EXAMPLES OF FRAUD

DOCTORS:

- Bill for services not provided, i.e. a chest x-ray when an x-ray was not taken.
- Duplicate Billing occurs when a provider bills Medicaid and the recipient or private insurance for the same service.
- Requires that the patient come back each week for the same problem or to get the same prescription when another appointment is not necessary, or a normal amount of medication could be prescribed.
- Upcode, i.e. identify a simple office visit as an emergency office visit or a comprehensive visit.
- Take unnecessary x-rays, blood work or perform other unnecessary services.
- Bill Medicaid for an office appointment when you did not have an appointment, or add additional family members' names for appointments.
- Have an unlicensed person perform services that only a licensed professional should render, and bill as if the professional had provided the service.
- Billing for more time than actually provided, i.e. counseling, anesthesia, etc.
- Alter date of service for billing purposes.

DENTISTS:

- Bill Medicaid for services not provided, i.e. a mouth x-ray when an x-ray was not taken, or for a cleaning that was not performed.
- Duplicate Billing occurs when a provider bills Medicaid and the recipient, or a private dental insurance for the same service.
- Provides poor quality dentures that do not fit, then states that for a certain amount of money, he/she can make you a “good” pair. Medicaid provides for good dentures.
- “Create” cavities to fill more teeth than need fixing, just to raise the reimbursement.
- Fill only one cavity per visit to increase the copay per procedure.
- Charge for services that supposedly aren’t covered by Medicaid, i.e. fluoride treatments. Fluoride treatments are a covered benefit for children.
- Dentist will clean teeth, and charge extra to clean the patient’s gums.
- Alter date of service for billing purposes.

CHIROPRACTORS:

- Upcode the severity of the injury.
- Increase the number of adjustments made per visit.
- Bill for office visits when no appointment is made.
- Require a copayment.
- Bill two insurance carriers for the same procedure.
- Alter date of service for billing purposes.
- Billing services provided by chiropractor under a doctor's ID number to increase reimbursement.
PODIATRISTS:
- Upcode, bill for a more expensive procedure than was actually performed, i.e. bill for surgery when the patient’s toe nails were trimmed.
- Bill for services when no services were provided.
- Visit a nursing home, and bill for treatments without being requested.

OPTOMETRISTS:
- Limit the number of glasses frames available to Medicaid clients, and tell them that they have to pay more for "attractive frames".
- Require that Medicaid reimburse the optician before the glasses are ordered.
- Demand a copay for services when the patient is under 21 years old.
- Charge for services that supposedly aren't covered by Medicaid, i.e. non-scratch lenses. When approved by Medicaid, this is a covered service.
- Charging for an extra Medicaid covered examination.

NURSING HOMES:
- Bill Medicaid for services not provided, i.e. a chest x-ray when an x-ray was not taken, food supplements not given, medications not distributed.
- Bill Medicaid for a resident who is no longer eligible, or who is no longer at the facility due to death or discharge.
- Kickbacks. Facility owner may require certain providers, such as pharmacies or laboratories, etc., to pay a certain portion of the money to the facility owner for access to the residents. Payment can take the form of cash, vacation trips or other compensation.
- Providing generic medications when a specific name brand drug is ordered and billed.
- Using the monthly Medicaid allotment of diapers/pads on non-Medicaid residents.

HOME HEALTH CARE:
- Agency billing for a home visit when none was provided.
- Agency billing for a longer visit than provided.
- Agency billing for a professional visit when an unskilled unlicensed person was sent to the home.
- Agency billing for more services than were actually provided, i.e. bath, when no bath was given.
ADULT FOSTER CARE [AFC] HOMES:

- Billing for services not rendered, i.e. medical care needed but not provided.
- Billing for more staff than actually are care providers. Including Administrators along with direct care staff to increase the payments from Medicaid.
- Not providing licensed individuals to supervise, or understaffing.
- Using the monthly Medicaid allotment of diapers/pads on a non-Medicaid resident.

HOSPITALS:

- Billing for services not rendered.
- Substituting generic drugs and billing for name brand medications.
- Substituting medical resident doctor services and billing for licensed medical practitioner services.
- Billing for more days than actually used.
- Billing for lab procedures not used.

PSYCHIATRIC HOSPITALS:

- Billing for counseling sessions not provided.
- Upcoding the severity of the medical problem.
- Billing for accommodations not used, private room versus a ward room.
- Adding on time for a counseling session.

SUBSTANCE ABUSE CLINICS:

- Requiring a copay before each visit.
- Billing for counseling sessions not provided.
- Billing for one hour sessions when less counseling time is provided.
- Using unlicensed counselors when a licensed counselor is required.

PHARMACIES:

- Substituting a generic for a name brand medication and billing for the name brand.
- Providing fewer pills than prescribed, but billing for the entire number of medications prescribed.
- Dispensing only part of the prescription in order to get another filling fee.
- Requiring a higher copay.

DURABLE MEDICAL EQUIPMENT:
Providing used or broken equipment and billing for new equipment.
Billing for equipment rental after the client has died or no longer needs the equipment.
Billing for rental when the client has paid for the product.
Billing for a more expensive item when a cheaper item was delivered.
Not picking up the item on time in order to get another month’s rental cost from Medicaid.
Billing for equipment not provided.

LABORATORY SCAMS:
- Bundling a series of tests, and then unbundling to individually bill certain tests to increase charges.
- Adding unprescribed tests to a series of tests that were ordered.
- Not doing the blood tests, but sending out results of another blood sample.

KICKBACKS:
- Provider refusing to do business with a supplier unless there is direct monetary compensation.
- Certain commission sales in the medical profession are considered a kickback.

MOBILE LABORATORIES:
- Providing unnecessary tests, especially x-rays and blood work.
- Billing for services not rendered.
- Billing for patients who are not enrolled patients.

AMBULANCE SERVICES:
- Upcoding the quality of services needed, i.e. billing for life support services when transportation was all that was needed.
- Changing hospital destinations to charge additional fees.
- Charging for additional services not rendered, i.e. oxygen, monitors.