5160-1-29 **Medicaid fraud, waste, and abuse.**

(A) 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, false statement, or misrepresentation 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 by the Ohio department of job and family services (ODJFS)~~.

(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.

(B) ~~ODJFS~~The Ohio department of medicaid (ODM) shall have in effect a program to prevent and detect fraud, waste, and abuse in the medicaid program. Where cases of suspected fraud to obtain payment from the medicaid program are detected, providers will be subject to a review ~~or an audit~~ by ~~ODJFS~~ODM and the case will be referred to the attorney general's medicaid fraud control unit and/or the appropriate enforcement officials. If waste and abuse are suspected or apparent, ~~ODJFS~~ODM and/or the office of the attorney general will take action to gain compliance and recoup inappropriate or excess payments ~~through audit and review~~ in accordance with rule ~~5101:3-1-27~~5160-1-27 or ~~5101:3-26-06~~5160-26-06 of the Administrative Code.

~~In all instances of fraud, waste, and abuse, any payment amount in excess of that legitimately due to the provider will be recouped by ODJFS through the office of fiscal and monitoring services, the state auditor, or the office of the attorney general.~~

(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, who performed the service or to whom services were 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~~5160-1-01 of the Administrative Code, not clinically proven and effective, and not consistent with medicaid program rules and regulations.

(5) Differing charges for the same services to medicaid ~~and~~versus non-medicaid consumers. For inpatient hospital services billed by hospitals reimbursed on a prospective payment basis, ~~ODJFS~~ODM 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 ~~5101:3-1-09~~5160-1-09 of the Administrative Code.

(7) Collusive activities~~,~~ involving the medicaid program~~,~~ between a medicaid provider and any person or business entity.

(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, scope of practice, or specific practice parameters of the person supplying the service.

(10) Misrepresenting by commission or omission any information on the provider enrollment and revalidation application,~~form or included in the enrollment packet~~agreement, or any documentation supplied by the provider to ODM.

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

(12) Any action which would constitute a violation of the False Claims Act (March 23, 2010), 31 U.S.C. § 3729-3733.

(D) ~~ODJFS~~ODM will not pay for services prescribed, ordered, or rendered by a provider, when those services were prescribed, ordered, or rendered by that provider after the date the provider was terminated under the medicaid program in accordance with rule ~~5101:3-1-17.6~~5160-1-17.6 of the Administrative Code.

(E) In instances when a provider suspects that there may be fraud, waste, or abuse by a

consumer, the provider should contact the local county department of job and family services (CDJFS). 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~~not personally needed and used by the consumer.

(F) Providers must assume responsibility for the business practices of employees. In accordance with rule 5160-1-17.2, the Ohio medicaid provider agreement requires each provider to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules. ~~ODJFS presumes that providers will~~ Providers shall 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:

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Certification

Date

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