MEDICAID FRAUD AND ABUSE

[redacted]

OUR PLEDGE

European Service at Home, INC is dedicated to reducing and possibly eliminating incidences of fraud and abuse from its programs and cooperates in fraud, waste and abuse investigations conducted by state and/or federal agencies, including:

Illinois State Police Medicaid Fraud Control Unit
Illinois Attorney General's Office
The Federal Bureau of Investigation
The Drug Enforcement Administration
The Health and Human Services Office of Inspector General (OIG)
Governor's Office of the Budget
U.S. Department of Health and Human Services (HHS)
Illinois Department of Human Services (DHS)
CMS
The United States Attorney's Office/ Justice Department

EUROPEAN SERVICE AT HOME INC POLICY

Supervision of policy and allegations of fraud, waste and abuse is overseen by Human Resources and Health Department. Responsibilities include:

- To review and investigate all allegations of fraud, exploitation, neglect, waste and abuse
- To take corrective actions for any supported allegations after a thorough investigation; and
- To report confirmed misconduct to the appropriate parties and/or agencies, including if deemed necessary make a report to Adult Protective Services and/or other appropriate authorities.

Once an allegation is made or department has been informed of suspected or confirmed fraud and/or abuse – an investigation starts immediately, including full cooperation with state and federal agencies.


U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OIG

THE LAW

THE LAW

European Service at Home, INC receives state and federal funding for payment of services provided to our Participants.

Therefore:

"*In accepting Claims payment from the Plan, Health Care Providers are receiving state and federal program funds, and are subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud, waste or abuse against the Medical Assistance program*."

-Centers for Medicare & Medicaid Services

FALSE CLAMIS ACT (FCA)

The False Claims Act (FCA) is a federal law that **prohibits** knowingly presenting (or causing to be presented) a **false or fraudulent claim to the federal government or its contactors**, including state Medicaid agencies, for payment or approval.

The FCA also **prohibits knowingly making or using** (or causing to be made or used) a **false record or statement to get a false or fraudulent claim paid or approved.**

No specific intent to defraud is required to violate the civil FCA.

The providers must certify that claims data presented to the government for payment is accurate to the best of its knowledge.

The **FCA encourages whistleblowers to come forward** by providing protection from retaliation. Penalties for violating the FCA could result of up to **three times the programs' loss plus $11,000 per claim filed. Imprisonment and criminal fines**, or both, and possible **exclusion from federal government health care programs.**

ANTI-KICKBACK STATUTE (AKS)

The AKS is a criminal law that **prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs.**

In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime.

The statute covers the ***payers*** of kickbacks-those who offer or pay remuneration- as well as the ***recipients*** of kickbacks-those who solicit or receive remuneration.

Criminal penalties and administrative sanctions for violating the AKS include **fines, imprisonment, jail terms, and exclusion from participation in the Federal health care programs.** Under the CMPL, physicians who pay or accept kickbacks also face penalties of up to $**50,000 per kickback plus three times the amount of the remuneration.**

Safe Harbor Regulations – protection under strict regulations and requirements.

PSYSICIAN SELF-REFERRAL LAW (STARK LAW)

Prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest or
- A compensation arrangement

The Stark law is a **strict liability statute**, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals.

Penalties for physicians who violate the Stark law include fines, CMPs for each service, repayment of claims, as well as exclusion from participation in the Federal health care programs.

UNITED STATES CRIMINAL CODE

The Criminal Health Care Fraud Statute, 18 U.S.C. Section 1347 prohibits**knowingly and willfully** executing, or attempting to execute, a scheme or lie in connection with the delivery of, or payment for, health care benefits, items, or services to either:

- Defraud any health care benefit program
- Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program

Example: Several medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary claims for unnecessary treatments.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

SOCIAL SECURITY ACT

An act to provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.

The Social Security Act was signed into law by President Roosevelt on August 14, 1935. In addition to several provisions for general welfare, the new Act created a social insurance program designed to pay retired workers age 65 or older a continuing income after retirement.

The Inspector General Act of 1978, as amended, allows the Office of the Inspector General (OIG) at the Social Security Administration (SSA) to collect your information, which OIG may use to investigate alleged fraud, waste, abuse, and misconduct related to SSA programs and operations.

Violation results in penalties which may include fines, imprisonment, benefit deductions or elimination and/or other civil monetary penalties.

EXCLUSION STATUTE

The OIG may impose permissive exclusions on entities convicted of any Federal health care programs fraud on various grounds, including:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud, or misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity
- Providing unnecessary or substandard services
- Submitting false or fraudulent claims to a Federal health care program
- Engaging in unlawful kickback arrangements
- Defaulting on health education loan or scholarship obligations

EXCLUSION STATUTE

OIG to exclude individuals and entities convicted of any of the following offenses from participation in all Federal health care programs:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances

If you employ or contract with an excluded individual or entity and Federal health care program payment is made for items or services, whether directly or indirectly, you may be subject to a civil monetary penalty and/or an obligation to repay any amounts attributable to the services of the excluded individual or entity.

This online database can be accessed from OIG's Exclusion Web site -- https://exclusions.oig.hhs.gov.

EXCLUSION STATUTE

Excluded providers may not participate in the Federal health care programs for a designated period. If an entity is excluded by OIG, then Federal health care programs, including Medicare and Medicaid, will not pay for items or services that are furnish, order, or prescribe. Excluded providers may not bill directly for treating Medicare and Medicaid patients, and an employer or a group practice may not bill for an excluded provider's services. At the end of an exclusion period, an excluded provider must seek reinstatement; **reinstatement is not automatic.**

The OIG maintains a list of excluded parties called the List of Excluded Individuals/Entities (LEIE).

This online database can be accessed from OIG's Exclusion Web site -- https://exclusions.oig.hhs.gov.

CIVIL MONETARY PENALTIES LAW (CMPL)

OIG may seek **civil monetary penalties and sometimes exclusion** for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. CMPs also may include an assessment of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received. **Penalties range from $10,000 to $70,000 per violation**. Some examples of CMPL violations include:

- Presenting a claim that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent;
- Presenting a claim that the person knows or should know is for an item or service for which payment may not be made;
- Violating the AKS;
- Violating Medicare assignment provisions;
- Violating the Medicare physician agreement;
- Providing false or misleading information expected to influence a decision to discharge;
- Failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency medical condition or in labor; and
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

THE FRAUD ENFORCEMENT AND RECOVERY ACT OF 2009 (FERA)

Passed by Congress to enhance the criminal enforcement of federal fraud laws, including the False Claims Act (FCA).

Penalties for violations of FERA are comparable to penalties for violation of the FCA. FERA does the following:

- Expands potential liability under the FCA for government contractors.
- Expands the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government contractor.
- Expands the definition of false record to include any record that is material to a false/fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITYY ACT (HIPPA)

HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.

Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.


FRAUD

WHAT IS FRAUD?

Fraud — Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable federal or state law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by any entity, including the CHC-MCO, a subcontractor, a Provider, or a Member/Participant.

WHAT IS MEDICARE FRAUD?

Medicare fraud typically includes any of the following:

- Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering, or paying remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health services

EXAMPLES OF MEDICARE FRAUD INCLUDE:

- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the medical records
- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items
- Knowingly ordering medically unnecessary items or services for patients
- Paying for referrals of Federal health care program beneficiaries
- Billing Medicare for appointments patients fail to keep

MEDICARE FRAUD EXPOSURE

Defrauding the Federal Government and its programs is illegal.

Committing Medicare fraud exposes individuals or entities to potential criminal, civil, and administrative liability, and may lead to imprisonment, fines, and penalties.

Criminal and civil penalties for Medicare fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate intervention. Providers and health care organizations involved in health care fraud risk being excluded from participating in all Federal health care programs and losing their professional licenses.

WHAT IS WASTE?

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

EXAMPLES OF MEDICARE WASTE

- Conducting excessive office visits or writing excessive prescriptions.
- Prescribing more medications than necessary for treating a specific condition.
- Ordering excessive laboratory tests.

ABUSE

WHAT IS ABUSE?

Abuse — Any practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the MA Program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or Agreement obligations and the requirements of federal or state statutes and regulations for healthcare in a managed care setting, committed by the MCO, a subcontractor, Provider, or Participant, among others.

WHAT IS ABUSE?

The difference between “fraud” and “abuse” depends on specific facts, circumstances, intent, and knowledge.

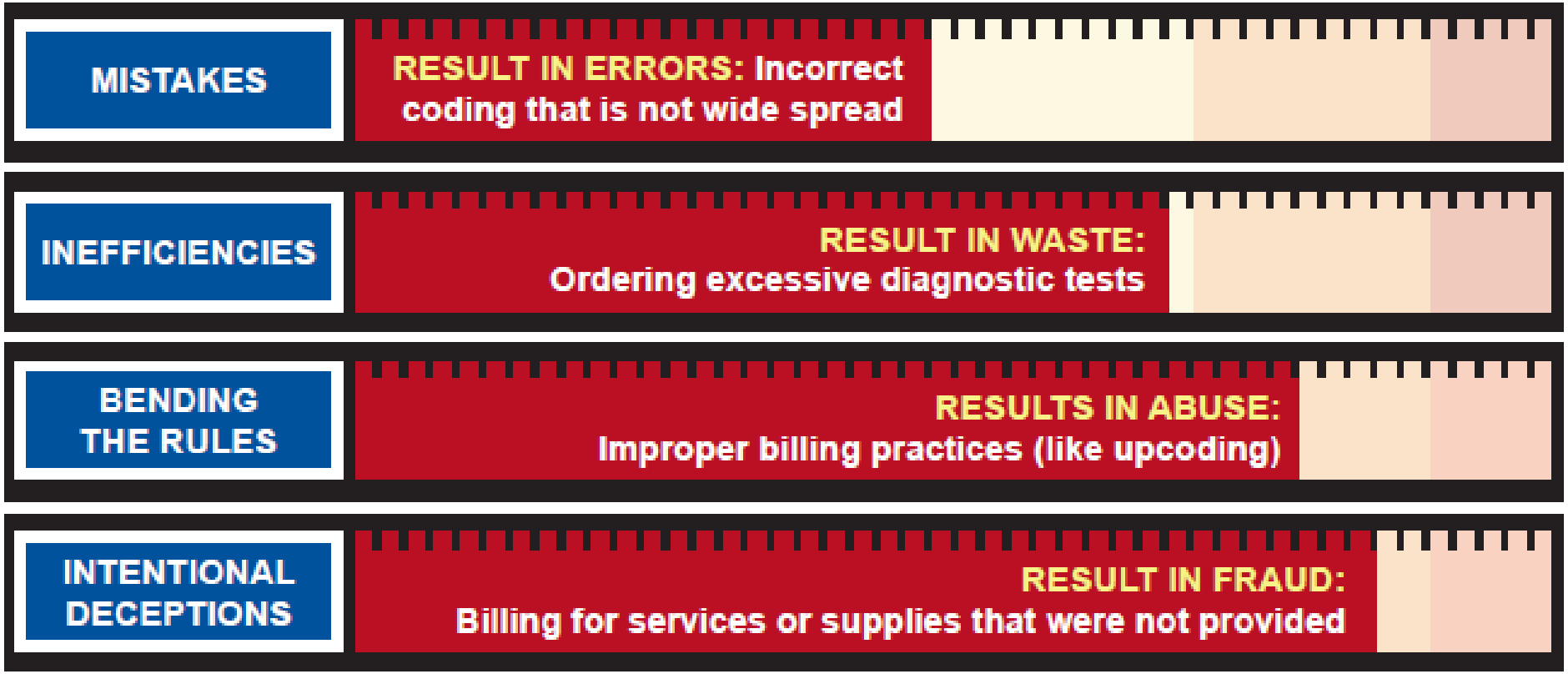
Examples of Medicare abuse include:

- Billing for unnecessary medical services
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes. Upcoding is when a provider assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement.

Medicare abuse can also expose providers to criminal and civil liability.

Program integrity includes a range of activities targeting various causes of improper payments.

ABUSE: TYPES OF IMPROPER PAYMENTS



WASTE AND RECOVERY

SOME EXAMPLES OF WASTE AND RECOVERY INCLUDE:

- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments.
- Overpayments resulting from incorrect revenue/procedure codes, retro TPL/Eligibility.
- Overpayment due to incorrect set-up or update of contract/fee schedules in the system.

WASTE RECOVERIES

The Department of Healthcare and Family Services and the Department of Health and Human Services require more frequent data matches for all individuals enrolled in Medicaid and other welfare programs. This monitoring can be phased in, starting with the highest-risk cases and the most frequently updated databases. To deter eligibility fraud and encourage compliance with income reporting, the departments also forward all cases canceled due to fraud or misrepresentation to the appropriate authorities for prosecution and benefit recovery.

As a result of these claims accuracy efforts, providers may receive letters from the Plan, or on behalf of the Plan, regarding recovery of potential overpayments and/or requesting medical records for review. Any questions should be referred to the contact information provided in the letter to expedite a response to questions or concerns.

Gov. Bruce Rauner's Health Care Fraud Elimination Task Force reported that the State has saved, prevented or recovered approximately $450 million in fraudulent or wasteful Medicaid spending in fiscal years 2016 and 2017 alone.

RETURNIG IMPORPER OR OVER PAYMENTS FOR MEDIAL PROVIDERS

Call the Illinois Department of Healthcare and Family Services Office of Inspector General at 217 -524-6119 or follow the prompts for Provider Self-Disclosure Protocol Act listed at https://hfs.illinois.gov/medicalproviders/notice.prn130307a.html.

Ensure proper documents are printed and completed including the Disclosure Report (including the CD) must be submitted by mail to the following address:

The Illinois Department of Healthcare and Family Services

Office of Inspector General c/o Self-Disclosure Protocol

Attention: Trish Phillips, Chief of Staff

404 5th Street

Springfield, IL 62763

Providers interested in alternate means of submission should contact the OIG at 217-524-6119.

No disclosure is complete until the department receives a complete Disclosure Report.

Provider Self-Audit Protocol

Matters related to an ongoing department audit of the provider are not generally eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an ongoing audit may be eligible for processing under the protocol.

If the OIG is already auditing or investigating the provider, and the provider wishes to avail themselves of the protocol, the provider should bring the matter to the attention of the assigned auditor and make a submission under the protocol.

If an outside agency is auditing or investigating the provider for the conduct, and the provider seeks to disclose an issue to the OIG, the provider should follow this guidance accordingly.

RECIPIENT FRAUD

WHAT IS RECIPIENT FRAUD?

Someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, **medical assistance**, or other public benefits **AND** that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS card, trafficking SNAP benefits or taking advantage of the system in any way.

RECIPIENT FRAUD

Illinois Department of Human Services has several types of programs through Family Community Resource Centers (FCRCs). Integrity of this program is of outmost importance and work in conjunction with state and federal agencies to detect fraudulent activity and investigate. The review of services identifies participants receiving excessive or unnecessary treatment, diagnostic services, drugs, medical supplies, or other services.

More information can be found at https://www.dhs.state.il.us/page.aspx?item=146937#:~:text=by%20phone%20at%201%2D844,(state.il.us).

REPORT SUPPLMENETAL NUTRITIONASSISTANCE PROGRAM (SNAP) AND LINK CARD FRAUD

You can report SNAP or Link fraud in a variety of ways:

File an EBT Theft claim for fraud committed against your LINK account at IDHS:Manage My Illinois Link Account (state.il.us)

Report Fraud against the SNAP program Online at IDHS:Report SNAP Fraud (state.il.us)

By phone at 1-800-843-6154, 1-866-324-5553 TTY/Nextalk, 711 TTY Relay

Report in person at any Family Community Service Resource CenterIDHS: Office Locator (state.il.us)

REPORT MEDICAID OR CASH PROGRAM FRAUD

You can report Medicaid or Cash fraud in a variety of ways:

- Online at Report Fraud | HFS (illinois.gov)
- by phone at 1-844-453-7283/1-844-ILFRAUD.
- Report in person at any Family Community Service Resource Center IDHS: Office Locator (state.il.us)

REPORT RETAILER FRAUD WITH THE LINK CARD

If you believe a Retailer is involved in Link card fraud, you can report that a variety of ways:

- Call the USDA Office of Inspector General:
  - (800) 424-9121
  - (202) 690-1622
  - (202) 690-1202 (TDD)
- Write:

  United States Department of Agriculture Office of Inspector General
  PO Box 23399
  Washington, DC 20026-3399

- * Submit a Complaint Online

ARE YOU A RETAILED WANTING TO REPORT FRAUD INVOLVING THE LINK CARD?

If you are reporting suspected fraud against or by a customer(s) you can use our general reporting methods:

- By Email at DHS.EBTRetailer.Reportfraud@Illinois.gov
- by phone at 1-800-843-6154, 1-866-324-5553 TTY/Nextalk, 711 TTY Relay
- Report in person at any Family Community Service Resource Center IDHS: Office Locator (state.il.us)

RECIPIENT FRAUD EXAMPLES

A Member/Participant is subject for review if any of the following criteria are satisfied:

- Member/Participant gets prescriptions filled at more than 2 pharmacy locations within one month.
- Member/Participant has prescriptions written by more than 2 physicians per month.
- Member/Participant fills prescriptions for more than 3 controlled substances per month.
- Member/Participant obtains refills (especially on controlled substances) before recommended days' supply is exhausted.
- Duration of narcotic therapy is greater than 30 consecutive days without an appropriate diagnosis.
- Prescribed dose outside recommended therapeutic range.
- Same/Similar therapy prescribed by different prescribers.
- No match between therapeutic agent and specialty of prescriber.
- Fraudulent activities (forged/altered prescriptions or borrowed cards).
- Repetitive emergency room visits with little or no PCP intervention or follow-up.
- Same/Similar services or procedures in an outpatient setting within one year.

RECIPIENT RESTRICTION PROGRAM

Lock-In—Recipients determined to be involved in fraudulent activities or identified as abusing services provided under the Medical Assistance Program who are restricted to a specific Provider(s) to obtain all of his or her services in an attempt to ensure appropriately managed care.

If the results of the review indicate waste, abuse or fraud, the participant will be placed on the Restricted Recipient Program for a period of five (5) years, which means the participant(s) can be restricted to a single:

- PCP
- Pharmacy
- Hospital/facility

Restriction to one Network Provider of a particular type will assist in coordination of care and provide for medical management.

RECIPIENT RESTRICTION REFERRALS

The IDPH receives referrals of suspected fraud, mis-utilization or abuse from a number of sources, including:

- Physician/pharmacy providers
- The Plan's Pharmacy Services Department
- Member/Participant/Provider Services
- Case Management/Care Coordination
- Special Care Unit
- Quality Assurance and Performance Improvement
- Medical Affairs
- Department of Human Services (DHS)

Network Providers who suspect Member/Participant fraud, waste or abuse of services can make a referral to the Recipient Restriction Program by calling the IDHS by phone 1-844-453-7283/1-844-ILFRAUD. All such referrals are reviewed for potential restriction.

PROVIDER FRAUD

EXAMPLES OF PROVIDER FRAUD

Billing for services not rendered or not Medically Necessary. For example:

- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients.
- Personal assistance services (PAS) cannot be rendered while a Participant is in an inpatient setting.
- Prescribing items or referring services which are not Medically Necessary.
- Misrepresenting the services rendered.
- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs.
- Retaining Medicaid funds that were improperly paid.
- Billing Medicaid recipients for covered services.
- Failure to perform services required under a capitated contractual arrangement.
- Up-coding to more expensive service than was rendered; billing for more time or units of service than provided.

SSN Trace & Validation

Criminal Background Check

Drug Testing

Identity Checks

Resume Validations

Education Verification

Employment Verification

Tenant Screening

Social Media Search

Credit Report

National Sex Offender Registry

Global Terror Report

Electronic I-9 & E-Verify

International Professional License Verification

SECURE CHECK360

EMPLOYEE SCREENING REQUIREMENTS

Required screening for exclusion from federal programs

As required by the Department of Human Services' Office of Inspector General (HHS-OIG) 42 CFR Section 455.436 and outlined in the Illinois Department of Human Services (DHS) Required Criminal Background Check and Registry Clearances to all providers who participate in Medicare, Medicaid or any other federal health care program are required to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in any of the aforementioned programs.

Employees should be screened for exclusion before employing and/or contracting with them and, if hired, should be rescreened on an ongoing monthly basis to capture exclusions and reinstatements that have occurred since the last search.

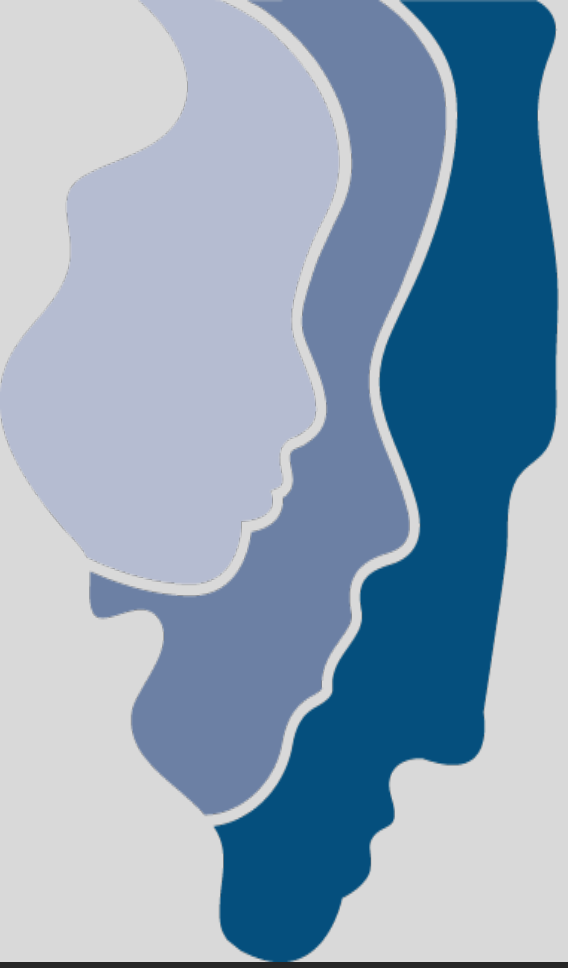
Required employee screening for exclusion from federal programs

Examples of individuals or entities that providers must screen for exclusion include, but are not limited to:

- Individual or entity who provides a service for which a claim is submitted to Medicaid;
- Individual or entity who causes a claim to be generated to Medicaid;
- Individual or entity whose income derives all, or in part, directly or indirectly, from Medicaid funds;
- Independent contractors if they are billing for Medicaid services;
- Referral sources, such as providers who send a Medicaid recipient to another provider for additional services or second opinion related to medical condition.

Required employee screening for exclusion from federal programs

The Illinois Department of Human Services are prohibited from paying for any items or services furnished, ordered, or prescribed by individuals or entities excluded from the Medical Assistance (MA) Program as well as other federal health care programs.



ILLINOIS DEPARTMENT OF PUBLIC HEALTH

IDPH

PROTECTING HEALTH, IMPROVING LIVES

REPORTING FRAUD

Information that will assist with an investigation

Contact Information (e.g. name of individual making the allegation, address, telephone number);

- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent or Abuse Activities;
- Timeframe of the Allegation(s).

For General Public & Providers - Report About Medicare & Medicaid

By Phone
Health & Human Services
Office of the Inspector General
1-800-HHS-TIPS
(1-800-447-8477)
TTY: 1-800-377-4950

By Mail
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026

By Fax
Maximum of 10 pages
1-800-223-8164

Online
Health & Human Services Office of the Inspector General Website

For People with Medicare; A & B, C, D Information

Medicare Parts A & B
By Phone
1-800-MEDICARE
(1-800-633-4227)
TTY: 1-877-486-2048

Medicare Part C
(Medicare Advantage)
Varies by plan
Refer to your plan's general contact and/or fraud-reporting information

Medicare Part D
(Medicare Drug Plan)
By Phone
1-877-7SAFERX
(1-877-772-3379)
OR
refer to your plan’s general contact and/or fraud-reporting information

If You Need Assistance Reporting Suspected Fraud, The Senior Medicare Patrol (SMP) is Here to Help

By Phone
1-877-808-2468

Online
Senior Medicare Patrol Website

For General Public - Report About the Health Insurance Marketplace

By Phone

1-800-318-2596
TTY: 1-855-889-4325

Reporting fraud waste and/or abuse to the commonwealth

REPORTING TO U.S. GOVERNMENT ACCOUNTABILITY OFFICE LINK TO REPORT FRAUD, ABUSE AND WASTE OF FEDERAL FUNDS:

https://www.gao.gov/about/what-gao-does/fraud

REPORTING TO ILLINOIS DEPRATMENT OF HUMAN SERVICERS LINK TO REPORT FRAUD, ABUSE AND VIOLATION OF MEDICAID, MEDICARE, CASH PROGRAMS, SNAP OR OTHER STATE ASSISTED PROGRAMS

https://www.dhs.state.il.us/page.aspx?item=146937#:~:text=You%20can%20report%20Medicaid%20or,(state.il.us)

HOW TO REPORT MEDICAIRE FRAUD STEP BY STEP

STEP 1: UNDERSTANDING THE BLEND OF MEDICARE FRAUD AND ABUSE

Medicare fraud is billing for services or supplies that were never provided or were provided but not medically necessary. Medicare abuse is a pattern of improper practices that result in unnecessary costs to Medicare, but may not be intentionally fraudulent, but still may potentially be remedied under the False Claims Act.

STEP 2: EVIDENCE AGAINST FRAUD

If you suspect Medicare fraud and abuse, it is important to speak with a whistleblower law firm before gathering any evidence to make sure you are lawfully gathering evidence.

STEP 3: CHOOSE A WHISTLEBLOWER LAW FIRM

Often individuals regret directly reporting the matter to the government and many years later want to involve a whistleblower law firm to try and obtain a whistleblower reward for their information, but unfortunately, that may be too late. A whistleblower law firm can help you navigate the legal process and can protect your rights.

STEP 4: WORKING WITH YOUR WHISTLEBLOWER ATTORNEY

Once you have chosen a whistleblower law firm, you will discuss your allegations and the evidence. Your attorney will review your evidence and help you understand the strengths and weaknesses of your case.

STEP 5: FILE A WHISTLEBLOWER COMPLAINT

If you decide to file a whistleblower complaint, your attorney will draft and file the complaint on your behalf. The complaint will detail your allegations of Medicare fraud and abuse and will provide evidence to support your claims.

STEP 6: COOPERATE WITH THE INVESTIGATION

After you file a whistleblower complaint, the appropriate authorities will investigate your allegations of Medicare fraud and abuse. It is important to cooperate fully with the investigation and to provide any additional evidence or information that may be requested. Your whistleblower law firm will assist you throughout the process.

STEP 7: PROTECTION FROM RETALIATION

One of the biggest concerns for Medicare fraud whistleblowers is retaliation from their employer. Retaliation can take many forms, including termination, demotion, harassment, and blacklisting. The False Claims Act statute provides strong measures to combat retaliation, but it doesn't mean that it doesn't occur.

STEP 8: RECEIVE WHISTLEBLOWER AWARD

If the government recovers funds as a result of your whistleblower complaint, you may be entitled to a whistleblower award up to 30% of what the government recovers. Your qui tam attorney will help you negotiate the terms of your award and work to help you receive the compensation you deserve.