§ 50781. Potential Overpayments.

(a) A potential overpayment occurs when all of the following conditions exist, as limited by (b).

(1) A beneficiary, or other person acting on the beneficiary's behalf, has been informed verbally and in writing on the MC 210 cover sheet (9/91), and the certification in the Statement of Facts (Medi-Cal), MC 210 (3/92), or on the cover sheet to and the Application for Cash Aid, Food Stamps, and/or Medical Assistance (SAWS 1) (9/90) CA 1/DFA 285-A1, or on the Important Information For Applicants and Recipients For Cash Aid, Food Stamps and Medical Assistance (SAWS 2A) (5/92) (Important Information) CA2/DFA 285-A2/MC 210, or on the Statement of Facts Cash and Food Stamps - (JA2) (4/90) CA2/DFA 285-A2 of his/her responsibility to report completely and accurately, facts required pursuant to Subdivision 1, Chapter 2, which would affect eligibility or share or cost, and to report any changes in those facts within 10 days.

(2) A beneficiary or the person acting on the beneficiary's behalf has completed and signed the Medi-Cal Applicant/Beneficiary Understanding, MC 210 (9/91) cover sheet and the certification in the Statement of Facts (Medi-Cal) MC 210 (3/92), or the certification in the Statement of Facts Cash Aid and Food Stamps - (JA2) (4/90) CA2/DFA 285-A2, or the certification in the Application for Cash Aid, Food Stamps, and/or Medical Assistance (SAWS 1) (9/90) CA1/DFA 285-A1, or the certification in the Important Information For Applicants and Recipients For Cash Aid, Food Stamps and Medical Assistance (SAWS 2A) (5/92) (Important Information) CA2/DFA 285-A2/MC 210 and has, within his/her competence, done any of the following:

(A) Provided incorrect oral or written information.

(B) Failed to provide information required pursuant to Subdivision 1, Chapter 2, which would affect the eligibility or share of cost determination.

(C) Failed to report changes in circumstances regarding any information required pursuant to Subdivision 1, Chapter 2, which would affect eligibility or share of cost within 10 days of the change.

(3) These facts, when considered in conjunction with other information available on the beneficiary's circumstances, would result in ineligibility or an increased share of cost.

(b) If an increase occurred in a person's income or assets and that increase would not have affected the person's eligibility or share of cost in the month in which there was an increase in income or assets or in the following month because of the 10-day notice requirements specified in Sections 50179, 50185 and 50653.5, no potential overpayment exists in either such month.

(c) No potential overpayment exists if the beneficiary informed the county department of circumstances which would result in ineligibility or an increased share of cost, and the county department failed to act on the information.

(d) No potential overpayment exists when there is a failure on the part of a beneficiary to perform an act which is a condition of eligibility if the failure is due to an error by the Department or the county department.

(e) For purposes of this section, potential overpayments shall be determined by applying the laws in effect in the month or months for which the potential overpayment is being determined.

§ 50781.5. Potential Overpayments -Unreported Other Health Coverage.

(a) A potential overpayment occurs when a beneficiary, or the person acting on the beneficiary's behalf, has knowingly failed to report other health coverage under either of the following circumstances:

(1) The other health coverage is of a type designated by the Department as not subject to post-service reimbursement, and the beneficiary who fails to utilize such other health coverage without good cause; or

(2) The beneficiary has received services for which Medi-Cal paid, and the beneficiary also claimed and received payment through private health care coverage.

§ 50782. Fraud.

Fraud occurs if an overpayment occurs and the beneficiary or the person acting on the beneficiary's behalf willfully failed to report facts as specified in Section 50781(a) with the intention of deceiving the Department, the county department or the Social Security Administration for the purpose of obtaining Medi-Cal benefits to which the beneficiary was not entitled.

§ 50783. County Action on Potential Overpayment.

(a) The county department shall take the following action when it appears that there may be a potential overpayment:

(1) Determine the correct eligibility status and share of cost based on the correct income, property and other circumstances.

(2) Determine whether a potential overpayment exists in accordance with Section 50781.

(3) If a potential overpayment exists, refer it to the Department or to the county unit contracting with the Department to collect overpayments in accordance with the procedures established by the Department.

(4) In those instances where the potential overpayment is due to the willful failure to report facts and there was a person acting on behalf of the beneficiary:

(A) Determine whether the beneficiary is competent to handle his/her own affairs.

(B) If the beneficiary is competent, require that the beneficiary act on his/her own behalf in the future.

(C) If the beneficiary is not competent, refer the case to Social Services and/or the public guardian or conservator to ensure that the beneficiary's interests are protected.

§ 50785. Action on Overpayment - Department of Health. [Repealed]

§ 50786. Action on Overpayment -Department of Health Services or County Unit C

(a) Upon receipt of a potential overpayment referral, the Department's Recovery Section or the county unit contracted to collect overpayments shall:

(1) Determine the amount of Medi-Cal benefits received by the beneficiary for the period in which there was a potential overpayment.

(2) Compute the actual overpayment in accordance with the following:

(A) When the potential overpayment was due to excess property, the actual overpayment shall be the lesser of the:

1. Actual cost of services paid by the Department during that period of consecutive months in which there was excess property throughout each month.

2. Amount of property in excess of the property limit during that period of consecutive months in which there was excess property throughout each month. This excess amount shall be determined as follows:

a. Compute the excess property at the lowest point in the month for each month.

b. The highest monthly amount determined in a. shall be the amount of the excess property for the entire period of consecutive months.

(B) When the potential overpayment was due to increased share of cost, the actual overpayment shall be the lesser of the:

1. Actual cost of services received in the month(s) which were paid by the Department.

2. Amount of the increased share of cost for the month(s) in which services were received which were paid by the Department.

(C) When the overpayment was due to excess property and increased share of cost, the actual overpayment shall be a combination of (A) and (B).

(D) When the potential overpayment was due to other factors which result in ineligibility the overpayment shall be the actual cost of services paid by the Department.

(E) Potential overpayments, due to beneficiary possession of other health coverage that is not subject to post-services reimbursement, shall be processed by the Department to determine and recover actual overpayments in all cases. The actual overpayment in such cases shall be the actual cost of services paid by the Department which would have been covered by private health insurance or other health coverage, had the coverage been known to the Department. The actual overpayment shall not include any costs which can be recovered directly by the Department from the health insurance carrier or other source.

(3) Refer those cases where there appears there may be fraud to the Investigations Branch of the Department.

(4) Take appropriate action to collect overpayments in accordance with Section 50787.

§ 50787. Demand for Repayment.

(a) The Department or the county unit contracted to collect overpayments shall demand repayment of actual overpayments in accordance with procedures established by the Department.

(b) The Department or the county unit contracted to collect overpayments shall inform the beneficiary, or the person acting on the beneficiary's behalf, in writing, of the overpayment amount and of his/her right to a state hearing on the overpayment in accordance with Section 50951. If the person requests a state hearing on the overpayment, collection action shall be suspended until a final decision has been rendered in accordance with Section 50953.

(c) The Department or the county unit contracted to collect overpayments may take other collection actions as permitted under state law against the income or resources of the beneficiary or the income and resources of any person who is financially responsible for the cost of the beneficiary's health care in accordance with Sections 50088, 50163, and 50185.

§ 50789. Failure to Repay. [Repealed]

§ 50791. Medi-Cal Overpayments Fraud - AFDC Cash Grant.

(a) When an AFDC overpayment occurs, the county department shall:

(1) Investigate any potential Medi-Cal fraud which is incidental to AFDC cash grant fraud and take appropriate action.

(2) Determine whether there was ineligibility for Medi-Cal as an AFDC recipient. If so, the county shall determine whether:

(A) Medi-Cal eligibility existed under any other program.

(B) There was a potential Medi-Cal overpayment.

(C) Report potential Medi-Cal overpayments to the county unit designated to collect Medi-Cal overpayments caused by AFDC recipients.

§ 50793. Utilization Restrictions.

(a) A beneficiary who has been determined by the Department to be misusing or abusing Medi-Cal benefits by obtaining drugs or other services at a frequency or amount not medically necessary may be subjected to one or more of the following forms of utilization restriction:

(1) Prior authorization for all Medi-Cal services.

(2) Prior authorization for specific Medi-Cal services.

(3) Restriction to utilization of a specific, beneficiary- or Department-selected pharmacy.

(4) Restriction to a specific, beneficiary- or Department-selected primary provider of medical services.

(b) Utilization restriction shall not apply in the following situations:

(1) Emergencies as defined in Section 51056.

(2) Referral of the restricted beneficiary to another provider by the beneficiary- or Department-selected primary provider of medical services.

(c) The Department shall impose utilization restriction upon a beneficiary only on the written order of the Director or the Director's designee. The written order, hereinafter referred to as the Notice of Action, shall:

(1) Include the reasons for the action.

(2) State the dates of the restriction period.

(3) Explain the beneficiary's right to and procedures for requesting a hearing.

(4) Be mailed to the beneficiary by regular mail at least ten days prior to the effective date.

(d) The restriction as described in (a) above shall be for a period of two (2) years from the effective date on the Notice of Action.

(e) Should the Department find during the term of the restriction that the potential for abuse still exists, so as to warrant continued restriction beyond the two (2) year period, the Department may extend the period of restriction. Each such extension shall:

(1) Be for an additional period of two (2) years.

(2) Require a separate Notice of Action in accordance with (c) above except that the Notice of Action must be mailed at least ninety (90) days prior to the effective date of the action.

(f) Should the beneficiary's request for a hearing be received prior to the effective date of the action:

(1) Said action will not be taken until the hearing has been held and a final decision rendered.

(2) The effective date of the action will be the first day of the month following the adoption, by the Director, of the final hearing decision, provided the notice of decision was mailed at least ten (10) days prior to the effective date of the action.

(g) Should the beneficiary's request for a hearing be received on or subsequent to the effective date of the action, said action will remain in full force and effect until the hearing has been held and a final decision rendered.

(h) Under no circumstances shall the months wherein a beneficiary is off restricted status solely due to requesting a hearing be counted toward the two year period as provided for in (d) or (e) above.

(i) There is no right to a hearing when a beneficiary is placed on restricted status as a result of his or her conviction of any misdemeanor or felony involving fraud or abuse of medical assistance benefits or services or in connection with any public assistance program.