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.~~"Abuse" has the same meaning as in 42 C.F.R. 455.2 (as in effect on October 1, 2023).

(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.~~"Fraud" has the same meaning as in 42 C.F.R. 455.2 (as in effect on October 1, 2023).

(3) "Waste" means any preventable act such as inappropriate utilization of services or misuse of resources that results in unnecessary expenditures to the medicaid program.

(B) The Ohio department of medicaid (ODM) ~~shall~~will 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 by ODM and the case will be referred to the attorney general's medicaid fraud control unit ~~and/or~~or the appropriate enforcement officials. If waste and abuse are suspected or apparent, ODM, ~~and/or~~ the office of the attorney general, or both will take action to gain compliance and recoup inappropriate or excess payments in accordance with rule 5160-1-27 or 5160-26-06 of the Administrative Code.

(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 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 versus non-medicaid ~~consumers~~recipients. For inpatient hospital services billed by hospitals reimbursed on a prospective payment basis, 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~~recipient or the ~~consumer's~~recipient's family, other than medicaid co-payments as designated in rule 5160-1-09 of the Administrative Code, or from other providers.

(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~~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, provider 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~~October 1, 2023), 31 U.S.C. 3729-3733.

(13) Non-compliance with the service definitions, activities, coverage, and limitations as listed in the applicable provisions in agency 5160 of the Administrative Code.

(D) 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 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~~recipient, the provider should contact the local county department of job

and family services (CDJFS). Cases of ~~consumer~~recipient 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 not personally needed and used by the ~~consumer~~recipient.

(4) Any action to falsely obtain medicaid eligibility as described in section 2913.401 of the Revised Code.

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

Effective:

Five Year Review (FYR) Dates: 3/15/2024

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Certification

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Date

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