Ohio Revised Code

Section 4121.444 Obtaining workers' compensation payments by deception prohibited.

Effective: June 30, 2006
Legislation: Senate Bill 7 - 126th General Assembly

(A) No person, health care provider, managed care organization, or owner of a health care provider or managed care organization shall obtain or attempt to obtain payments by deception under Chapter 4121., 4123., 4127., or 4131. of the Revised Code to which the person, health care provider, managed care organization, or owner is not entitled under rules of the bureau of workers' compensation adopted pursuant to sections 4121.441 and 4121.442 of the Revised Code.

(B) Any person, health care provider, managed care organization, or owner that violates division (A) of this section is liable, in addition to any other penalties provided by law, for all of the following 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. The interest shall be calculated from the date the payment was made to the person, owner, health care provider, or managed care organization through the date upon which repayment is made to the bureau or the self-insuring employer.

(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 act of deception;

(4) All reasonable and necessary expenses that the court determines have been incurred by the bureau or the self-insuring employer in the enforcement of this section.

All moneys collected by the bureau pursuant to this section shall be deposited into the state insurance fund created in section 4123.30 of the Revised Code. All moneys collected by a self-insuring employer pursuant to this section shall be awarded to the self-insuring employer.

(C)(1) In addition to the monetary penalties provided in division (B) of this section and except as provided in division (C)(3) of this section, the administrator may terminate any agreement between the bureau and a person or a health care provider or managed care organization or its owner and cease reimbursement to that person, provider, organization, or owner for services rendered if any of the following apply:

(a) The person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization is convicted of or pleads guilty to a violation of sections 2913.48 or 2923.31 to 2923.36 of the Revised Code or any other criminal offense related to the delivery of or billing for health care benefits.

(b) There exists an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization and proof of the specific intent of the person, health care provider, managed care organization, or owner to defraud, in a civil action brought pursuant to this section.

(c) There exists an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization in a civil action brought pursuant to sections 2923.31 to 2923.36 of the Revised Code.

(2) No person, health care provider, or managed care organization that has had its agreement with and reimbursement from the bureau terminated by the administrator pursuant to division (C)(1) of this section, or an owner, officer, authorized agent, associate, manager, or employee of that person, health care provider, or managed care organization shall do either of the following:

(a) Directly provide services to any other bureau provider or have an ownership interest in a provider of services that furnishes services to any other bureau provider;

(b) Arrange for, render, or order services for claimants during the period that the agreement of the person, health care provider, managed care organization, or its owner is terminated as described in division (C)(1) of this section;

(3) The administrator shall not terminate the agreement or reimbursement if the person, health care provider, managed care organization, or owner demonstrates that the person, provider, organization, or owner did not directly or indirectly sanction the action of the authorized agent, associate, manager, or employee that resulted in the conviction, plea of guilty, or entry of judgment as described in division (C)(1) of this section.

(4) Nothing in division (C) of this section prohibits an owner, officer, authorized agent, associate, manager, or employee of a person, health care provider, or managed care organization from entering into an agreement with the bureau if the provider, organization, owner, officer, authorized agent, associate, manager, or employee demonstrates absence of knowledge of the action of the person, health care provider, or managed care organization with which that individual or organization was formerly associated that resulted in a conviction, plea of guilty, or entry of judgment as described in division (C)(1) of this section.

(D) The attorney general may bring an action on behalf of the state and a self-insuring employer may bring an action on its own behalf to enforce this section in any court of competent jurisdiction. The attorney general may settle or compromise any action brought under this section with the approval of the administrator.

Notwithstanding any other law providing a shorter period of limitations, the attorney general or a self-insuring employer may bring an action to enforce this section at any time within six years after the conduct in violation of this section terminates.

(E) The availability of remedies under this section and sections 2913.48 and 2923.31 to 2923.36 of the Revised Code for recovering benefits paid on behalf of claimants for medical assistance does not limit the authority of the bureau or a self-insuring employer to recover excess payments made to an owner, health care provider, managed care organization, or person under state and federal law.

(F) As used in this section:

(1) "Deception" means acting with actual knowledge in order to deceive another or cause another to be deceived by means of any of the following:

(a) A false or misleading representation;

(b) The withholding of information;

(c) The preventing of another from acquiring information;

(d) Any other conduct, act, or omission that creates, confirms, or perpetuates a false impression as to a fact, the law, the value of something, or a person's state of mind.

(2) "Owner" means any person having at least a five per cent ownership interest in a health care provider or managed care organization.