PATIENT NEGLECT

As the elderly or disabled become more and more dependent on others for their care, it becomes increasingly important for individuals who accept the position of trust as caretakers of these vulnerable people to be held accountable for neglecting those in their care. Failure to provide the care and treatment necessary to maintain the welfare of those who depend on that care is every bit as dangerous and harmful as intentional assaultive behavior.

Criminal neglect of a care dependent person occurs when a caregiver knowingly, intentionally or recklessly fails to provide treatment, care, goods, or service that is necessary to maintain the health or safety of the care dependent person. The failure must then result in bodily injury to the care dependent person.

INDICATORS OF PATIENT NEGLECT

- Care dependent persons who are malnourished, dehydrated, or have untreated bedsores.
- Staff failing to follow doctors' orders with regard to treatment of a care dependent person.
- Failure to seek needed medical treatment for a care dependent person in a timely manner or not at all.
- Care dependent persons who appear unkempt, unclean, or disheveled.

If you suspect that Medicaid Fraud is being committed by a provider, or a care dependent person you know is suffering from patient neglect, write or call:

Office of Attorney General
Medicaid Fraud Control Unit
1600 Strawberry Square
Harrisburg, PA 17120
717-783-1481

Office of Attorney General
Medicaid Fraud Control Unit
10950 Route 30
North Huntingdon, PA 15642
724-861-3670

Office of Attorney General
Medicaid Fraud Control Unit
106 Lowther Street
Lemoyne, PA 17043
717-712-1220

Office of Attorney General
Medicaid Fraud Control Unit
1000 Madison Avenue
Norristown, PA 19403
610-631-5920

www.attorneygeneral.gov

Commonwealth of Pennsylvania
Office of Attorney General

PENNSYLVANIA
ATTORNEY GENERAL

MEDICAID FRAUD CONTROL UNIT

TOM CORBETT
ATTORNEY GENERAL

In 1978, the Pennsylvania Office of Attorney General created a Medicaid Fraud Control Unit whose purpose was to investigate and prosecute fraud committed by medical providers enrolled in the Medicaid program, as well as to investigate patient abuse and neglect in Medicaid funded health care facilities pursuant to the Medicare-Medicaid Anti-Fraud and Abuse Amendment of 1977.

The unit is a part of the Office of Attorney General's Criminal Law Division and is comprised of prosecutors, agents and auditors housed in three regional offices across the Commonwealth. The Medicaid Fraud Control Unit has the authority to file felony and misdemeanor charges against those who defraud the Medicaid program or commit patient neglect.

Tom Corbett
Attorney General

MEDICAID FRAUD

The Medicaid Fraud Control Unit investigates PROVIDER FRAUD. A provider is any business or individual that supplies health care goods and services to Medicaid recipients. Providers can be medical doctors, dentists, hospitals, nursing homes, pharmacies, durable medical equipment sellers, ambulance companies, or anyone else who bills the Medicaid Program for health care goods and services provided to a Medicaid recipient. A provider commits fraud by giving false information regarding services rendered to Medicaid recipients. The result is an increase in the cost of the Medicaid program, which eventually will be passed along to the taxpayers.

EXAMPLES OF MEDICAID FRAUD

- Billing for medical services not actually performed.
- Billing for a more expensive service than was actually rendered.
- Billing for separate services that should be combined into one billing.
- Billing twice for the same medical service.
- Dispensing generic drugs and billing for brand-name drugs.
- Giving or accepting something of value in return for providing medical services, i.e. kickbacks.
- Providing medically unnecessary services.
- Falsifying cost reports.
- Billing for ambulance runs to doctor appointments.

In many areas of the Commonwealth, Health Maintenance Organizations (HMO's) have contracted with the Department of Public Welfare to administer the Medicaid funded medical services.

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

Although HMO's can be defrauded by providers in ways similar to the fraud committed in the traditional fee-for-service setting, HMO's present unique fraud issues. Whereas in standard health care reimbursement situations the fraud is characterized by overbilling, an HMO environment creates an incentive to deny care to patients/consumers. This means that while a fee has been paid by the HMO to the provider for covered services, the services are denied or cut back for other than sound medical reasons. This not only defrauds the insurance company, but also compromises patient health.