

## 20.4 MEDICAID CLAIMS AND REPAYMENT PROCEDURES

This section describes the procedure for establishing claims and collecting repayments for Medicaid services.

### A. REPAYMENT OF CORRECTLY PAID BENEFITS – ESTATE RECOVERY

Under certain circumstances, the Department must be reimbursed for Medicaid expenditures made on behalf of an eligible client. Repayment of correctly paid benefits is required only for those who received nursing facility services, HCB Waiver, TBI Waiver, ICF/MR and related hospital and prescription drug services. BMS is responsible for implementing this law. Any inquiries are referred to BMS' Estate Recovery contract agency at 1-888-378-2836.

### B. REPAYMENT OF BENEFITS FOR WHICH CLIENT WAS INELIGIBLE

When it is determined that the client was ineligible for Medicaid and that the Department paid for medical services, the action depends upon whether or not the claim is due to intentional misrepresentation.

#### 1. Intentional Misrepresentation

When intentional misrepresentation is suspected and the amount of the medical payment is \$500 or more, the case is referred to IFM for investigation, using the IFM-1. Prior to the IFM referral, the Worker must determine that payment for medical services was made by the Department. The Worker must request such information from BMS in writing. The Medical Processing Unit produces a printout of the paid Medicaid expenses. This printout must be attached to the IFM-1.

The Worker takes no further action on the claim. If the IFM Investigator notifies the Worker that prosecution is not being pursued, the instructions in item 2 below are used.

#### 2. Unintentional Misrepresentation Or Worker Error

Unless intentional misrepresentation is established, repayment from the client is not pursued. BMS may pursue repayment from the provider of the medical services, but not from the client.

**C. PROVIDER FRAUD**

If fraud on the part of any provider of Medicaid services is suspected, the Worker must submit a memorandum to the Medicaid Fraud unit, Capitol Complex, Building 6, Charleston. The memorandum must contain the following information: provider name and address, reason fraud is suspected, detailed explanation of the information accumulated which leads to the suspicion of fraud, names and addresses of clients who might have knowledge which would help in a fraud investigation.