

TO BE RESCINDED

5160:1-2-20

Medicaid consumer fraud and erroneous payments.

(A) This rule sets out requirements for the identification and referral of consumer fraud and erroneous payments made by a medical assistance program on behalf of a consumer.

(B) Definitions.

- (1) "Abuse" means individual practices resulting in unnecessary cost to the medicaid program.
- (2) "Conviction" or "convicted" means a judgment of conviction has been decided by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.
- (3) "Erroneous payments" means medicaid reimbursement made for an individual who was ineligible at the time services were received. An erroneous payment may occur as a result of fraud or non-fraud.

(C) Administrative responsibilities. The administrative agency shall:

- (1) Upon notification of a complaint of medicaid fraud, abuse or questionable practices, conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation in accordance with 42 C.F.R. 455.15 and 42 C.F.R. 455.16 (as in effect November 1, 2009). If a full investigation is warranted, the investigation shall continue until:
 - (a) Appropriate legal action is initiated;
 - (b) The investigation is closed or dropped by the administrative agency due to insufficient evidence of fraud or abuse; or
 - (c) The matter is resolved by the administrative agency. The resolution may include but is not limited to:
 - (i) Sending a warning letter to the individual giving notice that continuation of the activity in question will result in further action;
 - (ii) Seeking recovery of erroneous payments.

- (2) Make a determination whether an erroneous payment was made as a result of unreported changes, excess income or excess resources and seek recovery as authorized in section 5111.12 of the Revised Code.
 - (3) Refer all cases of fraud or suspected fraud to the county prosecutor as described in section 2913.401 of the Revised Code. For cases determined to be fraud, the administrative agency shall accept any reimbursement plan ordered by a court or agreed to by the county prosecutor.
 - (4) Not recover erroneous claims paid by the administrative agency for an individual that would have remained eligible under another medical assistance program.
 - (5) Recover erroneous claims for the individual only through reimbursement. Erroneous payments shall not be recovered by reducing benefits or services to the individual.
 - (6) Not recover erroneous payments for the individual as a result of an administrative error not caused by the individual.
 - (7) Seek recovery from only the responsible adult or guardian of medicaid eligible children.
 - (8) Seek a recovery agreement by sending a JFS 07335 "Notice of Medicaid Overpayment" (rev. 4/2002), or electronic equivalent, to the individual.
 - (9) Follow rule 5101:9-7-06 of the Administrative Code.
- (D) Recovery of erroneous payments. The administrative agency shall recover erroneous payments beginning the date the individual would no longer have been eligible for medicaid had the change been reported in accordance with paragraph (B) of rule 5101:1-38-01 of the Administrative Code and the expiration of the prior notice period as required in rule 5101:6-2-04 of the Administrative Code.
- (1) For excess resources, the amount subject to recovery is the lesser of:
 - (a) The amount of the payment made on behalf of the individual; or
 - (b) The difference between the actual amount of countable resources and the applicable resource standard.

- (2) For excess income, the amount subject to recovery is the total amount of payments made on behalf of the individual during the months of the erroneous payment period.
- (3) For combinations of excess resources and excess income, the amount subject to recovery is the greater of either paragraph (D)(1) or paragraph (D)(2) of this rule.
- (4) For spenddown cases, as outlined in rule 5101:1-39-10 of the Administrative Code, the amount subject to recovery is the lesser of:
 - (a) The amount of payments made on behalf of the individual; or
 - (b) The difference between the amount of the liability in effect during the erroneous period and the correct amount of the liability.
- (5) Situations involving individuals receiving long-term care, waiver services or intermediate care facility for the mentally retarded (ICF/MR) services:
 - (a) Income. Erroneous payments made as a result of incorrect patient liability as outlined in paragraph (B) of rule 5101:1-38-01 of the Administrative Code.
 - (i) Determine if an erroneous payment was made as a result of an improper transfer of assets by the individual or authorized representative as outlined in rule 5101:1-39-07 of the Administrative Code.
 - (ii) The amount subject to recovery.
 - (a) If the individual should not have been made medicaid-eligible, the amount subject to recovery is the amount of payments made on behalf of the individual; or
 - (b) If the individual was correctly made medicaid-eligible but the patient liability was incorrectly calculated, the amount subject to recovery is the difference between the amount of the correct patient liability and the amount of the patient liability that was in effect during the erroneous payment period.

- (b) Resources. Erroneous payments made as a result of excess resources as outlined in rule 5101:1-39-05 of the Administrative Code.
 - (i) Determine if an erroneous payment was made as a result of an improper transfer of assets by the individual or authorized representative as outlined in rule 5101:1-39-07 of the Administrative Code.
 - (ii) The amount subject to recovery is the difference between the actual amount of countable resources and the applicable resource standard.
 - (iii) The individual may choose to increase the patient liability through payment of a lump sum to the nursing facility if the increase will reduce the resources to the appropriate limit. The reduction in resources shall be accomplished in one calendar month and in compliance with paragraph (D) of rule 5101:1-38-01.8 of the Administrative Code.

- (E) Individual responsibility. The individual shall complete and return the JFS 07335 "Notice of Medicaid Overpayment" (rev. 4/2002), or its electronic equivalent, within thirty days from the date the form was sent by the administrative agency.

Effective:

Five Year Review (FYR) Dates: 10/30/2014

Certification

Date

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