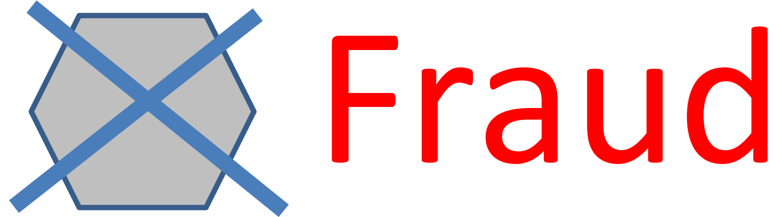
Understanding and Preventing Fraud and Abuse



Overview

Fraud and abuse in Medicaid cost states billions of dollars every year, diverting funds that could otherwise be used for additional services or to assist more individuals that need care. As a provider, contracted agency, member, caregiver, or recipient of funds, we must comply with Federal and State Laws and not engage in fraud or abuse. Honesty and integrity are expected of all who participate in the Medicaid programs.

What is Fraud?

Medicaid fraud is when a person knowingly cheats or is dishonest. The dishonesty results in a benefit such as overpayments. Medicaid fraud involves knowingly misrepresenting the truth to obtain unauthorized benefit. Abuse includes any practice that is inconsistent with acceptable practices and unnecessarily increase costs.

Examples of Fraud and Abuse can include:

- Recording hours on a timesheet that you did not work
- Approving/authorizing hours that employees did not work
- Recording more time or stating different times than what you actually worked
- Accepting kickbacks for referrals
- Stating you performed specific cares or tasks that you did not actually perform
- Changing timesheets without approval or clarification of hours worked
- Not providing the services that the individual needs
- Falsifying a workers compensation claim
- Falsifying documents
- Other falsifications or dishonest misrepresentation

Summary

Various programs have been developed at both the state and federal levels to prevent, identify and prosecute Medicaid fraud and abuse. Fraud may result in termination of services/funds, penalties, fines, and/or jail time. It is your responsibility to be a good steward of the funds you are using/receiving and be mindful of authorized hours.

How to Report

If you know of, or have reason to believe that fraud is occurring, it is your responsibility to immediately report this to Office of Inspector General at **1-877-865-3432 or** http://www.dhs.wisconsin.gov/