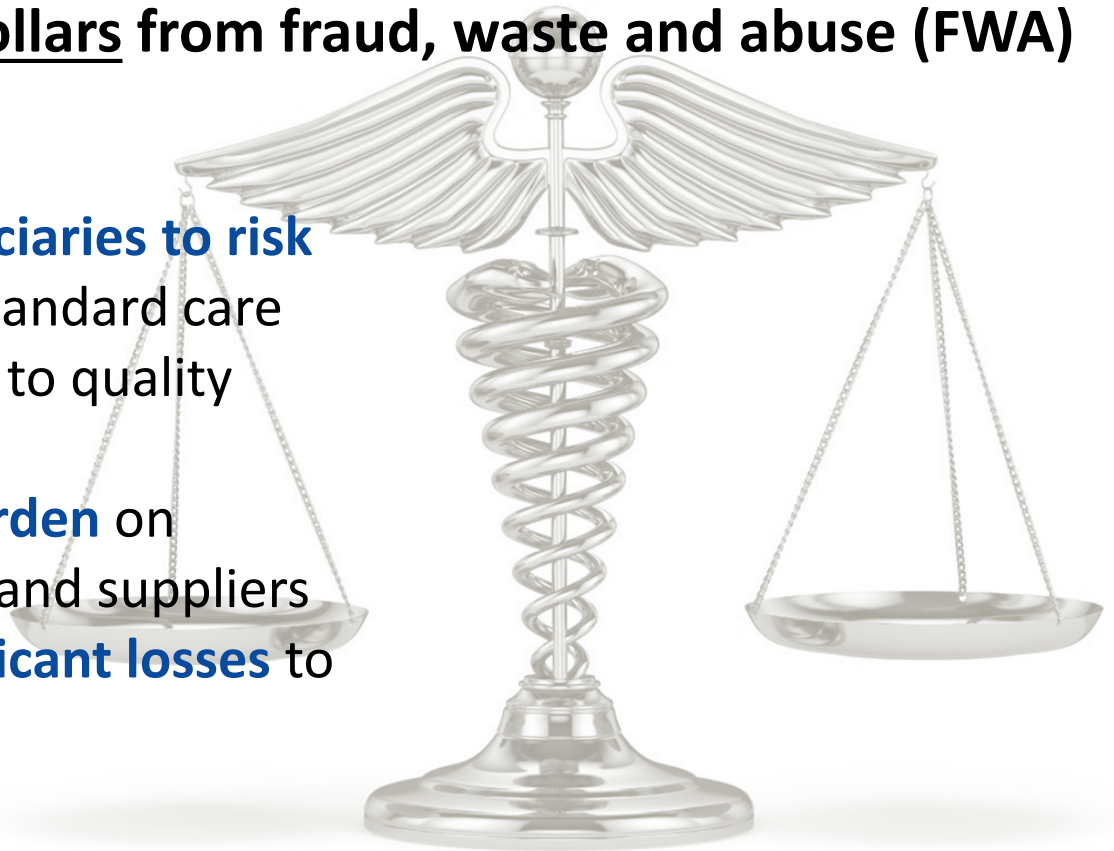
- Patients as Victims of Fraud
 - Common fraud schemes
 - Case studies
 - Prevention and detection techniques
- Patients as Perpetrators of Fraud
 - Focus on beneficiary fraud
 - Common schemes
- Protecting Patients from Fraud
 - Initiatives
 - Resources
 - Reporting Fraud



Program Integrity Priority

Balance protecting beneficiary access to critical health care services with reducing administrative burden on providers and safeguarding taxpayer dollars from fraud, waste and abuse (FWA)

- FWA **exposes beneficiaries to risk** and harm from substandard care
- FWA **restricts access** to quality health care services
- FWA **adds undue burden** on legitimate providers and suppliers
- FWA **results in significant losses** to Trust Funds



Patients as Victims of Fraud

Medically Unnecessary Services

Medically Unnecessary Services

Billing services unrelated or unnecessary to treat a patient's medical need



- **Ordering same tests for all beneficiaries**
- **Billing supplies/services patient does not want, need or for which patient does not qualify**
- **Prescribing drugs without legitimate clinical need**

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- Directed administration of unnecessary hematology and chemotherapy treatments and dangerously high doses of controlled substances to patients deliberately misdiagnosed to justify expensive treatments
- Kickback schemes for referrals to his own clinics and facilities
- Submitted \$225M in false claims and was paid \$91M

Case Study: Farid Fata, MD

Sentenced to 45 years in prison and \$17.6M forfeiture



Services Not Rendered

- Billing for lab or medical tests not performed
- Billing for services or products after patient's date of death
- Billing for supplies, drugs or equipment beneficiary does not receive

Services Not Rendered (SNR)

Billing for products or services not supplied to the beneficiary



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Billing for products or services not supplied to the beneficiary



Case Study: Albert Ades, MD

Sentenced to 37 months in prison and \$280K forfeiture

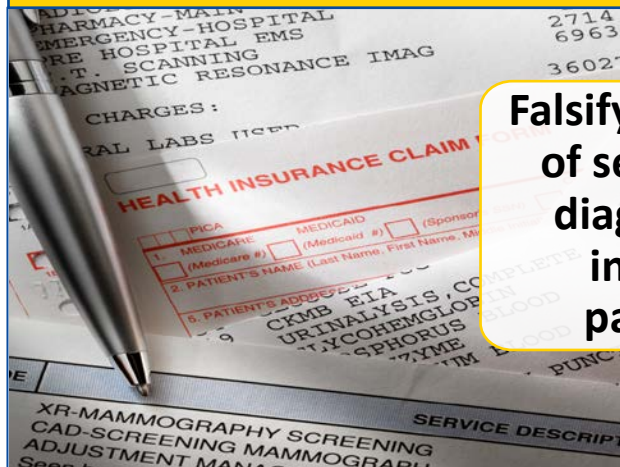


- Fraudulently billed Medicare, Medicaid and private payers for office visits that did not happen
- Wrote prescriptions, authorized refills and altered medical charts to make it appear as if he had seen patients
- Resulted in loss of \$280K from 2009-2013

Misrepresenting Products or Services

- Using higher-paying codes to define diagnosis
- Dispensing generic prescription and claiming brand name drug
- Billing separately for products or services grouped into a single rate

Misrepresenting Products or Services

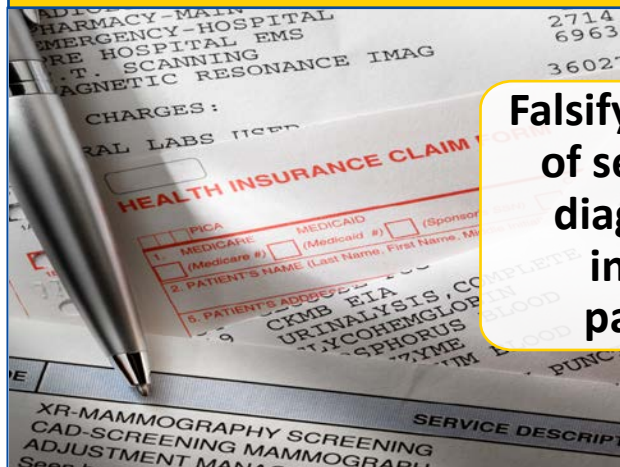


**Falsifying nature
of services or
diagnosis to
increase
payment**

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- Billing separately for products or services grouped into a single rate

Misrepresenting Products or Services



Falsifying nature of services or diagnosis to increase payment



Case Study: Hung Viet Tran

Sentenced to 20 months in prison and \$825K restitution

- Over 4 years, pharmacist billed for brand name prescriptions that were never dispensed
- Dispensed over the counter or cheaper generic drugs and billed Medicare and Medicaid for brand name
- Purchased 70,000 Costco brand fish oil capsules at 2.4 cents each and billed for expensive drug, Lovaza, reimbursed at \$1.64 each

Durable Medical Equipment (DME): Common Schemes

- Billing for equipment not supplied to patient
- Pre-billing and/or automatically refilling medical supplies
- Billing for customized equipment and providing standard equipment



Common DME Schemes

Billing for unnecessary equipment for beneficiaries who do not qualify and/or do not have legitimate medical need

Durable Medical Equipment (DME): Common Schemes

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Common DME Schemes

Billing for unnecessary equipment for beneficiaries who do not qualify and/or do not have legitimate medical need

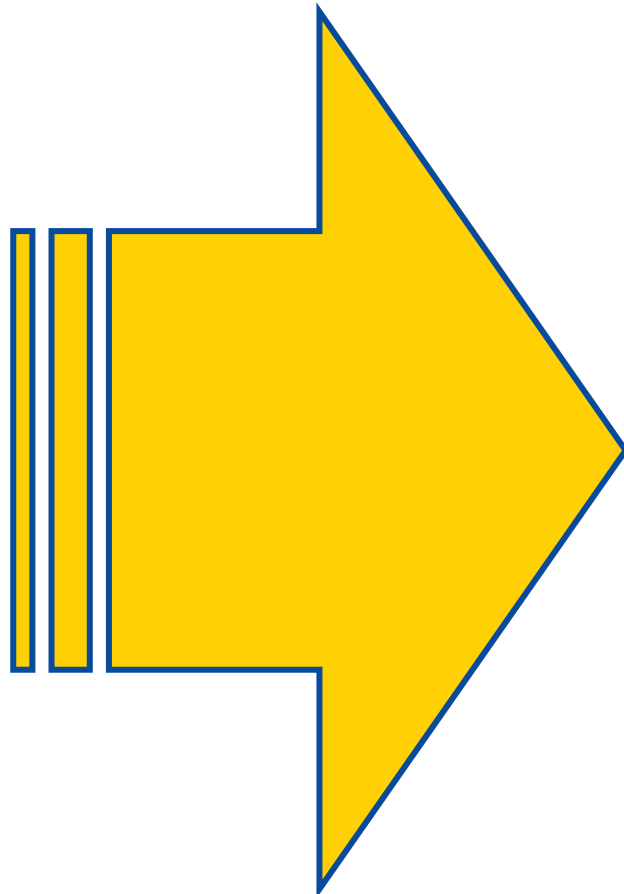


- Owner of Royal Medical Supply billed \$4M between 1/2006 and 10/2009 for power wheelchairs, knee and back braces that were either unnecessary or not provided
- Falsified documentation to support fraudulent billing, including fake home assessments and delivery records for equipment

Case Study:
Valery Bogomolny
Convicted and awaiting sentencing



Prevention and Detection of Common Fraud

- 
- **Review MSNs/EOBs** to confirm validity and **verify receipt** of all listed products and services
 - **Track dates** of office visits and procedures to compare to service dates on EOBs
 - **Review documents** before signing and never sign blank forms
 - **Use familiar providers** to order DME supplies and do not accept unneeded supplies
 - **Be wary of free offers** that require beneficiary name, personal information or health insurance claim number (HICN)

Prevention and Detection of Common Fraud

- **Review MSNs/EOBs** to confirm validity and **verify receipt** of all listed products and services

Hotline tips from members reporting discrepancies on their EOBs account for **60-70%** of one health plan's criminal investigations*



Telemarketing

Phone callers use phishing techniques to trick enrollees into providing identification numbers for fraudulent purposes

Recent Scams

Misdialing number similar to health plan's number leads to identity theft

Offers of **free items** by providing bank information to cover shipping costs

Free phones to Medicare or Social Security beneficiaries

Impersonating Medicare, Social Security or health plan to “verify” personal information

Special plans with **limited time offers** require Medicare identification and/or bank information to **act now**

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Prevention

Register personal phone numbers with **Do Not Call** registry (<https://donotcall.gov>)

Never provide HICN or personal information over the phone

Do not submit to pressure from a caller to “act now!”



Marketing and Enrollment Fraud



**Cold calls
from
agents and
brokers**

- Phone, email or door-to-door solicitation by persistent sales people
- Cold calls and solicitation are prohibited by marketing guidelines

- Proposed plan may not be in beneficiary's best interest
- Includes plan-switching for LIS beneficiaries for commissions
- Beneficiary should consider formularies, provider networks, plan costs, supplemental benefits

**Steering
into plan
for agent
incentives**



Medical Identity Theft

Fraudulent use of beneficiary's personal and medical identifier information for covered medical supplies, services or prescriptions

Submitting medical claims using unlawfully obtained medical identity

Perpetrated by friends, family, caregivers or criminal enterprises or as a result of health care data breach



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- **Financial loss** and/or **financial responsibility** for fraudulent and false claims (e.g., copay, coinsurance)
- **Compromised** medical records
- **Denial** of future medical claims
- **Loss** of credit/downgrade of credit score



Medical Identity Theft: Statistics



In 2015, **253 breaches** affecting >500 individuals combined for loss of **>112 million health records²**

Number of patients impacted by medical identity theft increased by 22% from 2014 to 2015¹



Medical identity theft victims pay at least **\$13,500** to resolve the crime and resultant issues³



Data breaches cost the health care industry about **\$5.6 billion** annually⁴

¹ <http://www.healthcareitnews.com/news/medical-identity-theft-sees-sharp-uptick>

² <http://www.forbes.com/sites/danmunro/2015/12/31/data-breaches-in-healthcare-total-over-112-million-records-in-2015/#4ec957537fd5>

³ <http://www.healthcareitnews.com/news/medical-identity-theft-hits-all-time-high>

⁴ <http://www.forbes.com/sites/danmunro/2015/12/31/data-breaches-in-healthcare-total-over-112-million-records-in-2015/#4ec957537fd5>

Medical Identity Theft: Prevention and Detection



Closely safeguard
personal information

Provide information on a **need-to-know** basis

- Not on sign-in sheets
- Not over the phone to unknown people
- Not in exchange for free services or screenings

Genetic Testing Fraud

National Medicare Fraud Alert
2015-01

Distribution of this Fraud Alert is limited to the following audience:
Regional Offices, Program Safeguard Contractors, Zone Program Integrity Contractors, the Office of Inspector General, and the State Medicaid program integrity directors.

SUBJECT Molecular Pathology/Genetic Testing Fraud Scheme

BACKGROUND

Beginning in 2013, the Medicare following gene analysis procedure 81355. The process uses a DNA sent to the laboratory. As with a must be ordered by a physician diagnosis or treatment of the patient to submit a copy of a signed patient to the laboratory.

ACTIVITY

A laboratory based in Salt Lake City, the country and conducting representative their booth Insurance beneficiaries bill Medicare.

The all Independent service with the labor

The claims data for

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Investigations & Audits Group

Date: June 10, 2015

To: All Medicare Advantage Plans



Protect Medicare Beneficiaries from Genetic Testing Fraud

The Centers for Medicare & Medicaid Services (CMS) has been notified that laboratories have been conducting "genetic testing" at health fairs. However, these tests must be ordered by a physician or qualified practitioner when it is medically necessary for the diagnosis or treatment of the patient, in addition, the ordering physician or practitioner is required to submit a copy of

CPI issued Fraud Alerts to ZPICS and Part C plans to raise awareness of the schemes and a Fraud Awareness Flyer for Senior Medicare Patrol to understand the importance of warning beneficiaries of the scams

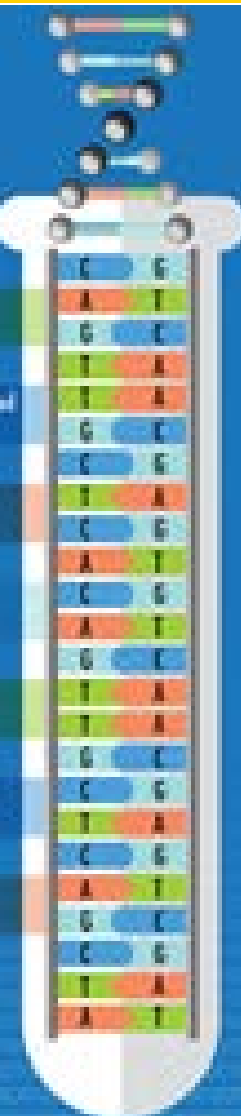
- Laboratory representatives give gift cards or other items of value to beneficiaries after providing services.

that laboratories have began providing analysis procedure codes: a DNA kit from which the molecular practitioner when it is the 42 Code of ts, and other

tic tests must o furnishes a results in the physician

physician or the order

Genetic Testing Fraud: Schemes



Lab representatives offer “free” health screenings at health fairs, taking swabs of beneficiaries’ cheeks for testing

Ice cream socials at senior and Section 8 housing and assisted living facilities for “education of prescription medications”

Beneficiaries give Medicare numbers and personal information for lab to bill Medicare and/or share results with their doctor

Bill for high dollar, medically unnecessary genetic tests without specified medical condition or physician orders

Medicare Coverage of Lab Testing Services



A lab test is covered by Medicare if it is:

- ✓ Medically necessary
- ✓ Ordered by the patient's physician or qualified practitioner
- ✓ Accompanied by copy of signed consent form and medical record documentation



- **Does not cover** screening services
- **Does not cover** tests to assess risk for and/or a condition unless it directly affects management of patient care
- **Does cover** legislatively mandated preventive services to prevent, provide early detection and manage disease to avoid complications

Genetic Testing Fraud: Reminders

- Genetic testing is expensive and required only under very specific circumstances
- Be conscious of false claims about benefits
- Medicare-covered services must be ordered by treating physician for legitimate medical need

Fraud Awareness

Genetic Testing Fraud: Case Study

- Genetic testing is expensive and required only under very specific circumstances
- Be conscious of false claims about benefits
- Medicare-covered services must be ordered by treating physician for legitimate medical need

Fraud Awareness

- Billed medically unnecessary urine drug and genetic testing to federal health care programs
- Allegedly paid kickbacks to physicians for referrals for expensive lab testing
- Millennium Health agreed to pay **\$256 million** to resolve alleged violations of the False Claims Act

Case Study Millennium Health

CMS revoked Medicare billing privileges of several labs for billing genetic testing services with no physician orders and with forged documentation



Patients as Perpetrators of Fraud

Who and Why of Beneficiary Fraud

Who commits beneficiary fraud?

Any Medicare beneficiary

Disability beneficiaries under age 65*

Low Income Subsidy recipients*

Why do beneficiaries commit fraud?

Supplemental income

Addiction

Beneficiary abuse by caretakers



**OIG and GAO reports indicate beneficiary fraud is common among those under 65 and receiving LIS benefit - <http://1.usa.gov/1XChBuj> and <http://go.cms.gov/1QOIgPx>*

Focus on Beneficiary Fraud

- Law enforcement is more actively **pursuing, investigating and charging** beneficiaries with health care fraud
- Fraudsters' **schemes** are becoming more **brazen and bold**
- Increased **collusion and coordination** is occurring among beneficiaries, providers and pharmacies
- Targeted **recruiting efforts** encourage beneficiaries to “get involved” in fraud



Beneficiary Fraud Schemes



Drug Seeking Behaviors

Doctor or pharmacy shopping, overutilization

Identity Theft

Potential issue of beneficiary harm

Complicit Relationships and Kickbacks

Financial relationships with providers or pharmacies

Recruiting and Buy-Back Schemes

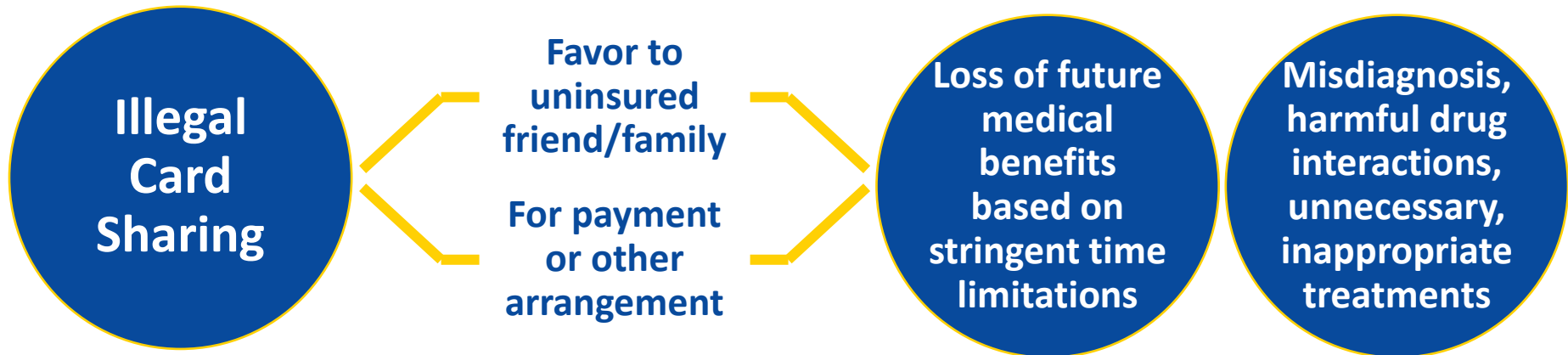
High dollar drugs with high street value for big profit

Enrollment and Eligibility Fraud

Attempting to enroll or qualify for low income subsidy

Card Sharing

Uninsured individual uses a legitimate beneficiary's Medicare identification to obtain medical care with beneficiary's consent and knowledge



Card Sharing

Uninsured individual uses a legitimate beneficiary's Medicare identification to obtain medical care with beneficiary's consent and knowledge

**Illegal
Card
Sharing**

Favor to
uninsured
friend/family

For payment
or other
arrangement

Loss of future
medical
benefits
based on
stringent time
limitations

Misdiagnosis,
harmful drug
interactions,
unnecessary,
inappropriate
treatments

Industry estimates show that
26% of beneficiaries
willfully share medical cards



Recent Beneficiary Fraud Headlines

McMinn Co. woman facing murder charges after alleged sale of prescription drugs

...allegedly sold...some of her legally prescribed methadone pills...the married mother of one daughter died of a drug overdose from them.

Ten Individuals Indicted in Medicare Fraud Scheme

...for allegedly participating in a scheme to defraud Medicare by submitting false and fraudulent claims and the payment and receipt of kickbacks in connection with a federal health care program...

Cops: DNA evidence traces suspect to shotgun, fake prescription

DNA evidence linked [redacted] to the incident and Shelton [redacted] shotgun, criminal [redacted] police in pursuit. [redacted] using fraud and deceit to obtain a controlled substance, forgery [redacted] substance, forgery and engaging

Medicare Recipient Pleads Guilty to Health Care Fraud

Defendant Used Forged Receipts to Collect More Than \$71,000

Pharmacy owner in West Virginia charged with defrauding Medicare and Medicaid

December 24, 2014, Charleston, WV — U.S. Attorney Booth Goodwin announced [redacted] a long-standing Kanawha City retail and compounding pharmacy, was charged by information with two counts of health care fraud and one count of misbranding drugs on Dec. 23.

...a Medicare beneficiary, is charged ...with submitting false claims...on her own behalf, seeking payment for drugs that were never dispensed to her.

Protecting Patients from Fraud

Revocations and Savings

New legislative authorities and tighter regulations strengthen CMS' ability to combat FWA and improper payments in Parts C and D



Deactivated **543,163 providers and suppliers** and revoked **34,888 providers and suppliers** since 2011



About **\$2.4 billion in payments** to revoked providers was/will be prevented since 2011



Saved **>\$25 billion** through recoveries and prepayment denials since 2011

Prescriber Enrollment Requirement

As of February 1, 2017, Medicare will no longer cover Part D drugs prescribed by providers not enrolled in or validly opted-out of Medicare

- Promotes *quality health care* through verification of prescribers' credentials
- Ensures only *competent, licensed individuals* enroll as Medicare providers
- Safeguards *health and wellness of beneficiaries* and *protects the Medicare Trust Funds* from fraudulent prescribers



Prescriber Enrollment Requirement: Impact on Beneficiaries

If a provider does not enroll in or validly opt-out:

- Part D will cover up to one 3-month provisional supply of prescription
- Provisional supply must be dispensed within 90 days, after which Part D will not cover other prescriptions or refills for the same drug from that provider
- Beneficiary will receive written notice that provider is not an approved Part D prescriber

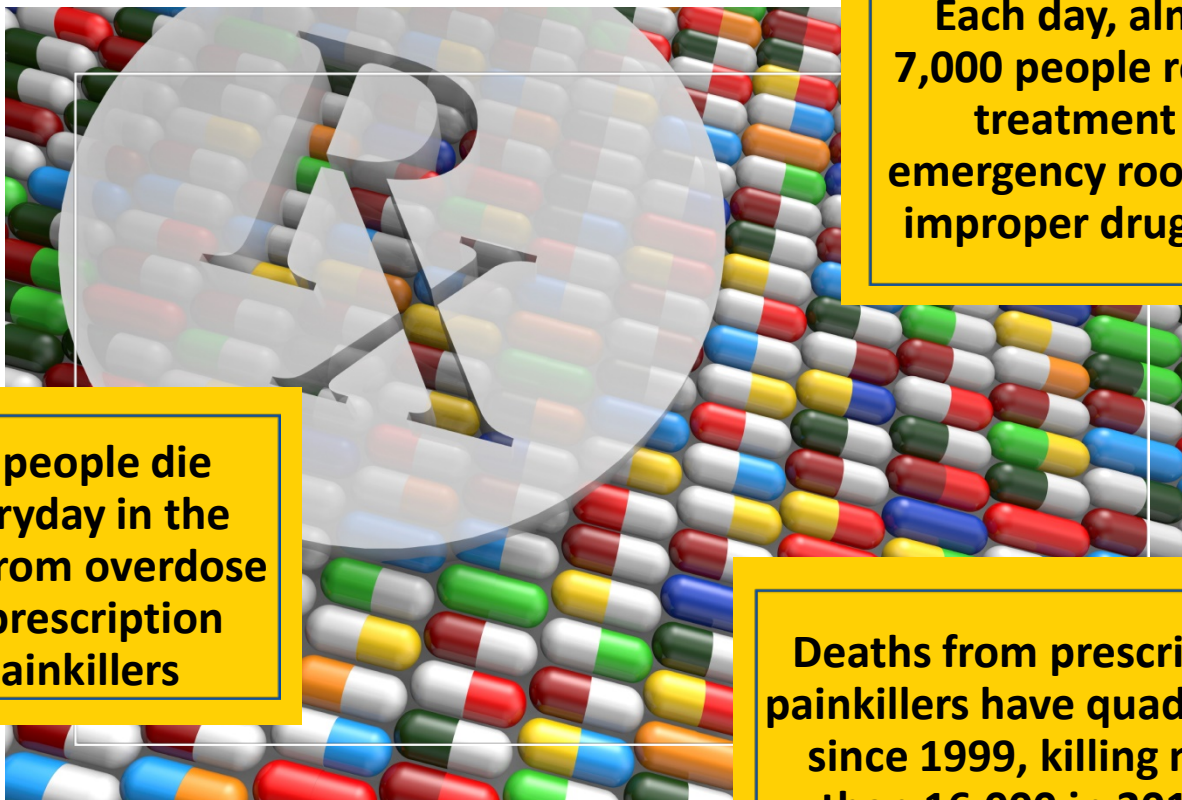


If provider validly opts-out:

- Part D drugs will continue to be covered
- Neither Medicare nor the Part C plan will pay for office visits or other services from the provider

**If provider is not an approved Part D prescriber,
Part D plan will not cover prescriptions**

Prescription Drug Abuse: A National Epidemic



**Each day, almost
7,000 people receive
treatment in
emergency rooms for
improper drug use***

**44 people die
everyday in the
U.S. from overdose
of prescription
painkillers**

**Deaths from prescription
painkillers have quadrupled
since 1999, killing more
than 16,000 in 2013****

*<http://www.cdc.gov/drugoverdose/epidemic/index.html>

**<http://www.cdc.gov/drugoverdose/data/index.html>

Overutilization Initiatives

CMS programs strengthen oversight of Part D to combat growing problem of prescription drug abuse

- New policies and system edits to monitor and track prescription drug use and potential overutilization
- Identify high risk beneficiaries for overutilization of opioids
- Curb the flow of diverted drugs and reduce drug overdoses

26% decrease in potential opioid overutilizers
47% decrease in first-time opioid overutilizers



Open Payments

- Publicly available information detailing **financial relationships** between physicians and pharmaceutical and medical device companies
- Enables beneficiaries to make **informed decisions** about providers
- May highlight **conflicts of interest** or **prescribing patterns** based on compensation by device or drug manufacturer



<https://www.cms.gov/openpayments/>

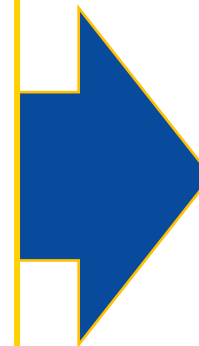


Senior Medicare Patrol (SMP): Empowering Seniors

54 SMP projects
in 2014 had
5,249 active
volunteers

Volunteers
conducted
202,862 one-on-
one counseling
sessions

Volunteers held
14,692 group
education
sessions that
reached **452,714**
beneficiaries



Activities
account for
more than
\$17 million in
savings from
2010 to 2014

For Senior Medicare Patrol program services in your state:

Call 800-562-6900 or visit

<http://insurance.wa.gov/your-insurance/medicare/report-medicare-fraud/>

State Health Insurance Assistance Program (SHIP)



Educate, advocate, counsel and empower people to make informed health care benefit decisions

Statewide Health Insurance Benefits Advisors (SHIBA)

<https://insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/>

Online Resources

Medicare.gov Resources

- How to report fraud
- Tips to prevent fraud
- Links to educational videos

Medicare.gov

CMS.gov Outreach and Education

- Fraud prevention toolkit
- Frequently Asked Questions
- Fact sheet for beneficiaries

CMS.gov

CMS Outreach & Education MEDIC (Parts C & D)

- Beneficiary outreach materials
- Online courses
- Quick reference cards and links

CMS Outreach & Education
MEDIC

CMS.gov Medicaid Integrity

- Tips for beneficiaries
- Infographics
- Fact Sheets

CMS.gov

Medicare Advantage and Part D Resources

The image displays a collection of resources for Medicare Advantage and Part D. On the left, several brochures are fanned out, featuring the CMS logo and various informational text. The central focus is a computer monitor showing the 'Outreach & Education MEDIC' website. The website has a blue header with the CMS logo and the text 'Sharing information to eliminate Medicare Parts C & D fraud'. Below the header, there's a 'Course Modules' section with a list: 'Introduction', '1. Parts C & D Basics', '2. How Each Program Works', '3. Who is Involved', and '4. Common Fraud Schemes'. The main content area is titled 'Medicare Advantage and Part D: Program Integrity Basics for Senior Advocacy Groups' and features a photo of an elderly man. A yellow arrow points to the navigation arrows in the top right corner of the website, with the text 'Use the green arrows to move through the course.' Below the website, there's a 'Fraud, Waste and Abuse Quick Reference' box. This box contains the text: 'To report suspected Medicare Advantage (Part C) and Prescription Drug (Part D) fraud, waste and abuse (FWA) and collaborate on cases, contact the NBI MEDIC at 1-877-7SafeRx or Martina Gilly, Benefit Integrity Manager 678-402-8514 gillym@healthintegrity.org'. It also includes a URL for more information: 'http://medic-outreach.rainmakersolutions.com'. At the bottom, there's a video thumbnail titled 'Look Out for Enrollment Fraud' showing an elderly woman standing next to a magnifying glass over a document, with a green checkmark and a play button icon.

Did You Know?
The Centers for Disease Control (CDC) has officially called drug abuse an epidemic. Although generally safe when taken as prescribed, misusing any prescription drug can be dangerous. Know the facts about prescription drug abuse.

- ❖ Accidental prescription drug deaths have more than quadrupled in the last 16 years.
- ❖ People who abuse drugs often get the drug from a relative.
- ❖ Having prescription drugs in your home increases the risk of drug abuse.

To discuss benefits, contact your local Medicare Customer Service Center. To report suspected Medicare Part C or D fraud, call 1-877-7SafeRx.

DO YOUR PART
If your health care provider is a Part D prescriber, your prescriptions must be covered by your prescription plan. If your health care provider is not a Part D prescriber, your prescriptions must be covered by your prescription plan.

- ❖ Ask your health care provider if they are a Part D prescriber.
- ❖ If your provider is not a Part D prescriber, you may need to see a new doctor who is a Part D prescriber for your prescriptions.
- ❖ Call your health plan about your coverage.

WARNING!
Genetic tests must be covered by Medicare. Some labs may offer a cheek swab as part of a "free" health screen to obtain your Medicare information or fraudulent billing purpose. Before you agree to genetic testing, ask your health plan about your coverage.

- The test is ordered by your doctor.
- The genetic test is medically necessary and covered by your plan.

To discuss benefits, contact your local Medicare Customer Service Center. To report suspected Medicare Part C or D fraud, call 1-877-7SafeRx.

DID YOU KNOW?
Medicare does not allow doctors to charge for writing a prescription. A typical doctor's visit involves a review of your medical history, discussion of a condition or symptoms, examination and/or treatment. A prescription is part of your treatment and is included in the cost of the doctor's office visit.

Some doctors may charge a cash-only fee. Requiring patients to pay cash is not illegal, but it is a business practice and may be a sign of fraud, waste or abuse.

Beware of a doctor who requires cash payment for a prescription, especially when there is no medical necessity.

To discuss benefits, contact your local Medicare Customer Service Center. To report suspected Medicare Part C or D fraud, call 1-877-7SafeRx.

Look Out for Enrollment Fraud

Review to spot any changes

Medicaid Resources

PROTECT YOURSELF PROTECT MEDICAID



Your Medicaid ID card and
should never be loaned

Medicaid card should

If you think someone is sharing
If you suspect Medicaid



There Are Many Types of Medicaid Fraud

Medicaid fraud is the intentional providing of false information to get Medicaid to pay for medical care or services.

Medical identity theft is one type of fraud. It involves using another person's medical card or information to get health care goods, services, or funds. Below are other types of fraud, and provider and beneficiary examples.

Type of Fraud	Provider Examples	Beneficiary Examples
Billing for Unnecessary Services or Items	Intentionally billing for unnecessary medical services or items.	
Billing for Services or Items Not Provided	Intentionally billing for services or items not provided.	
Unbundling	Billing for multiple codes for a group of procedures that are covered in a single global billing code.	
Upcoding	Billing for services at a higher level of complexity than provided.	
Card Sharing	Knowingly treating and claiming reimbursement for someone other than the eligible beneficiary.	Sharing your Medicaid identification (ID) card with someone else so they can obtain medical services.
Collusion	Knowingly collaborating with beneficiaries to file false claims for reimbursement.	Helping your doctor file false claims by having tests you do not need.
Drug Diversion	Writing unnecessary prescriptions, or altering prescriptions, to obtain drugs for personal use or to sell them.	Altering a doctor's prescription, going to multiple doctors to get more of the same drug, or selling your drugs to others.
Kickbacks	Offering, soliciting, or paying for beneficiary referrals for medical services or items.	Accepting payment from your doctor for referring other beneficiaries for medical services.
Multiple Cards	Knowingly accepting multiple Medicaid ID cards from a beneficiary to claim reimbursement.	Altering or duplicating a Medicaid ID card and using it or selling it for someone else to use.
Program Eligibility	Knowingly billing for an ineligible beneficiary.	Providing incorrect information to qualify for Medicaid.



Let Medicaid Give You a Ride

Medicaid covers the cost of emergency medical transportation for eligible individuals. An emergency is when your medical needs are immediate and you need to be transported to a hospital or other medical facility. This coverage does not consider this rule.

Medicaid covers rides to approved care. This coverage may also be able to get approval from your State.

Who Can Get a

Medicaid covers rides to approved care. This coverage may also be able to get approval from your State.

- Help you decide
- To help a friend
- Verify that you are
- Make sure that you
- Decide what type

How Do I Get a

- Be ready on time
- Call the ride service

Beneficiary Card Sharing

Medicaid fraud affects everyone. One activity that can play a part in Medicaid fraud, sometimes unknowingly, is sharing Medicaid beneficiary cards.

Sharing Your Medicaid

Sharing your Medicaid beneficiary card with someone else is illegal. Do not share your card with anyone.

Why Would

- To help a friend
- To sell or trade
- To protect card or
- Offer to help
- Setting up

This Could

- Be careful
- Do not share
- Not know
- Strangers may

Protect Your

Sometimes people say they are not. They may or may not be. Medicaid number

Key Message and Tips for Beneficiaries: My Responsibilities

Message

When you apply for Medicaid, make sure to give complete and accurate information. When you sign the Medicaid application, you provide information that is true to the best of your knowledge.

TIPS

- Bring your Medicaid card to every appointment.
- Never let anyone else use your card.
- File for any other Medicaid services you need.
- Pay back Medicaid if you are overpaid.
- Let your health care provider know if you change your address.
- Report any changes to your Medicaid card.

For more information about Medicaid, visit www.cms.gov or call 1-800-695-0283. For more information about Medicaid, visit www.cms.gov or call 1-800-695-0283.

Follow us on Twitter @CMSgov



Self-Directed Home and Community-Based Services: Understanding Your Role as a Beneficiary

Self-Directed Home and Community Based Services Basics

The Centers for Medicare & Medicaid Services (CMS) and the States are helping beneficiaries take steps to prevent payment errors to providers for self-directed home and community-based services (HCBS). These steps help ensure Medicaid continues to provide services to those who need them.

Understanding this information will help you make informed choices about your care, manage your care team, and ensure payment for the services provided to you.

Overview of Self-Directed Care

Federal and State laws allow you to self-direct your care. The first Medicaid-approved services that could be self-directed were personal support services. You help you manage your health and daily or weekly chores. Over the past 15 years, Medicaid laws have:

- Changed who can get services;
- Changed where you can get services; and
- Let some people with disabilities get services and items that help them live at home or in the community.

Overview of Home and Community-Based Services

Medicaid pays for services through many programs that help you live in your own home or community. If you have a disability, are aged, or have a chronic condition, you may be eligible to receive the care you need through one of these programs. These services may include:

- Home health care;
- Personal support;
- Private-duty nursing;
- Home-delivered meals;



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Report Fraud to Proper Authorities



- For Medicare improper billing, contact **1-800-Medicare**
- For Medicaid improper billing, contact State Medicaid Agency
- For identity theft, contact Federal Trade Commission or NBI MEDIC
- For criminal matters, contact OIG at **1-800-HHS-TIPS (1-800-447-8477)**

Questions

