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# 7 Understanding Your Rights and Responsibilities as a Provider

This chapter describes provider rights and responsibilities as mandated by the *Alabama Medicaid Agency Administrative Code*. The chapter contains the following sections:

- Provider Responsibilities
- Medicare/Medicaid Fraud and Abuse Policy
- Refunds

## 7.1 Provider Responsibilities

Providers who agree to accept Medicaid payment must agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, (such as, epidurals or spinal anesthetic) these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. Medicaid covers these services. Providers may not bill Medicaid recipients they have accepted as patients for covered labor and delivery-related pain management services.

Providers, including those under contract, must be aware of participation requirements that may be imposed due to managed care systems operating in the medical community. In those areas operating under a managed care system, services offered by providers may be limited to certain eligibility groups or certain geographic locations.

This section describes provider responsibilities such as maintenance of provider information, retention of records, release of confidential information, compliance with federal legislation, billing recipients, and agreement to the certification statement described in the *Alabama Medicaid Agency Administrative Code.*

### *7.1.1 Maintenance of Provider Information*

Providers must promptly advise the HP Provider Enrollment Department in writing of changes in address (physical or accounting), telephone number, name, ownership status, tax ID, and any other information pertaining to the structure of the provider's organization (for example, rendering providers). Failure to notify HP of changes affects accurate processing and timely claims payment.

Send change requests to HP Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

### *7.1.2 Reporting Change of Ownership Information*

Medicaid requires the owner of a Medicaid enrolled facility to report any change of ownership to Medicaid 30 business days prior to making such

change. A change of ownership requires that all parties involved shall collaborate to ensure that services are billed and paid to the correct owner using the correct NPI number.

Effective January 1, 2009, currently enrolled providers will be required to complete the Change of Ownership Information form and mail to the System Support Unit, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103. This information will be used in determining how the change in ownership will be processed. If necessary, Medicaid will instruct HP to close the provider's file. This form can be obtained by accessing Medicaid's website: www.alabama.medicaid.gov.

The new owner must submit a complete Medicaid Provider Enrollment Application packet to enroll as a Medicaid provider. The effective date of the new owner's enrollment is either the date of the sale or the date the application is received, whichever is later.

### *7.1.3 Retention of Records*

The provider must maintain and retain all necessary records, Remittance Advices (RAs), and claims to fully document the services and supplies provided to a recipient with Medicaid coverage. These must be available, upon request, for full disclosure to the Alabama Medicaid Agency. The *Alabama Medicaid Agency Administrative Code,* Chapter 1, states the following:

> *Alabama Medicaid providers will keep detailed records in Alabama, of such quality, sufficiency, and completeness except as provided in subparagraph (5) Rule No. 560-X-16-.02, that will fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients. These records will be retained for a period of three (3) years plus the current year.*

In the event of ongoing audits, litigation, or investigation, records must be retained until resolution of the ongoing action.

The provider must be able to provide, upon request and at no charge to Medicaid, related state or federal agencies, or the Alabama Medicaid fiscal agent, HP, original records. These records may include, but are not limited to, documents relating to diagnostic tests, treatment, service, laboratory results, and x-rays.

Providers will make all such records available for inspection and audit by authorized representatives of the Secretary of Health and Human Services, the Alabama Medicaid Agency, and other agencies of the State of Alabama. Provider records and operating facilities shall be made available for inspection during normal business hours.

Providers participating in the Alabama Medicaid program shall make available, free of charge, within ten (10) days, the necessary records and information to Medicaid investigators, members of the Attorney General's staff, or other designated Medicaid representatives who, in the course of conducting reviews or investigations, have need of such documentation to determine fraud, abuse, and/or other deliberate misuse of the Medicaid program. Depending on the number of records requested, Medicaid may provide a reasonable extension.

Failure to supply requested records might result in recoupment of the paid claims in question and additional action as deemed necessary by Medicaid including referral to law enforcement agencies.

Information pertaining to a patient's charges or care may be released only as directed by the Medicaid Regulations (see the *Alabama Medicaid Agency Administrative Code*, Chapter 20, for information pertaining to Third Party).

### *7.1.4 Release of Confidential Information*

Information about the diagnosis, evaluation, or treatment of a recipient with Medicaid coverage by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical, mental or emotional disorder, or drug abuse, is usually confidential information that the provider may disclose only to authorized people. Family planning information is sensitive, and confidentiality must be assured for all recipients.

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in the rules and regulations of the U.S. Department of Health and Human Services (HHS) or on the express authorization of the Commissioner of Social Security. The regulations of HHS regarding the confidentiality of records and information apply to both governmental and private agencies participating in the administration of the Program; to institutions, facilities, agencies, and persons providing services; and to those administrative services under an agreement with a provider of services. The rules governing release of private information and disclosure of classified information are contained in Chapters 20 and 27 of the *Alabama Medicaid Agency Administrative Code*, which is available to all Alabama Medicaid providers.

Information furnished specifically for purposes of establishing a claim under the Medicaid Program is subject to these rules. Such information includes the individual's Medical Assistance (Medicaid Title XIX) Identification (ID) Number, facts relating to entitlement to Medicaid benefits, other medical information obtained from state of Alabama agencies or the Medicaid Fiscal Agent, HP.

### *7.1.5 Compliance with Federal Legislation*

Participating providers of services under the Medicaid Program must comply with the requirements of Titles VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990.

Under the provisions of these Acts, a participating provider or vendor of services receiving federal funds is prohibited from making a distinction based on race, color, sex, creed, handicap, national origin, or age.

Once accepted, recipients must have access to all portions of the facility and to all services without discrimination. Recipients may not be segregated within any portion of the facility, provided a different quality of service, or restricted in privileges because of race, color, sex, creed, national origin, age, or handicap.

Medicaid is responsible for investigating complaints of noncompliance. Send written complaints of noncompliance to the following address:

**Alabama Medicaid Agency Commissioner**
**501 Dexter Avenue**
**P. O. Box 5624**
**Montgomery, AL 36103-5624**

### *7.1.6 Utilization Control – General Provisions*

Title XIX of the Social Security Act, Sections 1902 and 1903, mandates utilization control of all Medicaid services under regulations found at Title 42, *Code of Federal Regulations*, Part 456. Utilization review activities required by the Medicaid program are completed through a series of monitoring systems developed to ensure services are necessary and in the appropriate quality and quantity. Both recipients and providers are subject to utilization review monitoring.

Utilization control procedures safeguard against unnecessary care and services (both under and over utilization), monitor quality, and ensure payments are appropriate according to the payment standards defined by the Alabama Medicaid Agency. Most monitoring is performed using the Surveillance and Utilization Review (SUR) system, and the Quality Improvement and Standards Division. However, utilization review may also involve an examination of particular claims or services not within the normal screening when a specific review is requested by the Alabama Medicaid Agency or any related state or federal agency.

All providers identified as a result of provider review are made available to the Provider Review Department of the Alabama Medicaid Agency.

The primary goal of utilization review is to identify providers with practice patterns inconsistent with the federal requirements and the Alabama Medicaid Program scope of benefits. This review relies on a number of parameters including comparison of resource utilization with that of the provider's peer group.

The principal approach to resolution of inappropriate use is education of the provider. The education may include a provider representative visit or letter to assist with the technical aspects of the program, and (or) a physician education visit or letter to explain program guidelines relative to medical necessity, intensity of service, and the appropriateness of the service.

Depending on the intensity of the identified problem, the letter or visit may result in a review of claims before payment. This is indicated on the provider records maintained by HP, and may refer to claims for similar services, or all claims submitted by a particular provider. All claims that match the review criteria determined by Medicaid will suspend for manual review. As part of the review process, providers may be required to submit supporting documentation (for example, the medical record extract) for billed services. The documentation is used to ascertain the medical necessity for the services rendered.

### *7.1.7 Provider Certification*

The Medicaid Program is funded by both the state and the federal government. Therefore, the providers of medical services are required to certify compliance with, or agreement to, various provisions of both state and federal laws and regulations. The agreements required by the Medicaid Program are explained in the following paragraphs.

Payment for services is made on behalf of recipients to the provider of service in accordance with the limitations and procedures of each program.

**Offering incentives and advertising discounts.**

Provider is prohibited from offering incentives (such as discounts, rebates, refunds, or other similar unearned gratuity or gratuities) other than an improvement(s) in the quality of service(s), for the purpose of soliciting the patronage of Medicaid recipients. Should the Provider give a discount or rebate to the general public, a like amount shall be adjusted to the credit of Medicaid on the Medicaid claim form, or such other method as Medicaid may prescribe. Failure to make a voluntary adjustment by the Provider shall authorize Medicaid to recover same by then existing administrative recoupment procedures or legal proceedings.

Advertising the waiver of, or routinely waiving, Medicaid copayments is a prohibited “remuneration” under Section 22-1-11, Code of Alabama and 1128B of the Social Security Act (SSA)**.** Section 1128A (i) (6) of the SSA defines “remuneration” to include waiver of coinsurance and deductible amounts, unless (1) the waiver is not part of an advertisement or solicitation, (2) the provider does not routinely waive deductibles and copays, and (3) the provider either waives the amount after determining the recipient is in financial need or fails to collect the payment after making reasonable collection efforts.

**Medicaid payment can never be made directly to recipients.**

By submitting Medicaid claims, the provider agrees to abide by policies and procedures of the Program as reflected by the information and instructions in the *Alabama Medicaid Agency Administrative Code*. The provider also agrees to the following certification statement: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws." The requirements for this certification may be found in 42 Code of Federal Regulations §447.18.

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Added: .18

**Services must be reasonable and medically necessary.**

Medicaid is continuously evaluating and updating medical necessity for claims payment. In an effort to ensure accurate coding and payment of claims, diagnosis/procedure code criteria is applied. The correct use of a CPT or ICD-9 code alone does not guarantee coverage of a service. All services must be reasonable and necessary in the specific case and must meet the criteria of specific governing policies. Medical record documentation must support coding utilized in claim and/or prior authorization submission.

### *7.1.8 Billing Recipients*

When the provider of medical care and services files a claim with the Medicaid Program, the provider must agree to accept assignment. By accepting assignment, the provider agrees to accept the Medicaid reimbursement, plus any cost-sharing amount to be paid by the recipient, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on his behalf, must not be billed for the amount above that which is paid on allowed services.

**NOTE:**

Recipients may not be billed for claims rejected due to provider-correctable errors or failure to submit claims in a timely manner.

The recipient may be billed for services that are non-covered and for which Medicaid will not make any payment. Services that exceed the set limitation (for example, physician visits, hospital visits, or eyeglasses limit) are considered non-covered services. Medicaid does not reimburse providers for completing forms for school, family medical leave or other purposes not requested at the time of service. Providers may bill the recipient for this service under certain conditions. Providers are requested to confer with and inform recipients prior to the provision of services about their responsibilities for payment of services not covered by the Medicaid program. The requirements for payment can be found in 42 Code of Federal Regulations §455.18.

Recipients under 21 may qualify for additional Medicaid covered services beyond the yearly benefit limit. If treatment is deemed medically necessary to correct or improve conditions identified through the EPSDT screening process, these services will not be considered in the normal benefit limitations.

Added: **Payment Adjustment for Provider Preventable Conditions (PPC's) section**

### *Payment Adjustment for Provider Preventable Conditions (PPC's)*

Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPC's) and Other Provider Preventable Conditions (OPPCs).

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

It is the responsibility of the provider to identify and report any PPC and not seek payment from Medicaid for any additional expenses incurred as a result of the PPC.

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPC's must meet the following criteria:

- The PPC must be reasonable preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.

Added: The PPC must…the required information.

- The PPC must be clearly and unambiguously the results of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPC's for considerations should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Inpatient Hospitals must report Hospital Acquired Conditions (HACs) on the UB-04 claims form. Refer to Provider Manual Chapters 19 (Hospital) and 33 (Psychiatric Treatment Facilities).

**All providers** must report OPPCs via encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov. Providers that do not currently have a password for the Adverse Event reporting may require one by contacting Patricia Williamson at patricia.williamson@medicaid.alabama.gov or via phone at 334-353-4142.

Reportable OPPCs include but are not limited to:

- Surgery on a wrong body part or site
- Wrong surgery on a patient
- Surgery on a wrong patient

The following information is required for reporting:

- Recipient first and last name
- Date of Birth
- Medicaid number
- Date event occurred
- Event type

A sample form is on the Alabama Medicaid Agency website at www.medicaid.alabama.gov under Programs/Medical Services/Hospital Services. Providers may submit their own form as long as it contains all of the required information.

## 7.2 Provider Rights

This section describes the fair hearings process, informal conferences, appeals, and HP and Alabama Medicaid Agency responsibilities towards providers participating in the Alabama Medicaid Program.

Providers have freedom of choice to accept or deny Medicaid assignment for medically necessary services rendered during a particular visit. This is true for new or established recipients.

The provider (or their staff) must advise each recipient when Medicaid payment will not be accepted prior to services being rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted **must be recorded** in the recipient's medical record.

### *7.2.1 Administrative Review and Fair Hearings*

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code.*

When a denial of payment is received for an outdated claim, the provider may request an *administrative review* of the claim. A request for administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated**. In addition to a clean claim, the provider should send all relevant RAs and previous correspondence with HP or the Agency in order to demonstrate a good faith effort at submitting a timely claim. This information will be reviewed and a written reply will be sent to the provider.

In the case that the administrative review results in a denial of a timely request, the provider has the option to request a fair hearing. This written request must be received within 60 days of the administrative review denial.

In some cases, providers should not send requests for fair hearing for denied claims. An administrative review denial is the **final** administrative remedy for the following reasons:

- Recipient has exceeded yearly benefit limits.
- Recipient was not eligible for dates of service.
- Claim was received by the Agency more than 60 days after the claim became outdated.

Send requests for Administrative Review to the following address, care of the specific program area:

**Administrative Review**
**Alabama Medicaid Agency**
**501 Dexter Avenue**
**P.O. Box 5624**
**Montgomery, AL 36103-5624**

Include the program area in the address (for instance, write "Attn: System Support").

**NOTE:**

If all administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the Administrative Review does not result in a favorable decision, the provider may request an informal conference before proceeding to a Fair Hearing

## *NCCI Administrative Review and Fair Hearing*

Individual claim denials may be appealed at three levels. The levels, listed in order, are:

1. Redetermination Request—see section 7.2.4 below
2. Administrative Review – see below
3. Fair Hearing – see below

If all appeals have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family. This denial is a provider liability.

### Administrative Review

When the redetermination request results in a denial by HP, the provider may request an *administrative review* of the claim. A written request for an administrative review **must be received by the Alabama Medicaid Agency within 60 days of the date of the redetermination denial from HP**. The request should clearly explain why the provider disagrees with the redetermination denial. The request for an administrative review must include:

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review
- Correct Paper Claim for the procedure codes that denied
- Copy of previous request for redetermination correspondence sent to HP
- Copies of all relevant remittances advices or HP's redetermination denial notification
- Copy of any other useful documentation

Send the request for an Administrative Review along with all supporting documentation to:

**NCCI Administrative Review**
**Alabama Medicaid Agency**
**Attn: System Support Unit**
**501 Dexter Avenue**
**P. O. Box 5624**
**Montgomery, AL 36103-5624**

Documentation that is submitted after the Administrative Review request has been filed may result in an extension of the time required to complete the review. Further, any documentation noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the Administrative Review decision. Documentation not submitted at the Administrative Review level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the documentation late.

This information will be reviewed and a written reply will be sent to the provider within 60 days.

**Fair Hearing**

When the administrative review does not resolve the issue, the provider has the option to request a fair hearing. A written request must be received within 60 days of the date of the administrative review decision. The request must identify any new or supplemental documentation. Send the written request for a fair hearing to:

**Alabama Medicaid Agency**
**Attn: Office of General Counsel**
**501 Dexter Avenue**
**P. O. Box 5624**
**Montgomery, AL 36103-5624**

### *7.2.2 Informal Conferences*

A provider who disagrees with the findings of a utilization review may request an informal conference. Providers must make the request in writing to the Alabama Medicaid Agency at the above address. The informal conference is the intermediate step between the Administrative Review and the Fair Hearing process.

### *7.2.3 HP Responsibilities*

The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan. The present fiscal agent contract is with HP, P.O. Box 244032, Montgomery, Alabama 36124-4032. Their toll free telephone number is 1(800) 688-7989.

HP provides current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. HP prepares and distributes the *Alabama Medicaid Agency Provider Manual* to providers of Medicaid services. This manual is for guidance of providers in filing and preparing claims.

Providers with questions about claims should contact HP. Only unsolved problems or provider dissatisfaction with the response of HP should be directed to Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104, or by calling (334) 242-5000.

### *7.2.4 NCCI Redetermination Process*

Effective November 9, 2010, Medicaid introduced the NCCI edits into the Medicaid claims processing system. These edits were set as "informational" edits. On March 23, 2011, these edits were set to deny for any services that do not meet the NCCI edit criteria and were furnished on or after October 1, 2010.

The use of applicable modifiers is critical in successful implementation of the NCCI procedure to procedure edits. Once a claim or line item on the claim has been denied for an NCCI procedure to procedure edit, then the claim **cannot** be adjusted by the provider.

If a claim is denied for an NCCI Medically Unlikely Edit (MUE), the provider can resubmit the claim with the correct units as long as the units are equal to or lesser than the NCCI MUE edit allows. If the units are more than the NCCI MUE edit allows, then an appeal must be requested.

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The Medicaid NCCI Coding is available on the CMS NCCI website at:
*http://www.cms.gov/MedicaidNCCICoding/01_Overview.asp#TopOfPage*

**If the NCCI edit responsible for an NCCI denial has a modifier indicator of "0", an appeal can NEVER overturn the denial. These claims are final and no appeal is applicable except for an administrative law judge who can determine that the denied column two code should be paid. These instances will be rare.**

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "1" or is for an MUE, an appeal can be submitted.

All NCCI denials begin with an error code "59nn". To validate a claim denied for an NCCI error code, download the remittance advice from the web-portal which contains the Medicaid specific error codes.

**First Level of Appeal: Redetermination Request**

HP is responsible for the redeterminations, which is the **first** level of appeals and adjudication functions.

A *redetermination* is an examination of a claim and operative notes/medical justification by HP personnel. The provider has 60 days from the date of receipt of the initial claim determination to request a redetermination. The provider must complete the HP Enterprise Services Request for NCCI Redetermination Review form. The request for a redetermination must include:

- Completed NCCI Redetermination Review form
- Corrected Paper Claim for the procedure codes that denied
- Operative Notes/Medical Justification

Send the request for a Redetermination Review along with all supporting documentation to:

**HP Enterprise Services**
**Request for NCCI Redetermination**
**PO Box 244032**
**Montgomery, AL 36124-4034**

HP will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. The ICN region for the redetermination request will begin with '91'. For example: 9111082123456.

### *7.2.5 Alabama Medicaid Agency's Responsibilities*

The Alabama Medicaid Agency is responsible for mandating and enforcing Medicaid policy for the Alabama Medicaid Program.

## 7.3 Medicare/Medicaid Fraud and Abuse Policy

The Program Integrity Division is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, abuse and/or misuse in the Medicaid Program. This includes verifying that medical services are appropriate and rendered as billed, that services are provided by qualified providers to eligible recipients, that payments for those services are correct, and that all funds identified for collection are pursued.

Federal regulations require the State Plan for Medical Assistance to provide for the establishment and implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess payments. The Alabama Medicaid Agency has designated the Program Integrity Division through its Provider Review, Recipient Review, and Investigations Units to perform this function. These units are responsible for detecting fraud and abuse within the Medicaid Program through reviewing paid claims history and conducting field reviews and investigations to determine provider/recipient abuse, deliberate misuse, and suspicion of fraud. In addition, these units are utilized to aid in program management and system improvement.

Cases of suspected recipient fraud are referred to local law enforcement authorities for prosecution upon completion of investigation. Cases of suspected provider fraud and patient abuse are referred to the Medicaid Fraud Control Unit in the Alabama Attorney General's Office. This office was established under Public Law 95-142 and Health and Human Services guidelines to investigate, for possible prosecution, alleged provider fraud and patient abuse in the Medicaid Program. The requirements can be found in 42 Code of Federal Regulations Part 455, Program Integrity: Medicaid.

### *7.3.1 Providers Must Screen for Excluded Individuals*

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i) (2) of the Act; and 42 CFR section 1001.1901(b)) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

• All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;

• Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and

• Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable:

• Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;

•Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;

• Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;

• Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;

• Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;

• Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;

• Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and

• Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

To further protect against payments for items and services furnished or ordered by excluded parties, all current providers and providers applying to participate in the Medicaid program **must** take the following steps to determine whether their employees and contractors are excluded individuals or entities:

• Screen all employees and contractors to determine whether any of them have been excluded by searching the exclusion list located on the Alabama Medicaid Agency's website. All providers must check the list prior to hiring staff to ensure potential staff has not been excluded from participation in the program. All providers must check the list again monthly to ensure existing staff have not been excluded from participation in the program since the last search.

• Search the HHS-OIG website by the names of any individual or entity. All providers must search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.

• Providers must immediately report to Medicaid any exclusion information discovered.

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A (a) (6) of the Act; and 42 CFR section 1003.102(a)(2)).

### *Where Providers Can Look for Excluded Parties*

While the MED is not readily available to providers, the HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

Additionally, Medicaid maintains an exclusion list, pursuant to 42 CFR section 1002.210, which includes individuals and entities that the State has barred from participating in State government programs. The exclusion list is located on the Medicaid website under the Fraud/Abuse Prevention tab. All providers are obligated to search this list monthly whenever they search the LEIE.

## 7.4 Appeals

If eligibility of a provider has been terminated because of a criminal conviction for Medicaid fraud or abuse, or because of loss of required licensure, then no fair hearing need be given. A certified copy of the judgement of conviction or of the decision to revoke or suspend a provider's license shall be conclusive proof of ineligibility for further participation in the Medicaid Program. The pending status of an appeal for any such conviction or license revocation or suspension shall not abate the termination of Medicaid eligibility. If a conviction, license revocation, or suspension is reversed on appeal, the recipient or provider may apply for reinstatement to the Medicaid program. However, Medicaid will examine the reasons for the reversal and reinstatement will be at the sole discretion of the Commissioner.

## 7.5 Refunds

### Medicaid Refunds

If you receive payment for a recipient who is not your patient, or are paid more than once for the same service, please complete the Check Refund form. Refer to Section 5.11, Refunds, for instructions on completing the form. Appendix E, Medicaid Forms, contains a sample of the form.

### Medicaid Adjustments

If you wish to have an overpayment deducted from a future remittance, do not attach a check. Instead, state that you wish to have funds deducted from a future remittance. If you require an adjustment on a fully or partially paid claim, please use one of the following methods:

- Complete an online adjustment using Medicaid’s Interactive Web Portal an online adjustment using Medicaid’s Interactive Web Portal.
- Complete an online adjustment using Provider Electronic Solutions software or approved vendor software as described in Section 5.10, Adjustments.

**NOTE:**

For large numbers of adjustments, please contact the Provider Assistance Center at 1 (800) 688-7989.

All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts.

If providers receive duplicate payments from a third party and Medicaid, all duplicate third party payments must be refunded within 60 days by:

- Sending a refund of insurance payment to the Third Party Division, Medicaid
- Requesting an adjustment of Medicaid payment (a copy of the request **must** be sent to the Third Party Division, Medicaid).

If the provider releases medical records and/or information pertaining to a claim paid by Medicaid and, as a result of the release of that information, a third party makes payment to a source other than the provider or Medicaid, the provider is responsible for reimbursing Medicaid for its payment.