

MEDICAID FRAUD

What is Medicaid Fraud?

Medicaid fraud occurs when a Medicaid provider knowingly makes, or causes to be made, a false or misleading statement or representation for use in obtaining reimbursement from the Medicaid program. Medicaid fraud typically includes any of the following:

- **Billing for Unnecessary Services or Items:** *Intentionally billing for unnecessary medical services or items.*
- **Billing for Services or Items Not Provided:** *Intentionally billing for services or items not provided.*
- **Collusion:** *Knowingly collaborating with beneficiaries to file false claims for reimbursement.*



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Program Integrity

Program Integrity refers all cases of potential fraud to the South Carolina Attorney General's Office for possible criminal prosecution and enacts sanctions against providers who abuse the Medicaid program or fail to meet program expectations. Sanctions include:

1. Educational intervention
2. Referral to licensing boards
3. Suspension
4. Termination or exclusion from the program



State Attorney General's Office

The Attorney General is South Carolina's Chief Criminal Prosecutor, Chief Legal Officer and Securities Commissioner.

The duties and responsibilities of the Attorney General are described by common law, the state Constitution, and state statutes.

The SC Attorney General has authority to supervise the prosecution of all criminal cases in courts of record and targets fraud in the health care industry through the **Medicaid Fraud Control Unit.**



Medicaid Fraud Unit

The Medicaid Fraud Control Unit:

- investigates and prosecutes health care fraud committed by Medicaid providers and the physical abuse of patients and embezzlement of patient funds in facilities.
- enforces South Carolina laws protecting mentally or physically disabled or elderly citizens from neglect and abuse in long-term care facilities.



Report Medicaid Fraud

If you have any information about Medicaid provider fraud or patient abuse, please report it to the Medicaid Fraud Unit at:

➤ **1-888-364-3224 (Toll free)**

Tips can be made anonymously.



US Office of the Inspector General (OIG)

A key component of OIG's mission is to detect and root out fraud in Federal health care programs, including Medicare and Medicaid.



Efforts to curb fraud include:

- ✓ **conducting criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries;**
- ✓ **using state-of-the-art tools and technology in investigations and audits around the country;**
- ✓ **imposing program exclusions and civil monetary penalties on health care providers because of criminal conduct such as fraud or other wrongdoing;**
- ✓ **negotiating global settlements in cases arising under the civil False Claims Act, developing and monitoring corporate integrity agreements, and developing compliance program guidance.**

