

(C) IT IS NOT THE INTENT OF THE DEPARTMENT TO DELAY PAYMENT TO AN ELIGIBLE PROVIDER FOR THE COVERED SERVICES BECAUSE OF AN OUTSTANDING THIRD-PARTY LIABILITY WHICH CANNOT BE CURRENTLY ESTABLISHED OR IS NOT CURRENTLY AVAILABLE TO APPLY AGAINST THE RECIPIENT CHARGES. IF A PAYMENT (OR DENIAL) IS NOT FORTHCOMING FROM THE THIRD PARTY WITHIN THREE MONTHS, THE PROVIDER SHOULD PROCEED WITH SUBMISSION OF A BILL TO THE DEPARTMENT, INDICATING THE NAME AND ADDRESS OF THE POSSIBLE THIRD-PARTY PAYMENT SOURCE. THE DEPARTMENT HAS BEEN GRANTED SUBROGATION RIGHTS FOR DIRECT REIMBURSEMENT FROM AN INSURANCE COMPANY FOR PAID MEDICAL SERVICES. THIS CAPACITY IS PARTICULARLY USEFUL IN SITUATIONS IN WHICH ENTITLEMENT IS DETERMINED AFTER A LENGTHY REVIEW RESULTING FROM AUTOMOBILE ACCIDENTS OR PERSONAL INJURY CASES. THE DEPARTMENT WOULD APPRECIATE NOTIFICATION OF POTENTIAL SITUATIONS WHERE SUCH RECOVERY MAY BE FORTHCOMING. FOR EXAMPLE, WHEN A RECIPIENT REQUESTS A STATEMENT OF SERVICES OR PRESENTS A CLAIM FORM AFTER THE SERVICE HAS BEEN PROVIDED, THE CLAIM FORM IS NOT TO BE COMPLETED BY THE PROVIDER BUT SENT TO THE DEPARTMENT'S THIRD-PARTY RESOURCES SECTION. EXCEPT FOR PROVIDERS OF LONG TERM CARE SERVICES AS DEFINED IN CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE, IF AN ATTORNEY OR RECIPIENT REQUESTS MEDICAL INFORMATION ON ANY CASE WHERE MEDICAID HAS PAID THE BILL, THE REQUEST IS TO BE DIRECTED TO THE DEPARTMENT'S THIRD-PARTY RESOURCES SECTION AND NOT TO BE FURNISHED BY THE PROVIDER UNTIL ADVISED TO DO SO BY THE OHIO DEPARTMENT OF HUMAN SERVICES. NOTIFICATION WILL NOT AFFECT THE DEPARTMENT'S PAYMENT TO PROVIDER.

(D) RELATIONSHIP TO MEDICARE--"MEDICARE" (TITLE XVIII) IS A TOTALLY FEDERALLY FINANCED PROGRAM OF HOSPITAL INSURANCE (PART A) AND SUPPLEMENTAL MEDICAL INSURANCE BENEFITS (PART B) COVERING, GENERALLY, INDIVIDUALS AGE SIXTY-FIVE AND OVER, AND CERTAIN DISABLED INDIVIDUALS UNDER THE AGE SIXTY-FIVE. THESE TWO PARTS OF MEDICARE PAY FOR A BASIC PROGRAM OF MEDICAL COVERAGE UNDER WHICH THE PATIENT HAS A CERTAIN LIABILITY. MEDICAID ASSUMES THE LIABILITY FOR THE DEDUCTIBLE AND COINSURANCE ON INDIVIDUALS IT COVERS. THE DEPARTMENT PAYS THE MEDICARE PREMIUM OF ALL JOINTLY ELIGIBLE MEDICARE/MEDICAID RECIPIENTS, AND DOES NOT REIMBURSE PROVIDERS FOR ANY SERVICES PAYABLE BY MEDICARE EXCEPT FOR PAYMENT OF DEDUCTIBLES AND COINSURANCE.

MEDICARE ALSO PAYS FOR SKILLED NURSING FACILITY SERVICES, POST-HOSPITAL HOME HEALTH CARE SERVICES, AND WHOLE BLOOD. THE DEPARTMENT REDUCES ITS PAYMENT TO A MEDICAID SKILLED FACILITY TO THE AMOUNTS PAYABLE UNDER COINSURANCE.

(1) THE DEPARTMENT WILL PAY THE DEDUCTIBLE AND COINSURANCE AMOUNTS FOR THE RECIPIENT. IT WILL NOT, HOWEVER, PAY FOR ANY SERVICE NOT RECOGNIZED BY MEDICARE AS BEING MEDICALLY NECESSARY, NOR WILL IT PAY FOR ANY SERVICE PAYABLE BY (BUT NOT BILLED TO) MEDICARE. CERTAIN PROCEDURES ARE KNOWN TO BE PAYABLE BY MEDICARE. ANY MEDICARE COVERED PROCEDURE PROVIDED TO A MEDICARE/MEDICAID RECIPIENT WHICH IS INADVERTENTLY PAID FOR BY MEDICAID WILL BE SUBTRACTED FROM FUTURE PAYMENTS TO THE PROVIDER OR, FOR LONG-TERM CARE FACILITIES, AS PART OF A SETTLEMENT PROCESS DESCRIBED IN CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE.

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- (2) PROCEDURE FOR SUBMITTING--IN ORDER TO OBTAIN REIMBURSEMENT FROM MEDICAID (TITLE XIX) FOR SERVICES POTENTIALLY COVERED BY MEDICARE (TITLE XVIII), THE PROVIDER MUST BE A PROVIDER RECOGNIZED AS SUCH UNDER THE MEDICARE PROGRAM, AND MUST FIRST SUBMIT A CLAIM TO THE MEDICARE CARRIER FOR PART A SERVICES OR THE MEDICARE INTERMEDIARY FOR PART B SERVICES.
- (3) THE DEPARTMENT'S PAYMENT FOR SERVICES REIMBURSABLE UNDER MEDICARE IS LIMITED TO THE COINSURANCE AND DEDUCTIBLE.
- (a) NO PAYMENT WILL BE MADE FOR SERVICES DENIED BY MEDICARE FOR LACK OF MEDICAL NECESSITY. PAYMENT WILL BE MADE FOR DENIAL DUE TO REASONS OTHER THAN MEDICAL NECESSITY AS LONG AS THE SERVICES ARE COVERED UNDER THE MEDICAID PROGRAM. IN ORDER FOR SUCH CLAIMS TO BE CONSIDERED, A COPY OF MEDICARE'S REJECTION NOTICE MUST BE ATTACHED TO THE APPROPRIATE MEDICAID INVOICE COMPLETED IN ACCORDANCE WITH THE INSTRUCTIONS IN THE BILLING INVOICE.
- (b) NO PAYMENT WILL BE MADE FOR SERVICES PAYABLE BY (BUT NOT BILLED TO) MEDICARE. FOR SOME SERVICES, THIS ADJUSTMENT WILL BE MADE AUTOMATICALLY BY THE DEPARTMENT. IF PROVIDERS RECEIVE PAYMENT FROM MEDICAID FOR MEDICARE-COVERED SERVICES, PROVIDERS ARE TO NOTIFY THE DEPARTMENT.
- (c) NORMALLY, PAYMENT WILL NOT BE MADE FOR SERVICES RENDERED TO A MEDICARE ELIGIBLE INDIVIDUAL BY A PROVIDER WHO REFUSES MEDICARE ASSIGNMENT. IT IS RECOGNIZED, HOWEVER, THAT A PROVIDER MAY NOT ALWAYS BE AWARE THAT AN INDIVIDUAL IS ELIGIBLE FOR MEDICAID AS WELL AS MEDICARE. IN THESE INSTANCES PAYMENT OF PATIENT LIABILITY CAN BE MADE IF THE PROVIDER AGREES TO ACCEPT THE TOTAL OF THE MEDICARE AND MEDICAID PAYMENT AS PAYMENT IN FULL FOR THE SERVICE PROVIDED. PROVISIONS OF 42 CFR 477.271 PROHIBIT PAYMENT BY THE DEPARTMENT WHICH, WHEN ADDED TO OTHER PAYMENTS, EXCEEDS THE CHARGE RECOGNIZED BY MEDICARE.
- (E) THE DEPARTMENT'S PAYMENT AND MEDICARE PAYMENTS CONSTITUTE "PAYMENT IN FULL" AND NO ADDITIONAL PAYMENT MAY BE SOUGHT FROM THE RECIPIENT. IF PAYMENT (OTHER THAN COINSURANCE AND DEDUCTIBLE) IS INADVERTENTLY RECEIVED FROM BOTH MEDICARE AND MEDICAID FOR THE SAME SERVICE, THE CLAIMS ADJUSTMENT UNIT OF THE DEPARTMENT MUST BE NOTIFIED IN ACCORDANCE WITH THE PROVISION IN RULE 5101:3-1-07 OF THE ADMINISTRATIVE CODE. FAILURE TO NOTIFY THE DEPARTMENT OF SUCH DUPLICATE PAYMENTS WILL RESULT IN LOSS OF MEDICAID PROVIDER STATUS AND POSSIBLE LEGAL REFERRAL.
- (F) SEE RULE 5101:3-2-25 OF THE ADMINISTRATIVE CODE FOR THIRD-PARTY LIABILITY PROVISIONS SPECIFIC TO INPATIENT HOSPITAL SERVICES.
- (G) SEE CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE FOR THIRD-PARTY LIABILITY PROVISIONS SPECIFIC TO LONG-TERM CARE SERVICES.

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5101:3-1-51 MEDICAID GENERAL PROVISIONS.

- (A) "MEDICAID" IS A FEDERAL/STATE FINANCED PROGRAM WHEREBY MEDICAL, REHABILITATIVE, AND OTHER HEALTH-RELATED SERVICES ARE FURNISHED, THROUGH PUBLIC AND PRIVATE SOURCES, TO ELIGIBLE FAMILIES WITH DEPENDENT CHILDREN AND TO ELIGIBLE AGED, BLIND, OR DISABLED INDIVIDUALS WHOSE INCOME AND RESOURCES ARE INSUFFICIENT TO MEET THE COST OF NECESSARY MEDICAL CARE. THE OHIO MEDICAID PROGRAM COVERS THOSE MEDICAL SERVICES NECESSARY FOR THE DIAGNOSIS AND/OR TREATMENT OF A SPECIFIC PROBLEM. PREVENTIVE MEDICINE IS NOT A RECOGNIZED SERVICE ITEM UNDER THE MEDICAID PROGRAM EXCEPT FOR A SPECIALIZED HEALTH SCREENING PROGRAM FOR INDIVIDUALS TWENTY-ONE YEARS OF AGE AND UNDER KNOWN AS EPSDT. INFORMATION REGARDING THE EPSDT PROGRAM IS CONTAINED IN CHAPTER 5101:3-14 OF THE ADMINISTRATIVE CODE.
- (B) MEDICAL NECESSITY IS THE FUNDAMENTAL CONCEPT UNDERLYING THE MEDICAID PROGRAM. PHYSICIANS, HOSPITALS, DENTISTS, AND OTHER MEDICAL PROVIDERS RENDER OR AUTHORIZE MEDICAL SERVICES BASED ON THEIR PROFESSIONAL JUDGMENT THAT THE SERVICES ARE NEEDED BY THE INDIVIDUAL TO CORRECT OR AMELIORATE NONDEFERRABLE MEDICAL NEEDS. ODHS REIMBURSES MEDICAL PROVIDERS FOR THOSE SERVICES COVERED WITHIN THE SCOPE OF ITS MEDICAL ASSISTANCE PROGRAM. MOST MEDICAL PROCEDURES ARE COVERED WITHIN CERTAIN ADMINISTRATIVE PARAMETERS. SOME PROCEDURES ARE COVERED IF APPROVED IN ADVANCE BY ODHS. A FEW PROCEDURES ARE NOT ORDINARILY REIMBURSABLE. THE LIMITATIONS IMPOSED SHOULD NOT BE INTERPRETED AS INDICATING THE QUANTITY OR TYPE OF MEDICAL CARE TO BE DELIVERED, AS THIS IS BASED ON THE PROFESSIONAL JUDGMENT OF THE MEDICAL PROVIDER. THE LIMITATIONS ONLY REFLECT THE NECESSITY FOR ODHS TO CONTROL ITS FISCAL OBLIGATIONS. A PROVIDER OF MEDICAL SERVICES MAY REQUEST PAYMENT FOR A MEDICAL SERVICE WHICH HE BELIEVES IS ESSENTIAL FOR A PERSON'S WELL-BEING EVEN IF THAT MEDICAL SERVICE IS NOT ORDINARILY A REIMBURSABLE ITEM.
- (C) THE FOLLOWING GENERAL PRINCIPLES GOVERN THE ADMINISTRATION OF MEDICAID AND DETERMINE WHETHER A PARTICULAR MEDICAL SERVICE IS REIMBURSABLE.
- (1) THE INDIVIDUAL ORIGINATES ALL REQUESTS FOR MEDICAL SERVICES.
  - (2) THE INDIVIDUAL IS FREE TO EXERCISE HIS RIGHT TO CHOOSE THE PROVIDER OF HIS CHOICE UNLESS THE INDIVIDUAL RECEIVES SERVICES THROUGH A MANAGED CARE PROGRAM APPROVED UNDER THE STATE PLAN FOR MEDICAL ASSISTANCE, E.G., HEALTH MAINTENANCE ORGANIZATION.
  - (3) THE INDIVIDUAL RECEIVES THOSE MEDICAL SERVICES NECESSARY TO CORRECT OR AMELIORATE THE SPECIFIC MEDICAL COMPLAINT. PREVENTIVE MEDICINE IS NOT A COVERED SERVICE ITEM EXCEPT UNDER THE EPSDT PROGRAM.

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- (4) THE INDIVIDUAL MAKES NO PAYMENT (EXCEPT FOR LIABILITY IN A NURSING HOME) FOR MEDICAL SERVICES COVERED BY THE MEDICAID PROGRAM. THIS MEANS THAT A PROVIDER MUST ACCEPT THE MEDICAID PAYMENT AS PAYMENT IN FULL AND MAY NOT SEEK ADDITIONAL PAYMENT FOR ANY UNPAID PORTION OF THE BILL FROM THE PATIENT.
- (5) THE INDIVIDUAL RECEIVES MEDICAL SERVICES AT THE SAME COST AS OR LESS THAN NONMEDICAID PATIENTS. THIS MEANS THAT ODHS WILL NOT PAY FOR SERVICES THAT ARE FREE TO THE GENERAL PUBLIC, OR IN AN AMOUNT GREATER THAN THE PROVIDER'S CUSTOMARY AND PREVAILING CHARGE TO OTHER PATIENTS. FOR INPATIENT HOSPITAL SERVICES BILLED BY HOSPITALS REIMBURSED ON A PROSPECTIVE PAYMENT BASIS AS DEFINED IN CHAPTER 5101:3-2 OF THE ADMINISTRATIVE CODE, THE ODHS WILL NOT PAY, IN THE AGGREGATE, MORE THAN THE PROVIDER'S CUSTOMARY AND PREVAILING CHARGES FOR COMPARABLE SERVICES. SEE CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE REGARDING THE PROVISIONS OF THIS PARAGRAPH AS THEY APPLY TO PROVIDERS OF LONG TERM CARE SERVICES.
- (6) AN INDIVIDUAL MUST BE PROVIDED NEEDED SERVICES WITHOUT REGARD TO RACE, COLOR, SEX, AGE, NATIONAL ORIGIN, ECONOMIC STATUS, OR HANDICAP.
- (7) THE INDIVIDUAL HAS THE RIGHT TO A STATE HEARING IN ACCORDANCE WITH CHAPTER 5101:1-35 OF THE ADMINISTRATIVE CODE.

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5101:3-1-57 APPEALS PROCESS FOR PROVIDERS FROM PROPOSED DEPARTMENTAL ACTIONS.

(A) THE APPEALS PROCESS IS DESIGNED TO PROVIDE A HEARING UNDER CHAPTER 119, OF THE REVISED CODE (ADMINISTRATIVE PROCEDURES ACT) WHEREBY A PROVIDER MAY APPEAL THE PROPOSED DECISION OF THE DEPARTMENT TO SUSPEND, DENY, TERMINATE, OR NOT RENEW A PROVIDER AGREEMENT, OR TO IMPLEMENT A FINAL FISCAL AUDIT.

(1) THE APPEALS PROCESS DOES NOT APPLY IN THE FOLLOWING CIRCUMSTANCES:

(a) WHENEVER THE TERMS OF A PROVIDER AGREEMENT REQUIRE THE PROVIDER TO HAVE A LICENSE, PERMIT, OR CERTIFICATE ISSUED BY AN OFFICIAL, BOARD, COMMISSION, DEPARTMENT, DIVISION OR BUREAU, OR OTHER AGENCY OF STATE GOVERNMENT OTHER THAN ODHS, AND THE LICENSE, PERMIT, OR CERTIFICATE HAS BEEN DENIED OR REVOKED.

(b) WHENEVER PROVIDERS PARTICIPATE IN THE MEDICARE PROGRAM WHERE THE NEGATIVE ACTION TAKEN BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IS BINDING ON THE PROVIDER'S MEDICAID PARTICIPATION AND WHERE THE FEDERAL AGENCY PROVIDES AN OPPORTUNITY FOR A HEARING.

(2) IF A PROVIDER OBJECTS TO A PROPOSED ADJUDICATION ORDER OF THE DEPARTMENT WHICH WOULD RESULT IN THE DENIAL, TERMINATION, SUSPENSION, OR NONRENEWAL OF A PROVIDER AGREEMENT OR IF HE WISHES TO CONTEST A FINAL FISCAL AUDIT, THE PROVIDER MAY REQUEST A FORMAL HEARING WHICH SHALL BE GOVERNED BY CHAPTER 119, OF THE REVISED CODE. SUCH REQUESTS MUST BE SUBMITTED IN WRITING TO THE DIRECTOR, ODHS. IN ANY MEDICAID HOSPITAL FINAL SETTLEMENT IN WHICH GENERAL RELIEF PROGRAM MONIES OR CRIPPLED CHILDREN'S PROGRAM MONIES ARE OFFSET AGAINST MEDICAID MONIES, THE DEPARTMENT WILL OFFER A RIGHT OF APPEAL PURSUANT TO CHAPTER 119, OF THE REVISED CODE FOR ALL THREE PROGRAM AREAS.

(3) CONTINUATION OF PAYMENT DURING THE APPEAL OF THE PROPOSED TERMINATION OR NONRENEWAL OF A PROVIDER AGREEMENT WILL OCCUR AS FOLLOWS:

(a) PAYMENT UNDER REGULATIONS FOR COVERED SERVICES PROVIDED TO ELIGIBLE RECIPIENTS WILL CONTINUE DURING THE ADMINISTRATIVE APPEALS PROCESS.

(b) IN THE CASE OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES, PAYMENT WILL CONTINUE DURING THE ADMINISTRATIVE APPEALS PROCESS FOR THOSE RECIPIENTS ADMITTED TO THE FACILITY PRIOR TO THE DETERMINATION OF NONCERTIFICATION OR PROVIDER AGREEMENT TERMINATION. NO NEW ADMISSIONS WILL BE AUTHORIZED SUBSEQUENT TO THE EFFECTIVE DATE OF THE DEPARTMENT'S TERMINATION ACTION OR THE EFFECTIVE DATE OF NONCERTIFICATION BY THE OHIO DEPARTMENT OF HEALTH.

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- (B) OTHER ADMINISTRATIVE ACTIONS AFFECTING THE PROVIDER'S MEDICAID PROGRAM STATUS (SUCH AS RATE CALCULATIONS FOR LONG-TERM CARE FACILITIES) WHICH ARE NOT SUBJECT TO HEARINGS UNDER CHAPTER 119, OF THE REVISED CODE MAY BE RECONSIDERED BY THE APPROPRIATE DIVISION CHIEF UPON WRITTEN REQUEST BY THE AFFECTED PROVIDER TO THE DIRECTOR, ODHS.
- (C) SEE RULE 5101:3-2-0712 OF THE ADMINISTRATIVE CODE FOR ADDITIONAL INFORMATION CONCERNING THE APPLICABILITY OF THE APPEALS PROCESS TO INPATIENT SERVICES PROVIDED BY HOSPITALS SUBJECT TO PROSPECTIVE PAYMENT.
- (D) SEE CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE FOR ADDITIONAL PROVISIONS SPECIFIC TO LTCFS.

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5101:3-1-58 POLICY MONITORING.

UTILIZATION OF SERVICES COVERED UNDER THE MEDICAID PROGRAM IS MONITORED ON AN ONGOING BASIS, AS REQUIRED OF EACH STATE BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WHERE CASES OF SUSPECTED FRAUD OR MISREPRESENTATION TO ILLEGALLY OBTAIN PAYMENT FROM THE MEDICAID PROGRAM ARE DETECTED, PROVIDERS ARE SUBJECT TO AN AUDIT BY THE DEPARTMENT. IF FRAUD IS APPARENT, REFERRAL OF THE CASE TO LAW ENFORCEMENT OFFICIALS WILL BE MADE. OVERUTILIZATION OF SERVICES BY CERTAIN PROVIDERS, WHILE POSSIBLY NOT CONSIDERED FRAUDULENT ACTS, MAY CONSTITUTE ABUSE TO THE MEDICAID PROGRAM. THIS ABUSE RESULTS EITHER DIRECTLY OR INDIRECTLY IN FINANCIAL LOSSES TO THE MEDICAID PROGRAM, ITS RECIPIENTS, OR THEIR FAMILIES. VARIOUS METHODS, SUCH AS THOROUGH INVESTIGATION, AUDIT, AND/OR PEER REVIEW, WILL BE UTILIZED TO DETERMINE ABUSE. IN ALL INSTANCES OF FRAUD OR ABUSE, ANY AMOUNT IN EXCESS OF THAT LEGITIMATELY DUE TO THE PROVIDER WILL BE RECOUPED BY THE DEPARTMENT THROUGH ITS BUREAU OF SURVEILLANCE AND UTILIZATION REVIEW, THE STATE AUDITOR, OR THE OFFICE OF THE ATTORNEY GENERAL.

- (A) CASES OF PROVIDER FRAUD OR ABUSE MAY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:
- (1) DUPLICATE BILLING BY A PROVIDER WHICH APPEARS TO BE DONE WITH THE INTENTION OF DEFRAUDING THE STATE AGENCY.
  - (2) MISREPRESENTATION AS TO SERVICES PROVIDED, DATE OF SERVICE, OR TO WHOM PROVIDED.
  - (3) BILLING FOR SERVICES NOT PROVIDED.
  - (4) DIFFERING CHARGES FOR THE SAME ITEMS FOR MEDICAID AND NONMEDICAID RECIPIENTS. FOR INPATIENT HOSPITAL SERVICES BILLED BY HOSPITALS REIMBURSED ON A PROSPECTIVE PAYMENT BASIS AS DEFINED IN CHAPTER 5101:3-2 OF THE ADMINISTRATIVE CODE, ODHS WILL NOT PAY, IN THE AGGREGATE, MORE THAN THE PROVIDER'S CUSTOMARY AND PREVAILING CHARGES FOR COMPARABLE SERVICES.
  - (5) VIOLATION OF PROVIDER AGREEMENT BY REQUESTING OR OBTAINING ADDITIONAL PAYMENT FOR THE SERVICES RENDERED FROM EITHER THE RECIPIENT OR RECIPIENT'S FAMILY.
  - (6) COLLUSIONARY ACTIVITIES BETWEEN A MEDICAL PROVIDER AND OTHER PROVIDERS.
- (B) THE REVIEW OF A PROVIDER'S RECORDS WILL BE MADE IN ACCORDANCE WITH GENERALLY ACCEPTED AUDITING STANDARDS NECESSARY TO FULFILL THE SCOPE OF THE AUDITS. THE REVIEW SHALL BE OF THOSE RECORDS NECESSARY TO FULLY DISCLOSE THE EXTENT OF SERVICES PROVIDED TO INDIVIDUALS RECEIVING ASSISTANCE UNDER THE MEDICAID PROGRAM. INFORMATION MUST BE AVAILABLE REGARDING ANY SERVICES FOR WHICH PAYMENT HAS BEEN OR WILL BE CLAIMED TO DETERMINE THAT PAYMENT HAS BEEN OR WILL BE IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE REQUIREMENTS.

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- (1) UPON REQUEST, A MEMBER OF THE PROVIDER'S STAFF IS TO BE ASSIGNED TO ASSIST THE DEPARTMENT IN COLLECTING INFORMATION IDENTIFIED IN PARAGRAPH (B) OF THIS RULE. UPON REQUEST, THE PROVIDER WILL MAKE THE APPLICABLE RECORDS AVAILABLE TO STATE STAFF FOR PHOTOCOPYING.
- (2) FOR THE PURPOSES OF THIS RULE, THE DEPARTMENT SHALL HAVE THE AUTHORITY TO USE STATISTICAL METHODS TO AUDIT PROVIDERS AND TO DETERMINE ANY AMOUNT OF OVERPAYMENT.
- (C) THERE ARE INSTANCES WHEN THE PROVIDER SUSPECTS THAT THERE MAY BE RECIPIENT FRAUD, MISREPRESENTATION, OR OVERUTILIZATION OF SERVICES. CASES OF RECIPIENT FRAUD OR ABUSE MAY INCLUDE, BUT ARE NOT LIMITED TO:
  - (1) USE OF ANOTHER PERSON'S MEDICAID CARD.
  - (2) OBTAINING WHAT WOULD APPEAR TO BE EXCESSIVE QUANTITIES OF MEDICAL SUPPLIES OR OTHER SERVICES.
  - (3) POSSIBILITY OF EXCESSIVE PHYSICIAN VISITS BY VIRTUE OF THE NUMBER OF PRESCRIPTIONS GENERATED.
- (D) WHEN FRAUD OR ABUSE BY A RECIPIENT IS SUSPECTED, CONTACT SHOULD BE MADE WITH THE BUREAU OF SUR.
- (E) 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 THE CONTENTS OF RULES WILL NOT BE ACCEPTABLE TO THE DEPARTMENT WHEN VIOLATION OF DEPARTMENTAL RULES HAS BEEN DETERMINED.

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