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Objectives for Section 1400

1. Define Fraud and Abuse;
2. Determining Fraud and Abuse;
3. How to Respond to Fraud and Abuse.

1400.1 Introduction-Fraud and Abuse

Medicaid fraud is defined as:

- Knowingly and willfully making or causing to be made any false statement or false representation of a material fact (whether or not the individual is found eligible):
 - In an application for a Medicaid benefit or payment;
 - For use in determining rights to a Medicaid benefit or payment.
- Having knowledge of the occurrence of any event affecting the initial or continued right to Medicaid benefits or payments for the individual who filed the application or on whose behalf the application was filed, and concealing or failing to disclose that event with an intent to secure fraudulently those benefits or payments either in a greater amount or quantity than is due or when benefits or payments are not authorized;
- Applying to receive or receiving Medicaid benefits or payments for use and benefit of someone else, and knowingly and willfully converting any part of the Medicaid benefit or payment to a use other than the benefit of the enrolled Medicaid recipient;
- Fraudulently obtaining, attempting to obtain, or aiding another person in obtaining or attempting to obtain a Medicaid covered service by the use of:
 - Fraud, deceit, misrepresentation, or subterfuge;
 - Forgery or alteration of a Medicaid prescription;
 - Concealment of a material fact; or
 - Use of false names or addresses.
- Unauthorized possession of a blank provider prescription form;
- Possession of a Medical Care Program recipient identification card without authorization from the individual to whom the card was issued; or
- Manufacture, distribution, or possession of a counterfeit Medical Care Program recipient identification card or a provider prescription form.

Following are examples of the most frequent types of recipient fraud:

- Intentionally under-reporting or not reporting income and resources;
- Falsely reporting household composition, such as omitting wage earners from the Medicaid application.
- Failing to report changes in income, resources, or other circumstances within 10 days as required – e.g., moving out of state, receipt of cash lump sums;
- Failing to report third party insurance coverage;
- Lending a Medical Care Program recipient identification card to another person; and
- Forging or altering prescriptions.

If the LDSS or Local Health Department LHD has granted eligibility in error and can verify the period of ineligibility, these cases are referred to the DHMH Recoveries and Financial Services Division via the completion and submission of the DHMH Form 1169. A copy of Form 1169 may be found in the Appendix of Chapter 15: Liens, Adjustments and Recoveries.

1400.1- Procedural Changes Related to Recipient Fraud and Abuse of the Medicaid Program

See COMAR 10.09.24.14 and .14-1 for the definitions, policies, and procedures related to recipient fraud and abuse of the Medicaid program. There have been organizational and procedural changes since the regulations were promulgated.

The Corrective Managed Care Program, described in Regulation 14-1, was discontinued when the HealthChoice managed care program was implemented in 1996. The Department of Health and Mental Hygiene, however, retains the option to re-institute the program. A HealthChoice managed care organization (MCO), in accordance with COMAR 10.09.75, has the option to implement corrective managed care for enrollees who abuse the MCO's benefits.

In July 2006, all fraud, waste, and abuse investigation was transferred to the DHMH Office of the Inspector General (OIG).

- The Medicaid Program Integrity (PI) Division investigates allegations of possible Medicaid recipient fraud.
- If suspected fraud is detected by a LDSS or LHD state member, the case must be promptly reported to the OIG/PI Division via the DHMH Form 4243. A completed DHMH Form 4243 should be sent to the following address:

**Department of Health and Mental Hygiene
Office of the Inspector General – Medicaid Program Integrity
201 West Preston Street Rm. 520
Baltimore, MD 21201**

- The DHMH Form 4243 may be obtained from the PI Division by sending a written request to the address above, by calling 1-866-770-7175, or by visiting the website at: www.DHMH.Maryland.Gov/oig/sitepages/home.aspx Click on "Report Medicaid Fraud," then select "For agency use." A copy of Form 4243 may also be found in the Appendix of Chapter 15: Liens, Adjustments and Recoveries.
- Referrals for investigation of suspected recipient fraud are also generated from providers, police departments, the Social Security Administration, and citizens. They should call or write the PI Division to provide information and request an investigation.

Section 1400 Frequently Asked Questions and Answers (FAQs) Fraud and Abuse

1. What does the Medicaid Program Integrity (PI) Division Investigate?

They investigate allegation of possible Medicaid recipient fraud.

2. Where should a completed DHMH Form 4243 be sent?

To: Department of Health and Mental Hygiene
Office of the Inspector General – Medicaid Program Integrity
201 West Preston St., Rm. 520
Baltimore, MD 21201

3. What are some resources to obtain referrals for investigation of suspected recipient fraud?

Providers, police departments, the Social Security Administration, and citizens

4. What are some examples of the most frequent types of recipient fraud?

- Intentionally under-reporting or not reporting income and resources;
- Falsely reporting household composition, such as omitting wage earners from the Medicaid application;
- Failing to report changes in income, resources, or other circumstances within 10 days as required – e.g., moving out of state, receipt of cash lump sums; and
- Failing to report third party insurance coverage.

5. What is the website and phone number where you can report Medicaid Fraud?

Website: www.DHMH.Maryland.Gov/oig/sitepages/home.aspx

Contact number: 1-866-770-7175