5101:3-1-29 **Medicaid fraud, waste, and abuse.**

(A) The Ohio department of job and family services is required to have in effect a program to prevent and detect fraud, waste, and abuse in the medicaid program. Where cases of suspected fraud or misrepresentation to obtain payment from the medicaid program are detected, providers will be subject to a review or an audit by the department. In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general.

Overutilization of services by a provider, while possibly not considered fraudulent acts, may constitute abuse to the medicaid program. Consequently, in all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general. Waste and abuse results either directly or indirectly in financial losses to the medicaid program, its consumers, or their families. Various methods of audit and review will be utilized to determine waste and abuse. If waste and abuse is suspected or apparent, the department will take action to gain compliance and recoup inappropriate payments through audit and review as stipulated in rule 5101:3-1-27 of the Administrative Code.

(B) For purposes of this rule, the following definitions apply:

(1) "Fraud" is defined as an intentional deception, false statement or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law. If fraud is suspected or apparent, referral of the case to the attorney general's medicaid fraud control unit and/or the appropriate enforcement officials will be made.

(2) "Waste and abuse" are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of medicaid covered services and result in an unnecessary cost to the medicaid program.

(C) Cases of provider fraud, waste, and abuse may include, but are not limited to, the following:

(1) A pattern of duplicate billing by a provider to obtain reimbursement to which the provider is not entitled.

(2) Misrepresentation as to services provided, quantity provided, date of service, or to whom provided.

(3) Billing for services not provided.

(4) A pattern of billing, certifying, prescribing or ordering services that are not medically necessary or reimbursable in accordance with rule 5101:3-1-01 of the Administrative Code, not clinically proven and effective, and not consistent with medicaid program rules and billing instructions.

(5) Differing charges for the same services to medicaid and non-medicaid consumers. For inpatient hospital services billed by hospitals reimbursed on a prospective payment basis, the department will not pay, in the aggregate, more than the provider's customary and prevailing charges for comparable services.

(6) Violation of a provider agreement by requesting or obtaining additional payment for covered medicaid services from either the consumer or consumer's family, other than medicaid co-payments as designated in rule ~~5101:3-9-09~~5101:3-1-09 of the Administrative Code.

(7) Collusive activities between a medicaid provider and any person or business entity which would involve the medicaid program.

(8) Misrepresentation of cost report data so as to maximize reimbursement and/or misrepresent gains or losses.

(9) Billing for services that are outside the current license limitations or specific practice parameters of the person supplying the service.

(10) Misrepresenting by commission or omission any information on the provider enrollment form or included in the provider packet.

(11) Ordering excessive quantities of medical supplies, drugs and biologicals, or other services.

(D) The department will not pay for services subsequent to the date of termination which have been prescribed, ordered, or rendered by a provider who has been terminated under the medicaid program as defined in rule 5101:3-1-17.6 of the Administrative Code.

(E) There are instances when the provider suspects that there may be consumer fraud, misrepresentation, or overutilization of services. When fraud, waste, and abuse by a consumer is suspected, the provider should contact the local county department of job and family services. Cases of consumer fraud, waste, and abuse may include, but are not limited to:

(1) Alteration, sale, or lending of the medicaid card to others for securing medical services, or other related criminal activities.

(2) Receiving excessive medical visits and services.

(3) Obtaining services outside of those personally needed and used by the consumer.

(F) Responsibility for the business practices of employees must be assumed by providers. It is presumed that providers will take the necessary time to thoroughly acquaint themselves and their employees with all rules relative to their participation in the medicaid program. Ignorance of medicaid program rules will not be an acceptable justification for violation of department rules.

Effective: 03/27/2006

R.C. 119.032 review dates: 01/01/2009

CERTIFIED ELECTRONICALLY

Certification

03/17/2006

Date

Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02
Prior Effective Dates: 4/7/77, 7/1/80, 10/1/84, 10/1/87, 8/1/96, 5/30/02, 1/1/04, 12/30/05 (Emer)