IMPROPER MEDICAID BENEFITS & QUALITY CONTROL
IMPROPER MEDICAID BENEFITS

A. INTRODUCTION

When Medicaid benefits are made available to the recipients improperly, the State and Regional Offices must identify and take action to recover the amounts thus paid.

Improper payments arise from the following sources:

- Cases of suspected fraud. That is, the individual at the time of application or during the period of eligibility willfully falsifies, misrepresents, or withholds information which, if known, would have resulted in denial or reduction of Medicaid benefits to that recipient or a difference amount of Medicaid Income.

- Cases involving misunderstanding by the recipient (client error) or agency error.

- Cases involving the improper use of a Medicaid card by a person other than the eligible recipient.

B. TYPES OF IMPROPERLY PAID MEDICAID BENEFITS

When the Regional Medicaid Office becomes aware of a possible improper eligibility situation through contact with the client, quality control report, State Office referral or other source, the Regional Office will establish the facts and initiate appropriate steps to correct the case. The Regional Office will also determine the type of improper Medicaid eligibility situation.

The types are explained below. After determining the type of improper payment involved, the Regional Office will initiate an Improper Payment Report (DOM-354) to the State Medicaid Eligibility Division.