

# Medicaid Fraud

Medicaid fraud is a crime and if it is suspected, it must be reported to the Attorney General's office. The Attorney General's office will complete an investigation and if Medicaid fraud is proven, Medicaid eligibility will be lost. Other consequences can include arrest and prosecution, fines and jail time, civil damages and monetary penalties, exclusions from working in any facility receiving federal health care funds, and loss of certification.

In the context of this Policy and federal and state laws, "fraud" involves an act of deception, extortion, theft, misappropriation, false representation, conspiracy, corruption, collusion, embezzlement, or concealment of material facts. It also includes activities inconsistent with standard fiscal, business or medical practices that result in unnecessary cost to a government health care program or that fail to meet professionally recognized standards for health care. It can also include practices resulting in unnecessary cost to the Medicaid program.

**To report Medicaid fraud or abuse, please call 1-866-551-6328.**

The following non-exhaustive list provides a few examples of fraud that this Policy is designed to prevent and detect:

- Submitting or calling in time when not working
- Submitting or calling in time using someone else's name or ID number
- Doing tasks not authorized on the Plan of Care or not doing tasks required on the Plan of Care
- Knowingly submitting false information, such as employment documents
- Fraudulent financial reporting, including earnings management, improper revenue recognition, overstatement of assets and understatement of liabilities;
- Submitting claims for services that were not provided or without supporting documentation;
- Coding a service at a higher level than what was provided in order to obtain a higher payment amount;
- Falsifying or misrepresenting a diagnosis in order to receive payment that would not otherwise be owed, or that would otherwise be paid at a lower amount;
- Alteration of claims in order to receive a higher payment amount;
- Intentional double billing to obtain double payment;
- Falsifying bills to code non-covered services as covered services in order to obtain payment;
- Failing to report third party billing;
- Failing to maintain confidentiality of medical records;
- Bribery;
- Kickbacks;
- Knowing retention of overpayments; and
- High use of services that are not medically necessary in order to receive payments.

Additionally, any occurrence or suspected occurrence of Medicaid fraud or abuse must be reported by any Staff directly to a Director, the TCM, the CDDO if appropriate, and KDADS within 24 hours of the occurrence or suspected occurrence. Reports may be made in person, by telephone, by U.S. Mail or by e-mail.

Helper's Inc. is committed to the prevention and detection of Fraud and will keep the lines of communication open to encourage all Staff to report suspected or actual Medicaid fraud or abuse. Likewise, if any Staff member has any questions or concerns about this Policy, Helper's Inc. encourages the Staff member to consult with his or her direct supervisor, a Director, the TCM or Human Resources.

**There will be no retaliation against any Staff member for reporting suspected or actual Medicaid fraud or abuse or for participating in the investigation into a report of Medicaid fraud or abuse. However, any Helper's Inc.'s Staff member that has knowledge of Medicaid fraud or abuse, or has a reasonable basis to suspect Medicaid fraud or abuse, and fails to report the violation, has committed an act of unprofessional conduct and insubordination and may be subject to disciplinary action up to and including termination.**