Chapter 2 Medicare Eligibility

Medicare was originally targeted to people over age 65 on the assumption that they would be retirees and would be without the benefit of employer-sponsored medical care. The program has never covered people who take early Social Security retirement, although it does cover pre-65 individuals who are qualified for Social Security disability.

Because Medicare was designed to complement federal retirement benefits, eligibility is tied closely to eligibility for Social Security benefits. As with Social Security, the availability of coverage is determined by an applicant's age and the length of time the applicant (or his or her spouse) has worked in employment qualified under the Social Security Act regulations. People can qualify for and receive Medicare without enrolling for Social Security at age 65. They simply enroll in Medicare Part A and pay the Part B premium as if they had also enrolled in Social Security.

Generally, people are eligible for Medicare if they meet the following requirements:

-They or their spouses worked for at least ten years (40 quarters) in Medicare-covered employment. (Medicare-covered employment means employment that requires paying FICA taxes to Social Security and Medicare.)

-They are 65 years old. A person can also qualify for coverage if he or she is a younger person with a disability or with chronic kidney disease.

-They are citizens (by birth or naturalization), permanent residents of the United States, or they are legal resident aliens who have lived in the United States for at least five years.

Part A—Premium Free (for Most)
"Qualifying" Social Security wages are earnings on which Social Security payroll taxes or Social Security self-employment taxes are paid. Whichever work situation applies, the number of Social Security credits needed for Medicare coverage is the same. As a general rule, a person needs to have accumulated 40 quarters of qualified credits to be entitled to Medicare coverage.

With regard to the number of Social Security credits needed to qualify for Medicare coverage, a self-employed person is treated on the same basis as a person who is not self-employed.

Coverage and benefits under Part A require payment of monthly premiums if the applicant has not qualified via the 40-quarter rule. For instance, in 2020, for those who didn't qualify for premium-free Part A coverage, and for those with less than 30 quarters of coverage, the monthly premium for Part A was $458 per person. For those with 30 to 39 quarters of covered employment and for certain disabled persons with 30 or more quarters of covered employment, the premium was $252 per month.

An individual can get Part A at age 65 without having to pay monthly premiums if he or she meets the following requirements:

-He or she is already receiving retirement benefits from Social Security or the Railroad Retirement Board.

-He or she is eligible to receive Social Security or Railroad Retirement benefits but has not yet filed for them.

-He or she or his or her spouse had Medicare-covered government employment.

-He or she has received Social Security or Railroad Retirement disability benefits for 24 months.

-He or she is a kidney dialysis or kidney transplant patient.

Part B—Premiums Required
Coverage and benefits under Part B require payment of monthly premiums. Those who delay purchasing Part B beyond their initial eligibility period are assessed a 10 percent penalty for each full 12-month period that the person could have purchased Part B but failed to sign up for it.

Accuracy of Employment History
Accuracy of employment history is the key to obtaining Medicare benefits. The Social Security Administration keeps all records on file based on W-2 employer-reported earnings and Schedule SE self-employment taxes reported. Generally, federal workers employed after 1983 are eligible for Medicare in the same way that private industry workers are—because they have paid the Medicare hospital insurance part of the Social Security tax. Federal workers employed before 1983 may qualify to have their work credited toward Medicare eligibility under special provisions of the regulations. State and local government workers became eligible for Medicare-qualified employment in 1986.

There are also special regulations covering people who were employed in domestic work, farm work, or religious organizations that were exempt from Social Security tax payments. All of these atypical situations must be evaluated on a case-by-case basis with a Social Security representative.

Basic Enrollment
A person is enrolled in Medicare either:

1. Automatically
2. Active Application

Automatic Enrollment
Those who are not yet 65 but are already receiving Social Security or Railroad Retirement benefits do not have to apply for Medicare—they are enrolled automatically in both Part A and Part B and will automatically be eligible for benefits at age 65. Approximately three months before their sixty-fifth birthday, they will receive a Medicare card in the mail. If they do not want Part B, then they must reject Part B coverage by notifying CMS of their desire not to enroll at that time.

Disabled individuals are automatically enrolled in both Part A and Part B of Medicare beginning in their twenty-fifth month of disability. They will receive the card in the mail about three months before they are entitled to Medicare.

Enrollment by Application
If enrollees are not receiving Social Security or Railroad Retirement benefits, or if they require regular dialysis or a kidney transplant, then they need to actively apply for Medicare three months before turning 65, which is the beginning of the seven-month initial enrollment period. By applying early, they can avoid a possible delay in the start of their Part B coverage. Application can be made by contacting any Social Security Administration office, or by going to Medicare.gov and enrolling personally. If an enrollee or his or her spouse worked for a railroad, he or she should contact the Railroad Retirement Board.

Initial Enrollment Period
The initial enrollment period is seven months. It begins three months before an enrollee turns 65, includes the month the enrollee reaches age 65, and lasts for the next three months. This is the initial enrollment period for both Parts A and B.

If an individual does not enroll in Parts A or B during this initial seven-month period, then he or

she will have to wait to enroll until the next general enrollment period. General enrollment periods are held January 1 to March 31 of each year, and Part A and B coverage starts July 1 of that year.

Delaying Enrollment
If an individual delays enrolling in Medicare by 12 months or more, his or her premiums generally will be higher. As noted, Part B premiums increase 10 percent for each 12-month period that the person could have enrolled but did not, except in special cases, referred to as special enrollment periods. Under these special circumstances, the enrollee can delay Part B enrollment without having to pay higher penalized premiums.

If enrollees are age 65 or over and have group health insurance based on their (or their spouse's) current employment, or if the enrollee is disabled and has group health insurance based on his or her current employment or the current employment of any family member, then the enrollee has a choice:

He or she may enroll in Part B at any time while covered by the group health plan. Delaying enrollment past age 65 while still working and while covered by a group plan will not result in an increase in Part B premiums.

He or she can enroll in Part B during the eight-month enrollment period that begins the month after employment ends or coverage under the employer plan ends, whichever comes first. The coverage under the employer group health plan is considered "creditable" coverage, which allows the applicant to enroll in Medicare without a penalty.

If a person enrolls in Part B while covered by an employer plan or during the first full month when not covered by that plan, Part B coverage begins the first day of the month the person enrolls. If he or she enrolls during any of the seven remaining months of the special enrollment period, then coverage begins the month after enrolling. If the person does not enroll by the end of the eight-month period, then he or she will have to wait until the next general enrollment period that begins January 1 of the next year. The beginning of the month that the recipient enrolls is also the first month that he or she is entitled to the Medicare supplement open enrollment (guaranteed issue) period, which lasts for six months.

Even if a person continues to work after turning 65, he or she should consider signing up for Part A of Medicare if the person qualifies for premium-free Part A. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be advisable to sign up for Part B if the person has health insurance through his or her employer. He or she would have to pay the monthly Part B premium, and this would also trigger the six-month Medicare supplement open enrollment period, which cannot be changed or restarted. If an employer has 20 or more employees, the group health plan would be the primary payor and Medicare the secondary payor. In this case, the person could find value in Part B if the group health plan has high deductibles or coinsurance amounts. If an employer has fewer than 20 employees, Medicare would be the primary payor and the group plan would be secondary. Therefore, it might not be advantageous for the employee to enroll in Part B.

Consumers will not be penalized for delaying Medicare as long as they enroll within eight months of losing employer-provided coverage or retiring, whichever comes first.

Another enrollment factor to consider is whether a person has a health savings account (HSA) and wants to continue to make contributions to the HSA. Enrollment in any part of Medicare makes a person ineligible to contribute further to an HSA.

An individual must enroll in (or keep) Part B coverage if he or she wants to be able to join any of the Medicare Advantage managed care plans, Medicare medical savings accounts, Medicare supplement plans, or other Medicare health insurance options.

In summary, a person turning 65 or older can delay taking Part B if:

-He or she or his or her spouse (of any age) continues to work, and/or
-He or she is covered under a group health plan from that current employment

If a person does not have group health plan coverage based on current employment, and he or she delays taking Part B, the Part B monthly premium will increase by 10 percent for each 12 months that he or she could have had Part B and did not enroll in Part B.

If a person does not enroll in Part B when they should have and did not have creditable coverage, then he or she will only have a chance to sign up for Part B once a year—the general enrollment period—between January 1 and March 31. The Part B insurance will start in July of that year. If a person chooses to delay taking Part B because he or she currently has group health plan coverage, then the person may be able to avoid paying this higher premium by signing up for Part B while he or she has this creditable group coverage in place. The person can also sign up within eight months after the employment ends or the group health coverage ends, whichever comes first.

A note of caution: Under Medicare rules, COBRA is not considered to be creditable coverage. Consequently, delaying enrollment in Medicare Part B because one has COBRA will not avoid the Part B late enrollment penalty.

Medicare Cards
Once enrolled, insureds receive a Medicare card imprinted with their name and Medicare number, which they should show to providers whenever receiving medical care. This will ensure that a claim for payment is sent to Medicare. The card shows what coverage the insureds have (Part A, Part B, or both) and the date the coverage started. Insureds should also present to the provider their Medicare supplement company card, if they have such coverage. Those enrolled in a Medicare Advantage plan should present their MA plan card to the provider; these individuals do not have to show their Medicare card. Further, insureds should make sure to use their exact name and Medicare number. If the insured is married, then the spouse will also have his or her own card and Medicare number.

As a point of caution, under no circumstance should Medicare beneficiaries ever let anyone else use their Medicare cards. They should keep the number as safe as they would a credit card number. When traveling, insureds should take the Medicare card and/or their Medicare Advantage or Medicare supplement card with them and have it handy when calling about a Medicare claim. If a card is lost, the Social Security Administration should be contacted right away.

New, Safer Medicare Cards
Beginning in April 2018, Medicare started issuing Medicare cards without Social Security numbers on them. The reason behind the new cards was to prevent theft of an enrollee's personal information. The new Medicare cards have a computer-generated number that even recipients will not be able to detect or understand. The process was completed in 2019.

Basic Benefits and Benefit-Related Information

Medicare allows recipients to choose the way they receive their benefits. Recipients are enrolled automatically in the Original Medicare plan, which is the traditional payment-per-service arrangement. If they want to stay with the Original Medicare plan, they do not have to do anything.

Starting in 1999, Medicare offered more ways (other than Original Medicare Parts A and B) to receive benefits through other health plan choices. Choices that became (and remain) available include:

-Medicare managed care plans (such as health maintenance organizations, or HMOs)
-Preferred provider organizations (PPOs)
-Provider sponsored organizations
-Private fee-for-service plans (PFFSs)
-Medical savings account plans (MSAs)

All of the above are components of various Medicare Advantage plans. Again, no matter what other health plan choices a recipient makes, he or she is still in the Medicare program.

Benefit Periods and Reserve Days
Medicare calculates its hospital (Part A) coverage in benefit periods and reserve days. Understanding these terms helps to untangle the rules governing the length and frequency of hospital stays, and the deductibles that apply to different situations.

Benefit Period
The hospital Part A benefit period begins on the day an insured is admitted to the hospital and ends when he or she has been out of the hospital or other covered facility for 60 consecutive days. So, an insured could actually have two separate hospital visits within the 60 days and only pay the deductible once, because it is in the same benefit period. On the other hand, an insured could accumulate several benefit periods (and incur several deductibles) in a year.

For example, assume a patient is admitted to the hospital in January with pneumonia. That constitutes the first benefit period and the first deductible. Then, six months later in July, the patient is admitted to the hospital with a broken hip. That is the second benefit period and will require payment of another deductible. In December, the patient is admitted to the hospital with another malady—that would be the third benefit period and would require payment of a third deductible.

Reserve Days
With the exception of hospice care, the number of benefit periods that an insured can use is unlimited. However, if an insured has to stay in the hospital for more than 90 days, the days beyond the 90th day fall into a special category called reserve days.

During every benefit period that an insured uses, Medicare pays one amount (all but the deductible) toward the first 60 days of an admitted hospital stay and a lesser amount (coinsurance) toward the next 30 days, and an additional lesser amount for the following 60 days. The amount that Medicare will pay the hospital is determined by a code number assigned to a certain diagnostic related group (DRG). Medicare predetermines the DRG payment amount according to the zip code in which the hospital is located. After the 60-day hospitalization and the additional 30-day coinsurance period, insureds may use some or all of their reserve days, and for that, Medicare pays another amount. A Medicare beneficiary is entitled to only 60 reserve days in a lifetime.

Basic Deductibles
A deductible is the amount insureds must pay for health care before Medicare begins to pay. Each benefit period for Part A has a deductible, as does each calendar year for Part B. These deductible amounts can (and do) change every year.

Part A Deductible
For example, in 2020, the Part A deductible was $1,408 per benefit period for admitted patients. After the insured (or the Medicare supplement policy) pays this deductible, Medicare then pays all approved Part A expenses for the first 60 days. Because the Part A deductible applies to each benefit period, it is possible that a person (or their insurance company) may have to pay more than one deductible in a year if he or she is admitted to a hospital more than once outside of the

60-day benefit period. Based on the example provided earlier in which a patient experienced three separate benefit periods in one year, this person would have had to pay a total of $4,224 for the three deductibles (assuming the hospital stays took place in 2020).

Part B Deductible
In 2020, the calendar year Medicare Part B deductible was $198. In other words, the beneficiary is responsible for the first $198 of approved expenses for physician and other medical services and supplies for the year. After he or she has met the annual deductible, Medicare generally pays 80 percent of all other approved charges for covered services for the rest of the year. The insured (or the insured's Medicare supplement policy) is responsible for the other 20 percent co-payment and/or an additional 15 percent charge that certain physicians may add to their bills. Home health services under Part B have no deductible or coinsurance. Medicare Advantage policies also treat this deductible differently.

Basic Co-Payments
The patient is also responsible for co-payments. Co-payments are the payments that the beneficiary or his or her health insurance (in addition to Medicare) must make to cover expenses that Medicare does not pay.

There are various references to "co-payments" and "coinsurance" in Medicare literature. Co-payments are a set dollar amount, while coinsurance is a percentage of a charge. You will see references to each in Medicare and in Medicare Advantage plans.

Basic Claims
Several years ago, Congress decided that one of the ways to control Medicare costs was to have all claims filed similarly and, at some future date, electronically filed. So Congress mandated that medical service providers, including doctors, must file Medicare claims directly from their offices for all their Medicare patients. This attempt at cost control actually had a beneficial effect for consumers—it eliminated much paperwork for Medicare recipients.

Also eliminating both Medicare and Medicare supplement claim paperwork is the procedure now known as automatic claims. For insureds who have Medicare supplement policies, the Medicare carrier files the claims for the insured with his or her Medicare supplement insurer after the carrier processes the original claim. In the case of a Medicare Advantage enrollee, the provider bills the plan, and Medicare carriers are not involved.

One of the most serious problems affecting the Medicare program over the years has been the problem of improper claims and benefit payments made by Medicare. Although Medicare claims it works hard to address the problem of improper claims, as well as duplicate and overpayment of claims, the problem of waste, fraud, and abuse in the system still accounts for as much as $60 billion a year, according to its own government sources.

Part A Claims
Billing for services that constitute Part A expenses is done directly between the health care provider and a Medicare administrative intermediary. The insured is not responsible for filing the claim and should not be billed by the provider before Medicare reviews the claim. A hospital may ask the insured to pay the deductible and any noncovered expenses at the time of discharge; however, this is unlikely if the insured presents his or her Medicare Part A identification card.

After making a determination on the claim, Medicare will send the insured a statement called a Medicare Summary Notice, or MSN, once every three months. This form carries a prominent notice stating: "This is not a bill." The form contains information about the action that Medicare took regarding the claim. It will indicate the following:

-The name of the person or organization who furnished the medical services

-The dates that the services were rendered
-The date of the notice
-The claim number and the claimant's Medicare number, name, and address
-The amount of the Medicare benefits that were used in paying the claim; the services provided;
-The benefit days used; the noncovered charges; the deductibles and coinsurance
-The amount, if any, that the insured is responsible for paying, or whether that information has
-Been forwarded to a Medicare supplement company
-The phone number and address of the Medicare intermediary that processed the claim
-The Customer Information Service Box
-Appeals information

If the insured is responsible for a payment, the notice will state the amount and the reason—the deductible, for example—for the balance due. Insureds should not make a payment based on this statement; the provider will bill them separately for the charges indicated if the charges have not already been paid or forwarded to the Medicare supplement company.

In a Medicare Advantage plan, enrollees will be treated differently. The Medicare Advantage plan will send an "Explanation of Benefits" for claims for Parts A and B and a separate "Monthly Prescription Drug Summary" for any prescriptions drugs utilized in that month.

Part B Claims
Part B claims may be more confusing to the patient. The medical care provider is still responsible for billing Medicare, but there are a number of possible variations. The provider may or may not be a participating provider, and he or she may or may not accept assignment. Both situations influence the amount that the insured or his or her insurance plan must pay.

When insureds seek treatment from a doctor or other medical provider, they provide their Medicare identification number to the provider. The provider makes a copy of the insured's Medicare card. After treating the insured, the provider bills Medicare on behalf of the insured. Although insureds can pay the provider at the time of service, they don't need to do this, because the insured has given the provider his or her Medicare identification card.

If the insured does not pay the provider, then Medicare will pay the provider directly. If the insured does pay the provider, then Medicare will send the reimbursement directly to the insured.

Under federal law, the medical care provider must file the claim for the insured. The claim will then automatically be referred to the insured's Medicare supplement carrier, if he or she has one. If the insured is in a Medicare Advantage plan, the provider sends the claim to the plan. Processing the Medicare claims and payments are contracted claims processing companies that have a contract with the federal government. The organizations handling Part A claims from hospitals, skilled nursing facilities, home health agencies, and hospices are called intermediaries. The organizations that handle Medicare Part B claims are called carriers. Sometimes the same organization handles both Part A and Part B claims, but the insured will still receive separate notices.

For Part B claims, Medicare sends a notification to the patient in the form of an MSN (Medicare Summary Notice). This form has the same purpose as the MSN that is sent after review of Part A claims. The MSN form for Part B looks differently and is slightly more complicated to read and understand. Either form may also be a benefit denial letter.

Medicare Summary Notice
It is important to read Medicare Summary Notices carefully—again, the MSN is not a bill. Insureds should study the MSN carefully and make sure that they received the services, medical equipment, or supplies for which Medicare was billed. If the insured has any questions, he or she should contact the carrier or intermediary listed on the front of the notice. If insureds disagree

with a claims decision, they have the right to file an appeal; they should follow the instructions on the notice for filing. In addition, if insureds find and report a charge on the MSN that they did not receive and Medicare paid for, they may be eligible for a reward. In fact, CMS announced that it would increase the reward for whistleblowers who report Medicare fraud and whose tips lead to the recovery of Medicare overpayments. Whistleblowers can receive up to 15 percent of any amount recovered as a result of their tips, with a cap of $9.9 million on payouts.

Insureds should note the following on their MSNs:

-The date the MSN was sent
-The customer service information box, if they have questions about their MSNs
-Their Medicare number, which should match the number on their Medicare cards
-Their name and address—If this information is incorrect on the MSN, then insureds should contact -both the Medicare intermediary shown on the MSN and the Social Security Administration immediately.
-The "Help Stop Fraud" message—States how to protect themselves and Medicare against fraud and abuse.
-Inpatient claims on their Part A Hospital Insurance
-Outpatient claims on their Part B Medical Insurance—Includes services provided, the amount charged, the amount Medicare approved, the amount Medicare paid the provider, and the amount
-The patient or his or her Medicare supplement company may be billed.
-Dates of service—These dates show when services were provided, and insureds can use these
-Dates to compare with the dates shown on their hospital bills.
-Claim number—Each claim is assigned a claim number, which insureds may be asked to provide when calling about their MSNs.
-Benefit days used—Shows the number of days used in the benefit period for Part A only.

Claims Records
Also, it is important that insureds keep track of their MSNs and the medical claims filed and paid. Sometimes providers bill insureds for more than they are entitled to collect. The total amount due from a patient is not always readily apparent at the time the service is rendered. A provider may ask the insured to pay the co-payment or deductible amounts at the time of the service. This amount is based on the fee the provider expects to receive from Medicare, which may or may not be accurate.

The only way to protect against overpaying a provider on a claim is for insureds to be aware of and to fully understand Medicare's claim decision, and to keep a log of all payments (MSNs) made by Medicare, the insured, and any other insurance carriers involved, such as a Medicare supplement company. This is no small task—in fact, in the late 1990s, two articles appeared in the New England Journal of Medicine that indicated as high as 90 percent of hospital billings were in error, usually in favor of the hospital. Again, it may be financially rewarding to an insured who finds an MSN error.

Medicare Fraud

Medicare fraud is an intentional deception or misrepresentation that an individual knows to be false and carries out with the knowledge that the deception could result in the payment of an unauthorized Medicare benefit. Some examples of Medicare fraud are:

-Intentionally billing for services that have not been provided
-Receiving kickbacks or bribes
-Intentionally billing non-covered services as covered services
-Committing forgery (unauthorized use of a person's signature)

Medicare is taking strong action to combat fraud and abuse in key areas. The goal is to make sure Medicare only does business with legitimate providers and suppliers who will provide Medicare

beneficiaries with high-quality services. The effort to prevent and detect fraud, abuse, and waste is a cooperative one that involves CMS as well as Medicare beneficiaries, Medicare contractors, providers, and state and federal agencies, such as the Office of the Inspector General, the Department of Health and Human Services, the FBI, and the Department of Justice. MIPPA 2008 and the ACA created several programs that gave legal teeth to the prevention and detection of fraud in Medicare dealings and provided for statutory criminal jail sentences for offenders.

Insureds should be suspicious if the provider tells them that:

-The test is free, and the provider only needs the insured's Medicare number for the provider's records.
-Medicare wants the insured to have the item or service.
-The provider knows "how to get Medicare to pay for it."
-The more tests the provider provides, the cheaper those tests are.
-The equipment or service is free.

Insureds should be suspicious of providers who:

-Routinely waive co-payments without checking on the insured's ability to pay
-Advertise free consultations to Medicare beneficiaries
-Claim they represent Medicare
-Use pressure or scare tactics to sell costly medical services and diagnostic tests
-Bill Medicare for services that the insured does not recall receiving

Consumer Tips
The following is a list of tips that clients can use to help prevent fraud:

-Do not give out your Medicare health insurance claim number except to your doctor or other Medicare providers.
-Do not allow anyone except appropriate medical professionals to review your medical records or to recommend services.
-Do not contact your physician to request a service that you do not need.
-Be careful in accepting Medicare services that are represented as being free.
-Be cautious when you are offered free testing or screening in exchange for your Medicare card number.
-Be cautious of any provider who maintains that they have been endorsed by the federal government or by Medicare.

Avoid a provider of health care items or services who tells you that the item or service is not usually covered, but they know how to bill Medicare to get it paid.

Health care fraud, whether against Medicare or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs. The Medicare recipient must remember the importance of eliminating fraud in the program. That is why Medicare developed financial rewards for recipients who report fraud.

Medicare and its contractors actively work to prevent attempts to defraud Medicare and to support investigations and prosecutions of such defrauders. Many of the successful law enforcement actions were begun through Medicare contractors and regional office staff who identified problems and issues and through contractors' referrals to the HHS Inspector General.

The Recovery Audit Contractor (RAC) Program
MMA 2003 created a three-year temporary program—the Recovery Audit Contractor (RAC) program—which became a permanent program as of January 2010. The RAC program is designed

to protect Medicare payments of questionable claims in four major areas:

-Duplicate payments
-Fiscal intermediary mistakes
-Medical necessity
-Coding problems (more accurately "upcoding" to a higher Medicare reimbursement level)

The RAC program has made great strides in saving Medicare money, but it is not without its critics in the medical field who feel the program is too aggressive and essentially punishes providers who make simple mistakes. For instance, the RAC will visit a hospital to determine if a patient was coded as "Admitted," thereby making the patient stay a Part A claim. If the RAC determines that the stay should have been coded "Under Observation," making the service a Part B claim (covered at a lesser amount of 80 percent), they will want reimbursement of their Part A claim money. This may seem like an insignificant matter, but for several years, hospitals have had to appeal these claims. By mid-2018, the number of such appeals had accumulated to 600,000.

Other Programs
The False Claims Act introduced the concept of dealing with those who abuse or game the Medicare system, and goes further than the RAC program. Simply, when outright fraud is discovered, the False Claims Act gives legal teeth to indictment, arrest, and prosecution of fraudsters. During the first decade of 2000, the main perpetrators of Medicare fraud were found in the durable medical equipment and home health care provider market.

On May 20, 2009, Health and Human Services took further measures with a new high-level task force called Health Care Fraud Prevention and Enforcement Action Team, whose main emphasis is to arrest and prosecute fraudsters with longer prison sentences as a goal. In addition, the Fraud Enforcement and Recovery Act of 2009 included insurance operations in its recovery goals.

In 2011, Medicare announced that it had abandoned its "pay and chase" technique of paying providers first, then trying to recover fraudulent payments. Medicare now requires more careful background checks on providers before instituting payments, and in some cases, requires bonding of the provider.

Fraud or Abuse?
Fraud and abuse have the same effect: they steal valuable resources that should go toward beneficiaries' Medicare benefits. Fraud robbed the Medicare system of more than $200 billion during the first 15 years of this century, according to the Department of Health and Human Services Office of the Inspector General. Others claim the cost is much more. Their assertion is that Medicare overpays through fraud, overpayment, duplicate payment, waste, and abuse as much as $60 billion per year. The primary difference between fraud and abuse is the person's intent. Was the person aware that he or she was committing a crime?

Fraud as defined by CMS is an intentional deception or misrepresentation that someone makes, knowing it is false, that could result in the payment of unauthorized benefits. A scheme does not have to be successful to be considered fraudulent.

Abuse involves actions that are inconsistent with sound medical, business, or fiscal practices. Abuse directly or indirectly results in higher costs to the Medicare program through improper payments that are not medically necessary.

Working closely together to identify fraud and abuse are:

-The Centers for Medicare and Medicaid Services
-Medicare enrollees
-Fellow Medicare contractors

-The Department of Health and Human Services Office of Inspector General
-The FBI
-The United States Attorney's offices—Department of Justice
-Local, county, and state law enforcement jurisdictions

In the process, these groups and individuals develop cases to refer to federal law enforcement authorities. They also support civil and/or criminal prosecutions, recover lost money, and eliminate bad providers from the Medicare system.

Fraud and abuse can take many forms. Some common forms may include but are not limited to:

-Billing for services or supplies never provided
-Misrepresenting the services rendered
-Misrepresenting the diagnosis to justify payment for services
-Altering claim forms to obtain a higher payment amount
-Soliciting, offering, or receiving a kickback, bribe, or rebate
-Making secret, unlawful agreements between a supplier, beneficiary, and/or other health care
-Provider that result in higher costs or charges to Medicare
-Deliberately applying for more than one payment for the same service
-Unlawfully completing a certificate of medical necessity
-"Upcoding" by providers to receive a higher payment for services than would be allowed by entering the proper DRG code
-Falsifying documents
-Misrepresenting the place of service

Penalties for Fraud
The United States Attorney's Office targets fraudulent health care providers for civil and/or criminal prosecution. Among the penalties are these:

-The False Claims Act provides for fines of up to $10,000 and damages up to three times the amount of the fraudulent submission. Violators may serve up to five years in prison.

-The anti-kickback provisions of the Social Security Act provide for fines of up to $25,000 and up to five years in prison.

-Civil monetary penalties provide for fines of up to $50,000 and damages up to three times the amount of the fraudulent submission.

-The Racketeer Influenced and Corrupt Organizations (RICO) Act has recently been used in Medicare fraud cases. Those convicted criminally can be sentenced to up to 20 years in prison. Civil conviction under RICO provides for asset forfeiture.

-The Health Insurance Portability and Accountability Act (HIPAA) created a new crime called health care fraud. This crime allows for up to 10 years in prison, up to 20 years in prison if serious bodily injury results, or up to life in prison if death occurs.

-The Department of Health and Human Services Office of Inspector General can also exclude a health care provider from all government-paying programs, including the Medicare system.
The Recovery Audit Contractor Program became a permanent program as of January 2010. Also, in 2011, CMS began inspecting contractors themselves to see if they had developed consistent incorrect patterns of payment.

-In May 2009, HHS developed the Health Care Fraud Prevention and Enforcement Action Team to arrest and prosecute fraudsters with longer prison sentences.

-The Fraud Enforcement and Recovery Act of 2009 included insurance companies in its goal of protecting Americans from fraudulent activities of securities and banking entities.
In 2011, CMS began a program to investigate overpayments in Medicare Advantage and Medicare Part D programs.

Combined, these laws and the efforts of the agencies to enforce them have recovered billions of dollars and resulted in the prosecution and imprisonment of countless individuals—both within the medical industry and outside of it.

Medicare's Customer Service

CMS worked with the Office of the Inspector General to help design messages that would better enable beneficiaries to identify any potential fraud or abuse of the program. The result is a simple, easy-to-read format that all users agree is the most useful tool developed to date to inform beneficiaries about actions on their Medicare claims.

Telephone Service and Internet Service

When they need information, the majority of Medicare beneficiaries use the telephone as their principal source of help and information. Medicare receives over 25 million telephone calls per year with questions about billing and understanding the Medicare program.

To continually review, renew, and improve their approaches as new activities emerge, CMS developed an overall Medicare beneficiary telephone customer service strategy that also includes standards and performance measures to evaluate the effectiveness of customer service. The strategy incorporates feedback on customer service goals and expectations from beneficiaries, CMS staff, carriers, fiscal intermediaries, quality improvement organizations, state health insurance assistance programs, and the Social Security Administration (SSA).

The Continuous Improvement Quality Call Monitoring initiative is an effort to develop a systematic national approach to ensuring the quality of the Medicare contractor beneficiary telephone service. This initiative provides CMS with a direct way to ensure that all call centers handling Medicare inquiries adhere to acceptable performance standards, including waiting time, call-backs, transfers, busy signals, hours of operations, etc.

Each year, CMS publishes a booklet titled "Medicare and You" for beneficiaries. The book lists numerous scenarios throughout its content that address handling questions or complaints that beneficiaries may have regarding a multitude of Medicare situations. The book also includes advice enrollees can follow if they suspect fraud. The Medicare website, www.medicare.gov, is listed frequently, as are the Medicare Helpline toll-free number, 1-800-Medicare, and the State Health Insurance Assistance Program office.

Enrollments in Medicare are surging as more baby boomers reach age 65. The most logical first step is to contact the Social Security/Medicare office in one's local district to obtain enrollment information. However, Social Security has been reducing public office hours as well as locations, and has been advising applicants to enroll directly at medicare.gov. Enrollment was a simple and quick process that could be completed over the Internet, but in 2018, certain security measures were put in place that, unfortunately, can make the process more cumbersome. Applicants must now answer a series of "identity" questions that are intended to protect Social Security and Medicare benefits from being utilized by people who are not eligible to sign up for them—usually through false identities. Consumers who want to work with a "live" person should contact their local Social Security-Medicare office.