STATE OF OHIO

5111.03 Provider offenses.

(A) No provider of services or goods contracting with the department of job and family services pursuant to the medicaid program shall, by deception, obtain or attempt to obtain payments under this chapter to which the provider is not entitled pursuant to the provider agreement, or the rules of the federal government or the department of job and family services relating to the program. No provider shall willfully receive payments to which the provider is not entitled, or willfully receive payments in a greater amount than that to which the provider is entitled; nor shall any provider falsify any report or document required by state or federal law, rule, or provider agreement relating to medicaid payments. As used in this section, a provider engages in "deception" when the provider, acting with actual knowledge of the representation or information involved, acting in deliberate ignorance of the truth or falsity of the representation or information involved, or acting in reckless disregard of the truth or falsity of the representation or information involved, deceives another or causes another to be deceived by any false or misleading representation, by withholding information, by preventing another from acquiring information, or by any other conduct, act, or omission that creates, confirms, or perpetuates a false impression in another, including a false impression as to law, value, state of mind, or other objective or subjective fact. No proof of specific intent to defraud is required to show, for purposes of this section, that a provider has engaged in deception.

(B) Any provider who violates division (A) of this section shall be liable, in addition to any other penalties provided by law, for all of the following civil penalties:

(1) Payment of interest on the amount of the excess payments at the maximum interest rate allowable for real estate mortgages under section 1343.01 of the Revised Code on the date the payment was made to the provider for the period from the date upon which payment was made, to the date upon which repayment is made to the state;

(2) Payment of an amount equal to three times the amount of any excess payments;

(3) Payment of a sum of not less than five thousand dollars and not more than ten thousand dollars for each deceptive claim or falsification;

(4) All reasonable expenses which the court determines have been necessarily incurred by the state in the enforcement of this section.

(C) As used in this division, "intermediate care facility for the mentally retarded" and "nursing facility" have the same meanings given in section 5111.20 of the Revised Code.

In addition to the civil penalties provided in division (B) of this section, the director of job and family services, upon the conviction of, or the entry of a judgment in either a criminal or civil action against, a medicaid provider or its owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to section 109.85 of the Revised Code, shall terminate the provider agreement between the department and the provider and stop reimbursement to the provider for services rendered from the date of conviction or entry of judgment. As used in this division, "owner" means any person having at least five per cent ownership in the medicaid provider. No such provider, owner, officer, authorized agent, associate, manager, or employee shall own or provide services to any other medicaid provider or risk contractor or arrange for, render, or order services for medicaid recipients, nor shall such provider, owner, officer, authorized agent, associate, manager, or employee receive reimbursement in the form of direct payments from the department or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any participating provider or risk contractor. The provider agreement shall not be terminated or reimbursement terminated if the provider or owner can demonstrate that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the conviction or entry of a judgment in a criminal or civil action brought pursuant to section 109.85 of the Revised Code. Nothing in this division prohibits any owner, officer, authorized agent, associate, manager, or employee of a medicaid provider from entering into a medicaid provider agreement if the person can demonstrate that the person had no knowledge of an action of the medicaid provider the person was formerly associated with that resulted in the conviction or entry of a judgment in a criminal or civil action brought pursuant to section 109.85 of the Revised Code.

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2913.40 Medicaid fraud.

(A) As used in this section:

(1) "Statement or representation" means any oral, written, electronic, electronic impulse, or magnetic communication that is used to identify an item of goods or a service for which reimbursement may be made under the medical assistance program or that states income and expense and is or may be used to determine a rate of reimbursement under the medical assistance program.

(2) "Medical assistance program" means the program established by the department of job and family services to provide medical assistance under section 5111.01 of the Revised Code and the medicaid program of Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.

(3) "Provider" means any person who has signed a provider agreement with the department of job and family services to provide goods or services pursuant to the medical assistance program or any person who has signed an agreement with a party to such a provider agreement under which the person agrees to provide goods or services that are reimbursable under the medical assistance program.

(4) "Provider agreement" means an oral or written agreement between the department of job and family services and a person in which the person agrees to provide goods or services under the medical assistance program.

(5) "Recipient" means any individual who receives goods or services from a provider under the medical assistance program.

(6) "Records" means any medical, professional, financial, or business records relating to the treatment or care of any recipient, to goods or services provided to any recipient, or to rates paid for goods or services provided to any recipient and any records that are required by the rules of the director of job and family services to be kept for the medical assistance program.

(B) No person shall knowingly make or cause to be made a false or misleading statement or representation for use in obtaining reimbursement from the medical assistance program.

(C) No person, with purpose to commit fraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Contrary to the terms of the person's provider agreement, charge, solicit, accept, or receive for goods or services that the person provides under the medical assistance program any property, money, or other consideration in addition to the amount of reimbursement under the medical assistance program and the person's provider agreement for the goods or services and any cost-sharing expenses authorized by section 5111.0112 of the Revised Code or rules adopted pursuant to section 5111.01, 5111.011, or 5111.02 of the Revised Code.

(2) Solicit, offer, or receive any remuneration, other than any cost-sharing expenses authorized by section 5111.0112 of the Revised Code or rules adopted under section 5111.01, 5111.011, or 5111.02 of the Revised Code, in cash or in kind, including, but not limited to, a kickback or rebate, in connection with the furnishing of goods or services for which whole or partial reimbursement is or may be made under the medical assistance program.

(D) No person, having submitted a claim for or provided goods or services under the medical assistance program, shall do either of the following for a period of at least six years after a reimbursement pursuant to that claim, or a reimbursement for those goods or services, is received under the medical assistance program:

(1) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods or services for which the claim was submitted, or for which reimbursement was received, by the person;

(2) Knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to disclose fully all income and expenditures upon which rates of reimbursements were based for the person.

(E) Whoever violates this section is guilty of medicaid fraud. Except as otherwise provided in this division, medicaid fraud is a misdemeanor of the first degree. If the value of property, services, or funds obtained in violation of this section is one thousand dollars or more and is less than seven thousand five hundred dollars, medicaid fraud is a felony of the fifth degree. If the value of property, services, or funds obtained in violation of this section is seven thousand five hundred dollars or more and is less than one hundred fifty thousand dollars, medicaid fraud is a felony of the fourth degree. If the value of the property, services, or funds obtained in violation of this section is one hundred fifty thousand dollars or more, medicaid fraud is a felony of the third degree.

(F) Upon application of the governmental agency, office, or other entity that conducted the investigation and prosecution in a case under this section, the court shall order any person who is convicted of a violation of this section for receiving any reimbursement for furnishing goods or services under the medical assistance program to which the person is not entitled to pay to the applicant its cost of investigating and prosecuting the case. The costs of investigation and prosecution that a defendant is ordered to pay pursuant to this division shall be in addition to any other penalties for the receipt of that reimbursement that are provided in this section, section 5111.03 of the Revised Code, or any other provision of law.

(G) The provisions of this section are not intended to be exclusive remedies and do not preclude the use of any other criminal or civil remedy for any act that is in violation of this section.

Amended by 129th General AssemblyFile No.29,HB 86, §1, eff. 9/30/2011.

Effective Date: 06-05-2002; 09-29-2005; 2007 HB119 09-29-2007

Nursing facility or intermediate care facility for the mentally retarded providers whose agreements are terminated pursuant to this section may continue to receive reimbursement for up to thirty days after the effective date of the termination if the provider makes reasonable efforts to transfer recipients to another facility or to alternate care and if federal funds are provided for such reimbursement.

(D) For any reason permitted or required by federal law, the director of job and family services may deny a provider agreement or terminate a provider agreement.

For any reason permitted or required by federal law, the director may exclude an individual, provider of services or goods, or other entity from participation in the medicaid program. No individual, provider, or entity excluded under this division shall own or provide services to any other medicaid provider or risk contractor or arrange for, render, or order services for medicaid recipients during the period of exclusion, nor, during the period of exclusion, shall such individual, provider, or entity receive reimbursement in the form of direct payments from the department or indirect payments of medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any participating provider or risk contractor. An excluded individual, provider, or entity may request a reconsideration of the exclusion. The director shall adopt rules in accordance with Chapter 119. of the Revised Code governing the process for requesting a reconsideration.

Nothing in this division limits the applicability of section 5111.06 of the Revised Code to a medicaid provider.

(E) Any provider of services or goods contracting with the department of job and family services pursuant to Title XIX of the "Social Security Act," who, without intent, obtains payments under this chapter in excess of the amount to which the provider is entitled, thereby becomes liable for payment of interest on the amount of the excess payments at the maximum real estate mortgage rate on the date the payment was made to the provider for the period from the date upon which payment was made to the date upon which repayment is made to the state.

(F) The attorney general on behalf of the state may commence proceedings to enforce this section in any court of competent jurisdiction; and the attorney general may settle or compromise any case brought under this section with the approval of the department of job and family services. Notwithstanding any other provision of law providing a shorter period of limitations, the attorney general may commence a proceeding to enforce this section at any time within six years after the conduct in violation of this section terminates.

(G) The authority, under state and federal law, of the department of job and family services or a county department of job and family services to recover excess payments made to a provider is not limited by the availability of remedies under sections 5111.11 and 5111.12 of the Revised Code for recovering benefits paid on behalf of recipients of medical assistance.

The penalties under this chapter apply to any overpayment, billing, or falsification occurring on and after April 24, 1978. All moneys collected by the state pursuant to this section shall be deposited in the state treasury to the credit of the general revenue fund.

Effective Date: 06-26-2003; 2007 HB119 09-29-2007

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2913.47 Insurance fraud.

(A) As used in this section:

(1) "Data" has the same meaning as in section 2913.01 of the Revised Code and additionally includes any other representation of information, knowledge, facts, concepts, or instructions that are being or have been prepared in a formalized manner.

(2) "Deceptive" means that a statement, in whole or in part, would cause another to be deceived because it contains a misleading representation, withholds information, prevents the acquisition of information, or by any other conduct, act, or omission creates, confirms, or perpetuates a false impression, including, but not limited to, a false impression as to law, value, state of mind, or other objective or subjective fact.

(3) "Insurer" means any person that is authorized to engage in the business of insurance in this state under Title XXXIX of the Revised Code, the Ohio fair plan underwriting association created under section 3929.43 of the Revised Code, any health insuring corporation, and any legal entity that is self-insured and provides benefits to its employees or members.

(4) "Policy" means a policy, certificate, contract, or plan that is issued by an insurer.

(5) "Statement" includes, but is not limited to, any notice, letter, or memorandum; proof of loss; bill of lading; receipt for payment; invoice, account, or other financial statement; estimate of property damage; bill for services; diagnosis or prognosis; prescription; hospital, medical, or dental chart or other record; x-ray, photograph, videotape, or movie film; test result; other evidence of loss, injury, or expense; computer-generated document; and data in any form.

(B) No person, with purpose to defraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Present to, or cause to be presented to, an insurer any written or oral statement that is part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive;

(2) Assist, aid, abet, solicit, procure, or conspire with another to prepare or make any written or oral statement that is intended to be presented to an insurer as part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive.

(C) Whoever violates this section is guilty of insurance fraud. Except as otherwise provided in this division, insurance fraud is a misdemeanor of the first degree. If the amount of the claim that is false or deceptive is one thousand dollars or more and is less than seven thousand five hundred dollars, insurance fraud is a felony of the fifth degree. If the amount of the claim that is false or deceptive is seven thousand five hundred dollars or more and is less than one hundred fifty thousand dollars, insurance fraud is a felony of the fourth degree. If the amount of the claim that is false or deceptive is one hundred fifty thousand dollars or more, insurance fraud is a felony of the third degree.

(D) This section shall not be construed to abrogate, waive, or modify division (A) of section 2317.02 of the Revised Code.

Amended by 129th General AssemblyFile No.29,HB 86, §1, eff. 9/30/2011.

Effective Date: 06-04-1997