

Learning Resource Guide

Preventing Frauds and Scams

ElderCare Online's Learning Resource Guide Preventing Frauds and Scams

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Introduction

This Learning Resource Guide, "Preventing Frauds and Scams," is intended to be a guide to some of the most common types of health care fraud schemes that are perpetrated against our elders. From fake health claims on pills or lotions, to sophisticated million-dollar rip-offs, our elders are frequent targets of financial abuse.

Carefully read this guide and familiarize yourself with the different issues involved and use it as a reference when something looks fishy. The old standard "If it seems too good to be true, it probably is" is a good reality check to follow. Even though Medicare and Medicaid often pay most of the bills for your elder's care, don't turn a blind eye to scams there. As the government shells out more and more tax dollars to pay for this waste, you the taxpayer end up footing the bill. Occasionally, honest providers get caught in the net, are forced to close down or to play by exceedingly strict rules and thus find it harder to provide quality care to your elders and you.

Federal and state government agencies have responsibility for pursuing and prosecuting cases of fraud. You can help by referring suspicious cases to the appropriate agencies list at the end of each section.

Sources: Federal Trade Commission, Health Care Financing Administration, Food and Drug Administration.

1. Fraudulent Health Claims

Billions of consumer dollars are wasted on unproven, fraudulently marketed, and sometimes useless health care products and treatments. In addition to wasting their money, consumers with serious medical problems may be wasting valuable time before they seek proper treatment. Even worse, some products may cause serious harm and endanger lives.

Fortunately, there are ways to tell which health-related claims are likely to be legitimate. This Learning Resource Guide will help you spot false and unsubstantiated claims. It describes some typical areas where fraud flourishes and suggests how you can protect yourself.

How to Spot False Claims

Remember the first rule of thumb for evaluating health claims: If it sounds too good to be true, it probably is. Also, learn to recognize the typical phrases and marketing techniques used to deceive consumers:

- The product is advertised as a quick and effective cure-all for a wide range of ailments or for an undiagnosed pain;
- The promoters use key words, such as *scientific breakthrough*, *miraculous cure*, *exclusive product*, *secret ingredient* or *ancient remedy*;
- The promoter claims the medical profession or research scientists have conspired to suppress the product;
- The advertisement includes undocumented case histories claiming amazing results;
- The product is advertised as available from only one source, and payment in advance is required.

In addition, health care clinics that require patients to travel away from home to receive treatment may be suspect. While many clinics offer effective treatments, some prescribe untested, unapproved, ineffective, and possibly dangerous "cures." Moreover, physicians who work in such clinics may be unlicensed or lack appropriate specialization. For these reasons, you should contact state or local health authorities where the clinic is located before you arrange to go.

Finally, don't rely on promises of a "money-back guarantee." Be aware that many fly-by-night operators will not be around to respond to a refund request.

Why Health Fraud Schemes Work

Health fraud is a business that sells false hope. It preys on people who are victims of diseases that have no medical cures, such as AIDS, arthritis, multiple sclerosis, and certain forms of cancer. It also thrives on the wishful thinking of those who want short-cuts to weight loss or improvements to personal appearance. It makes enormous profits because it promises quick cures and easy solutions to better health or personal attractiveness.

Some Medical Problems That Attract Health Fraud Schemes

Cancer

A diagnosis of cancer can bring feelings of fear and hopelessness. Many people may be tempted to turn to unproven remedies or clinics that promise a cure. Although some cancer patients have been helped by participating in legitimate clinical trials of experimental therapies, many others have wasted time and money on fraudulently marketed, ineffective treatments.

When you are evaluating cancer-cure claims, keep in mind that no single device or remedy is capable of treating all types of cancer. Cancer is a name given to a wide range of diseases that require different forms of treatment best determined by a medical doctor.

For more information about cancer, contact the American Cancer Society office listed in your yellow pages. To order free publications on cancer research and treatment, call the National Cancer Institute's Cancer Information Service: 1-800-422-6237.

Arthritis

If you are among the estimated 37 million Americans who suffer from one of the many forms of arthritis, be aware that this disease invites a flood of fraudulent products and services. This is because medical science has not yet found a cure for arthritis. The Arthritis Foundation advises that symptoms should be monitored by a doctor because the condition can worsen if it is not properly treated.

An estimated \$2 billion is spent annually on unproven arthritis remedies. Thousands of dietary and natural "cures" are sold for arthritis -- mussel extract, vitamin pills, desiccated liver pills, and honey and vinegar mixtures. Many scientists believe there is insufficient medical evidence to suggest that a lack of vitamins or minerals causes arthritis or that taking dietary supplements can give relief. For a free brochure about unproven remedies, call the Arthritis Foundation, toll-free, 1-800-283-7800 (9:00 a.m.-7:00 p.m., Eastern Time, Monday-Friday), or write: Arthritis Foundation, P.O. Box 19000, Atlanta, Georgia 30326.

Precautions for Taking Dietary Supplements

There are thousands of dietary supplements on the market. Many contain vitamins and minerals to supplement the amounts of these nutrients that people get from the food they eat. There also are many products on the market that contain substances such as high-potency free amino acids, botanicals, enzymes, herbs, animal extracts, and bioflavonoids.

Some dietary supplements have documented benefits; the advantages of others are unproven and claims about those products may be false or misleading. For example, claims that you can eat all you want and lose weight effortlessly are not true. To lose weight, you must lower your calorie intake or increase your calorie use through exercise. Most experts recommend doing both. Similarly, no body building product can "tone you up" effortlessly or build muscle mass without exercise. Claims to the contrary are false. Other questionable claims may involve products advertised as

effective in curing insomnia, reversing hair loss, relieving stress, curing impotency, improving memory or eyesight, and slowing the aging process.

In addition to lacking documented effectiveness, some dietary supplements may be harmful under some conditions of use. Reports of adverse reactions to dietary supplements are monitored by the U.S. Food and Drug Administration to identify emerging safety issues.

According to the FDA, the following substances in dietary supplements are among those that raise serious safety issues at certain concentrations: chaparral, comfrey, yohimbe, lobelia, germander, willow bark, guar gum, jin bu huan, ma huang, L-tryptophan, phenylalanine, and germanium. In addition, some vitamins and minerals can cause problems for some people when taken in excessive doses. These include vitamin A, niacin, vitamin B₆, vitamin D, iron, and folic acid. And remember, a label of "natural" is no guarantee of a product's safety or effectiveness.

Consumers who use dietary supplements should always read product labels to determine the % daily value for various nutrients contained in the product. Also, it's a good idea to seek advice from a health professional before taking dietary supplements, particularly for children, adolescents, older or chronically ill persons, and women who are pregnant or breast-feeding.

For More Information or To Report a Problem

- To determine the value of a health care product or treatment, consult a pharmacist, doctor, or other health professional.
- To report a company you believe may be making false advertising claims, call the Federal Trade Commission's Consumer Response Center at (202) FTC-HELP; TDD: (202) 326-2502 or use the online complaint form available at <http://www.ftc.gov> You can write to the CRC at:

Federal Trade Commission,
6th and Pennsylvania Avenue,
NW., Washington, DC 20580.

- To report a company for falsely labeling its products or to report a serious adverse effect associated with the use of a dietary supplement, call your local Food and Drug Administration office.
- For information about a particular hospital, clinic, or treatment center, contact state or local health authorities where the facility is located. If it is in a foreign country, contact that government's health authority to see that the facility is properly licensed and equipped to handle the procedures involved. For information about facilities in Mexico, contact the Secretary of Health (Secretaria De Salud) in the Mexican state where the facility is located. Here is a list of phone numbers for Mexican states that border the U.S.:

Baja California (112) 201-38
Sonora (62) 13-42-81
Chihuahua (41) 13-38-05
Coahuila (84) 15-57-33
Nuevo Leon (8) 343-31-37
Tamaulipas (131) 222-93

- In addition, you may wish to contact your state Attorney General's office or a local consumer agency to get more information or to report problems. These offices are listed in your telephone directory.

2. Medicare Fraud Schemes

Durable Medical Equipment

- Unscrupulous suppliers use a variety of means to obtain Medicare numbers, knowing that having a supply of these numbers is an open door to obtaining Medicare dollars fraudulently. Some of their methods:
 - Calling beneficiaries under the guise of conducting a “health survey” – one of the questions is “What is your Medicare number?”;
 - Offering beneficiaries a free “health screening” (e.g., blood pressure check, cholesterol test, etc.) and asking the same question;
 - Paying beneficiaries for their Medicare number;
 - Offering beneficiaries “free” services or supplies (e.g., milk, bread, clothing, etc.) in exchange for their Medicare number;
 - Obtaining lists of Medicare beneficiaries and their Medicare numbers from nursing homes or board and care homes by selling the operators/administrators on “new” Medicare benefits that will help the facility.
- Adult diapers have been billed as Female Urinary Collection Devices (FUCD). These diapers are not covered by Medicare. Suppliers misrepresented the item and patients’ conditions in billing. Medicare paid nearly \$9 per FUCD; the diapers cost the suppliers 26 cents. Charges to Medicare have been as high as \$5,200 per month per patient.
- Lymphedema pumps are supplied to beneficiaries who did not meet medical necessity requirements; suppliers falsified claim forms and Certificates of Medical Necessity (CMNs). Medicare was billed for higher-priced pumps; pumps costing nearly \$3,000 less were actually supplied;
- Medicare has been billed for nebulizer drugs which are used to relieve symptoms of emphysema and bronchitis. Claims review showed inappropriate quantities and combinations were billed. In fact, the suppliers were not even providing the drugs billed to Medicare;
- Oxygen concentrators have been provided to patients who have need for oxygen. Because Medicare requires patients to be tested by an independent laboratory before paying for oxygen, suppliers have engaged in chemes with physicians and labs to falsify oximetry results;
- Hospitals have allowed durable medical equipment (DME) companies to provide them with “discharge planners.” These employees work in the hospital, but their salaries are paid by, and they represent, the supplier. They make sure that patients receive every item imaginable (e.g., hospital beds, wheelchairs, walkers, etc.), whether they need them or not;
- Vendors offer “free” cases of milk supplements or groceries, then bill Medicare for costly enteral/parenteral supplies;
- Some suppliers have ownership in or arrangements with physiological labs which falsify oximetry tests to certify patients’ need for home oxygen.

Things to look for...

- In facilities, look for DME items that have been provided to all or most residents (for example, all patients in a nursing home have air fluidized beds);
- Does it appear that the consumer required the supplies or equipment received?;
- Beware of fraudulent attempts to obtain Medicare numbers (telemarketing, health screenings, medical surveys, offers of “free” items or cash);
- Did the supplier waive co-payments and deductibles in the absence of financial need?;

- Be cautious of “free” services billed to Medicare or other insurers;
- Review EOBs/MSNs to insure that services billed coincide with services provided.

Managed Care

- Failure to deliver services or under-utilization of services. Because many plans pay contract providers a monthly capitated rate, some practitioners have failed to provide needed care so as not to exceed their monthly plan payment;
- In order to limit or discourage services to plan members, some providers allot limited office hours for managed care plan (MCP) patients. These patients may not be able to schedule an appointment with the practitioner when they need it;
- Some MCPs have offered cash incentives to consumers to enroll in their plan;
- The contract practitioner or the MCP, itself, have encouraged beneficiaries to disenroll from the MCP in order to receive costly treatment or procedures. Beneficiaries are told that they can re-enroll following completion of the course of treatment;
- Because most MCPs require referral to non-plan providers (specialists, hospitals, etc.), some plan physicians have accepted kickbacks in exchange for the referrals;
- Any of the schemes that have been described for the traditional “fee-for-service” providers can be perpetrated in the managed care environment.

Things to look for...

- Beneficiary complaints of having to wait several days or weeks to see the provider;
- Beneficiaries who have received incentives for enrolling or disenrolling in MCPs;
- Allegations of services not received; medical supplies or equipment not as ordered; or continued billing to the plan when the beneficiary no longer has or needs the equipment.

Kickbacks: What is a kickback?

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

Examples...

- Providing hospitals or nursing homes with discharge planners, home care coordinators or home care liaisons to induce referrals;
- Paying a fee to a physician for each patient care plan certified by the physician on behalf of the home health agency;
- Providing “free” patient services, such as 24-hour nursing coverage, to board and care facilities in return for home health referrals;
- Paying a fee to a board and care operator or employee for each resident referred to a home health agency; in effect, buying patients;
- Offering free services to beneficiaries, including meals and transportation, if they agree to switch home health providers;
- Paying beneficiaries \$50 each time they receive “treatment” at a clinic.

In these cases, the “free” services and “business” inducements are typically misrepresented so that Medicare pays for them as though they were legitimate, covered services. Often these services are paid for by some other program.

Home Health Agencies and Hospice

Why home health agencies (HHAs) and hospice services?

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

Fraud Schemes...

- Billing for services to patients who do not meet the definition of "homebound;"
- Billing for more visits than provided;
- Billing housekeeping or custodial services as skilled nursing or therapy services;
- Unfair marketing practices – some HHAs have offered incentives such as free groceries or free transportation, to beneficiaries in exchange for their Medicare number or for switching to their agency;
- Kickbacks – some HHAs have offered cash or other benefits to physicians for referring patients and/or signing treatment plans for patients who do not meet the conditions for home health care;
- Patients who do not meet the eligibility requirements for hospice (terminal illness with 6-month or less life expectancy) have been enrolled by hospice personnel;
- Some hospices have received duplicate payments, billing both Medicare and Medicaid;
- Some HHAs have provided home health aides to patients in assisted living facilities. Services provided by the aides should be provided by the assisted living facility;
- Some board and care facilities are owned by HHAs. In these cases, most of the residents of the board and care homes receive home health from the HHA that owns the facility. In addition, the home health services are often not necessary;
- Some registered nurses have provided care to their relatives and then billed it as home health care;
- Some agencies have been found to have ties with durable medical equipment (DME) companies. Because of these financial relationships, the HHA personnel have ordered large numbers of supplies that the patient does not need.

Things to look for...

- Beneficiaries who are not homebound but who are receiving home health services;
- Beneficiaries who are not terminally ill but are enrolled in hospice;
- Review EOBs/MSNs to ensure that services billed coincide with services provided;
- All, or most residents in board and care homes or assisted living facilities, receive home health care from the same HHA.

Clinical Laboratories

Why laboratory services?

- Beneficiaries have not received EOBs/MSNs; Medicare pays 100%;
- Physicians do not see what the laboratories bill to Medicare;
- For most lab tests, Medicare has not required labs to submit diagnosis or symptom information to support the need for services.

Fraud Schemes...

- Labs have added tests not ordered by the physicians and billed them separately to Medicare;
- Labs market their tests as panels to the physicians, but split certain tests of the panels and bill them separately to Medicare. For example, a physician will order a "Chem 14," which the lab has identified as a panel containing 14 specific lab tests. The physician understands that the lab will bill the service as a 14-test automated panel. However, the lab bills Medicare for a 12-test panel and bills separately for two of the tests, increasing their Medicare payment;
- "Rolling labs" have gone to senior centers, shopping malls, etc. and offered "free" diagnostic tests. Patients are required to complete a registration form which includes their insurance billing number. The insurers are then billed for a variety of tests the beneficiary never received;
- Labs have billed for services not ordered or provided. In a 6-day period, one lab submitted to Medicare 717 claims for 416 beneficiaries (many of whom were already dead) and received \$330,000. One of the "referring" physicians listed on the claims had been dead for 2 years. In a random sample, nearly a third of beneficiaries had never received services from the lab or did they know the referring physician listed on their claims.

Things to look for...

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

Independent Physiological Labs (IPLs)

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

Why IPLs?

- There are no professional licensing requirements. All that is needed in order to obtain a provider number is a business license;
- In the past, Medicare contractors have not verified the existence of the lab's equipment or of the lab itself;
- There is huge potential for quick profit;
- IPLs have found it relatively easy to obtain beneficiaries' Medicare numbers.

Fraud schemes...

- Many IPLs have falsified results of oxygen tests to substantiate the need for oxygen. One test required is an O₂ saturation level taken while resting. Several IPLs have been found to have offices located up one or two flights of stairs, thus requiring the patient to climb the stairs right before the test is performed. Many of the IPLs have been found to have ties to oxygen suppliers;
- Some IPLs have advertised "stroke prevention" testing. They perform a series of diagnostic tests, all or most of which are not medically necessary and/or proven effective for the purposes advertised;
- Some IPLs are performing sleep studies without a physician order. They are falsifying ordering physician information in order to receive Medicare payment;

- One IPL sent nurses to the homes of patients who required cardiac monitoring using an “event recorder.” The equipment was hooked up for approximately 20-30 minutes, then removed and taken with the nurse. The provider billed Medicare for 24-hour attended monitoring of these patients. In addition, the lab billed the same claims for numerous patients to two separate Medicare carriers in an attempt to receive duplicate payment;
- One national IPL billed Medicare for over \$5.9 million for Medical Resonance Imaging (MRI) services that were not provided. The provider used several different business names, none of which were viable businesses – the addresses provided on their applications were merely mail drops.

Things to look for...

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

Hospitals

Why hospital services?

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

Fraud schemes...

- For outpatient services, billing multiple view x-rays when only one view was taken;
- Misrepresentation of discharge date in order to obtain inpatient and outpatient reimbursement. One drug and alcohol rehabilitation facility discharged their inpatients on paper but not in reality. The hospital received the diagnosis related group (DRG) reimbursement for the inpatient stay and then also billed for outpatient services. Since the patients never left the hospital, the facility should only have received the DRG payment;
- Misrepresentation of the patient’s condition (diagnosis code) on the claim form in order to charge the DRG category and, therefore, increase the reimbursement;
- Some patients have been held in observation status for 3-4 days rather than admitted as a hospital inpatient. Hospital observation services are reimbursed as a percentage of charges (through Part B), and therefore, the Medicare payment is usually higher than what the facility would have received through the DRG reimbursement;
- Ineligible items, such as trips, club memberships, dinner and drinks have been billed to Medicare via the hospital’s cost report.

Things to look for...

- Review EOBs/MSNs to ensure that services billed coincide with services provided;
- Review itemized statements from the hospital to assure that the patient has not been charged for items provided. Remember, however, that for inpatient services, the itemized charges usually do not have an impact on the Medicare reimbursement;

Ambulance

Why ambulance services?

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

Fraud schemes...

- Billing for advanced life support services (ALS) when basic life support service (BLS) was provided. Documentation is often falsified to indicate the patient needed oxygen, a key indicator to establish medical necessity for ALS;
- Ambulance transports are provided to ambulatory dialysis patients to and from the dialysis center and billed as medically necessary transports. In one case, patients were filmed walking to the vehicle and riding in the front seat of the ambulance or were transported in a regular automobile. In addition, two or three patients were transported in the same vehicle, yet Medicare was billed as if they were individual trips;
- Billing for more miles than traveled for transport. Air ambulance services have reported their mileage in ground miles instead of nautical miles;
- Falsification of documentation to substantiate the need for a transport from a hospital back to the patient's home. Medicare will only cover transport from hospital to home if the patient could not go by any other means (e.g., car, taxi or ambulance).

Things to look for...

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

Physicians/Practitioners

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

Why physician/practitioner services?

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

Fraud schemes...

- Toenail clipping (routine foot care) is only covered if there is some underlying medical condition warranting professional services. To obtain payments, some podiatrists or other physicians have misrepresented the diagnoses on the claim, indicating fungal infection where none exists. Another scam is to bill routine foot care as foot surgery;
- An optometrist always bills the comprehensive level of eye exam even when he/she performs the lower level exam;
- A chiropractor sees his patients two times per week but routinely bills for three services each week;
- An ophthalmologist falsified documentation for a test that is used to establish the need for cataract surgery. The doctor performed the and billed Medicare for more than 100 unnecessary surgeries;

- A provider bills acupuncture (non-covered) as a covered service. In one instance, a physician billed acupuncture services as physical therapy. In another case, the physician misrepresented the acupuncture services as joint injections.

Things to look for...

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

Mental Health Services

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

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

Why mental health services?

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

Fraud schemes...

- Routine upcoding of psychotherapy sessions by the mental health provider -- psychiatrist, clinical psychologist (CP) or clinical social worker (CSW). There are several variations on this scam, for example:
 - A psychiatrist conducts group sessions in a nursing or residential facility but bills for individual therapy;
 - A CP bills for 50 minute sessions but actually saw the patient for only 20-30 minutes
- Some PHPs are enrolling patients who either cannot benefit from the therapy or who receive little more than social or recreational activities. Typically, the patients have not authorized the services and are not told that they are receiving psychotherapy;
- Trips to the store, cooking classes, listening to music and other recreational activities have been billed as psychotherapy;
- Non-licensed staff have performed therapy sessions that have been billed as though provided by or under the direct supervision of a licensed practitioner;
- Billing for inpatient psychiatric treatment for weight reduction programs. Frequently, these programs include transportation to the facility. Clients are told their insurance will cover the costs for the program but are not made aware that the services will be billed as mental health services. The program usually ends when the insurance money runs out;
- "Coffee, cookies and conversation" – One CMHC advertised a social gathering to seniors in the community. The seniors went to the CMHC, met the staff and subsequently received Medicare EOBs indicating that they received psychotherapy services.

Things to look for...

- Group therapy sessions were recreational or diversional are being provided;
- The presence of mental health providers with patients who are non-communicative or cannot benefit from psychotherapy (patients in coma, patients in the late stages of Alzheimer's Disease, etc.);
- Review EOBs/MSNs to ensure that the services billed coincide with the services provided.

Nursing Services

Why nursing homes?

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

Fraud schemes...

- Providing medically unnecessary physical, occupational or speech therapies (PT, OT, ST). Therapies often supplied to large groups of patients but billed as if provided individually. For example, a physical therapist spends 30 minutes with a group of 10 patients and Medicare is billed for 30 minutes of PT for each patient;
- Billing social activities or life services as psychotherapy;
- Billing for medical supplies not provided to the patient. Where the patient is not under a Medicare Part A-covered stay, facilities may bill for certain medical supplies under Part B. Numerous instances of billing for supplies not received by beneficiaries have been detected;
- Irrigation kits are often supplied to nursing facilities for ostomy patients in quantities far greater than needed. In many cases, sterile kits are not medically necessary. Many nursing homes break kits down and add individual components to their central supply area;
- Suppliers have billed Medicare for custom-fitted body jackets – the actual items supplied are plain, wrap-around corsets secured by Velcro straps. Medicare is billed for custom-fitted, molded body jackets. Reimbursement was often several hundred dollars for an item that cost \$30;
- "Gang visit" – Practitioner (such as an optometrist or podiatrist) stopping by all or most patients in a facility without rendering any services, but billing as if a service had been provided. Most of the patients do not have prior symptoms or a condition warranting the practitioner's service.

Things to look for...

- Kits marked for individual patients used for other patients or held in extremely large supply in storage areas. This may be a sign that unnecessary supplies are being provided or that necessary supplies are being provided in a quantity much greater than required;
- Therapies (PT, OT, ST) being provided to groups of patients. These services may be billed to Medicare as if provided individually;
- Therapies (including psychotherapy) being provided to patients who cannot benefit from the services (especially patients with advanced Alzheimer's Disease or in a coma);

- Every resident has the same medical equipment (for example, the same brand of walker and type of wheelchair). It is highly unlikely that every patient needs or uses the same equipment. Moreover, the government may be paying twice for the equipment. Medicare pays on behalf of each patient, and Medicaid factors the cost of durable medical equipment into the daily rate that is paid to the facility;
- Patient file access provided to persons who are not actual practitioners for specific patients.

Who to Contact If You Suspect Fraud

If you believe Medicare is being ripped-off, call or write the Medicare company that paid the claim. The name, address, and telephone number are on the Medicare explanation of benefits which shows what Medicare paid.

Before contacting the Medicare claims processing company, carefully review the facts as you know them and as shown on explanation of benefits. Write down:

1. The provider's name and any identifying number you may have.
2. The item or service you are questioning.
3. The date on which the item or service was supposedly furnished.
4. The amount approved and paid by Medicare.
5. The date of the explanation of benefits.
6. The name and Medicare number of the person who supposedly received the item or service.
7. The reason you believe Medicare should not have paid.
8. Any other information you may have showing that the claim for the item or service should not have been paid by Medicare.

If you plan to write rather than call, clearly state at the beginning of your letter that you are filing a fraud complaint. This will help to ensure that your complaint is forwarded to the fraud unit.

Office of Inspector General Hotline

If you prefer you may call the OIG Hotline at 1-800-HHS-TIPS (1 800 447- 8477).

3. Medicaid Fraud Schemes

The Medicaid program is a federal health program, run by every state, for the poor and medically needy. The program generally pays for a wide array of medically necessary services including hospital, nursing home, home care, physician services, laboratory services, medical equipment, mental health services and other health care services. Each state decides which services they will pay for. The federal government's share of the cost of the program ranges from 50 to 78% and is based on the state's per capita income. To report suspected cases of fraud in Medicaid, contact your state Attorney General.

Some examples of Medicaid fraud include:

- **Billing for Services Not Rendered:** A provider bills for services not rendered, x-rays not taken, or a hospital or nursing home continues to bill for services for a patient who has died or been transferred.
- **Double-Billing:** A provider bills both the Medicaid program and a private insurance company (or recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.
- **Substitution of Generic Drugs:** A pharmacy bills Medicaid for a brand name prescription but supplies a low-cost generic drug to the recipient.
- **Unnecessary Services:** A doctor performs numerous tests which are medically unnecessary; equipment or medical supplies are provided and billed for when not medically necessary.
- **Overutilization:** When unnecessary services are provided for the purpose of billing the Medicaid program.
- **Underutilization:** When necessary services are not provided for the purpose of keeping costs down.
- **Upcoding:** Medicaid is billed for more expensive procedures than those that are performed; individual therapy codes are billed for group sessions.
- **Kickbacks:** A provider requires another provider to pay a portion of the money the second provider receives for rendering services to the first provider's Medicaid patients.

4. Hearing Aids

If you suffer from a hearing impairment like 21 million other Americans, you may consider buying a hearing aid. Before you do, determine whether a hearing aid will work for you and what to look for when shopping for one.

How does a hearing aid work?

A hearing aid is an electronic device with a small microphone that amplifies weak sounds through a small speaker. You must have some ability to hear for the device to work. And because hearing loss affects people in different ways, you need to get the right device for you.

Why do people lose their hearing?

Medically, there are two major types of hearing loss. *Conductive* hearing loss involves the outer and middle ear. It usually results from a wax blockage, a punctured eardrum, birth defects, ear infections, or it may be genetic. Conductive hearing loss generally can be corrected surgically.

Sensorineural—or "nerve"—hearing loss involves damage to the inner ear. It can be caused by aging, prenatal and birth-related problems, viral and bacterial infections, genetics, trauma (such as a severe blow to the head), exposure to loud noises, the use of certain drugs, or fluid buildup or a benign tumor in the inner ear. Sensorineural hearing loss usually can't be repaired surgically; it's usually corrected with a hearing aid.

Where can I buy a hearing aid?

"Dispensers"—merchants or audiologists—sell hearing aids. Ask friends or family for referrals. You also can check out prospective dispensers with your local Better Business Bureau, consumer protection agency, or state Attorney General. Your state or local consumer protection office may have records of complaints against dispensers or physicians, and can tell you how they responded to the complaints. Consumer protection officials also can tell you whether dispensers or audiologists must be licensed or certified by the state.

How can I tell whether I need a hearing aid?

Get an ear examination from a licensed physician. An examination will insure that there are no underlying illnesses or medical problems associated with the hearing loss: sometimes a hearing loss can be a symptom of a medical condition. As a result, you'll want to be wary of advertisements for hearing aids that dismiss the need for an examination—the distributor may be selling inadequate products. In addition, don't feel pressured into buying a hearing aid—ask for more information or a second opinion.

You also should get a hearing evaluation from a dispenser or an audiologist. The cause and severity of hearing loss varies from person to person. An evaluation will help a dispenser or audiologist select and fit you with an appropriate hearing aid.

Can I get a trial period?

Many states recommend or require that consumers get at least a free 30-day trial period. There usually is a service fee—five to 20 percent of the purchase price—if you return the hearing aid during that time. In fact, many manufacturers will make adjustments during the trial period, and allow returns within 60 to 90 days of purchase at no charge to the dispenser.

Buying a hearing aid from a door-to-door salesperson or through the mail is risky. If you buy from a door-to-door salesperson at any location that is not the salesperson's regular place of business, you have the right to cancel any sale for \$25 or more within three business days.

Some states don't allow hearing aids to be sold through the mail. That's because it's hard to get a proper fit. If your state does allow mail-order sales, federal law requires companies to ship your purchase when promised and give you the option to cancel the order for a refund.

What about purchase agreements?

The hearing aid purchase agreement—or contract—should include all terms of the transaction, including a clear explanation of all verbal promises. In reviewing your agreement, consider the following:

- Is the warranty honored by the manufacturer or by the dispenser? In some cases, a manufacturer may not honor its warranty unless the hearing aid is purchased from a seller authorized by the manufacturer.
- What services—if any—will be provided free of charge, and how long will they be provided?
- Will I get a "loaner" if my hearing aid needs repair?

What are the federal standards for hearing aid sales?

The Federal Trade Commission (FTC) is responsible for monitoring the business practices of hearing aid dispensers and vendors. The FTC can take action against companies that mislead or deceive consumers. Such companies may use misleading sales and advertising practices—giving inaccurate information about hearing loss, hearing aid performance, refund policies, or warranty coverage. The law further requires companies offering warranties to fully disclose all terms and conditions of their warranties.

The Food and Drug Administration (FDA) enforces regulations that deal specifically with the manufacture and sale of hearing aids. According to the FDA, the following conditions must be met by all dispensers before selling a hearing aid:

- Dispensers must obtain a written statement from the patient, signed by a licensed physician. The statement must be dated within the previous six months, state that the patient's ears have been medically evaluated, and that the patient is cleared for fitting with a hearing aid.
- A patient age 18 years or older can sign a waiver for a medical examination, but dispensers must avoid encouraging the patient to waive the medical evaluation requirement. Dispensers also must advise the patient that waiving the examination is not in his best health interest.
- Dispensers must advise patients who appear to have a hearing problem to consult promptly with a physician.

- The FDA regulations also require that an instruction brochure be provided with the hearing aid that illustrates and describes its operation, use, and care. The brochure must list sources for repair and maintenance, and include a statement that the use of a hearing aid may be only part of a rehabilitative program.

What are the state standards for hearing aid sales?

Many states have laws governing hearing aid sales. Most states license hearing aid dispensers. You also may be protected by implied warranties created by state law. Your state Attorney General's office can tell you what laws apply to hearing aid sales in your state.

Where can I complain?

If you have questions or complaints concerning the sales practices of a hearing aid dispenser, contact your state Attorney General's office, your local consumer protection agency, or the Better Business Bureau. You also may file a complaint with the FTC by writing to: Consumer Response Center, Federal Trade Commission, Washington, DC 20580, or by calling 202-FTC-HELP (382-4357); TDD: 202-326-2502.

5. Telemarketing Fraud

Consumers lose more than \$40 billion a year to telemarketing fraud. People over 50 years of age are especially vulnerable and account for about 56 percent of all victims, according to a recent study by the American Association of Retired Persons. Scam artists often target older people, knowing they tend to be trusting and polite toward strangers and are likely to be home and have time to talk with callers.

You can help empower your parents and others who may be targets of fraudulent telemarketers by describing some tip-offs to rip-offs, letting them know their rights and suggesting ways they can protect themselves.

Tip-Offs to Phone Fraud

Many scams involve bogus prize offers, phony travel packages, get-rich-quick investments and fake charities. Con artists are skilled liars who spend a lot of time polishing their sales pitches. As a result, it can be difficult to see through their scams.

Alert those you care about to be on their guard if they hear the buzz words for fraud. Among the tip-offs are:

- You must act "now" or the offer will expire;
- You've won a "free" gift, vacation or prize — but you must pay for "postage and handling" or some other charge;
- You must send money, give a credit card or bank account number or have your check picked up by courier — before you've had a chance to consider the offer carefully;
- It's not necessary to check out the company with anyone — including your family, lawyer, accountant, local Better Business Bureau or consumer protection agency;
- You don't need written information about the company or its references;
- You can't afford to miss this "high-profit, no-risk" offer.

It's the Law

It also is helpful for people who are the targets of fraudulent telemarketers to know their rights. Anyone who is troubled by calls — whether abusive, deceptive or simply annoying — should know that, under federal law:

- It's illegal for a telemarketer to call you if you have asked not to be called;
- Calling times are restricted to the hours between 8 a.m. and 9 p.m.;
- Telemarketers must tell you it's a sales call, the name of the seller, and what they are selling — before they make their pitch. If it's a prize promotion, they must tell you that you don't have to pay or buy anything to enter or win;
- Telemarketers may not lie about any information, including any facts about their goods or services, the earnings potential, profitability, risk or liquidity of an investment, or the nature of a prize in a prize-promotion scheme;
- Before you pay, telemarketers must tell you the total cost of the goods and any restrictions on getting or using them, or that a sale is final or non-refundable. In a prize promotion, they must tell you the odds of winning, that no purchase or payment is necessary to win and any restrictions or conditions of receiving the prize;
- Telemarketers may not withdraw money from your checking account without your express, verifiable authorization;

- Telemarketers cannot lie to get you to pay;
- You do not have to pay for credit repair, recovery room or advance-fee loan/credit services until these services have been delivered.

How to Protect Targets of Telemarketing Fraud

You also can help people you care about develop responses that will end an unwanted sales call. Possible responses to unwanted callers include:

- "I don't do business with people I don't know;"
- "Please put me on your 'Do-Not-Call List;'"
- "I'll need to see written information on your offer before I consider giving you money;" or
- "You can send that information to my attorney's office at"
- Perhaps the easiest response is, "I'm not interested. Thank you and good-bye."

Urge your parents or anyone else troubled by calls to resist high-pressure sales tactics. Legitimate businesses respect the fact that a person is not interested.

Remind an older person to:

- Say so if they don't want the seller to call back. If they do call back, they're breaking the law. That's a signal to hang up;
- Take their time, and ask for written information about the product, service, investment opportunity or charity that's the subject of the call;
- Talk to a friend, relative or financial advisor before responding to a solicitation. Their financial investments may have consequences for the family or close friends;
- Hang up if they're asked to pay for a prize. Free is free;
- Keep information about their bank accounts and credit cards private unless they know who they're dealing with;
- Hang up if a telemarketer calls before 8 a.m. or after 9 p.m.;
- Check out any company with the state and local consumer protection office before they buy any product or service or donate any money as a result of an unsolicited phone call;
- Finally, remind an older person not to send money — cash, check or money order — by courier, overnight delivery or wire to anyone who insists on immediate payment.

If you suspect a scam, call your state attorney general. The Federal Trade Commission's Telemarketing Sales Rule gives state law enforcement officers the power to prosecute fraudulent telemarketers.

For More Information

Consumer Response Center
Federal Trade Commission
Washington, DC 20580

(202) FTC-HELP [382-4357]; TDD: (202) 326-2502

You also can file a complaint with the Commission by contacting the CRC by phone, by mail, or online.

National Consumers League
1701 K Street, NW
Washington, DC 20006
(202) 835-3323

The National Consumers League and the American Association of Retired Persons conducted research on telemarketing fraud targeting the elderly and offer suggestions for older people and their families in a brochure, "They Can't Hang Up," available from the National Consumers League.

To stop telephone sales calls from many legitimate national marketers, send your name, address and telephone number to:

Direct Marketing Association
Telephone Preference Service
P.O. Box 9014
Farmingdale, NY 11735-9014

To remove your name from many national direct mail lists, write:

Direct Marketing Association
Mail Preference Service
P.O. Box 9008
Farmingdale, NY 11735-9008