SMP Counselor Training Manual

SMP Resource Center

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Acknowledgments

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About This Edition

This February 2023 edition is updated from the previous versions. Previous editions of this manual were published in 2016 and 2012.

Throughout the manual, look for "Tip" boxes (like this one), which highlight key tips.

About the SMP Resource Center

The Senior Medicare Patrol National Resource Center, more commonly known as "The SMP Resource Center," is funded by the U.S. Administration for Community Living (ACL), Department of Health & Human Services (DHHS), and has existed since 2003. The SMP Resource Center serves as a central source of information, expertise, and technical assistance for the Senior Medicare Patrol (SMP) projects.

National SMP Website: www.smpresource.org

This website provides education to the public on health care fraud and how to contact their local SMP. It also contains a "Resources for SMPs" portal with resources, training, and technical assistance for the SMP projects nationwide.

Nationwide Toll-free Number: 877-808-2468

Available Monday through Friday, 9:00 a.m. – 5:30 p.m. Eastern Time

Email: info@smpresource.org

Training Overview

The goal of SMP Counselor Training is to provide SMP volunteers and other SMP team members with the necessary skills and resources to answer basic SMP questions and provide individual SMP education consistently across the country.

As an SMP counselor, you will provide a valuable service to Medicare beneficiaries in your state by helping them become better health care consumers and helping identify potential areas of Medicare fraud, errors, and abuse.

Objectives

Upon completion of this SMP Counselor Training, you will be able to:

1) Determine if a question is an SMP basic interaction, an SMP complex interaction, or not an SMP interaction

2) Help beneficiaries review their MSNs (Medicare Summary Notices) and EOBs (Explanations of Benefits) to detect potential fraud, errors, and abuse
3) Help beneficiaries use a My Health Care Tracker to review their MSNs and EOBs
4) Handle SMP basic interactions using effective counseling skills and SMP resources
5) Send other types of questions to the appropriate person or entity for help

State and Local Information

This manual provides information that applies to SMP counselors nationwide. Throughout this manual, use the "State and Local Information" boxes (like this one) to help you think about questions to ask related to local processes and resources specific to your SMP program.

About This Manual

This training manual provides detailed information to help you meet each of the objectives listed above.

Chapter 1: Types of SMP Questions defines the types of questions received by SMPs and provides guidance to identify each type of question, which types of questions to answer yourself, and which to have someone else answer.

Chapter 2: How to Read MSNs and EOBs guides you through the process to review MSNs and EOBs with or on behalf of Medicare beneficiaries.

Chapter 3: How to Use the My Health Care Tracker explains how to help beneficiaries use a My Health Care Tracker to review their MSNs and EOBs.

Chapter 4: Counseling Skills focuses on soft skills by guiding you through the basic steps to effective counseling and providing counseling tips and strategies.

Chapter 5: Handling SMP Questions helps you address frequently asked questions and prepare for what to do before, during, and after each SMP counseling session.

The **Appendices** provide additional SMP counseling resources.

- Appendix A: Types of SMP Questions Flow Chart
- Appendix B: Contacts Outside of the SMP
- Appendix C: Frequently Asked Questions
- Appendix D: Process Checklist
- Appendix F: SMP Counseling Resources

Throughout the manual, look for "Caution" boxes like this one, which highlight areas to watch out for!

About This Training

For those of you who are fairly new to answering questions and providing basic counseling to beneficiaries and caregivers, this SMP Counselor Training will provide you with a chance to learn new counseling skills. For others, this will be a chance to review

and practice skills that you have used in the past. If you are an expert counselor, you may have an opportunity to help mentor those who are newer to counseling.

Regardless of your skill level as a counselor, it is important to learn how to effectively handle questions that are asked of SMPs across the country and in your local area, including providing a professional, accurate, and consistent response.

Additional Training

Prior to beginning your work as an SMP counselor, it is important to complete any additional training that may be needed for this role. Talk with your SMP director or coordinator of volunteers for more information about additional training.

- **SMP Foundations Training:** SMP Foundations Training provides a foundation of knowledge about the SMP program, Medicare basics, and Medicare fraud, errors, and abuse. It is recommended that you complete the SMP Foundations Training prior to this SMP Counselor Training.
- **Privacy and Confidentiality Training:** SMP counseling sessions often require access to confidential Medicare beneficiary information. Since you will be handling sensitive information as an SMP counselor, it is recommended that you take Privacy and Confidentiality Training in addition to SMP Counselor Training.
- **SIRS Training:** All SMP counseling sessions are entered into SIRS (the SMP Information and Reporting System) as "individual interactions." If your SMP expects you to enter data about your own counseling sessions, you will need to take training on how to use SIRS.
- **Other Training:** Your SMP may also require you to take other training, depending on your specific role at your SMP. For example, if you will handle complex interactions, SMP Complex Interactions Training will be needed.

SMP Training in TRAX

SMP training on a variety of topics is available in TRAX: Training Tracker, as described in Appendix E.

State and Local Information #1: SMP Roles

Which role(s) will you perform for your SMP? Will you perform other roles than SMP counselor (e.g., presenter or complex interactions specialist)? If you're not sure, talk with your SMP director or coordinator of volunteers.

State and Local Information #2: Training

What training is expected of you as an SMP counselor? For more information about expectations in your state, see your SMP job description and/or talk with your SMP director or coordinator of volunteers.

State and Local Information #3: SIRS Data Entry

Will you enter individual interactions and/or other data in SIRS? If you're not sure, talk with your SMP director or coordinator of volunteers.

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CHAPTER 1: Types of SMP Questions

SMP Individual Interactions

As mentioned in SMP Foundations Training, the mission of the Senior Medicare Patrol (SMP) program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. The SMP mission involves educating beneficiaries about the SMP program, outreach and education events, volunteer opportunities, and/or potential Medicare fraud, errors, and abuse.

Individual interactions are questions received by the SMP program that result in conversations related to the SMP mission. As the name implies, individual interactions take place with one individual as opposed to a group presentation, although caregivers and/or family members may also be present.

The total number of SMP individual interactions is reported to the Office of Inspector General (OIG) in the SMP's annual OIG Report. This means that **all** individual interactions **must** be entered into SIRS (the SMP Information and Reporting System).

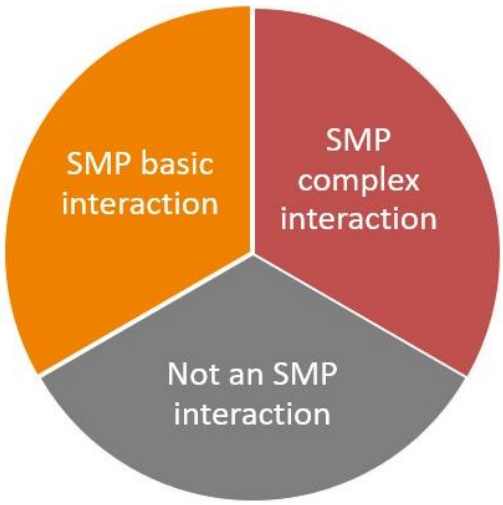
This chapter describes the two types of individual interactions that are managed by SMPs: basic and complex.

SMP Individual Interactions

Any time spent assisting a Medicare beneficiary, caregiver, or family member one-on-one on a topic related to the SMP mission is an individual interaction.

Note: The term "beneficiary" is used throughout this manual to include the Medicare beneficiary, family members, caregivers, and others who receive SMP services.

- **Basic interactions** focus on educating and informing Medicare beneficiaries, their families, and caregivers about preventing, detecting, and reporting health care fraud, errors, and abuse.
- **Complex interactions** require additional actions beyond providing education or information.



Although both types of interactions are counted as individual interactions in SIRS and on the OIG Report, it's important to know which is which, because different processes and training are needed for basic vs. complex interactions.

This chapter also describes how to distinguish SMP individual interactions from other types of questions that are not SMP interactions. Questions that are not related to SMP are not entered into SIRS or included on the OIG Report.

State and Local Information #4: Individual Interactions at your SMP

At a local level, your SMP makes a difference! The efforts of each state contribute to the national totals. How many individual interactions did your SMP handle in your state last year and how many does your SMP hope to handle this year? If you don't know, ask your SMP director or coordinator of volunteers.

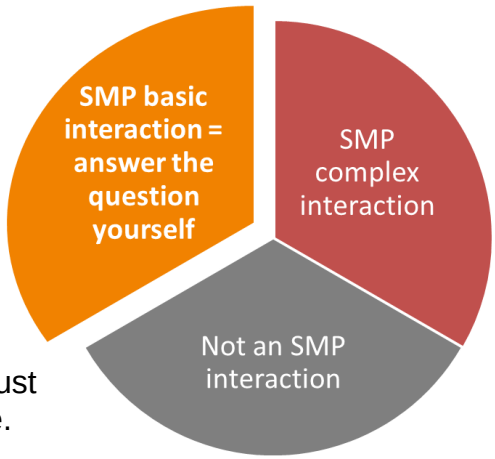
Color-coding

The following color-code is used throughout this manual and in related SMP training materials:

- Orange = SMP basic interaction
- Red = SMP complex interaction
- Gray = Not an SMP interaction

Basic Interactions

Basic interactions focus on educating and informing Medicare beneficiaries, their families, and caregivers about preventing, detecting, and reporting health care fraud, errors, and abuse.



Key Points About Basic Interactions

- Basic interactions are important outreach activities of the SMP program.
- Basic interactions involve questions that can be resolved by providing education or information about the SMP program.
- Basic interactions can take as little time as just a few minutes or as long as an hour or more.
- Basic interactions take place in a variety of settings. For example:
  - At the SMP office
  - Over the phone
  - Online
  - After a group education session, if an individual wants to discuss a specific concern (NOT as part of a group question-and-answer session)

SMP Basic Interactions

If an individual interaction can be resolved by providing education or information on a topic related to the SMP mission, it's a **basic** interaction.

When meeting with a beneficiary, if their question is an SMP basic interaction, you can answer it yourself using your knowledge and skills as an SMP counselor.

  - At an SMP exhibit at a health fair, if an individual wants to discuss a specific concern

- As part of beneficiary education, you may need to review personal identifying information and/or documentation, such as Medicare cards or numbers, MSNs, EOBs, and/or information about a medical condition.
  - For example, you may need to look at the beneficiary's MSN or EOB with them in order to teach them how to read it and look for areas of potential fraud, errors, or abuse. You'll learn more about how to read MSNs and EOBs in Chapter 2.
  - If the beneficiary doesn't have documents with them that are needed to answer their question, you may need to schedule another basic interaction so they can bring their documentation for review.
  - If the beneficiary's question requires additional action beyond providing education or information, you should send them to someone at your SMP who handles complex interactions (known as a complex interactions specialist) for follow-up as needed.
- For basic interactions, additional follow-up may be needed by the SMP in order to find an answer to the question, but no additional action (such as a referral) is needed by the SMP to resolve an issue.
- In addition to educating beneficiaries, basic interactions are also used to help identify potential fraud, errors, or abuse. If additional follow-up is needed by the SMP, the interaction is considered a complex interaction.

Basic Interactions and SMP Counselor Training

Basic interactions are the focus of this SMP Counselor Training. You will learn more about basic interactions and how to handle these types of questions and conversations throughout the rest of this training.

Confidentiality

SMP counselors need to ensure that they are protecting beneficiary information, including protected health information (PHI) and personal protected information (PPI).

Follow your SMP's processes regarding maintaining the confidentiality of beneficiary personal information, including taking any necessary training as described in the training overview at the beginning of this manual.

Examples of Basic Interactions

Examples of SMP basic interactions include:

- General information about the SMP program
- A request for information about an upcoming SMP presentation
- A request for a copy of a publication that your SMP recently released
- A request for information about becoming an SMP volunteer
- Basic, individualized education about how to read an MSN or EOB, use the My Health Care Tracker, and/or recognize Medicare fraud, errors, and abuse

Two Ways to Handle Basic Interactions

As an SMP counselor, you have two options when handling basic interactions: answer the question while you're with the beneficiary or take some time to get an answer and follow up with the beneficiary later.

1) If you know the answer to the question, you can answer it while you are talking with the beneficiary. If you don't know the answer but think you can find it quickly, you may ask the beneficiary to wait while you review your resources. You will learn more about how to answer questions in Chapter 5.

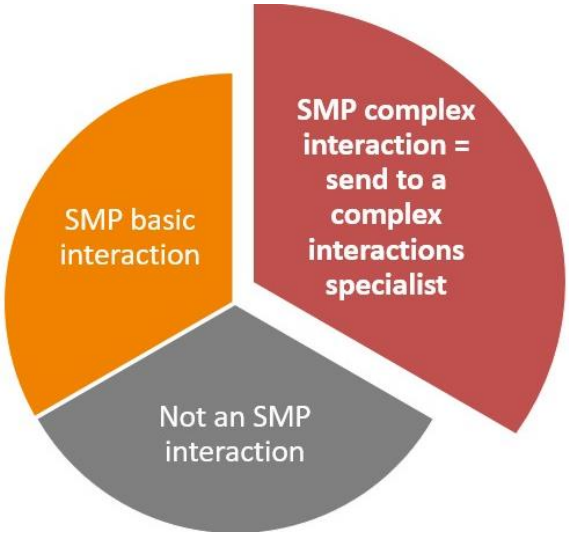
2) If you don't know the answer and don't want to keep the beneficiary waiting while you find it – or if they don't have time to wait – let them know that you will get an answer and call them back. Getting an answer and calling back is a common practice for SMP counselors, especially at first. If you need to call the person back, make sure to get their name, phone number, and the best time to reach them.

Asking for Help

Don't be afraid to ask for help or admit when you don't know the answer! Never provide an answer if you aren't 100% confident that it's accurate!

Complex Interactions

Complex interactions require additional actions beyond providing education or information. Examples of these additional actions include conducting research, following up with a provider or 1-800-Medicare, or making a referral. Complex interactions require additional training. If you have not been trained to handle complex interactions, send these types of questions to someone at your SMP who has been trained to handle them (aka a complex interactions specialist).



Key Points About Complex Interactions

- Like basic interactions, complex interactions are related to the SMP mission. To be considered a complex interaction, there must be a complaint of potential fraud, errors, or abuse that needs further research or other SMP follow-up.

- Complex interactions are questions that generally require the SMP team member to obtain and review beneficiary personal identifying information and/or information related to the issue, complaint, or allegation in order to conduct further research or referral.

    - If copies of documentation (such as MSNs or EOBs) must be collected from the beneficiary and kept in the SMP's possession in order to resolve the problem, it's a complex interaction.

- Addressing potential fraud, errors, and abuse is all complex interactions work. If any of these is suspected, it will require follow-up by the SMP and/or other appropriate

SMP Complex Interactions

If an individual interaction **cannot** be resolved by providing education or information and requires additional action on behalf of the SMP to resolve a complaint of potential fraud, error, or abuse, it's a **complex** interaction.

When discussing fraud and abuse with clients and other SMPs, keep in mind the concept of "innocent until proven guilty." Because of this, SMPs use the terms "suspected" or "potential" fraud and abuse.

entities to make the final determination, take action, and achieve a remedy for Medicare, Medicaid, and/or the beneficiary.

- Complex interactions are typically resolved with a great amount of time, research, and/or review.
    - They cannot be resolved in a single phone call or conversation.

Complex interactions involve cases of potential fraud, abuse, **and** errors. In some situations, what looks like fraud could be an error or vice versa.

State and Local Information #5: Documentation

The beneficiary may bring their MSNs, EOBs, and/or other documentation with them to an individual counseling session. During the session, you can teach the beneficiary how to read their MSNs and/or EOBs and answer their questions. However, if you suspect fraud, errors, or abuse, copies of these documents may be needed for complex interactions cases.

What are your SMP's processes for handling beneficiary sensitive, personal identifying information and reviewing beneficiary documents, both in person and online? If you need to send the beneficiary to an SMP complex interactions specialist, how does your SMP handle the collection and transfer of documents? Talk to your SMP director and/or coordinator of volunteers to make sure you're familiar with your SMP's processes related to reviewing and handling documentation.

- Complex interactions often require the SMP to act or speak on behalf of the beneficiary.
    - They cannot be resolved by providing education or information; additional action must be taken by the SMP to resolve a problem.
    - A release of information form allows the SMP to act or speak on behalf of the beneficiary. If one is needed, it's a complex interaction.
- Complex interactions may result in an "SMP referral."
    - SMPs use the term "referral" when the SMP works with outside agencies on behalf of the beneficiary to resolve the issue.
    - SMP cases that need to be referred to outside organizations are always complex interactions.
- Complex interactions may be identified as part of a basic interaction.
- Complex interactions require extensive training.

- A significant amount of subject-matter education, training, and/or experience is necessary to address complex interactions.
- If you are not trained to handle complex interactions, make sure you know who handles them at your SMP.

Counselors vs. Complex Interactions Specialists

SMP counselors help beneficiaries read their statements. SMP complex interactions specialists help beneficiaries address fraud, errors, or abuse. If reviewing the beneficiary's MSN or EOB reveals questionable charges, send the beneficiary to an SMP complex interactions specialist.

SMP Complex Interactions Training

Separate SMP Complex Interactions Training must be completed prior to handling complex interactions.

Examples of Complex Interactions

Examples of SMP complex interactions include:

- A report of a potential error made by a provider in billing Medicare that the provider is unwilling to acknowledge or resolve
- A report of a solicitation offering durable medical equipment or genetic testing kits, resulting in the company providing equipment or supplies that have not been ordered by the beneficiary's physician
- A beneficiary reports giving out their Medicare number over the phone to someone claiming to be from Medicare or Social Security
- A beneficiary calls to report a Medicare scam that they avoided
- A beneficiary has been switched to hospice even though they aren't terminally ill, and now they're being denied necessary medical treatment

Sometimes a conversation with a beneficiary that starts as a basic interaction may later turn into a complex interaction. These questions should be sent to a complex interactions specialist for follow-up.

- A beneficiary sees a charge on their MSN or EOB for a service they never received, from a provider they don't know
- A representative from a senior housing complex reports that residents are being offered money or gifts as incentives to utilize specific providers or services

The SMP Counselor Role

SMP counselors don't handle complex interactions unless they have received SMP Complex Interactions Training. If you have not been trained to handle complex interactions, please send them to a complex interactions specialist.

Too Complex to Decide?

Certain topics can be so complicated that it's best to let someone trained in complex interactions determine whether the question is a basic interaction, a complex interaction, or not an SMP interaction.

Here are a few examples:

- A beneficiary calls because they just gave out their Social Security number and they don't think they should have.
- A beneficiary calls requesting help, saying Medicare won't pay because the beneficiary has other insurance.
- A beneficiary calls complaining about advertisements for Medicare-related plans or Medicare-covered products that they think are misleading.
- A caregiver calls with concerns about poor quality of care in the medical services their mother is receiving.

If you aren't sure, rather than trying to handle the question yourself, send the beneficiary to a complex interactions specialist.

Note: If you **have** been trained as a complex interactions specialist, see your *SMP Complex Interactions Training Manual* for help with a variety of complex situations.

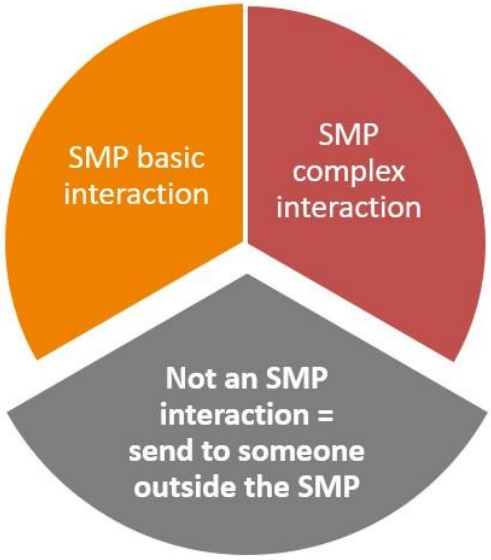
Questions That Aren't SMP Interactions

It's only natural that organizations that help people will get questions outside of their program's scope of work. The same is true for SMP. Although many questions received by SMPs are related to the SMP mission, some are not. Questions that aren't related to the SMP mission should be sent to organizations outside of the SMP that are prepared to handle each type of question.

Remember the SMP Mission:

To empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education

Key Points About Questions That Aren't SMP Interactions



- To properly identify which questions should be handled by the SMP and which should be sent to someone outside of the SMP, consider the SMP mission and review the information provided throughout this SMP Counselor Training.
- Questions that aren't related to the SMP mission are **not** counted on the OIG Report as SMP individual interactions, regardless of how much time is spent answering the question.
- It is important to make sure that SMPs are handling every possible issue that should be addressed by the SMP while not taking SMP time to address issues that are not part of the SMP mission.
- As an SMP counselor, you will need to determine who is best suited to answer each question that isn't an SMP interaction. If the question is not related to the SMP mission, you can help the beneficiary by sending them to an organization outside of the SMP that has the appropriate expertise. In this way, SMPs remain in their role without ignoring other important beneficiary needs and while ensuring that SMP time is spent focusing on questions that **are** related to the SMP mission.

- Providing resources and/or guidance for these types of questions is commonly called "information and assistance services." In such cases, you will give out relevant contact information to the beneficiary, empowering them to contact that organization on their own behalf. See Appendix B: Contacts Outside of the SMP for a list of organizations that may be able to assist beneficiaries when their questions are outside of the scope of the SMP mission.

"Information and assistance services" that are not related to the SMP mission are **not** considered to be SMP individual interactions.

Examples of Questions that Aren't SMP Interactions

Examples of services handled by organizations outside of the SMP include:

- Consumer protection issues that are not related to the SMP mission; questions about scams or identity theft that are not related to Medicare, such as the grandparent scam or romance scams
- Internet crime schemes, such as email spam, "you have won the lottery" emails, and phishing (unsolicited emails that entice an individual to visit a fraudulent website and provide sensitive, personal information)
- Benefits counseling; questions about which Medicare plan is best for the beneficiary
- Medicare appeals; a question related to an appeal that the beneficiary is filing
- Coverage questions, such as whether Medicare or Medicaid will cover a nursing home stay
- Change of address for Medicare and/or Social Security
- Other information and assistance in the field of aging

Although you won't answer these types of questions directly, it will be part of your role as an SMP counselor to get the beneficiary pointed in the right direction for help. You'll learn about where to send these kinds of questions later in this manual, particularly in Chapter 5 and Appendix B.

SMP vs. Other Counseling Programs

In some states, team members assigned to SMP counseling may also "wear other hats." Put another way, this means individual staff, partners, and volunteers may perform work for multiple programs, sometimes at the same time. The hat they wear in a given moment depends on the specific question they are addressing. For example, they may counsel for a SHIP (State Health Insurance Assistance Program), an AAA (Area Agency on Aging), or an ADRC (Aging and Disability Resource Center). Those are just a few common programs that, like SMP, serve older adults, often with the help of volunteers.

This manual is dedicated to SMP-specific activities and reporting. It is outside the scope of this manual to address the reporting requirements of other counseling programs. Naturally, if you wear only an SMP hat and all of your efforts are dedicated entirely to SMP work, more of the questions you answer will be reportable in SIRS.

SMP Role vs. Other Roles

If you are an SMP team member who wears multiple "hats," consider which hat you are wearing when you are conducting and reporting your activities. Know the difference between work done by the SMP vs. work done by other counseling programs in your state. Questions you answer as part of your role with other counseling programs should be reported to the funders of those other programs.

State and Local Information #6: How Many "Hats" Do You Wear?

Is your SMP also a SHIP, ADRC, and/or other counseling service? Will you be expected to do other types of counseling in addition to your work as an SMP counselor? If your answers are "yes," this will affect the way you report your efforts to your agency. Many agencies juggle multiple reporting requirements. Ask your SMP director or coordinator of volunteers for guidance.

Identifying Types of SMP Questions

The chart below reviews some of the highlights that will help you determine whether a question is an SMP basic interaction, an SMP complex interaction, or not an SMP question:

Basic Interaction	Complex Interaction	NOT an SMP Question
Is related to the SMP mission	Is related to the SMP mission	Is **not** related to the SMP mission
A meeting between the SMP and a beneficiary or caregiver to educate or provide information related to the SMP program and/or potential health care fraud, errors, or abuse	An issue, complaint, or allegation that requires detailed information in order to conduct further research or referral to outside agencies that can resolve the problem (such as the OIG and/or CMS); speaking or acting on behalf of the beneficiary may also be needed	Consumer protection issues, scams, or identity theft, such as the grandparent scam or romance scams
Answering a question	Researching a solution to a problem	Internet crime schemes
A single contact with the beneficiary with little or no follow-up	Multiple contacts with the beneficiary and others are required	Benefits counseling
Sometimes requires review of personal identifying information and/or documentation	Almost always requires review and collection of personal identifying information and/or documentation	Medicare appeals
Can be resolved by providing education or information to answer a question	Cannot be resolved by providing education or information alone; additional actions must be taken by the SMP to resolve a problem	Coverage questions
Handled by SMP counselors	Handled by SMP complex interactions specialists	Handled by someone outside the SMP

See Appendix A: Types of SMP Questions Flow Chart to determine if a question is a basic interaction, a complex interaction, or not an SMP interaction.

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CHAPTER 2: How to Read MSNs and EOBs

Overview

Two types of statements are received by Medicare beneficiaries: MSNs (Medicare Summary Notices) and EOBs (Explanations of Benefits). Both MSNs and EOBs are statements, not bills.

MSNs	EOBs
Beneficiaries enrolled in Original Medicare (Parts A and B) receive MSNs. MSN design is standard, since all MSNs come directly from Medicare.	Beneficiaries enrolled in Medicare Advantage (Part C) plans or Medicare Prescription Drug Plans (Part D) receive EOBs. EOB design varies from plan to plan. However, CMS issues requirements about the type of information EOBs must include.

In this chapter, you will learn how to help beneficiaries review their MSNs and EOBs to detect potential fraud, errors, and abuse.

MSNs and EOBs explain:

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

Reviewing MSNs and EOBs

When reviewing the beneficiary's MSN or EOB, here are some general questions to consider:

- Did the beneficiary receive the service, product, or test?
- Did the doctor order this service, product, or test?
- Was the beneficiary billed for the same service, product, or test more than once?
- Is the charge or service related to the beneficiary's condition or treatment?

MSN & EOB Review Is Critical!

When MSNs and EOBs are received, it is important for beneficiaries to review them immediately and check for mistakes. The My Health Care Tracker (Chapter 3) and the Medicare Statements Tip Sheet outline information to look for on MSNs and EOBs. Use these resources to guide beneficiaries through the MSN review process and share them with beneficiaries to use when reviewing their own MSNs and EOBs. For more about resources, see Appendix E.

eMSNs

Instead of receiving paper MSNs, Medicare beneficiaries can have their MSNs delivered electronically as eMSNs by visiting Medicare.gov to log into (or create) a secure Medicare account. After signing up, an email is sent to the beneficiary letting them know when each new eMSN is available at Medicare.gov.

Information to Look for on MSNs and EOBs

The following chart, excerpted from the Medicare Statements Tip Sheet, provides a checklist of items to look for when reviewing MSNs and EOBs.

Plan	Coverage	Statement	Information to Look for
Medicare Part A (Hospital Insurance)	Inpatient hospital, skilled nursing facility, home health, and hospice care (the MSNs for each of these is a bit different)	MSN (quarterly or online at Medicare.gov)	• Date of Service • Provider Name and Address • Benefit Days Used • Claim Approved? (Yes or No) • Non-Covered Charges • Amount Medicare Paid • Maximum You (Beneficiary) May Be Billed • Notes for Claim • Appeals Information • QMB Status
Medicare Part B (Medical Insurance)	Outpatient services (doctor visits, lab tests, medical equipment, ambulance, immunizations, screenings, and more)	MSN (quarterly or online at Medicare.gov)	• Date of Service • Provider Name and Address • Service Provided & Billing Code (or Quantity & Service Provided) • Service Approved? (Yes or No) • Amount Provider Charged • Medicare-Approved Amount • Amount Medicare Paid • Maximum You (Beneficiary) May Be Billed • Notes for Claim • Appeals Information • QMB Status
Medicare Part C (Medicare Advantage)	Medicare-covered benefits and others, according to the beneficiary's Medicare Advantage plan	Explanation of Benefits (EOB) from the Medicare Advantage plan (monthly, if benefits are used)	The beneficiary's MA plan provides an Explanation of Benefits statement that describes what the plan has covered.
Medicare Part D (Prescription Insurance)	Prescription drugs	Explanation of Benefits (EOB) from the drug plan (monthly, if benefits are used)	• Year-to-date costs in the drug plan • Total out-of-pocket and drug costs • Current coverage information (deductible, coverage gap, etc.) • Summary of claims since last EOB • Any updates to the plan's formulary
Supplemental Insurance (Medigap)	Benefits covered by private insurers	Explanation of Benefits (EOB) from Medigap company	• Total charges • What Medicare paid • What Medigap paid

Sample MSN – Part A

Sample MSNs provided by CMS at www.Medicare.gov

Medicare Summary Notice 1
for Part A (Hospital Insurance)

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

2

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME
STREET ADDRESS
CITY, ST 12345-6789 3

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	**1EG4-TE5-MK72**
Date of This Notice	**September 16, 20XX**
Claims Processed Between	**June 15 – September 15, 20XX**

Your Deductible Status 4

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You have now met your **$X,XXX.00** deductible for **inpatient hospital** services for the benefit period that began May 27, 20XX

Be Informed!

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

Your Claims & Costs This Period 5

Did Medicare Approve All Claims? **YES**

See page 2 for how to double-check this notice.

Total You May Be Billed **$2,898.50**

Facilities with Claims This Period 6

June 18 – June 29, 20XX
Otero Hospital

July 1 – July 18, 20XX
Lexington Health Center

1 – MSN Title. The title is large and bold.

2 – DHHS Logo. The official U.S. Department of Health & Human Services (DHHS) logo.

3 – Beneficiary Information. Beneficiaries should check their name, their Medicare number, the date the Medicare contractor issued the MSN, and the dates of the claims listed. The MSN reports claims for a three-month period.

4 – (Part A) Deductible Status. Beneficiaries owe a deductible at the start of a benefit period before Medicare pays for Part A services. They can check their deductible information under "Your Deductible Status." Beneficiaries may face more than one Part A deductible in a calendar year; see the "Benefit Periods" section on the MSN.

5 – Claims & Costs This Period. This feature indicates if Medicare approved or denied claims within the three-month MSN claim period as well as **the total the provider(s) can bill the beneficiary**. The beneficiary's cost normally is the sum of the unmet deductible and coinsurance charges for inpatient hospital and SNF (skilled nursing facility) stays.

6 – Facilities with Claims This Period. This section names the hospitals, SNFs, and hospice providers that submitted claims during the three-month MSN claim period. The beneficiary should verify the list of dates for services received during this claim period.

7 – Help in Other Languages. For help in a language other than English or Spanish, call 1-800-Medicare and say "Agent." Say the language needed for free translation services.

7

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要国语帮助，请致电联邦医疗保险，请先说"agent"，然后说"Mandarin"。 **1-800-MEDICARE (1-800-633-4227)**

Sample MSN – Part A

Jennifer Washington

Making the Most of Your Medicare (1)

How to Check This Notice (2)

Do you recognize the name of each facility? Check the dates. Did you have a service or visit that day?

Did you get the claims listed? Do they match those listed on your receipts and bills?

If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

How to Report Fraud (3)

If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).

Some examples of fraud include offers for free medical services, or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

You can make a difference! Last year, Medicare saved tax-payers **$4.2 billion**—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

How to Get Help with Your Questions (4)

1-800-MEDICARE (1-800-633-4227)
Ask for "hospital services." Your customer-service code is 05535.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call **1-555-555-5555.**

1 – Section Title. This helps beneficiaries find where they are in the MSN with its many sections. Titles are on the top of each page.

2 – How to Check This Notice. Medicare offers helpful tips on what to check when reviewing the MSN. The questions are part of Medicare's effort to enlist beneficiaries' help in catching mistakes and spotting potential fraud.

3 – How to Report Fraud. Beneficiaries can help Medicare save money by reporting fraud! This section places Medicare's key fraud prevention messages prominently on the MSN. It directs beneficiaries to call 1-800-Medicare. SMPs typically encourage beneficiaries to contact their local SMP to report suspected fraud.

4 – How to Get Help with Questions. Beneficiaries should call 1-800-Medicare with questions or concerns about the claim. They should contact the SHIP (State Health Insurance Assistance Program) for help with Medicare plan comparisons, Medigap information, and appeals.

Jennifer Washington

Sample MSN – Part A

Making the Most of Your Medicare

5 – Benefit Periods. This section explains how the Part A benefit period works. It also reports the number of covered inpatient hospital and SNF days that remain in the benefit period.

6 – Messages from Medicare. Medicare updates these messages regularly, so beneficiaries should check them on each MSN they receive. They will find information here about new preventive benefits and seasonal benefits such as the flu vaccine.

Your Benefit Periods 5

Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.

Inpatient Hospital: You have **56 out of 90 covered benefit days** remaining for the benefit period that began May 27, 20XX.

Skilled Nursing Facility: You have **65 out of 100 covered benefit days** remaining for the benefit period that began May 27, 20XX.

See your "Medicare & You" handbook for more information on benefit periods.

Your Messages from Medicare 6

If you haven't gotten your flu vaccine, it isn't too late. Please contact your health care provider about getting the vaccine.

Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

You can now get your Medicare Summary Notices (MSNs) online! Receive your electronic MSNs (eMSNs) every month by signing up at https://www.medicare.gov/forms-help-and-resources/e-delivery.html.

Medicare eBooks give you fast and free information at your fingertips! They can be viewed on all types of eReaders, sucha as the iPad or Kindle, and we add new eBooks all the time. Find them at https://www.medicare.gov/pubs/ebook/ebooks.html.

Jennifer Washington | **Sample MSN – Part A** | THIS IS NOT A BILL | Page 3 of 4

Your Inpatient Claims for Part A (Hospital Insurance) 1

Part A Inpatient Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Definitions of Columns 2

Benefit Days Used: The number of covered benefit days you used during each hospital and/or skilled nursing facility stay. (See page 2 for more information and a summary of your benefit periods.)

Claim Approved?: This column tells you if Medicare covered the inpatient stay.

Non-Covered Charges: This is the amount Medicare didn't pay.

Amount Medicare Paid: This is the amount Medicare paid your inpatient facility.

Maximum You May Be Billed: The amount you may be billed for Part A services can include a deductible, coinsurance based on your benefit days used, and other charges.

For more information about Medicare Part A coverage, see your "Medicare & You" handbook.

July 1 – July 18, 20XX 3

Lexington Health Center, (555) 555-1234
815e Irving Park Rd, Streamwood, IL 60107-3073
Referred by Warren Pierce

4	Benefit Days Used	Claim Approved? 5	Non-Covered Charges	Amount Medicare Paid	6 Maximum You May Be Billed	See Notes Below
Benefit Period starting May 27, 20XX	17 days	Yes	$0.00	$7,012.27	**$2,062.50**	
Total for Claim #21034400232702ILA			$0.00	$7,012.27	**$2,062.50**	**A,B**

1 – Type of Claim. Claims for inpatient hospital, skilled nursing facilities (SNFs), home health, or hospice services.

Note: *Part B hospital outpatient claims are shown in a format similar to Part A inpatient claims. Both may appear in the same MSN.*

2 – Definitions. Terms Medicare uses to explain its coverage and payment decisions.

3 – Your Visit. Dates the beneficiary received services from the Part A provider. Beneficiaries should keep their bills and compare them to the MSN to ensure they received all the services listed.

4 – Benefit Period and Benefit Days Used. When the beneficiary's current benefit period began and how many covered inpatient hospital or SNF days were used.

5 – Claim Approved? Medicare's decision to approve or deny coverage is shown here.

6 – Max That May Be Billed. The total amount the facility can bill the beneficiary. It's highlighted and in bold for easy reading. The beneficiary or a supplemental insurance policy owes this to the provider.

7 – Notes. See the bottom of the page for explanations of the items and supplies the beneficiary received. This section explains reasons for coverage denials, crossover claims to supplemental insurance companies, and more.

Notes for Claims Above 7

A Days are being subtracted from your total inpatient hospital benefits for this benefit period. The "Your Benefit Periods" section on page 2 has more details.

B $2,062.50 was applied to your skilled nursing facility coinsurance.

Jennifer Washington

Sample MSN – Part A

How to Handle Denied Claims or File an Appeal

Get More Details

1

If a claim was denied, call or write the hospital or facility and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the facility to contact our claims office to correct the error. You can ask the facility for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

If You Disagree with a Coverage Decision, Payment Decision, or Payment Amount on this Notice, You Can Appeal

2

Appeals must be filed in writing. Use the form to the right. Our claims office must receive your appeal within 120 days from the date you get this notice.

We must receive your appeal by:

January 14, 20XX

If You Need Help Filing Your Appeal

3

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your facility: Ask your facility for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Find Out More About Appeals

For more information about appeals, read your "Medicare & You" handbook or visit us online at www.medicare.gov/appeals.

1 – Get More Details. Beneficiaries can call 1-800-Medicare to learn what to do about denied claims. Note that providers can submit corrected claims when the original claim was mistaken.

2 – Beneficiaries Can File an Appeal. Beneficiaries have 120 days to appeal claim denials. The appeal deadline is shown in the text box. Note that Medicare can extend the appeal deadline for "good cause," including serious illness and death in the family.

3 – If a Beneficiary Needs Help Filing an Appeal. Beneficiaries should call 1-800-Medicare with questions or concerns about the claim. They should contact the SHIP for help with Medicare plan comparisons, Medigap information, and appeals.

Customer service representatives (CSRs) at 1-800-Medicare will explain reasons for coverage denials and send copies upon request of the basis used to deny payment on the claim.

CSRs also provide general information about appeals. The SHIP program is also a resource on this topic. Health care providers may sometimes appeal denials themselves.

Note: If additional Medicare claims occur beyond what will fit on page 3 of the MSN, the claim information is shown on additional pages following page 3. The information shown on page 4 of this sample MSN will always appear on the last page of the MSN, regardless of the number of pages needed for claims.

Jennifer Washington

Sample MSN – Part A

THIS IS NOT A BILL | Page 4 of 4

How to Handle Denied Claims or File an Appeal

4 – Appeals Form. Beneficiaries must file appeals of coverage denials in writing. This first step in the appeals process is called a "redetermination request." Beneficiaries should follow the step-by-step directions when filling out the form and take special note of numbers 5 and 6 about identifying and copying all documents sent with the redetermination request.

File an Appeal in Writing

4

Follow these steps:

1 Circle the service(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your facility for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o Contractor Name
Street Address
City, ST 12345-6789

Note: This address may be different depending on the type of claim. Medicare works with a number of different payment contractors who receive appeal requests.

MSNs: Part A vs. Part B…
What's the Difference?

	Part A	Part B
Coverage	Hospital insurance	Medical insurance
Page 1	"Facilities with Claims this Period"	"Providers with Claims this Period"
Page 2	"Your Benefit Periods"	"Medicare Preventive Services"
Page 3	"Benefit Period"	"Service Descriptions"
Last Page	N/A (no difference)	

Sample MSN – Part B

Sample MSNs provided by CMS at www.Medicare.gov

Medicare Summary Notice 1
for Part B (Medical Insurance)

Page 1 of 4

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

2

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME 3
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	**1EG4-TE5-MK72**
Date of This Notice	**September 16, 20XX**
Claims Processed Between	**June 15 – September 15, 20XX**

Your Deductible Status 4

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met **$85.00** of your **$XXX.00** deductible for 20XX.

Be Informed!

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

Your Claims & Costs This Period 5

Did Medicare Approve All Services?	**NO**
Number of Services Medicare Denied	**1**

See claims starting on page 3. Look for **NO** in the "Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed	**$80.88**

Providers with Claims This Period 6

June 18, 20XX
Steven Thiele D C

June 28, 20XX
Leo Zygelman, CH

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果需要国语帮助, 请致电联邦医疗保险, 请先说"agent", 然后说" Mandarin".
1-800-MEDICARE (1-800-633-4227) 7

1 – MSN Title. The title is large and bold.

2 – DHHS Logo. The official U.S. Department of Health & Human Services (DHHS) logo.

3 – Beneficiary Information. Beneficiaries should check their name, their Medicare number, the date the Medicare contractor issued the MSN, and the dates of the claims listed. The MSN reports claims for a three-month period.

4 – (Part B) Deductible Status. Beneficiaries pay a yearly deductible for Part B services before Medicare pays. They can check the status of their deductible on page 1 of the MSN. The Part B approved amount applies to the deductible.

NOTE: In this sample, the deductible status is not consistent with the claim shown on page 28.

5 – Claims & Costs This Period. This feature indicates if Medicare approved or denied claims within the three-month MSN claim period as well as **the total amount the provider(s) can bill the beneficiary**. The total usually includes the sum of the unmet deductible and 20 percent coinsurance, but it also may include excess charges for unassigned claims and charges for excluded services.

6 – Providers with Claims This Period. This section names the providers, including physicians and labs, who submitted claims during the three-month period. Beneficiaries should verify the providers and dates of service.

7 – Help in Other Languages. For help in a language other than English or Spanish, call 1-800-Medicare and say "Agent." Say the language needed for free translation services.

Sample MSN – Part B

Jennifer Washington THIS IS NOT A BILL | Page 2 of 4

Making the Most of Your Medicare 1

How to Check This Notice 2

Do you recognize the name of each doctor or provider? Check the dates. Did you have an appointment that day?

Did you get the services listed? Do they match those listed on your receipts and bills?

If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

How to Report Fraud 3

If you think a provider or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

You can make a difference! Last year, Medicare saved tax-payers **$4.2 billion**—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

How to Get Help with Your Questions 4

1-800-MEDICARE (1-800-633-4227)
Ask for "doctors services." Your customer-service code is 05535.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call 1-555-555-5555.

1 – Section Title. This helps beneficiaries find where they are in the MSN, with its many sections. Titles are on the top of each page.

2 – How to Check This Notice. Medicare offers helpful tips on what to check when reviewing the MSN. The questions are part of Medicare's effort to enlist beneficiaries' help in catching mistakes and spotting potential fraud.

3 – How to Report Fraud. Beneficiaries can help Medicare save money by reporting fraud! This section places Medicare's key fraud prevention messages prominently on the MSN. It directs beneficiaries to call 1-800-Medicare. SMPs typically encourage beneficiaries to contact their local SMP to report suspected fraud.

4 – How to Get Help with Questions. Beneficiaries should call 1-800-Medicare with questions or concerns about the claim. They should contact the SHIP for help with Medicare plan comparisons, Medigap information, and appeals.

Jennifer Washington

Sample MSN – Part B

Making the Most of Your Medicare

5 – Preventive Services. Many Medicare beneficiaries are unaware of Medicare's preventive services and that the program covers many services at 100 percent of the approved amount. Look for the apple icon, indicating a preventive service, in the *Medicare & You* handbook.

6 – Messages from Medicare. Medicare updates these messages regularly, so beneficiaries should check them on each MSN they receive. They will find information here about new preventive benefits and seasonal benefits such as the flu vaccine.

Medicare Preventive Services 5

Medicare covers many free or low-cost exams and screenings to help you stay healthy. For more information about preventive services:

- Talk to your doctor.
- Look at your "Medicare & You" handbook for a complete list.
- Visit www.Medicare.gov for a personalized list.

Your Messages from Medicare 6

Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.

To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

Want to see your claims right away? Access your Original Medicare claims at www.Medicare.gov, usually within 24 hours after Medicare processes the claim. You can use the "Blue Button" feature to help keep track of your personal health records.

Jennifer Washington

Sample MSN – Part B

THIS IS NOT A BILL | Page 3 of 4

Your Claims for Part B (Medical Insurance) 1

Part B Medical Insurance helps pay for doctors' services, diagnostic tests, ambulance services, and other health care services.

Definitions of Columns 2

Service Approved?: This column tells you if Medicare covered this service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged.

Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid your provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

June 18, 20XX 3

Dr. Susan Jones, M.D., (555) 555-1234

Brevard County Physical Therapy Center, 32 Main Street, Brevard, NC 28712-4187

Service Provided & Billing Code 4	Service Approved? 5	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed 6	See Notes Below
Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minut (97110)	Yes	$45.00	$28.54	$22.83	**$5.71**	
Total for Claim #02-10195-592-677		$45.00	$28.54	$22.83	**$5.71**	A

1 – Type of Claim. Claims can either be assigned or unassigned.

Note: *Part B hospital outpatient claims are shown in a format similar to Part A inpatient claims. Both may appear in the same MSN.*

2 – Definitions. Terms Medicare uses to explain its coverage and payment decisions.

3 – Your Visit. Dates the provider delivered a service or item. Beneficiaries should keep their bills and compare them to the MSN to make sure they received all the services listed.

4 – Service Descriptions. This section describes the service(s) or item(s) the beneficiary received.

5 – Approved Column. Medicare's decision to approve or deny coverage is shown here.

6 – Max That May Be Billed. The total amount the provider can bill the beneficiary. It's highlighted and in bold for easy reading. A supplemental insurance policy may cover some, or all, of this amount.

7 – Notes. See the bottom of the page for explanations of the items and supplies the beneficiary received. This section explains reasons for coverage denials, crossover claims to supplemental insurance companies, and more.

Continued →

Notes for Claims Above 7

A **Your claim was sent to your Medicare Supplement Insurance (Medigap policy), Wellmark BlueCross BlueShield of N. Carolina.** Send any questions regarding your benefits to them.

Jennifer Washington

Sample MSN – Part B

How to Handle Denied Claims or File an Appeal

Get More Details

1

If a claim was denied, call or write the provider and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn't, ask the provider to contact our claims office to correct the error. You can ask the provider for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

2

If You Disagree with a Coverage Decision, Payment Decision, or Payment Amount on this Notice, You Can Appeal

Appeals must be filed in writing. Use the form to the right. Our claims office must receive your appeal within 120 days from the date you get this notice.

We must receive your appeal by:

January 13, 20XX

If You Need Help Filing Your Appeal

3

Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your provider: Ask your provider for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

Find Out More About Appeals

For more information about appeals, read your "Medicare & You" handbook or visit us online at www.medicare.gov/appeals.

1 – Get More Details. Beneficiaries can call 1-800-Medicare to learn what to do about denied claims. Note that facilities can submit corrected claims when the original claim was mistaken.

2 – Beneficiaries Can File an Appeal. Beneficiaries have 120 days to appeal claim denials. The appeal deadline is shown in the text box. Note that Medicare can extend the appeal deadline for "good cause," including serious illness and death in the family.

3 – If a Beneficiary Needs Help Filing an Appeal. Beneficiaries should call 1-800-Medicare with questions or concerns about the claim. They should contact the SHIP for help with Medicare plan comparisons, Medigap information, and appeals.

Customer service representatives (CSRs) at 1-800-Medicare will explain reasons for coverage denials and send copies upon request of the basis used to deny payment.

CSRs also provide general information about appeals. The SHIP may be able to help prepare the written appeal. Health care providers may sometimes appeal denials themselves.

Note: If additional Medicare claims occur beyond what will fit on page 3 of the MSN, the claim information is shown on additional pages following page 3. The information shown on page 4 of this sample MSN will always appear on the last page of the MSN, regardless of the number of pages needed for claims.

Jennifer Washington

Sample MSN – Part B

How to Handle Denied Claims or File an Appeal

4 – Appeals Form. Beneficiaries must file appeals of coverage denials in writing. This first step in the appeals process is called a "redetermination request." Beneficiaries should follow the step-by-step directions when filling out the form and take special note of numbers 5 and 6 about identifying and copying all documents sent with the redetermination request.

File an Appeal in Writing 4

Follow these steps:

1 Circle the service(s) or claim(s) you disagree with on this notice.

2 Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.

3 Fill in all of the following:

Your or your representative's full name (print)

Your or your representative's signature

Your telephone number

Your complete Medicare number

4 Include any other information you have about your appeal. You can ask your provider for any information that will help you.

5 Write your Medicare number on all documents that you send.

6 Make copies of this notice and all supporting documents for your records.

7 Mail this notice and all supporting documents to the following address:

Medicare Claims Office
c/o Contractor Name
Street Address
City, ST 12345-6789

Note: This address may be different depending on the type of claim. Medicare works with a number of different payment contractors who receive appeal requests.

The Not-So-Obvious Parts of the MSN

The following topics related to claims in Original Medicare give some context for questions that may arise as you review MSNs with beneficiaries, their families, or their caregivers.

Look for this

These boxes indicate text to look for on the beneficiary's MSN to help determine what has happened.

Advance Beneficiary Notice (ABN)

An ABN is a notice that a provider or supplier may have asked a beneficiary with Original Medicare to sign stating that Medicare may not pay for certain services. It provides the beneficiary an opportunity to choose whether or not to accept services that may not be covered by Medicare. In determining the appropriateness of charges to a beneficiary, you need to know if they signed an ABN. The ABN explains to the beneficiary that they will have to pay if Medicare doesn't.

There are many rules governing the use of ABNs. When the situation involves error or misunderstanding of Medicare rules, it can often be resolved at the beneficiary/provider level with SMP intervention, if needed. SMPs and beneficiaries should understand the following key points if a beneficiary has signed a legitimate ABN:

- ✓ The beneficiary may be responsible for all or part of the entire claim.
- ✓ If the beneficiary checked (on the ABN) that they wanted the service, the particular option they selected is important. These are the three options the beneficiary would have chosen from:

    1. Beneficiary accepts the service and DOES want the provider to bill Medicare.
    2. Beneficiary accepts the service and does NOT want the provider to bill Medicare.
    3. Beneficiary declines the service altogether.

Look for this

In the Notes section of the beneficiary's MSN

"You signed an Advance Beneficiary Notice (ABN). You are responsible for the difference between the upgrade amount and the Medicare payment."

- ✓ When a beneficiary signs an ABN accepting the service, the provider can immediately begin collecting payment or requesting payment upfront.
- ✓ If Medicare ultimately covers all or part of the charges, the beneficiary is owed a timely refund for the portion they had already paid after signing the ABN.
- ✓ Review the *Medicare & You* handbook and CMS (Centers for Medicare & Medicaid Services) online resources for more information about ABNs.

Part B "Assignment"

Look for this
In the Notes section

"This item or service cannot be paid unless the provider accepts assignment."

"Assignment" means a doctor, supplier, or other service provider agrees to accept the Medicare-approved amount as full payment. Participating providers accept assignment in all cases; however, non-participating providers can also accept assignment on a case-by-case basis. Selecting providers and suppliers who "accept assignment" limits out-of-pocket costs for beneficiaries in Original Medicare to the deductible and coinsurance amount. Some providers do not accept assignment and can charge beneficiaries higher prices, resulting in excess charges to beneficiaries.

The following facts about assignment and its impact on out-of-pocket costs to beneficiaries are important to keep in mind:

- With assignment, the provider or supplier must accept Medicare's approved amount as payment in full, even if this amount is less than their actual charge.
- Most physicians accept assignment, but it's still important to ask. Physicians who don't accept assignment can bill no more than 15 percent above Medicare's approved amount. This is called "the limiting charge."
- Some providers and suppliers, particularly durable medical equipment (DME) suppliers, are not bound by the limiting charge. As a result, they can bill more than 15 percent above Medicare's approved amount, up to the actual cost of the item.
- With assigned claims Medicare pays the provider directly, whereas with unassigned claims Medicare sends its payment to the beneficiary, who might have been asked to pay in full at the time of service.
- Accepting assignment is sometimes required.
  - Some Part B providers and suppliers, such as clinical diagnostic labs and ambulance companies, must accept assignment.
  - A few states **require** enrolled providers to accept the Medicare-approved amount as full payment. To find out if that applies in your state, contact your SHIP. Visit www.shiphelp.org or call 1-877-839-2675 to get the contact information for the local SHIP.
  - Beneficiaries who qualify for both Medicare and Medicaid (called "dual-eligibles") should not be billed for coinsurance or excess charges. See the text box to the right and the Sample MSN – QMB Status section of this chapter for more information.

Look for this
In the Notes section of the beneficiary's MSN

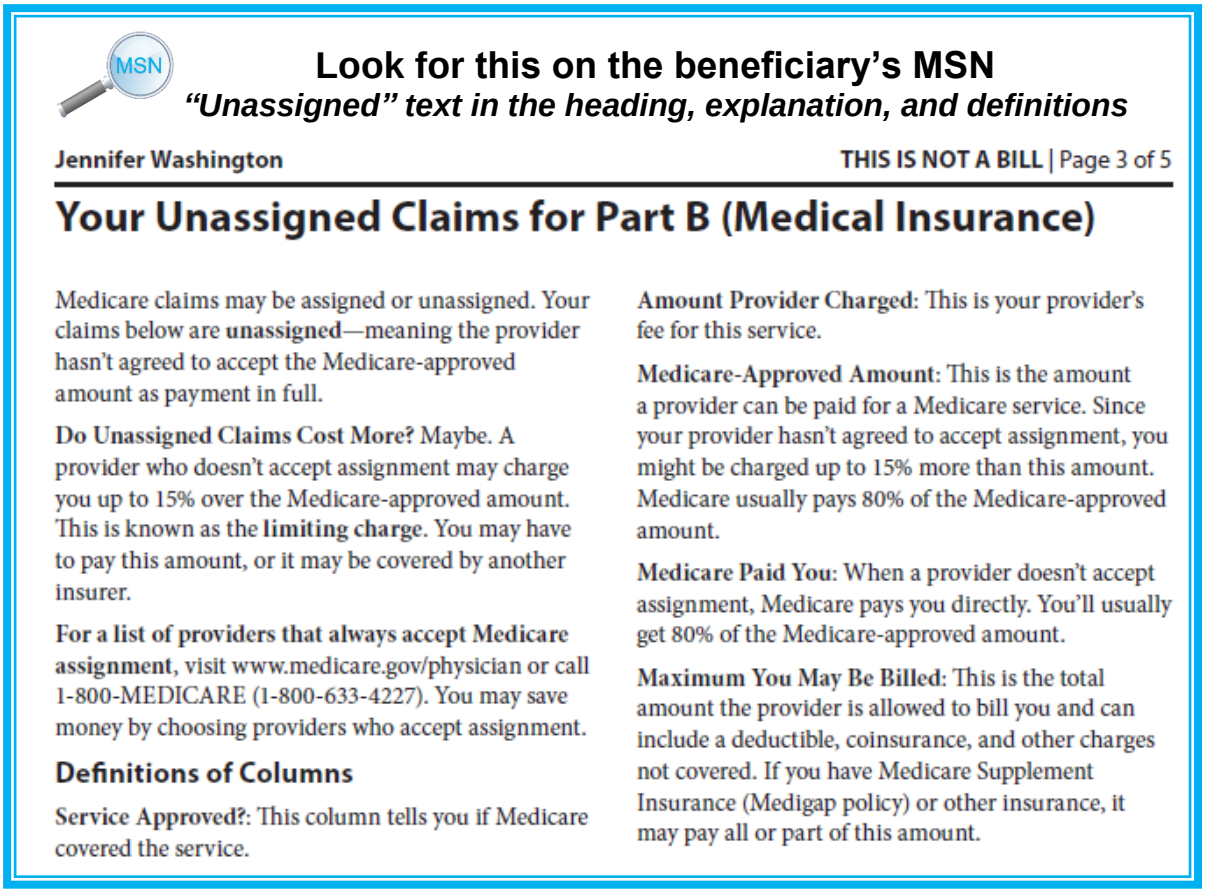
"Because you have Medicaid, your provider must agree to accept assignment."

"Non-participating Providers"

Some providers choose not to sign an agreement with Medicare that requires them to accept assignment for all Medicare-covered services. They are called "non-participating providers." They can, however, accept assignment on a case-by-case basis. It's important to ask if they will accept assignment in an individual case.

Here's what happens if the beneficiary's doctor, provider, or supplier doesn't accept assignment:

- The beneficiary might have to pay the entire charge at the time of service. Their doctor, provider, or supplier is required to submit a claim to Medicare for any Medicare-covered services they provide; they can't charge the beneficiary for submitting a claim.
- Medicare refers to claims from non-participating providers and suppliers as "unassigned." With unassigned claims, Medicare sends payment to the beneficiary, not the provider.



- Non-participating physicians can charge the beneficiary more than the Medicare-approved amount, but there's a "limiting charge." The provider can only charge the beneficiary up to 15% over the Medicare-approved amount.

The approved amount for non-participating providers is 95% of the physician fee schedule amount.

- If a provider refuses to submit a claim to Medicare, the beneficiary should call 1-800-Medicare for help. In some cases, the beneficiary might have to submit their own claim to Medicare using Form CMS-1490S to get paid back.

The limiting charge applies only to certain Medicare-covered services and doesn't apply to durable medical equipment and some supplies.

"Opt Out" Providers

Look for this
In the Notes section

"This item or service was denied because the ordering or referring physician does not participate in Medicare."

Certain doctors and other health care providers choose not to enroll in the Medicare program at all. They are called "opt out" providers. They can't submit claims to Medicare except in emergencies and urgent care situations. The beneficiary can still see these providers, but the provider must enter into a private contract with the beneficiary. A private contract is a written agreement between the beneficiary and a doctor or other health care provider who has decided not to receive payments from Medicare. The private contract only applies to the services provided by the doctor or other provider who asked the beneficiary to sign it.

The beneficiary doesn't have to sign a private contract. They can always go to another provider who gives services through Medicare. If the beneficiary signs a private contract with their doctor or other provider, these rules apply:

Medicare won't pay any amount for the services received from a non-enrolled doctor or provider, even if it's a Medicare-covered service.

- The beneficiary will have to pay the full amount of whatever this provider charges them for the services they get. They and their provider will set up their own payment terms through the contract.
- If the beneficiary has a Medicare Supplement Insurance (Medigap) policy, it won't pay anything for the services they receive. Beneficiaries should call their insurance company before they receive the service if they have questions.
- The provider must tell the beneficiary if Medicare would pay for the service if they received it from another provider who accepts Medicare.
- If the provider has been excluded from Medicare, they must tell the beneficiary.
- The beneficiary can't be asked to sign a private contract for emergency or urgent care.

- The beneficiary is always free to get services not covered by Medicare if they choose to pay for a service themselves.

Before signing a private contract with any doctor or other health care provider, Medicare beneficiaries can contact their local SHIP for help.

List of Opted-Out Physicians

For a listing of all physicians and practitioners who are currently opted out of Medicare, use the Provider Opt-Out Affidavits Look-up Tool at https://data.cms.gov/tools/provider-opt-out-affidavits-look-up-tool.

Case Example of Part B: "Total Owed by the Beneficiary"

The total amount owed by a beneficiary with Medicare Part B can vary, depending on the situation. The following example illustrates this point. It is for a beneficiary on Original Medicare without Medicaid or a Medigap plan who is receiving an ultralight manual wheelchair:

	Provider or Supplier **Accepts Assignment (Participating)**	Provider or Supplier **Does Not Accept Assignment (Non-Participating)**	Provider or Supplier has **Opted Out (Non-Enrolled)**
Provider or Supplier Actual Charge	**$2,300**	**$2,300**	**$2,300**
Medicare-approved Amount	**$2,000**	**$2,000**	Medicare will not pay the beneficiary or the provider anything. The beneficiary owes 100% of the cost.
Medicare's 80 Percent of Approved Amount	**$1,600**	**$1,600**	
Beneficiary's 20 Percent Coinsurance	**$400**	**$400**	
Excess Charge	**N/A**	**$300**	
Total Owed by the Beneficiary	**$400**	**$700**	**$2,300**

Enrollment Change

There are several times when a beneficiary could change from Original Medicare to a Medicare Advantage plan and back again. In many cases, the coverage starts the beginning of the next month. There are times, however, when coverage may not start for months, which could be confusing for the beneficiary and provider, who may be sending claims to Medicare or a Medicare Advantage plan incorrectly.

Look for this

In the Notes section of the beneficiary's MSN

"Our records show that you are enrolled in a Medicare health plan. Your provider must bill this service to the plan."

Qualified Medicare Beneficiaries (QMBs)

The QMB (pronounced quim-bee) program is a state-administered Medicaid program that helps low-income Medicare beneficiaries by paying their Medicare premiums and covering Medicare's cost-sharing charges, including deductibles, coinsurance, and copays. In 2017, there were 7.7 million individuals (more than one out of eight Medicare beneficiaries) enrolled in the QMB program.

Look for this

In the Notes section of the beneficiary's MSN

"You're in the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. Health care providers who accept Medicare can't bill you for the Medicare costs for this item or service, but you may be charged a small Medicaid copay."

Federal law has special billing protections for QMBs. Medicare prohibits providers and suppliers from billing an individual enrolled in the QMB program for any cost-sharing charges for services and items that Medicare Part A and Part B cover. This means that hospitals cannot collect the Part A deductible and physicians and suppliers cannot collect the 20% Part B coinsurance from QMBs. Note that individuals enrolled in QMB cannot elect to pay Medicare cost-sharing charges, but in some states, they may owe a small Medicaid copay.

QMB and Other Assistance Programs

People with limited income and resources may qualify for assistance programs that could also affect what they are charged for and how that appears on their MSN or EOB.

Some common assistance programs that are available to beneficiaries who qualify are outlined in the chart below.

Assistance Program	Type of Program	Description
Medicaid	Joint federal and state program	Helps pay medical costs for some people with limited income and/or resources. **Note:** Some people qualify for both Medicare and Medicaid. In Medicare terminology, they are referred to as "dual-eligibles" or "duals."
Qualified Medicare Beneficiary (QMB) program	Joint federal and state program	This Medicare Savings Program (MSP) is available to those with limited income and assets. Original Medicare premiums, deductibles, and coinsurance charges are covered. **Note:** For more information about how QMB status appears on an MSN, see the following pages for sample MSNs showing QMB status.
"Extra Help"	Federal program administered by CMS and Social Security Administration	Also known as the "Low-Income Subsidy" (or "LIS"), it helps beneficiaries who have limited income and resources with the premiums, deductibles, and copayments associated with a Medicare Prescription Drug Plan (Part D).
State Pharmacy Assistance Programs (SPAPs)	State programs *(Not available in all states)*	Help certain people pay for prescription drugs, usually based on income and assets.
Supplemental Security Income (SSI)	Social Security Administration program	Pays a monthly amount to supplement the incomes of people with limited income and resources who are disabled, blind, or age 65 or older. The beneficiary is also automatically enrolled in Medicaid.

For more information on applying for assistance programs, SMPs and Medicare beneficiaries can contact their local SHIP.

Sample MSN – QMB Status

Sample MSN from www.justiceinaging.org

When reviewing an MSN with a Medicare beneficiary who is enrolled in the QMB program, there are several items you can look for, as described below.

Notice for Jennifer Washington

Medicare Number	**1EG4-TE5-MK72**
Date of This Notice	**September 16, 20XX**
Claims Processed Between	**June 15 – September 15, 20XX**

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met **$85.00** of your **$XXX.00** deductible for 20XX. (1)

Be Informed! (2)

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

Your Claims & Costs This Period

Did Medicare Approve All Services?	**YES**
Number of Services Medicare Denied	**0**

See claims starting on page 3. Look for **NO** in the "Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed	**$0.00**

Providers with Claims This Period

1 – Your Deductible Status. This can be ignored as long as the beneficiary remains a QMB. QMBs are protected from paying Medicare deductibles. The box keeps track of deductible payments in case the individual loses QMB status during the year.

2 – Be Informed. The QMB protection appears in the "Be Informed!" box on the first page (as shown here).

June 18, 20XX

Steven Thiele D C, (555) 555-1234

Orange Eye Center, 370 Boston Post Rd, Orange, CT 06477-3534

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed (3)	See Notes Below
Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minute (97110)	Yes	$45.00	$28.54	$22.83	**$0.00**	A
Total for Claim #02-11040-017-700		$45.00	$28.54	$22.83	**$0.00**	

3 – Maximum You May Be Billed. Every listing of a Medicare-approved service received by the beneficiary shows $0.00 in this column.

Continued →

Notes for Claims Above

A You're in the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. Health care providers who accept Medicare can't bill you for the Medicare costs for this item or service, but you may be charged a small Medicaid copay.

4

4 – Claim Details.

- **Approved Claims:** In the claims detail notes section, the note for each Medicare-approved service received by the beneficiary will include the following QMB protection explanation, as shown above: *You're in the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. Health care providers who accept Medicare can't bill you for the Medicare costs for this item or service, but you may be charged a small Medicare copay*.
- **Denied Claims:** In the claims detail notes section, the note for each service received by the beneficiary that was denied by Medicare will include this messaging: *Medicare has denied payment for this service or item. But your Medicaid coverage may help pay for this service or item.*

Sample EOBs

Sample EOBs from three different plans are shown on the following pages.

- UnitedHealthcare
- Humana
- Blue Cross Blue Shield

UnitedHealthcare

Sample EOB from www.uhc.com

Service Center
Address
City, State, ZIP Code
Phone: 1-888-888-8888

Have more questions about your claim?
Visit (name of member website)
for all your claim and benefit information.

Date

John Johnson
Address
City, State, ZIP Code

1. Patient
Name of the person who received the medical care.

Member/Patient Informati 1
Member/Patient: John Johnson
Member ID: 123456789
Group Name: ABC Company
Group #: 1234567

2. Claims Summary
Summary section shows the "math" with details on how much the plan pays, plan discounts, and how much the beneficiary may owe their provider.

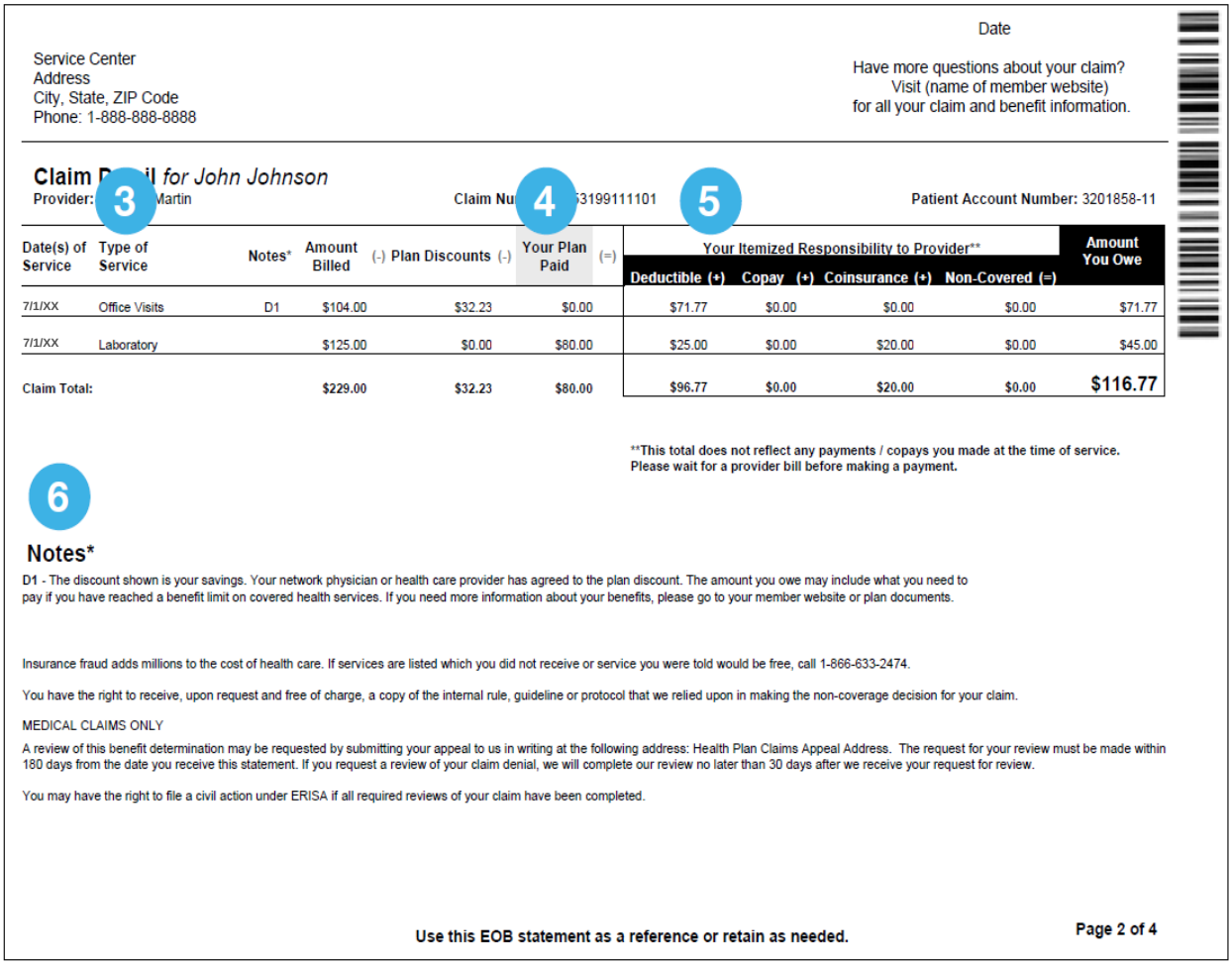
Explanation of Benefits Statement 2
This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary Detailed claim information is located on following page(s)

Dollar Amount	Description
$229.00	**Amount Billed** This is the total amount that your provider billed for the services that were provided to you.
$32.23	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$80.00	**Your Plan Paid** This is the portion of the amount billed that was paid by your plan.
$116.77	**Total Amount You Owe the Provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non-covered charges. This amount does not include any payments made to the subscriber.* If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. *When coordination of benefits applies, this amount will include payments made to the subscriber.

Use this EOB statement as a reference or retain as needed. **Page 1 of 4**

3. **Type of Service**
   This section shows a brief description of the service provided. Details are provided in the "Notes" section (see #6 below).
4. **Your Plan Paid**
   The amount of benefits paid to the employee or provider.
5. **Your Itemized Responsibility to Provider** and **Amount You Owe**
   This section shows the amount the beneficiary owes to the provider.
6. **Notes**
   This section gives more detail on how the claim was processed. It also shows the beneficiary's appeals options and other helpful information.



Date

Service Center
Address
City, State, ZIP Code
Phone: 1-888-888-8888

Have more questions about your claim?
Visit (name of member website)
for all your claim and benefit information.

Claim D[illegible] *for John Johnson*
Provider: [illegible] Martin Claim Nu[illegible]3199111101 Patient Account Number: 3201858-11

Date(s) of Service	Type of Service	Notes*	Amount Billed	(-) Plan Discounts (-)	Your Plan Paid (=)	Your Itemized Responsibility to Provider** Deductible (+)	Copay (+)	Coinsurance (+)	Non-Covered (=)	Amount You Owe
7/1/XX	Office Visits	D1	$104.00	$32.23	$0.00	$71.77	$0.00	$0.00	$0.00	$71.77
7/1/XX	Laboratory		$125.00	$0.00	$80.00	$25.00	$0.00	$20.00	$0.00	$45.00
Claim Total:			**$229.00**	**$32.23**	**$80.00**	$96.77	$0.00	$20.00	$0.00	**$116.77**

**This total does not reflect any payments / copays you made at the time of service.
Please wait for a provider bill before making a payment.

Notes*

D1 - The discount shown is your savings. Your network physician or health care provider has agreed to the plan discount. The amount you owe may include what you need to pay if you have reached a benefit limit on covered health services. If you need more information about your benefits, please go to your member website or plan documents.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-866-633-2474.

You have the right to receive, upon request and free of charge, a copy of the internal rule, guideline or protocol that we relied upon in making the non-coverage decision for your claim.

MEDICAL CLAIMS ONLY

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: Health Plan Claims Appeal Address. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review.

You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

Use this EOB statement as a reference or retain as needed.

Page 2 of 4

Humana

Sample EOB from https://support.humana.com

1. **Patient.** The person who received services.
2. **Claim Summary.** Summary of what was billed, plan discounts, and the member responsibility.

HUMANA.

TEOBQTEOB031A07312011114000000002-MTV
Member Name
Member Address
TAMPA, FL 33624
MEX

Claim Receipt

Explanation of benefits and claim payments

THIS IS NOT A BILL page 1 of 6

Patient 1
Name:
Member ID:
Group Name:
Group ID:
Plan Type:
Birth Date:
Patient Account:

Subscriber
Name:
Subscriber ID:
Address:

Plan payment will be made under separate mailing.

This claim receipt represents your claim after it was adjusted.

Claim Summary
Claim Number:
Provider: PILAR CEKAN
Service Date:
Processed on:
Benefits Paid to:

2

	Provider Charges	Paid to Member	Amount you may owe
Total Billed	$60.00		
Plan Discounts	-$36.57		
Excluded Charges			$0.00
Member Responsibility			
Copay			$0.00
Deductible			$0.00
Coinsurance			$0.00
Plan Paid		$23.43	
Claim Totals	**$23.43**	**$23.43**	**$0.00**

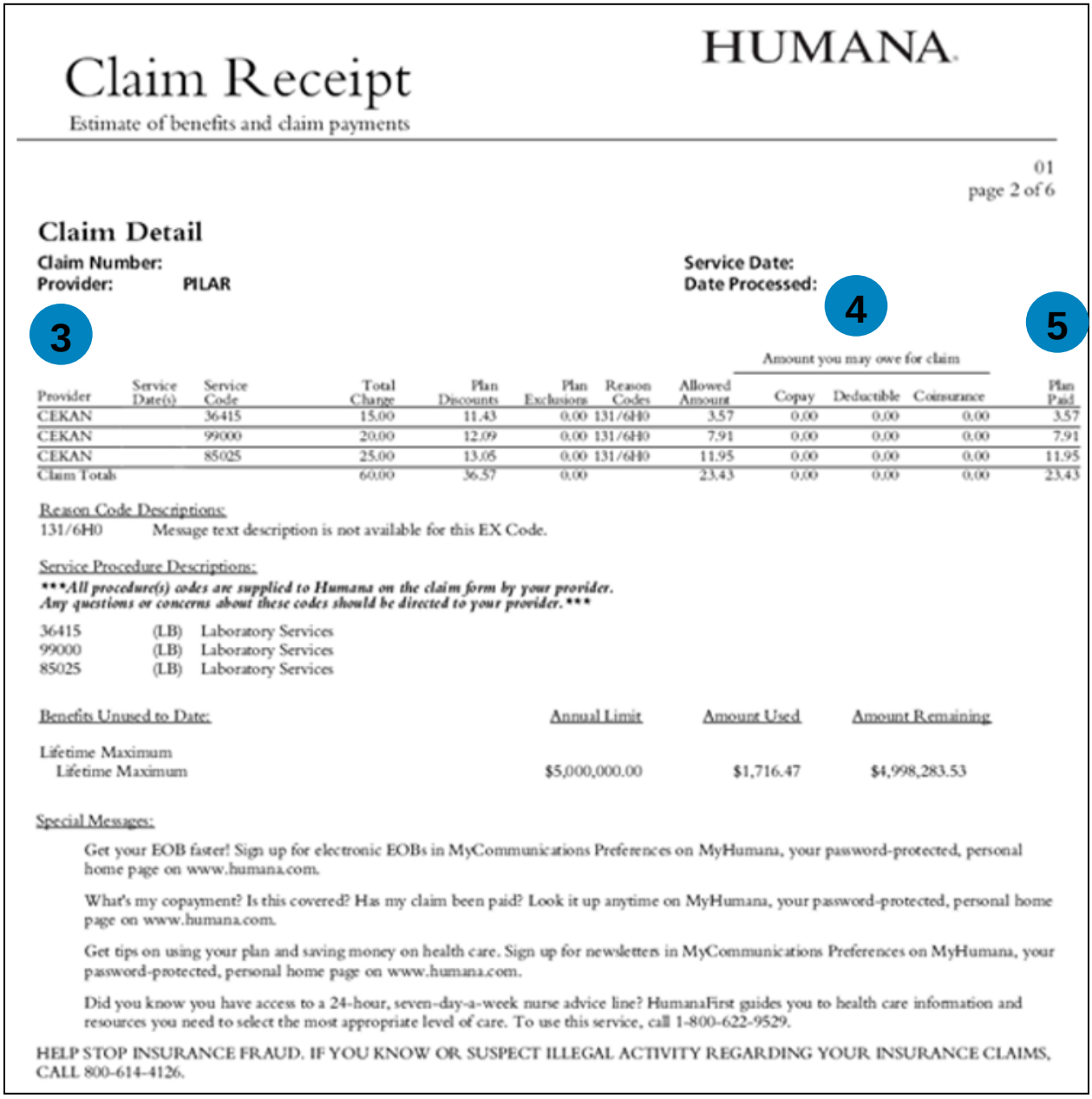
Estimated Amount You May Owe

Notes: Please compare these totals with the bill you receive from your provider.

Document ID: 20110728500057
Form No. GCA0CEOHH

Questions about your plan or this receipt call 1-888-357-6767 or visit WWW.HUMANA.COM

3. **Claim Detail.** Includes a breakdown of providers, service dates, service codes, and plan discounts.
4. **Amount You May Owe for Claim.** The amount a beneficiary may owe for a claim, including copay, deductible, and coinsurance.
5. **Plan Paid.** The amount the plan paid.



HUMANA

Claim Receipt

Estimate of benefits and claim payments

01
page 2 of 6

Claim Detail

Claim Number:
Provider: PILAR

Service Date:
Date Processed:

3 4 5

Provider	Service Date(s)	Service Code	Total Charge	Plan Discounts	Plan Exclusions	Reason Codes	Allowed Amount	Amount you may owe for claim: Copay	Deductible	Coinsurance	Plan Paid
CEKAN		36415	15.00	11.43	0.00	131/6H0	3.57	0.00	0.00	0.00	3.57
CEKAN		99000	20.00	12.09	0.00	131/6H0	7.91	0.00	0.00	0.00	7.91
CEKAN		85025	25.00	13.05	0.00	131/6H0	11.95	0.00	0.00	0.00	11.95
Claim Totals			60.00	36.57	0.00		23.43	0.00	0.00	0.00	23.43

Reason Code Descriptions:
131/6H0 Message text description is not available for this EX Code.

Service Procedure Descriptions:
***All procedure(s) codes are supplied to Humana on the claim form by your provider.
Any questions or concerns about these codes should be directed to your provider.***

36415 (LB) Laboratory Services
99000 (LB) Laboratory Services
85025 (LB) Laboratory Services

Benefits Unused to Date:	Annual Limit	Amount Used	Amount Remaining
Lifetime Maximum			
Lifetime Maximum	$5,000,000.00	$1,716.47	$4,998,283.53

Special Messages:

Get your EOB faster! Sign up for electronic EOBs in MyCommunications Preferences on MyHumana, your password-protected, personal home page on www.humana.com.

What's my copayment? Is this covered? Has my claim been paid? Look it up anytime on MyHumana, your password-protected, personal home page on www.humana.com.

Get tips on using your plan and saving money on health care. Sign up for newsletters in MyCommunications Preferences on MyHumana, your password-protected, personal home page on www.humana.com.

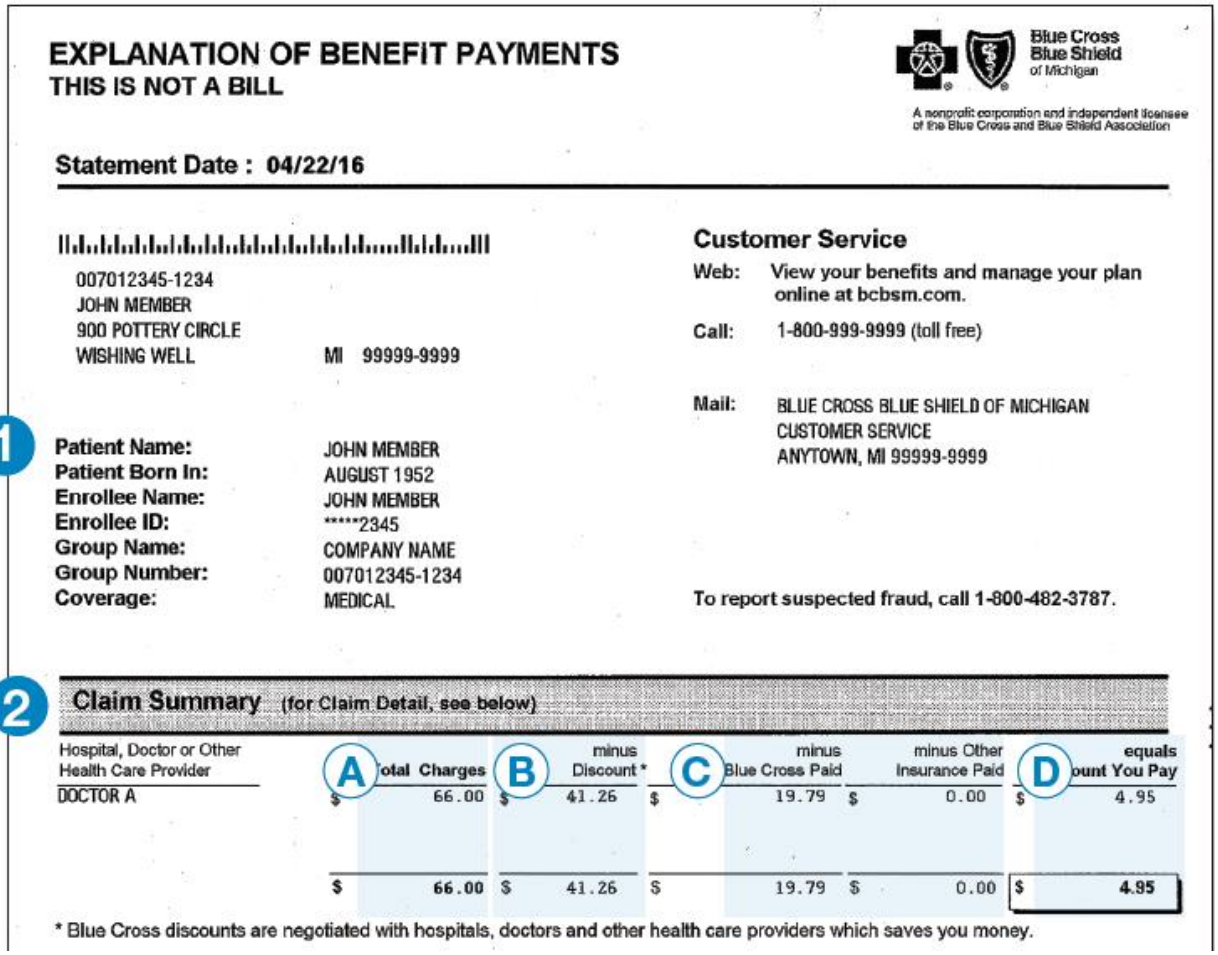
Did you know you have access to a 24-hour, seven-day-a-week nurse advice line? HumanaFirst guides you to health care information and resources you need to select the most appropriate level of care. To use this service, call 1-800-622-9529.

HELP STOP INSURANCE FRAUD. IF YOU KNOW OR SUSPECT ILLEGAL ACTIVITY REGARDING YOUR INSURANCE CLAIMS, CALL 800-614-4126.

Blue Cross Blue Shield

Sample EOB from www.bcbsm.com

1. **Beneficiary Information.** Identifies who this EOB statement is for.
2. **Claim Summary.** Summarizes claims by doctor, hospital, or other health care provider as follows:
   - A. Represents the amount submitted to Blue Cross on the claim.
   - B. What the beneficiary saved by being a Blue Cross member.
   - C. What Blue Cross paid and amounts the beneficiary's other insurance(s) paid.
   - D. What the beneficiary pays. They may have already paid or may still owe this amount. The beneficiary should never be asked to pay more than this amount.



EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

Blue Cross Blue Shield of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Statement Date : 04/22/16

007012345-1234
JOHN MEMBER
900 POTTERY CIRCLE
WISHING WELL MI 99999-9999

Customer Service
Web: View your benefits and manage your plan online at bcbsm.com.
Call: 1-800-999-9999 (toll free)
Mail: BLUE CROSS BLUE SHIELD OF MICHIGAN
CUSTOMER SERVICE
ANYTOWN, MI 99999-9999

1
Patient Name: JOHN MEMBER
Patient Born In: AUGUST 1952
Enrollee Name: JOHN MEMBER
Enrollee ID: *****2345
Group Name: COMPANY NAME
Group Number: 007012345-1234
Coverage: MEDICAL

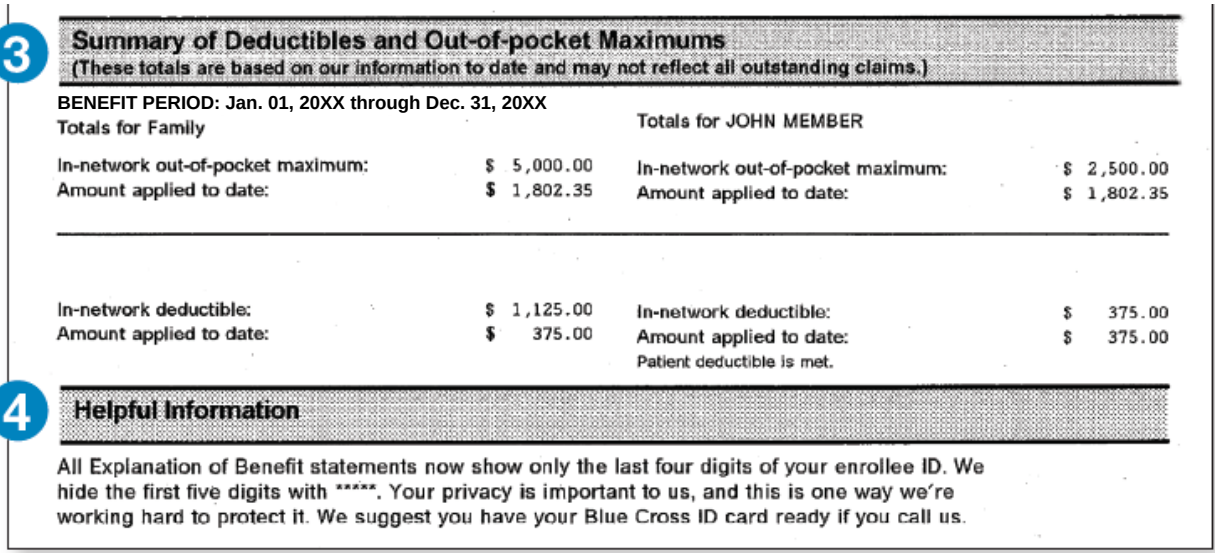
To report suspected fraud, call 1-800-482-3787.

2 **Claim Summary** (for Claim Detail, see below)

Hospital, Doctor or Other Health Care Provider	A Total Charges	B minus Discount *	C minus Blue Cross Paid	minus Other Insurance Paid	D equals Amount You Pay
DOCTOR A	$ 66.00	$ 41.26	$ 19.79	$ 0.00	$ 4.95
	$ 66.00	$ 41.26	$ 19.79	$ 0.00	$ 4.95

* Blue Cross discounts are negotiated with hospitals, doctors and other health care providers which saves you money.

3. **Summary of Deductibles.** Shows the balances to date for deductibles and out-of-pocket maximums for the beneficiary's current benefit period.
4. **Helpful Information.** Important information about the beneficiary's coverage, tips to lower health care costs, and ways to improve overall health.



3

Summary of Deductibles and Out-of-pocket Maximums
(These totals are based on our information to date and may not reflect all outstanding claims.)

BENEFIT PERIOD: Jan. 01, 20XX through Dec. 31, 20XX

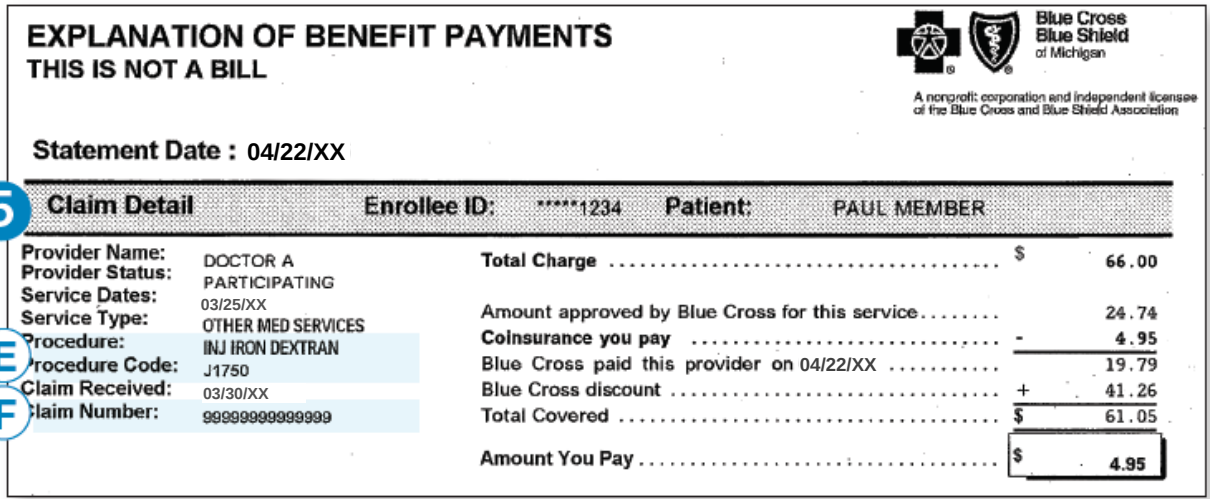
Totals for Family		Totals for JOHN MEMBER	
In-network out-of-pocket maximum:	$ 5,000.00	In-network out-of-pocket maximum:	$ 2,500.00
Amount applied to date:	$ 1,802.35	Amount applied to date:	$ 1,802.35
In-network deductible:	$ 1,125.00	In-network deductible:	$ 375.00
Amount applied to date:	$ 375.00	Amount applied to date:	$ 375.00
		Patient deductible is met.	

4

Helpful Information

All Explanation of Benefit statements now show only the last four digits of your enrollee ID. We hide the first five digits with *****. Your privacy is important to us, and this is one way we're working hard to protect it. We suggest you have your Blue Cross ID card ready if you call us.

5. **Claim Detail.** Shows detailed information about each claim Blue Cross processed. It provides additional detail about the types of cost sharing applied to the claim. The sum of all claims in this section for the same provider should match the numbers in the Claim Summary section.
    E. Information the beneficiary's provider puts on the claim to identify the medical service received.
    F. The unique number Blue Cross assigns to a claim. The beneficiary can reference this number if they need to call about this claim.



EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

Blue Cross Blue Shield of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Statement Date : 04/22/XX

5 **Claim Detail** Enrollee ID: *****1234 Patient: PAUL MEMBER

Provider Name:	DOCTOR A
Provider Status:	PARTICIPATING
Service Dates:	03/25/XX
Service Type:	OTHER MED SERVICES
E Procedure:	INJ IRON DEXTRAN
Procedure Code:	J1750
Claim Received:	03/30/XX
F Claim Number:	99999999999999

Total Charge	$	66.00
Amount approved by Blue Cross for this service		24.74
Coinsurance you pay	-	4.95
Blue Cross paid this provider on 04/22/XX		19.79
Blue Cross discount	+	41.26
Total Covered	$	61.05
Amount You Pay	$	4.95

Tips for Reading EOBs

Now that we've reviewed sample MSNs and information to help you read them, let's take a closer look at EOBs for Medicare Advantage (Part C) and Prescription Drug Plans (Part D). When reviewing EOBs, it is important to keep in mind that there are a variety of options to beneficiaries in the types of plans available.

For example, Medicare Advantage plans include:

- Health Maintenance Organization (HMO) Plans
- Preferred Provider Organization (PPO) Plans
- Private Fee-For-Service (PFFS) Plans
- Special Needs Plans (SNPs)
- Medicare Medical Savings Account (MSA) Plans

EOB Design and CMS Requirements

EOB design varies from plan to plan; however, CMS issues requirements about the type of information EOBs must include.

Medicare rules require all Medicare Advantage EOBs to include the following:

- Crucial details about the covered services, including all claims for Part A and Part B covered services and any supplemental benefits offered by the plan
- Names of providers who billed
- The billed amount
- The plan's payment
- The beneficiary's share of the approved amount
- Information about how to appeal, unless it is provided separately, in order to meet the CMS guidelines about timeliness
- Other rules too numerous to mention here, such as EOB formatting guidelines

Medicare rules require the following information in Part D EOBs:

- A record of the person's total out-of-pocket costs, including:
    - A record of the total drug costs transferred from previous plans if a person changed plans during the year
    - A summary of the person's year-to-date costs in the plan, including the deductible
- Information about the person's current coverage period, the initial coverage period, the coverage gap, and catastrophic coverage
- A summary of the claims processed since the last EOB

- Any updates to the drug plan's formulary, if applicable
- How to contact the plan with questions, such as what beneficiaries can do if they question the accuracy of the EOB or disagree with coverage decisions made by the plan

In Network vs. Out of Network

"In network" refers to the facilities, providers, and suppliers the beneficiary's health insurer or plan has contracted with to provide health care services. The beneficiary pays less if they use doctors, hospitals, and other health care providers that belong to the plan's network.

"Out-of-network" refers to the facilities, providers, and suppliers the beneficiary's health insurer or plan has not contracted with to provide health care services. The beneficiary pays more (sometimes up to the full cost) if they use doctors, hospitals, pharmacies, and providers outside of the network.

Look for this

In the Notes section of the beneficiary's EOB

"*You have used a provider who is not in your health plan's network and the service may not be covered or may be subject to a higher deductible and/or coinsurance.*"

In some plans, the beneficiary may be able to go out of network for certain services. However, it usually costs less if they get their care from a network provider. This is called an HMO with a point-of-service (POS) option.

SMP
Senior Medicare Patrol
Preventing Medicare Fraud

SMP Counselor Training Manual

CHAPTER 3: How to Use the My Health Care Tracker

Overview

My Health Care Trackers provide Medicare beneficiaries with helpful tips, important phone numbers, and a place to log their health care appointments for later comparison with MSNs and EOBs.

Beneficiaries can use the trackers to compare information they documented from their appointments and products received with their insurance statements, thereby helping to detect potential Medicare fraud, errors, and abuse. They can also learn about the vital work that SMPs and SHIPs perform, how they can volunteer, and contact information for other resources they may need.

These trackers are intended to accompany the national SMP flyer and are commonly used by SMPs as handouts during SMP counseling sessions. A link to tracker designs is in the SMP Resource Library. The SMP Resource Center's public-facing website has a tracker page with a flip-through version.

This chapter explains how to help beneficiaries use a My Health Care Tracker to review their MSNs and EOBs.

Instructions for Using the My Health Care Tracker

Educating beneficiaries about how to use the My Health Care Tracker can be an important part of your role as an SMP counselor. Be familiar with how to use the tracker and be prepared to provide instructions and assistance to beneficiaries as needed.

Refer to the basic directions provided within the tracker as needed. They are:

1) Take this tracker with you to your medical appointments.
2) Record information from your appointments in this tracker. Include:
    - The date, length of visit *(such as 5, 15, 30, or 45 minutes),* medical provider, and reason for the visit
    - The names of the tests, *(such as X-rays, blood drawn, urine testing, ultrasound, and checked weight, height, and blood pressure),* equipment, or prescriptions
3) When your Medicare Summary Notice (MSN) or Explanation of Benefits (EOB) arrives, compare the information. **Place a check mark** to the right of the entry

ONLY if:

- The date, length of visit, medical provider, and reason for the visit match the MSN or EOB
- The names of the tests, equipment, or prescriptions on the MSN or EOB are the same names that you recorded in your tracker

4) Contact your provider or local Senior Medicare Patrol office if:
   - You need assistance comparing your completed tracker with your MSN or EOB
   - You've completed your comparison and identified boxes for which there are no check marks
   - There are charges on your MSN or EOB for visits, tests, equipment, or prescriptions you didn't receive or were not ordered by your doctor
   - You were billed twice for the same visit, test, equipment, or prescription

My Health Care Tracker Tips for Beneficiaries

When explaining how to use the tracker, here are some additional tips to share:

1) Before each health care appointment, ask yourself these questions:
   - Is this appointment going to be covered by Medicare or my other insurance?
   - What over-the-counter or prescription medications am I taking?
2) Make sure that you understand what your physician is telling you before leaving your appointment. If you don't, ask them to try to explain what they are telling you in a different way.
3) Take this tracker with you when you travel, in case of emergency.

Sample Comparison: MSN vs. My Health Care Tracker

The sample on the next page provides a comparison between an MSN and a completed My Health Care Tracker for a physical therapy visit on June 18.

As shown in the comparison on the next page, when comparing the tracker to the MSN or EOB, check the date, length of visit, medical provider, and reason for the visit to make sure they match on the statement and the tracker.

Also check for names of tests, equipment, or prescriptions and make sure they match.

In this example, we can see that the following information matches on the MSN and the tracker:

- ✓ Date = June 18
- ✓ Length of visit = 15 minutes
- ✓ Medical provider = Dr. Susan Jones
- ✓ Reason for the visit = physical therapy

June 18, 20XX

Dr. Susan Jones, M.D., (555) 555-1234

Brevard County Physical Therapy Center, 32 Main Street, Brevard, NC 28712-4187

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minut (97110)	Yes	$45.00	$28.54	$22.83	**$5.71**	
Total for Claim #02-10195-592-677		$45.00	$28.54	$22.83	**$5.71**	**A**

Appointment List

Date: June 18, 20XX

Provider Name: Susan Jones

Reason for Visit: Therapy for shoulder

RECEIVED

- ☐ Blood Drawn
- ☐ CT/PET/MRI
- ☐ Dialysis
- ☐ Medical Device (Ex: DME, brace)
- ☐ Medication
- ☐ Oxygen
- ☐ Shot (Ex: flu, pneumonia)
- ☐ Urine Test
- ☐ X-ray
- ☒ Other Therapy

LENGTH OF VISIT (In person or virtual, in minutes)

☐ 0-5 ☒ 5-15 ☐ 15-30 ☐ 30-45

NOTES

Used the weight bands today.

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CHAPTER 4: Counseling Skills

Overview

In addition to your knowledge about Medicare fraud, errors, and abuse, Medicare statements, and My Health Care Trackers, it takes good communication skills, or "soft skills," to hold a successful SMP counseling session. Soft skills are personal, interpersonal, and nontechnical skills that are used to interact with others in a positive manner.

This chapter focuses on soft skills by guiding you through the basic steps to effective counseling and providing counseling tips and strategies.

Steps to Effective Counseling

Step 1: Set the Stage

Whether you are meeting the beneficiary in person, over the phone, or online, it is important to start off on the right foot by demonstrating professionalism and inspiring confidence. Make the beneficiary comfortable that they have come to the right place and the right person!

Remote Counseling

Additional steps should be taken if you are meeting with the beneficiary online. See the section about remote counseling later in this chapter for more information.

The following are things to remember when you and the beneficiary first meet:

Make a good first impression

- When working with beneficiaries, making a good first impression can help them feel more comfortable confiding in you.
- It can also help them be more open to hearing about the SMP mission and trusting you to answer their question.
- If in person, wear a name badge with your name and title, if available.
- If online, show your full name and agency on the screen, if possible, and use your agency background, if available.

Greet the beneficiary

- Smile and introduce yourself by name, agency, and job title.
- Demonstrate confidence that you can help.
- Be prepared with an icebreaker, such as the weather or their trip to your office/their ability to access your session online or by phone.
- If in person, accompany the beneficiary to a place where you can speak in confidence, such as an inner office area.

Explain how you can help

- Briefly describe the Senior Medicare Patrol program, which provides

information and counseling related to Medicare fraud, errors, and abuse.

- Explain your role as an SMP counselor.
- Also be clear about what you cannot do to help the beneficiary. Remember that you may not have all the answers but can either find answers or send the beneficiary to someone who can help. See Appendix B as needed.

State and Local Information #7: Disclaimers

Does your SMP use any type of disclaimer when holding counseling sessions? Ask your SMP director or coordinator of volunteers.

Step 2: Listen Actively

Effective counseling depends on your ability to listen actively. Active listening takes work and requires a certain amount of preparation and organization. Whether you are talking to a beneficiary face-to-face, over the phone, or online, you must listen to what they are telling you so that you can help meet their needs.

Invite the beneficiary to explain their questions or issues

- Ask the beneficiary to briefly describe their questions, issues, and/or situations.
  - You may ask a question like, "What can I help you with today?"
  - You may also want to learn if the beneficiary has already talked with someone at the SMP about their questions or issues.
- Let the beneficiary explain their questions or issues without interruption and listen carefully. This is your chance to discover the reason for the call or visit and determine what you can do to help.

Notes

Take notes while you meet with the beneficiary. This will help you remember the details of your conversation, both for tracking purposes and for possible follow-up.

Focus on the beneficiary

- Stop. Listen. You can't hear if you do all of the talking.
- Give the beneficiary your undivided attention. Focus on the beneficiary and do not get distracted.
- Be patient. Do not make assumptions about the beneficiary's question or the answer. Wait until you have the whole story!
- It is not easy for people to talk about important things. Let the other person finish speaking before you begin to formulate your response. If you are thinking about your response, you are not listening to what they are saying and you may miss key points.
- Treat the beneficiary in a caring manner. Be supportive and professional.
- If culturally appropriate, lean toward the beneficiary; look at them and maintain eye contact.

Ask clarifying questions

- Use questions to sort out the details of the beneficiary's situation until you know exactly what the question or problem is and how you can help.
- Clarifying, or follow-up, questions help you focus on the beneficiary's concern.
- When possible, use open-ended questions (questions that do not have a quick "yes" or "no" answer).
- Sometimes you will need to ask detailed questions that limit responses to the factual information needed. You may want to ask questions that start with:
    - Who
    - What
    - When
    - Where
    - Why
    - How

Confirm your understanding of the situation and the beneficiary's needs

- Summarize the situation at several different points during the conversation. Be sure you perceive the way the beneficiary sees the problem, not just the way you believe it is.
- If you determine that you don't understand the situation correctly, ask additional clarifying questions and confirm your understanding again.
- Identify the beneficiary's needs. If the beneficiary doesn't know exactly what they need, you may need to talk with them further to help figure it out.

Listening "Don'ts"

DON'T fall into the trap of inadequate listening!

Inadequate listening includes:

- Zoning out: This is most likely to happen when you have heard a similar story or situation repeatedly. Remember that each situation is different, and you could miss something important if you don't listen to all aspects of the situation.
- Interrupting brusquely: This is likely to happen when the beneficiary has gone off on a tangent. Try gently redirecting them instead.

Step 3: Respond Appropriately

In this section, we discuss counseling skills related to providing an answer to the beneficiary's question. Details of the SMP counseling process are provided in Chapter 5 and Appendix D: Process Checklist.

Identify the type of question

As described in Chapter 1, start by determining whether each question is an SMP basic interaction, an SMP complex interaction, or not an SMP question.

Provide accurate and objective information in a clear and supportive manner

Once you have a good understanding of what the question is and how you might be able to help the beneficiary, you can provide the answer or let them know who they should contact for further assistance.

- Answer directly. Give simple answers to simple questions.
- Use straightforward language; avoid jargon.
- As applicable, educate the beneficiary on Medicare fraud, errors, and abuse. Define terms or concepts in a way that makes them easier to understand. Be patient and pace your discussion to match the beneficiary's needs.
- Always tell the truth and be objective.
    - Give only facts for which you have documentation or certain knowledge.
    - Do not feel like you have to memorize all of the information you have learned! Use your training manual and other resources, which provide most of the information you need.
    - If you don't know the answer to the question or if you are in doubt, admit it. Then, offer to get the answer and get back to the beneficiary.
    - As needed, ask for help or send the beneficiary to the appropriate person at your SMP.

Confirm that you have met the beneficiary's needs

- Ask if you have answered the beneficiary's question fully or if they still have additional questions or concerns.
- Before the meeting ends, determine if any additional follow-up is needed and make sure the beneficiary knows what to expect.
    - What can or should the beneficiary do on their own behalf? Do they need to follow up directly with another organization to get the answer?
    - Do you need to send them any brochures or other materials to help answer their question?
    - Do you need to call them back later with an answer or send them to someone else in your organization for additional follow-up?

Close the counseling session by thanking the beneficiary for their time and leaving them with a positive comment or action. Let them know that if they have questions at any time, they can contact you or your organization again.

Tips for Effective Counseling

When preparing for your counseling sessions, consider the following tips:

- **Acronyms and Jargon**
  - Avoid acronyms and jargon or explain what they mean if they're essential to the conversation. For example, acronyms like EOB and MSN should either be explained or referred to as "Medicare statements."
- **Assumptions**
  - Don't assume you know what the beneficiary's needs are. Don't decide what is needed before you hear the details of the specific situation.
  - Don't make assumptions about what beneficiaries do or do not already know about fraud and scams. They may know more than you think! Consider the FTC's "Pass it On" concept when meeting with beneficiaries, families, and caregivers. Ask those in the know to pass the information on to someone they know who could be helped by it.

Pass It On!

The Federal Trade Commission (FTC) offers a consumer education campaign for active older people called "Pass It On." The FTC's campaign is based on the idea that older adults are part of the solution, not simply victims of scammers.

For more information about the FTC's "Pass It On" campaign and related resources, visit: http://ftc.gov/PassItOn.

- **Bias**
  - Biases can stem from many sources, including culture, upbringing, socioeconomic status, political beliefs, or religious beliefs. Most of us hold specific political and religious beliefs, and it is important to notice when either of these comes into play in a session.
  - Our biases may be unconscious – also referred to as implicit – and can be used to take cognitive shortcuts when people have limited information or time. For example, when you meet with a client, they may use unconscious bias when trying to decide if you are trustworthy. They will use previous experiences to come to a conclusion.
  - Bias can cause people to notice information that supports their beliefs and ignore information that does not. Each person's interpretations are based on their beliefs. Even having read the same handout, their bias will tend to shape the way they perceive the details, further confirming their beliefs. This is true for both the counselor and the beneficiary.

Check Your Bias

Getting rid of bias may be impossible, but if we understand our own biases, we can better serve clients without judgment or assumptions based upon bias. Project Implicit is an international collaboration of scientists, started through Harvard University, that measures implicit (or unconscious) bias. Anyone can take one or more of their implicit bias tests to assess whether they have implicit bias based on a variety of factors, including gender, politics, race, religion, or sexual orientation. To assess your biases, visit: https://implicit.harvard.edu/implicit/takeatest.html.

- **Body Language**
  - Be aware of your body language and tone of voice. Pay attention to nonverbal cues from the beneficiary.
  - Use body language to demonstrate sincere interest. Body language tells people a lot about your attitude toward them and their problems. People who listen intently also use their body to communicate interest. You may lean toward the beneficiary slightly or maintain eye contact, smiling or frowning appropriately.
  - Use facial expressions to let beneficiaries know you are truly interested in helping them. Make sure your expressions are genuine and appropriate to the conversation.
- **Desire**
  - You must want to hear what the beneficiary is saying. If you are too tired or simply not interested, you will not be a good listener!
- **Feelings**
  - Be friendly. Always keep your temper, even if you are asked a question you don't know the answer to or hear something you don't agree with.
  - Consider that the beneficiary may be confused and/or emotional. They may have heard conflicting and/or misinformation prior to speaking with you.
  - Focus on the feelings the person is expressing as well as the information.
  - Accept what the person is feeling. You can acknowledge that they are upset, frustrated, or sad even if you don't agree with their reasons.
  - Give the person time to express their feelings. Do not automatically jump to conclusions or give a quick answer.

- Observe signs of anxiety or misunderstanding and provide appropriate assurances to ease the beneficiary's situation.

- **Interactive Communication**
  - Match the beneficiary's tempo and tone.
  - Provide precise explanations to avoid misunderstandings.
  - Encourage the beneficiary's participation in pursuing ways to resolve their questions.
  - Remain flexible about your ideas for resolving problems and be open to the beneficiary's ideas.
  - Stay in charge. Be prepared to take control of the conversation as needed to ensure you stay in charge and on schedule.
  - Keep things moving; there is a rhythm to a good question-and-answer exchange.

- **Patience**
  - Listen patiently as the beneficiary describes their situation. Each situation has its own details. You may guide the beneficiary through the story with a series of questions.
  - In most cases you are not the first person the beneficiary has talked to about their situation. Allow them to feel as though you have listened and that you understand their problem.

- **Point of View**
  - Try to look at the situation from the beneficiary's point of view. Remember things that make people different, such as:
    - Culture
    - Education
    - Personality
    - Health history
    - Life experiences
    - Economic status

Cultural Competency in SMP Counseling

When meeting with beneficiaries, it's important to understand how to work with individuals from different cultures, diverse populations, and social identity groups.

Resources related to cultural competency are available in the SMP Resource Library. See Appendix E for more information.

- **Practice Makes Perfect**
    - The only way to learn to use counseling skills effectively is to get out there and do it! Pay attention to what you are thinking and feeling as you talk with beneficiaries, and you will discover a lot about yourself.

> **State and Local Information #8: Practice Makes Perfect!**
>
> Will your SMP provide opportunities for you to practice handling counseling sessions as part of your training process? Ask your SMP director or coordinator of volunteers.

- **Professionalism and Respect**
    - Treat the beneficiary with respect.
    - Maintain a cordial but professional tone.
- **Reflection and Understanding**
    - Periodically paraphrase what you have heard to ensure that you understand the situation.
    - Understand what the person is trying to say. Then seek to be understood yourself.
- **Storytelling**
    - Try to avoid long, personal stories that distract from the goal of the counseling session.
        - As the counselor, you need to keep the whole exchange professional while remaining cordial, even friendly, with the beneficiary. Try to keep the beneficiary on track, discussing problems you are equipped to help them with. Any time spent socializing won't accomplish the goal of the counseling session and may leave the beneficiary feeling they have found a sympathetic ear but their problem wasn't solved.
    - There are times when personal disclosure will help foster trust. However, avoid personal details.
        - Personal disclosure should only be used to put someone at ease or to earn trust. Avoid saying too much about yourself. Too much detail invites similar detail from the beneficiary and that can derail a productive counseling session.

- **Topic**
    - Remember that you may be talking with people who have little knowledge of Medicare and health insurance. Too much information can be confusing and overwhelming. Do not allow yourself to get off topic or share all of the information you received during training. The purpose of the counseling session is to help beneficiaries with the specific information that they need, not to impress them with everything you know. Keep your response as simple as possible.
    - Please refrain from:
        - Political or religious opinions
        - Speaking negatively of Medicare and Medicaid
        - Endorsing any specific products or services
        - Jokes that may be considered offensive
        - Identifying a specific provider as fraudulent when it's not a matter of public record
    - When in doubt, ask your SMP director and/or coordinator of volunteers if a particular topic is appropriate to include in your counseling session or if it should be handled by someone else.

What NOT to Say

#1: "I know it ALL!"

It's okay if you don't know all of the answers. In fact, it's expected. Even the experts do not always have the answers to every question right away. Remember, you have many resources to help you. Both beneficiaries and SMP team members will appreciate your hard work to find out the proper information. Please **do NOT guess**.

#2: "That's fraud!"

Do not say that the beneficiary's situation is fraud or abuse. Instead, use the terms "suspected" or "potential" fraud or abuse.

#3: Medical or legal advice

Even if you are a doctor, lawyer, nurse, etc., and you have professional training in that area, it is not your role within the SMP to address these types of questions.

Tips for Remote Counseling

Remote counseling is a common way to provide SMP counseling, but it comes with some challenges. Even under ideal conditions, miscommunications or misunderstandings can be common. Because counseling remotely can make the communication process more tenuous, it requires a concentrated focus.

Although counseling remotely can seem overwhelming, it doesn't have to be. The trick is to be well organized and be prepared in advance by reviewing the following strategies for effective phone and online communication.

Remote Counseling Strategies

- **Check perceptions.** According to Professor Emeritus Albert Mehrabian, between 55% and 60% of believability comes from body language. Another way of looking at this is that 60% of communications are not available to the listener while on the phone. This makes it very difficult to tell if communications are understood. One strategy to ensure everyone is on the same page is called "perception checking." The basic elements of perception checking include:
    - Describe what you heard in a nonjudgmental way.
    - Interpret what you heard in a nonjudgmental way.
    - Request clarification.

  The technique may show that people are often talking about or perceiving things from very different perspectives or even talking about two very different things.
- **Be an active listener.** Effective listening as a counselor is a nuanced skill. A counselor needs to not only listen to what is said but also how it's said, why it's being said, and what it means in the context of that client. This is particularly true on the phone when you do not have nonverbal cues to inform your perception. If you do not understand something, ask for clarifications or use perception checking.
- **Flexibility is always a must.** It is not unusual for beneficiaries and caregivers to want to talk about the state of things within their lives and the country as a whole. It is important to take the time to listen and acknowledge their situation and feelings. Understand that calls may take longer and that their success may hinge on your willingness to listen for a reasonable period of time.
- **Show a genuine interest in the person on the phone.** This is always true but is complicated by the lack of nonverbal cues. Here are some important practices to show you are genuinely interested:
    - Use their name.

  - Actively listen. Let the other person talk and then paraphrase or summarize what you heard.
  - Ask questions.
  - Show respect. Do not interrupt while the other person is talking. Give them time to speak.
  - Encourage them. This is always important but even more so during trying times.

- **Avoid distractions.** Focus, focus, focus! Avoid multitasking. Work actively at being an active listener by being in the moment with the person you are serving.
- **Summarize.** Toward the end of the call, provide a summary of the call, highlighting important key points discussed. This is important to ensure everyone is on the same page. Do this in a conversation style rather than a summary statement. Effective engagement is relationship-based and not solely based on imparting information. The more effective you can engage those you serve, the more likely you are to meet their needs.

Online Counseling Strategies

The following strategies apply specifically to counseling online:

State and Local Information #9: Online Counseling

Does your SMP provide online counseling? If so, what platform(s) is/are used and what training will you receive to use the necessary technology? Ask your SMP director or coordinator of volunteers.

- **Be familiar with the platform you are using.** Know the ins and outs of setting up and facilitating a meeting using the program and be ready to help troubleshoot issues the participants may have.
- **Check your internet connection**. Test the connection beforehand by running a quick practice call with a few co-workers or friends.
- **Don't stray from the purpose of the call.** The face-to-face connection that comes with a video call can help the conversation flow more easily than it does in an audio call; however, remember to focus on the counseling purpose of the call.
- **Be a few minutes early**. Log in early and be ready to start a few minutes ahead of time. Observe proper professional meeting behavior throughout the meeting.
- **Mute yourself when you're not talking.** Muting yourself every time someone else is speaking prevents others from hearing any background noises around you.

- **Use headphones.** Wearing headphones helps you hear everyone more clearly and vice versa.
- **Dress for the occasion.** Be presentable (if using video).
- **Be aware of your surroundings.** Adjust your work setup so that you face a window or are exposed to plenty of light. Make sure your background is professional and work appropriate. Additionally, ensure you have a private place for a confidential counseling session.
- **Stay seated and stay present.** Do not walk around with your camera or computer. If you must do this, turn off the camera.
- **Be considerate**. Let other people speak. Wait until they are done to chime in.
- **Close other desktop applications.** Be conscious of what you have open on your computer when you share screens during these virtual meetings. Close things you don't want to be seen and make sure that you are sharing only things that need to be shared and not your personal information.

Handling Strong Emotions or Difficult Behaviors

Every contact brings with it the possibility of challenges unrelated to the complexities of Medicare or social services programs. People may come to an appointment in an emotional or behavioral state that can create hurdles and must be addressed either upfront or throughout the session. It helps to try to understand the causes of these hurdles so that you can minimize, as much as possible, their impact.

- **Volatility.** A client may be angry because they have had their personal and economic life disrupted by potential fraud, errors, or abuse. They may be verbally contentious about government programs.
- **Emotional needs.** A client may be focused on a recent health issue or other personal issues, including social isolation.
- **Noncompliance.** You might encounter an individual who enters the building or session and refuses to follow your agency's guidelines.

Strategies

If strong emotions or difficult behaviors arise, regardless of whether you are trying to deescalate, emotionally support, or negotiate, each situation can benefit from some common and effective strategies. The goals are to induce calm and prioritize safety.

- **Do not take their anger personally.** Realize that they are reacting to previous experiences or emotional states.
- **Do not argue.** Your task is to deescalate or to remove roadblocks so you can effectively assist the beneficiary.

- **Listen without interruption.** Do not try to compete or take over the conversation. Manage the session by listening and assessing the situation. Use your active listening skills to try and understand what they are truly upset about. When the opportunity allows, paraphrase or summarize to acknowledge what you believe the core issue is, if possible.
- **Display empathy.** By acknowledging their frustrations without judgment, you can help calm people. They will see that you do care about solving their problem, even if it may mean sending them to an outside entity.
- **Be flexible and patient.** Understand that you each have the same goal in mind. Be willing to stay where the person is and redirect them to the purpose of your appointment as soon as respectfully possible.
- **Suggest realistic steps for resolution.** Once you feel things have begun to calm, it will be important to establish the next steps. You might say something like:
    - "I can certainly appreciate your frustration with the current situation. Perhaps our next step is for me to assist you with your specific questions related to the SMP program. At the end, I can share some other resources that might help."
- **Prioritize safety**. If they display threatening or aggressive behavior that doesn't respond to your deescalation techniques, create physical distance. Back away or make an excuse for leaving the room.

There may be times when your efforts are not effective or when the individual's needs are beyond your expertise. Their emotional or behavioral state needs more targeted assistance from another type of provider. In these cases, it is important to understand your agency's policies or procedures. Know this information before any session. Always remember and stay within the boundaries of your role. When additional assistance is needed that goes beyond the scope of the SMP program, see Appendix B to determine which organization may be able to help.

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CHAPTER 5: Handling SMP Questions

Before You Start: Be Prepared!

Being prepared to hold SMP counseling sessions will help you be more at ease and have a more rewarding and enjoyable counseling experience. In this chapter, we will pull together everything you have learned so far and detail how to handle SMP questions. You can ensure you are prepared by doing your homework, knowing the processes within your SMP, and using SMP resources.

When you meet with beneficiaries, have your resources handy, especially this chapter and the appendices from this manual.

Do Your Homework

To answer as many questions yourself as possible, do your homework and become familiar with the information provided in your SMP training materials.

- Review this *SMP Counselor Training Manual* and reference it as needed when answering questions. In particular, familiarize yourself with the FAQs section of this chapter and the appendices.
- Also review the *SMP Foundations Training Manual* and reference it as needed for information about the SMP mission, Medicare basics, and Medicare fraud, errors, and abuse.

State and Local Information #10: Homework

Is there any extra homework or other training materials you should be familiar with in your local area prior to holding an SMP counseling session? Ask your SMP director or coordinator of volunteers.

Although you are certainly not expected to memorize everything in these manuals, you should be familiar with the basic content and know where to look for additional information if needed. This will help you answer as many questions yourself as possible.

State and Local Information #11: SMP Counseling Processes

What are the counseling processes for your SMP? Discuss with your SMP director or coordinator of volunteers.

Know the Process

The process for handling SMP questions varies by state or region. However, certain key concepts are the same across the country. It's important for you to be aware of the process to handle each type of question. See Appendix D: Process Checklist and discuss any state-specific process information with your SMP director and/or coordinator of volunteers.

Role-specific Processes

As described in Chapter 1, if you wear multiple "hats," consider which hat you are wearing when answering questions.

Use SMP Resources

A variety of reference materials may be used during individual counseling sessions to help you answer questions and educate beneficiaries further about Medicare fraud, errors, and abuse. Be familiar with SMP resources, and don't be afraid to use them!

See Appendix E: SMP Counseling Resources for information about resources for SMP counselors and tips on finding resources in the SMP Resource Library.

During the Session: FAQs

All of your SMP Counselor Training is leading up to this moment: actually handling SMP questions! By the time you meet with a beneficiary, you will be familiar with the information in this training, comfortable with your counseling skills, and able to use your resources to help get beneficiaries the answers and help they need.

In this section of the manual, we will tie together information from the previous chapters by reviewing how to handle frequently asked questions (FAQs) for each type of question: SMP basic interactions, SMP complex interactions, and questions that aren't SMP individual interactions.

SMP Basic Interactions

If the question is a basic interaction (as described in Chapter 1 and Appendix A), you can answer it yourself. Here are some examples of common SMP basic interactions and information about how to handle each of them:

FAQ #1: Can you tell me more about the SMP program?

Answer: Use your own knowledge about the SMP program to answer this question and reference the *SMP Foundations Training Manual* and other SMP resources as needed for details. For example, the national SMP flyer and bookmark and the SMP tip sheets (described in Appendix E) can be used for your own information and as handouts for beneficiaries. You can also encourage them to visit www.smpresource.org for more information about the SMP program.

FAQ #2: Is there an SMP presentation I can attend sometime soon?

Answer: Use your own knowledge about presentations offered by your SMP and/or send this person to someone at your SMP who knows more about presentations and can provide more information.

FAQ #3: Could you send me a copy of the SMP flyer I read about in a recent newspaper article?

Answer: Follow your SMP's processes for sending materials and/or send this person to someone at your SMP who can help.

FAQ #4: Could you tell me more about what SMP volunteers do and how I can sign up?

Answer: Share information about your own experience volunteering for the SMP program and send this person to your coordinator of volunteers or someone else who can provide more information about volunteering for the SMP.

FAQ #5: I don't understand how to read my MSN/EOB. Can you help?

Answer: One of the most important roles of SMP counselors is to review Medicare Summary Notices (MSNs) and Explanations of Benefits (EOBs) with beneficiaries. This includes educating beneficiaries about how to read their MSNs and EOBs and answering beneficiary questions related to MSNs and EOBs. See Chapter 2 for details about how to review MSNs/EOBs and see Chapter 3 for details about how to use the My Health Care Tracker.

FAQ #6: I received a My Health Care Tracker in the mail (or at a presentation), and I have some questions about how to use it. Can you help?

Answer: See Chapter 3 for details about how to use the My Health Care Tracker and see Chapter 2 for details about how to review MSNs/EOBs.

FAQ #7: I was reviewing my MSN and My Health Care Tracker, and I think I see something that's not right. How do I know if it's fraud, errors, or abuse?

Answer: Educating beneficiaries about how to recognize fraud, errors, and abuse is an important part of your role as an SMP counselor. In some situations, a beneficiary may think that they have detected fraud, errors, or abuse but during the conversation you may determine that the problem is really a lack of understanding

Questions for Other SMP Team Members

In some situations, you may receive specific types of questions, complaints, and concerns that should be sent directly to someone at your SMP who specializes in that area. For example, if you receive a request for information about volunteering with the SMP, you may need to send the person to your coordinator of volunteers.

State and Local Information #12: Other SMP Questions

Who handles complex interactions at your SMP? Who handles requests to become an SMP volunteer? What other types of questions go to someone else at your SMP? Ask your SMP director or coordinator of volunteers.

Use the Medicare Statements Tip Sheet!

The Medicare Statements Tip Sheet explains what an MSN and EOB are, what they explain, how to use them to detect fraud, errors, and abuse, and information to look for. See Appendix E for tips on finding resources in the SMP Resource Library.

about how Medicare works. Let's face it: Medicare can be confusing! In these situations, you may be able to answer a basic Medicare question and/or look at the beneficiary's MSN or EOB with them to help resolve their confusion.

Depending on the situation, this type of question could be a basic interaction, a complex interaction, or not an SMP question, as shown below.

Basic Interaction	NOT an SMP Question	Complex Interaction
If this type of question is answered in one conversation and does not require research or follow-up, it's a basic interaction.	If in-depth Medicare information is needed that is unrelated to the SMP mission, send the beneficiary to your local SHIP.	If, after reviewing the beneficiary's MSN or EOB with them: • Additional, in-depth review of personal documents is needed; • If you identify potential fraud, errors, or abuse; or • You aren't sure, Send them to a complex interactions specialist.

See Appendix E: SMP Counseling Resources for resources to help answer this type of question. For example, the SMP Foundations Training materials provide basic information about the difference between fraud, errors, and abuse, and several tip sheets related to fraud, errors, and abuse are available to use in conversations with beneficiaries.

FAQ #8: I was reviewing my MSN and I noticed that Medicare is paying for a service from a provider I don't know. Should I report this?

Answer: This question can also be caused by confusion on the part of the beneficiary. This concern often arises when a beneficiary receives services that are not commonly performed in the beneficiary's presence, such as lab test processing or an X-ray reading by a radiologist. To avoid confusion, beneficiaries or their caregivers can ask the physician's office staff if other suppliers, labs, or doctors will bill Medicare for services related to this visit. You may suggest that beneficiaries contact their provider to verify that the doctor authorized the charges. You can also review the beneficiary's MSNs to make sure that Medicare was billed only for the services the physician performed or referred.

Basic Interaction	NOT an SMP Question	Complex Interaction
As long as this situation can be resolved by educating the beneficiary, you	If in-depth Medicare information is needed that is unrelated to the	If any of the following is true, send the beneficiary to a complex interactions specialist: 1) The beneficiary is not comfortable

can answer it yourself as a basic interaction.	SMP mission, send the beneficiary to the local SHIP.	contacting the provider. 2) The beneficiary contacts their provider and can't get the answers they need. 3) The beneficiary indicates that this is not only a service from a provider that they don't know but that they also didn't even receive the service!

FAQ #9: I need a new Medicare card. Can you help?

Answer: Ask the beneficiary if they think the card was stolen or simply lost.

Basic Interaction	Complex Interaction
If the card is lost and the beneficiary doesn't suspect that someone stole it, they can call 1-800-Medicare to request a replacement or access their Medicare.gov account to print a new one. 1) If the beneficiary is requesting a new card, it will be paper, not coated in plastic. 2) If the beneficiary is printing a new card themselves, it's fine to print it using black and white instead of color.	If the card was stolen or if the beneficiary is in doubt about whether it was stolen, send them to a complex interactions specialist.

Know When to Get an Answer and Call the Person Back

If you can't answer the question right away, it's better to admit that you need to look into it and get back to the beneficiary than to provide an incorrect answer. Make note of the person's name, contact information, and the best time to reach them.

Let the beneficiary know that it may take a few days to find the information and that you or someone else from your SMP will contact them once you have an answer. Be sure to follow up on your session. Even if you don't get the information for the beneficiary within a few days, follow up and let them know your progress. It is important for beneficiaries to know that they have not been forgotten.

State and Local Information #13: SIRS Data for Basic vs. Complex

When a basic interaction becomes a complex interaction, how is the SIRS data entry handled at your SMP? Will you perform the initial data entry into SIRS and email the reference number to someone at your SMP who handles complex interactions or should you follow some other process? Ask your SMP director or coordinator of volunteers.

SMP Complex Interactions

As described in Chapter 1, if an individual interaction cannot be resolved by providing education or information and requires additional action on behalf of the SMP to resolve a complaint of potential fraud, errors, or abuse or if it's too complicated to be sure, it's a complex interaction. See Chapter 1 to review examples of complex interactions.

If the question is a complex interaction, unless you have received training to handle complex interactions yourself, you should send the beneficiary to a complex interactions specialist for follow-up.

Take note of information you receive during your counseling session that may be useful to the person who will handle the complex interaction at your SMP.

Here are a few frequently asked questions that are SMP complex interactions and additional information about how to handle each of them. The most common types of complex interactions fall within FAQ #10. FAQs #11 – 14 are examples of situations that are too complicated to decide and should also be sent to a complex interactions specialist (as mentioned in Chapter 1).

FAQ #10: How do I report suspected Medicare fraud, errors, or abuse?

Answer: Send all reports of suspected Medicare fraud, errors, or abuse to a complex interactions specialist. See Chapter 1 for examples.

Errors that need to be resolved are also complex interactions. Send the beneficiary to someone at your SMP who handles complex interactions to follow up and track the issue.

If the beneficiary calls to report a Medicare scam they **avoided**, this could also be a complex interaction!

Send the beneficiary to someone at your SMP who handles complex interactions to decide if there is enough information to make a referral.

SMP Complex Interactions: Too Complex to Decide

FAQ #11: I just gave out my Social Security number and I don't think I should have. Do you think this was a scam, and what should I do?

Answer: If the beneficiary thinks their SSN has been compromised and they may be a victim of identity theft, send them to a complex interactions specialist to track the issue in SIRS and help guide the beneficiary through the process to resolve the issue.

FAQ #12: Medicare says they won't pay since I have other insurance. Can you help me?

Answer: When the Medicare program does not have primary payment responsibility – that is, when another entity has the responsibility for paying before Medicare – Medicare may be the "secondary payer," not the primary payer. Primary payer examples include employer group health plans, COBRA, retiree health plans, no-fault insurance and liability insurance, and workers' compensation insurance. If a beneficiary has other health coverage besides Medicare, and many do, coordination of benefits rules decide which pays first. Since these situations are often too complicated to be sure how to handle, send these questions to a complex interactions specialist.

FAQ #13: Can you help me with a quality-of-care concern?

Answer: Complaints related to the quality of medical services received should be sent to a complex interactions specialist so that they can make a referral and follow up as needed.

FAQ #14: I keep getting phone calls from someone who claims I'm not getting all of my Medicare benefits and offering to help me get the most out of Medicare. Is this a scam?

Answer: These types of phone calls are often the result of a beneficiary responding to a TV advertisement or a postcard solicitation offering a deal on health care benefits. Once the beneficiary responds, they are added to a contact list, which can result in a variety of solicitation phone calls, such as calls about Medicare plans offering special benefits, Social Security money back, $0 plans, etc. These calls are likely coming from Medicare Advantage (Part C) plan representatives who are trying to get the beneficiary to switch plans.

Your role as an SMP counselor is to send these questions to a complex interactions specialist. This situation may involve all three types of responses, as shown in the chart below.

Basic Interaction	NOT an SMP Question	Complex Interaction
Let the beneficiary know they should ask to be taken off the list each time they get an unsolicited call.	If the beneficiary wants to make sure they are on the best plan for them, they can contact their local SHIP.	Also send the beneficiary to a complex interactions specialist in order to report the calls they're receiving.

Not SMP Interactions

As we have seen throughout this manual, the SMP may receive questions that are not related to the SMP mission. These questions are not SMP interactions and should be sent to the appropriate entity to address the beneficiary's concern.

If the question isn't related to the SMP mission, ask a few questions to try to narrow down the issue. This will help you send the beneficiary to an appropriate agency.

If you need to send the beneficiary to someone else for an answer, provide all available contact information, including the name of the organization, phone number, email address, and web address.

FAQ #15: I want to report a consumer scam or internet scam that attempted to get my money. What should I do?

Answer: SMPs are naturally concerned about reports of consumer and internet scams (such as lottery scams, the grandparent scam, and romance scams), and these concerns certainly need to be addressed. However, it is not the role of the SMP to manage the resolution of consumer or internet scams that are not related to the SMP mission. Your role in these cases is to send consumers to the appropriate entities that can help them with their concerns.

Direct the beneficiary (or other consumer) to the appropriate agency based on the situation. For example:

- Complaints of consumer fraud can be reported by victims (or by someone else on their behalf) at the Federal Trade Commission (FTC)'s complaint reporting site: https://reportfraud.ftc.gov/.
- If the consumer gave out their banking information, they should contact their financial institution to close out the account or take other action as determined appropriate by the financial institution.
- If a suspected crime has been committed, they should contact their local law enforcement to report the issue.
- See Appendix B for additional credit reporting tips. For example, consumers can receive free credit reports at www.annualcreditreport.com, sign up for the Do Not Call Registry at www.donotcall.gov, and more.

Sometimes beneficiaries call with concerns about a survey they received from a source that seems legitimate (e.g., CMS) asking for personal information.

Legitimate surveys are sent regularly by CMS and other government and medical organizations. Legitimate surveys do not ask for Social Security numbers, Medicare numbers, or credit card numbers.

Find out who the survey is from and what kind of information is requested, then review the list of FAQs in Appendix C to determine how to handle the situation.

- Information and resources to help consumers report and recover from consumer scams are available from the FTC on its consumer website: www.consumer.ftc.gov.
- To order bulk supplies of free FTC brochures and other resources for your SMP, visit the FTC's bulk order website: https://bulkorder.ftc.gov/.

Is it an SMP interaction? It all depends on the SMP mission!

For many questions, the decision to send the beneficiary to someone outside of the SMP comes down to whether the question is related to the SMP mission. You may need to spend some time talking with the beneficiary before you can determine if the question involves potential Medicare fraud, errors, or abuse and where to send the beneficiary for additional assistance.

Ask consumers if they have Medicare and if their Medicare number may have been compromised. If the complaint of a consumer scam or identity theft is potentially related to Medicare or health care fraud, treat this as a complex interaction.

FAQ #16: Someone tried to get ahold of my Social Security number, but I didn't give it to them. What should I do?

Answer: Send the beneficiary to the FTC and local law enforcement, as described in the previous FAQ. If the question is related to the SMP mission or if the beneficiary did give out their Social Security number, send them to a complex interactions specialist.

FAQ #17: Which Medicare plan is best for me?

Answer: Sometimes beneficiaries who need help choosing the right Medicare plan during their enrollment period turn to the SMP for help. When this happens, please remember that counseling beneficiaries on Medicare benefits and plan choices is the function of the SHIP, not the SMP. Answering these types of questions can be very complex and time-consuming and is best left to the experts.

Your role as an SMP counselor is to put the beneficiary in touch with the local SHIP program (unless you are also trained as a SHIP counselor). To find the SHIP in your state, visit the SHIP Technical Assistance Center website: www.shiphelp.org. If the beneficiary's benefits counseling question is in addition to a complaint about fraud, errors, or abuse, the question should be sent to a complex interactions specialist.

FAQ #18: Can you help me with a coverage question?

Answer: Sometimes beneficiaries who need help with Medicare coverage questions turn to the SMP for help. For example, they may want to know if Medicare or Medicaid covers a nursing home stay. As with the previous FAQ, answering coverage questions is the function of the SHIP, not the SMP. Unless you are also trained as a SHIP counselor, send the beneficiary to the local SHIP program for assistance.

FAQ #19: Can you help me file an appeal with Medicare?

Answer: If a beneficiary's Medicare claim is denied, they may want to file an appeal. Although you can direct the beneficiary, it is not the SMP's role to help with a Medicare appeal.

If a Medicare appeal is the beneficiary's only concern, this is not within the SMP mission. SHIPs (www.shiphelp.org) help beneficiaries understand the appeals process and provide assistance when needed. Your role as an SMP counselor (unless you are also a SHIP counselor) is to put the beneficiary in touch with their local SHIP.

If the Medicare appeal is in addition to a complaint of fraud, errors, or abuse, this issue should be sent to a complex interactions specialist.

FAQ #20: Can you help me with information and assistance that's not related to the SMP mission?

Answer: For questions that are not related to the SMP mission, your role as an SMP counselor is to direct the beneficiary to an information and assistance provider or other appropriate organization outside of the SMP that is prepared to handle each type of question. Some agencies that can help beneficiaries include Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), Long-Term Care Ombudsmen (LTCO), State Health Insurance Assistance Programs (SHIPs), 1-800-Medicare, Eldercare Locator, and Social Security.

For a list of agencies where you can send beneficiaries for help with questions that are not related to the SMP mission, see Appendix B: Contacts Outside of the SMP.

State and Local Information #14: Information and Assistance

Some SMPs have state or local resources and/or contacts for information and assistance services (such as an internal non-SMP staff person or other local AAA contact) in addition to the ADRC and/or Eldercare Locator. Does your SMP have any local information and assistance services? Which resources does your SMP prefer that you contact first? Ask your SMP director or coordinator of volunteers.

After the Session: Tracking and More

After each counseling session is complete, take the following steps as needed:

- Send the beneficiary any applicable materials or provide their contact information and request for materials to someone at your SMP who will do this. For example:
  - Flyers or tip sheets related to the question you discussed
  - An SMP business card with contact information
- Get the answers for any basic questions that you weren't able to answer and call the beneficiary back or provide their contact information to someone at your SMP who will follow up.
- Notify the appropriate person at your SMP of any complex interactions ASAP so that they can follow up right away. Follow your SMP's processes regarding collecting documents for further research by a complex interactions specialist.
- Follow your SMP's process to track each counseling session.

Process Checklist

See Appendix D for a checklist of the steps to take following an SMP counseling session.

SMP Tracking and the OIG Report

As mentioned earlier, each SMP counseling session is entered into SIRS as a basic interaction and included on the OIG Report. In addition, information about time worked by volunteers, staff, and partners related to these sessions (including driving time, setup, etc.) is entered into SIRS and included on the OIG Report. This means that all the time you spend on SMP counseling sessions, as well as any other work or training you do for the SMP, should be tracked and reported so that it can be included on the OIG Report.

Submitting complete and accurate data for the OIG Report is important to SMPs for several reasons:

- It shows the media and the general public the excellent work that is being done by the SMP to educate beneficiaries about how to prevent health care fraud.
- It helps support continued funding for the SMP program.
- It provides required information to the Office of Inspector General (OIG) and the Administration for Community Living (ACL).

Although all SMPs are required to submit an OIG Report each year, the process used for gathering reporting data varies somewhat from one SMP to another. Familiarize yourself with and follow the process used by your SMP to collect data.

State and Local Information #15: Tracking

Talk with your SMP director or coordinator of volunteers about expectations for tracking data related to counseling sessions, including individual interactions and time spent on SMP work. Who will enter each type of data into SIRS? Is this data also tracked in another way, such as electronic or paper forms? How is information shared securely among SMP team members who need it?

Are You Ready?

Now that you have learned about how to effectively handle SMP basic interactions, talk with your SMP director or coordinator of volunteers about how to ensure you are ready to begin working as an SMP counselor! Remember to use the FAQs, process checklist, and other resources in the appendices to help you prepare for, conduct, and follow up after each counseling session.

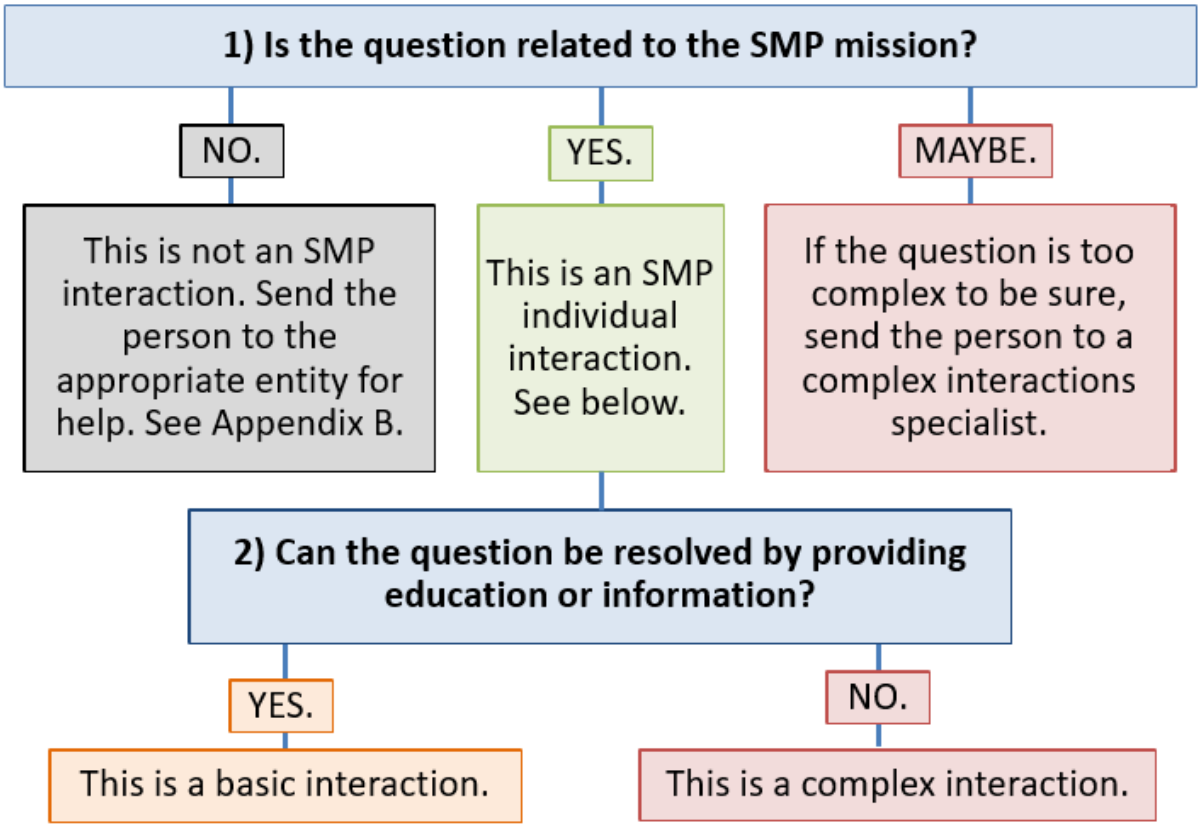
SMP
Senior Medicare Patrol
Preventing Medicare Fraud

SMP Counselor Training Manual

Appendices

Appendix A: Types of SMP Questions Flow Chart

Use the chart and descriptions below to determine if a question is an SMP individual interaction or not, and if so, which type of individual interaction: basic or complex. See Chapter 1 for additional information.



1) Is the question related to the SMP mission?

The SMP mission:

- The mission of the Senior Medicare Patrol (SMP) program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.
- The SMP mission involves educating beneficiaries about the SMP program, outreach and education events, volunteer opportunities, and/or potential Medicare fraud, errors, or abuse.

No.	This is not an SMP interaction. Send the person to the appropriate entity for help. See Appendix B: Contacts Outside of the SMP.
Yes.	This is an SMP individual interaction. See below for one final step to determine the type of individual interaction: basic or complex.
Maybe.	If the question is too complex to be sure, send the person to a complex interactions specialist unless you have completed SMP Complex Interactions Training.

2) Can the question be resolved by providing education or information?

Education or information:

- Basic interactions are outreach and education activities of the SMP program. The purpose of these types of interactions is to educate and inform.
- Any question that requires additional actions beyond providing education or information (such as conducting research, following up with a provider or 1-800-Medicare, or making a referral) should be sent to a complex interactions specialist.

Yes.	If the question can be resolved by providing education or information, it's a basic interaction! You will learn how to handle basic interactions in this SMP Counselor Training.
No.	If additional action is needed, it's a complex interaction! Send the person to a complex interactions specialist unless you have completed SMP Complex Interactions Training.

Appendix B: Contacts Outside of the SMP

Use the state-specific and national agency grids below to identify which agency may be best suited to answer each question that is not related to the SMP mission. Provide the appropriate contact information to the beneficiary.

State-specific Agencies	What They Do	How to Find Them in Your State
Adult Protective Services (APS)	Promote safety, independence, and quality of life for older persons and persons with disabilities who are being mistreated or in danger of being mistreated and are unable to protect themselves	Visit the National Adult Protective Services Association (NAPSA) website: www.napsa-now.org/.
Aging and Disability Resource Centers (ADRCs)	Provide information and assistance services statewide; available in most states	Eldercare Locator: https://eldercare.acl.gov Search by location or call 1-800-677-1116.
Area Agencies on Aging (AAAs)	Address the needs and concerns of all older persons regionally and locally. Coordinate and offer services that help older adults remain in their homes, aided by programs such as Meals on Wheels, homemaker assistance, and others to make independent living a viable option	Eldercare Locator: https://eldercare.acl.gov Search by location or call 1-800-677-1116.
Attorneys General (AG) Offices	Act as public advocates in areas such as consumer protections; handle criminal appeals and serious statewide criminal prosecutions	National Association of Attorneys General website: www.naag.org
Better Business Bureaus (BBBs)	Monitor advertising and selling practices, provide consumers with information about companies, help resolve consumer complaints, and alert consumers to bad business and advertising practices	National website: www.bbb.org
Consumer Protection Services (various)	State agencies are dedicated to consumer protection, including but not limited to banking authorities, utility commissions, and security administrators	Visit www.usa.gov to search for consumer protection agencies in your state.

State-specific Agencies	What They Do	How to Find Them in Your State
Insurance Commissioners	Facilitate fair and equitable treatment of insurance consumers; promote reliability, solvency, and financial solidity of insurance institutions; and support and improve state regulation of insurance	National Association of Insurance Commissioners website: www.naic.org
Law Enforcement	Address complaints of scams, fraud, and criminal activity locally, including suspicious solicitation through door-to-door sales, telemarketing, and the mail	See your local phone directory.
Long-Term Care Ombudsmen (LTCO)	Provide information and education on long-term care insurance; provide advocacy for long-term care residents	National LTCO Resource Center: www.ltcombudsman.org Visit the map.
State Health Insurance Assistance Programs (SHIPs)	Provide information, assistance, and counseling to Medicare beneficiaries on a range of Medicare, Medicaid, and Medigap matters, such as: Medicare definitions, benefits, coverage, enrollment, and appeals; Medicare Prescription Drug Plan and Medicare Advantage options; and public health care benefit programs for those with limited income and assets	SHIP Technical Assistance Center website: www.shiphelp.org

National Agencies	What They Do
AnnualCreditReport.com	Provides consumers with free credit reports from each credit reporting company every 12 months at www.annualcreditreport.com

Centers for Medicare & Medicaid Services (CMS)	Provide Medicare information for consumers via their toll-free number and website (including an account login for personalized information):
	• 1-800-Medicare (1-800-633-4227): Answer beneficiary questions about general Medicare information or specific eligibility, enrollment, benefit, billing, or claims information
	• www.medicare.gov: Access all types of Medicare information, including a list of plans in each area and online access to the *Medicare & You* handbook
	• www.medicare.gov/account/login: Access Medicare's free, secure online service for personalized information regarding Medicare benefits and services
	  ○ Claims (such as MSNs) can be viewed within days of processing
	  ○ Beneficiaries can also sign up for eMSNs to receive an email each month when MSNs are available instead of receiving a paper copy every three months

Consumer Credit Reporting Industry	Allow consumers to opt out of receiving prescreened offers of credit and insurance at www.optoutprescreen.com
Direct Marketing Association (DMA)	Allow consumers to opt out of unsolicited commercial mail and email: www.dmachoice.org
Do Not Call Registry	Allow consumers to avoid receiving telemarketing calls by registering at 1-888-382-1222 or www.donotcall.gov
Eldercare Locator	Provides information and assistance services on aging for all states. Visit https://eldercare.acl.gov and search by location or topic or call 1-800-677-1116.
Federal Communications Commission (FCC)	Regulate interstate and international communications by radio, television, wire, satellite, and cable; responsible for implementing and enforcing America's communications law and regulations. Visit https://www.fcc.gov/.

National Agencies	What They Do
Federal Trade Commission (FTC)	Serve as the nation's consumer protection agency; collect complaints about companies, business practices, and identity theft; provide information and resources about consumer fraud and identity theft: • FTC consumer website: www.consumer.ftc.gov/ • FTC bulk order website: https://bulkorder.ftc.gov/ • FTC site for victims of identity theft: www.identitytheft.gov • FTC site to report a complaint of consumer fraud: https://reportfraud.ftc.gov/ (English) or https://reportefraude.ftc.gov/ (Spanish)
The FBI's Internet Crime Complaint Center (IC3)	Provide a wealth of information about internet crime schemes, such as email spam, "you have won the lottery" emails, and phishing (unsolicited emails that entice an individual to visit a fraudulent website and provide sensitive personal information); receive reports of incidents of internet crime. Visit www.ic3.gov.
Securities and Exchange Commission (SEC)	Protect investors against fraud; oversee the key participants in the securities world, including securities exchanges, securities brokers and dealers, investment advisors, and mutual funds. Visit www.sec.gov/.
Social Security	Provide information about Part A and/or Part B eligibility and enrollment. Provide replacement Medicare cards. Help beneficiaries change their address for Medicare and Social Security. Help beneficiaries apply for "Extra Help" with Medicare prescription drug costs. Beneficiaries can sign up for a "My Social Security" account to track earnings, get estimates of benefit payouts, and more. Visit www.ssa.gov or call 1-800-772-1213.
U.S. Postal Inspection Service	Investigate any crime in which the U.S. mail is used to further a scheme, whether it originated in the mail, by telephone, or on the internet. To report suspected mail fraud, call your local post office for guidance or submit a complaint online at: https://www.uspis.gov/report.

Appendix C: FAQs Summary List

Chapter 5 provides frequently asked questions and answers for SMP counselors. The chart below serves as a quick reference guide to make it easier to find each FAQ.

Type	Number	Question	Page
Basic Interaction	FAQ #1	Can you tell me more about the SMP program?	74
	FAQ #2	Is there an SMP presentation I can attend?	74
	FAQ #3	Could you send me a copy of an SMP flyer?	74
	FAQ #4	Could you tell me more about what SMP volunteers do and how I can sign up?	75
	FAQ #5	Can you help me read my MSN/EOB?	75
	FAQ #6	Can you help me use a My Health Care Tracker?	75
	FAQ #7	I was reviewing my MSN and My Health Care Tracker, and I think I see something that's not right. How do I know if it's fraud, errors, or abuse?	75
	FAQ #8	I was reviewing my MSN and I noticed that Medicare is paying for a service from a provider I don't know. Should I report this?	76
	FAQ #9	I need a new Medicare card. Can you help?	77
	FAQ #10	How do I report suspected Medicare fraud, errors, or abuse?	78
Complex Interaction	FAQ #11	I just gave out my Social Security number and I don't think I should have. What should I do?	78
	FAQ #12	Medicare says they won't pay since I have other insurance. Can you help me?	79
	FAQ #13	Can you help me with a quality-of-care concern?	79
	FAQ #14	I keep getting phone calls from someone who claims I'm not getting all of my Medicare benefits. Is this a scam?	79
Not an SMP Question	FAQ #15	I want to report a consumer scam or internet scam that attempted to get my money. What should I do?	80
	FAQ #16	Someone tried to get ahold of my Social Security number, but I didn't give it to them. What should I do?	81
	FAQ #17	Which Medicare plan is best for me?	81
	FAQ #18	Can you help me with a coverage question?	82
	FAQ #19	Can you help me file an appeal with Medicare?	82
	FAQ #20	Can you help me with information and assistance that's not related to the SMP mission?	82

Appendix D: Process Checklist

Use the checklist below for tips and reminders when handling SMP questions:

Before the Session

- Complete all necessary training!
  - Your SMP Foundations Training knowledge will help you provide information about the SMP program, Medicare, and Medicare fraud, errors, and abuse.
  - Your SMP Counselor Training knowledge will help you handle SMP questions using effective counseling skills, resources, etc.
  - Your training on privacy, confidentiality, and other topics as required by your SMP will help you follow your SMP's processes.
- Gather and organize your resources. Have them handy when meeting with beneficiaries so that you are prepared to answer questions. Resources are described in detail in Appendix D. Suggested resources include:
  - *SMP Foundations Training Manual*
  - *SMP Counselor Training Manual*, especially the appendices and the FAQs in Chapter 5.
  - My Health Care Trackers, SMP flyers, tip sheets, etc.
- Think about where and how you will meet with the beneficiary (over the phone, online, in person, at the office, etc.) and prepare yourself and your space appropriately.
  - Over the phone or online
    - Follow your SMP's processes for meeting over the phone or online. For example, determine which online meeting platform to use and practice using it.
  - At the SMP office (scheduled appointments or walk-ins)
    - Put away materials that aren't pertinent. Never leave confidential information open on a desk.
  - Scheduled appointments away from the SMP office
    - Identify an appropriate setting to talk privately.
  - At community outreach education events or individual Q&A following group education sessions
  - Other _____
- Regardless of where and how you plan to meet with the beneficiary, inform them of what to bring with them to the counseling session: MSNs, EOBs, bills, Medicare cards, a completed My Health Care Tracker, etc.

Counseling Tips

- Be prepared to help beneficiaries with disabilities or language differences so they will have access to the SMP's services.
- If meeting face-to-face, make sure the counseling site is private and free from distractions.
- For scheduled appointments:
  - While some individual counseling sessions may be quick, others could take up to an hour or more. Make sure that both you and the beneficiary have enough time to address the question or issue.
  - Call to confirm the date and time of the session.
- If the question might take more time to answer or additional privacy is needed, ask the beneficiary if they would prefer to schedule an appointment for later.

During the Session

- Set the stage.
  - Make a good first impression.
  - Greet the beneficiary.
  - Introduce yourself.
  - Explain how you can help.
- Listen actively.
  - Invite the beneficiary to explain their situation or problem.
  - Ask clarifying questions and take notes as needed.
  - Focus on the beneficiary.
  - Confirm your understanding of the situation and the beneficiary's needs.
- Identify the type of question (basic interaction, complex interaction, or not an SMP interaction) by asking yourself these questions:
  - Is the question related to the SMP mission?
  - Can the question be resolved by providing education or information?
- Respond based on the type of question,
  - Basic interaction:
    - Answer the question using your knowledge and resources.
    - If you can't answer the question right away, let the beneficiary know that you need to look into it and get back to them. Make sure to get their contact information and best time to call.

  - Complex interaction:
    - Note as many details as you can, including information about their question or concern and their contact information.
    - Let the beneficiary know who at your SMP will receive their information, when they can expect to hear from the SMP, and how to contact the SMP directly if needed.
  - Not an SMP interaction:
    - Try to narrow down the issue. This will help you send the beneficiary to the most appropriate agency.
    - See Appendix B: Contacts Outside of the SMP to identify which agency may be best suited to help the beneficiary. Provide the agency's information to the beneficiary so that they can follow up on their own.
- Confirm that you have met the beneficiary's needs and ask them to pass on what they have learned.

After the Session

- Send the beneficiary any applicable materials or provide their contact information and request for materials to someone at your SMP who will do this. For example:
  - Flyers or tip sheets related to the question you discussed
  - An SMP business card with contact information
- Get the answers for any basic questions that you weren't able to answer and call the beneficiary back or provide their contact information to someone at your SMP who will follow up.
- Notify the appropriate person at your SMP of any complex interactions ASAP so that they can follow up right away. Follow your SMP's processes regarding collecting documents for further research by a complex interactions specialist.
- Follow your SMP's process to track each counseling session.

Appendix E: SMP Counseling Resources

General information about SMP resources at www.smpresource.org is provided in the *SMP Foundations Training Manual*. This manual focuses on training and resources specifically for SMP counselors.

SMP Login: Accessing the SMP Resource Library and TRAX

The SMP Login area at www.smpresource.org provides access to the SMP Resource Library and/or TRAX: Training Tracker, depending on each SMP team member's access level. The training curricula developed by the SMP Resource Center are available exclusively in TRAX. If you do not already have access to TRAX and/or the library, talk to your SMP director or coordinator of volunteers to find out if they want you to have access to TRAX, the library, or both. To begin the account setup process, go to the SMP Login page, click the link to "Create an account," and complete the account sign-up form.

State and Local Information #16: Access to TRAX and the SMP Resource Library

Will you have access to TRAX: Training Tracker and/or the SMP Resource Library? Ask your SMP director or coordinator of volunteers.

Training for SMP Counselors in TRAX

The following training is recommended for SMP counselors and is available in TRAX. Additional training may also be recommended or required by your SMP.

Curriculum Name	Brief Description
Welcome to TRAX	Provides an overview of how to take training in TRAX
SMP Foundations Training	Provides a foundation of knowledge about the SMP program, Medicare basics, and Medicare fraud, errors, and abuse
SMP Counselor Training	Provides training on how to answer basic SMP questions and provide individual SMP education
Privacy & Confidentiality Training	Addresses an array of federal and other issues related to privacy and confidentiality
SMP Resource Library 101	Provides training about how to use the library
SIRS Training – Basic Data Entry	Provides training to enter your own basic data into SIRS

SMP Counselor Training Curriculum

The SMP Counselor Training curriculum in TRAX that accompanies this manual is intended for all SMP counselors. It includes online training, an assessment, and related resources for SMP counselors, such as the national SMP flyer and bookmark, My Health Care Tracker, Medicare Statements Tip Sheet, and a link to additional tip sheets at www.smpresource.org > Medicare Fraud > Fraud Schemes.

Resources for SMP Counselors in the Library

A variety of additional resources that may be useful for SMP counseling sessions are available in the SMP Resource Library. Resources include those developed nationally for SMPs and those developed by individual SMPs that can be used by other SMPs. Because resources are constantly being added, we cannot provide a complete listing of resources here. Search tips are provided below to help you find the resources you need.

SMP Resource Library FAQs

The FAQs tab in the library provides instant access to help with the most frequently asked questions related to the library and TRAX. It's a great place to go if you need help with the library and want an answer right away.

Note: *The Center makes translations of resources available whenever possible. When available, they will be located in the SMP Resource Library together with the English language version.*

Search for a specific resource by name using the keyword search.

Use the standard keyword search to start typing the name of a specific resource. When you see the name in the list that appears, select it and click "Search." For example:

- **National SMP Flyer and Bookmark:** The Administration for Community Living (ACL) released the national SMP flyer in 2022 and bookmark in 2017. Both resources focus on the SMP program and mission, including messaging about how to "Protect, Detect, and Report."
    - Search for the ACL entries called "National SMP Flyer" and "National SMP Bookmark."
- **My Health Care Tracker:** Medicare beneficiaries can use the trackers to record what happens at doctors' appointments and then compare that information with the products and services received with their insurance statements, thereby helping to detect potential Medicare fraud, errors, and abuse. They can also learn about the vital work that SMPs and SHIPs perform, how they can volunteer, and contact information for other resources they may need.
    - Search for the SMP Resource Center entry called "My Health Care Tracker."

- **Tip Sheets:** The SMP Resource Center has developed tip sheets related to a variety of fraud schemes for SMPs to use in their outreach and education efforts. National SMP tip sheets, videos, infographics, and additional resources are available on the SMP Resource Center website at www.smpresource.org > Medicare Fraud > Fraud Schemes. Editable versions of the national tip sheets, as well as infographics and press releases, can be found in the SMP Resource Library.
    - For example, search for the SMP Resource Center entry called "Medicare Statements Tip Sheet."

Search for a list of related resources using the keyword search.

Use the keyword search to type a word (or part of a word) that might appear in the name or description of pertinent resources and click "Search." For example:

- **Counsel:** To find resources related to counseling, use this keyword search to see a list of resources that include "counseling" or "counselor" in the name or description.
- **Cultur:** To find resources related to cultural competency, cultural humility, etc., use this keyword search to see a list of resources that include "culture," "cultures," or "cultural" in the name or description.
- **Soft skills:** To find resources related to "soft skills" (described in Chapter 4), use this keyword search.
- **Inclusive:** To find resources related to inclusive language and services, use this keyword search.

Search for a specific type or topic of resource using the advanced search.

Use the advanced search feature to select a specific resource type, topic, origin, etc. with or without a keyword. For example:

- **Tip sheets:** To find editable versions of the national tip sheets developed by the SMP Resource Center and ACL, select both "ACL" and "SMP Resource Center" as the origin and "Tip Sheet" as the type.
- **Communication skills resources:** To find all resources related to counseling that are categorized as "communication skills," select "Communication Skills" as the topic.

State-specific Materials

In addition to resources that are provided nationally, other resources may be developed or customized by your state or local SMP.

The following is a list of materials that are commonly used as handouts at the local/state level. Ask your SMP director or coordinator of volunteers if your SMP uses any of these types of materials, or others, as handouts:

- Local tip sheets, emails, or newsletters

- Local press releases about scams, fraud, and/or SMP
- Testimonials from volunteers or other team members
- Local scam stories: scams to watch out for and/or successful cases resolved in your area

State and Local Information #17: SMP Resources and Processes

Which state and/or local resources are available to you during counseling sessions, including printed or electronic materials and SMP team members you can ask for help? Does your SMP have any specific processes related to using SMP resources, including those developed by your SMP and those developed by other contributors to the library? Ask your SMP director or coordinator of volunteers.

Index and Definitions of Key Terms

This section is both an index and glossary of key terms for SMPs. It provides definitions and lists page numbers within this manual for more information about each term.