Ohio | Department of Medicaid

05/01/2019 **16LRAR0147**

0025850
The Good Shepherd Home
c/o Lutheran Social Services
500 W. Worthington Blvd. Road
Worthington, OH 43085

Action Required: Respond within 30 days email
Re: Initial Written Summary Of Nursing Facility Post-Payment Claims Overpayment Review
Provider Number: **0025850**
Provider Name: **The Good Shepherd Home**
Review Period: **07/01/2015** through: **06/30/2016**

Dear Administrator:

The Ohio Department of Medicaid (ODM) has conducted a post-payment review pursuant to Ohio Revised Code §5165.49 and determined that you were overpaid by Medicaid for nursing facility patient days and/or patient liability claims during the review period referenced above.

As a result of this review, ODM has determined that you owe **$2,771.00**. Please refer to the enclosed report for details of the calculations leading to the amount determined to be owed.

If the provider wishes to contest the findings, the provider may request to participate in a bureau-level resolution process. The bureau-level resolution process is an informal exchange of information regarding the review findings with the goal of reaching a resolution. If the provider would like to participate in the bureau-level resolution process, the provider should indicate this on the enclosed Initial Post-Payment Claims Overpayment Review Response Form, sign, date and return the form to ODM at the email address on the form. Supporting documentation may be submitted separately, and your assigned auditor will work with you to arrive at an agreed upon and reasonable date. At the conclusion of the resolution process, the provider will be notified in writing of the results. If the provider does not agree with the bureau-level resolution process results, the provider will be given an opportunity to request a reconsideration by the Medicaid director pursuant to Ohio Revised Code §5165.49.

If the provider contests the findings of the resolution process and wants to participate in the bureau-level resolution process but would like the Medicaid director to consider the review results, the provider should indicate this on the enclosed Initial Post-Payment Claims Overpayment Review Response Form, sign, date and return the form to ODM at the address on the form. The provider **must** submit supporting documentation with their request.

If the provider is in agreement with the review findings and does not wish to contest the findings, the provider should indicate this on the enclosed Initial Post-Payment Claims Overpayment Review Response Form, sign, date and return the form to ODM at the email address on the form. The provider may also indicate on the form the provider's preferred repayment option.

If we do not receive your Post-Payment Claims Overpayment Review Response Form within thirty (30) days, the final overpayment amount will be deducted from your next available vendor payment from ODM pursuant to Ohio Revised Code §5164.59.

Thank you for your assistance. If you have any additional questions or concerns, please contact Jeff Fukuda at (614) 752-2626 or jeffrey.fukuda@medicaid.ohio.gov.

Sincerely,

Mark Graves
Bureau Of Program Integrity
Long-Term Care Audits
MARK.GRAVES@MEDICAID.OHIO.GOV

Enclosure(s)

Certified mail, return receipt request number 9414 7266 9904 2122 9251 36

INITIAL POST-PAYMENT CLAIMS OVERPAYMENT REVIEW RESPONSE FORM

Tracking Number: 16LRAR0147
Provider Name: The Good Shepherd Home
Provider Number: 0025850 Mailing Date: May 1, 2019
Review Period: July 01, 2015 through June 30, 2016 Total Overpayment Due ODM:$2,771.00

This form must be received by ODM, within 30 days of the mailing date.

INDICATE YOUR SELECTION BELOW

☐ **By checking this box, the provider is indicating its agreement with the initial review findings and indicating how it wants to repay the overpayment by checking the appropriate box below.** ***If you do not indicate a choice, the full amount due will be deducted from your next vendor payment from ODM.***

☐ Deduct the full amount due from my next monthly payment from ODM.

☐ Deduct equal installments, including interest, from my monthly payments from ODM for the next (circle one) 2 3 4 5 6 months.

☐ **By checking this box, the provider is requesting to participate in a bureau-level resolution process.** Supporting documents may be submitted separately. Your assigned auditor will work with you to arrive at an agreed and reasonable date.

☐ **By checking this box, the provider is requesting to skip the bureau-level resolution process and proceed directly to reconsideration by the Medicaid director.** All information and documentation the provider wants the director to consider MUST be submitted along with this request form.

Authorized Provider Representative _____ Title _____
(Please Print)

Signature _____

Address _____

_____

Prov. Rep. Email Address _____
(Please Print)

Other Business Email Address(es) _____
(Please Print)

Telephone number (___) _____ Date _____

Please complete and return via Email To : ltcaudits@medicaid.ohio.gov

Note: By completing and submitting this form to ODM, your organization is acknowledging notification of Medicaid overpayment, pursuant to Ohio Revised Code § 5164.57