STOP MEDICAID FRAUD

What is "Medicaid Fraud?" As a provider of Medicaid services, Medicaid fraud could involve one of the following acts:

1. **Services not provided** (**Example**: Falsifying Medicaid documents such as Plan of Care Worksheet; documenting hours that were not provided; falsifying mileage on Plan of Care Worksheet; documenting transportation destinations or miles that did not occur).
2. **Allegations of abuse, neglect or exploitation** (Example: Worker theft of member's debit card or medications; worker allegedly threw phone at member).
3. **Visits not provided** (Example: Case Manager or RN documents that a six month visit was made. Member was not home and was in a nursing home).
4. **Falsifying credentials** (Example**:** The nurse in not a Registered Nurse and bills for the nursing service).
5. **Billing for unnecessary services** (Example**:** Provider falsifies the member's diagnoses, ADL's or medical information to provide unnecessary services for the member).
6. **Double billing** (**Example**: Worker provides Medicaid Transportation Services at the same time as Non-emergency Medical Transport or NEMT through DHHR).

What are the potential consequences for committing Medicaid fraud?

- Civil and/or criminal prosecution that may lead to a ***JAIL*** sentence or payment of ***FINES***.

Where do I report allegations of Medicaid fraud?

- The Medicaid Fraud Control Unit at 304-558-1858.

Are providers or workers really charged or convicted of Medicaid fraud?

- Yes. Providers (and workers) are charged and convicted of Medicaid fraud for allegations such as member exploitation, services not provided, member neglect, double billing, visits not provided and other incidents of fraud.

This document was developed by the Aged and Disabled Waiver Quality Improvement Advisory Council.