

State: Alabama

Director: Jacqueline G Thomas Jacqueline.thomas@medicaid.alabama.gov

Assistant:

Information/Link/Attachment :

PROVIDER REVIEW

SELF AUDIT PROCESS

Description:

Provider self-auditing is an administrative method that may be useful in a Program Integrity office setting. It is best applied to investigations of overpayments which do not involve fraud and abuse. It's an administrative process that shifts time consuming internal investigation and recovery processes to a provider-based recovery process. It changes the reviewer's responsibility to validating the information reported back and initiating appropriate follow-up action.

Self-Audit Process vs Desk Audit:

In the usual provider investigation, the analyst detects a problem, initiates requests for data or claims, determines and amount of overpayment for the time period under investigation and then sends a letter to the provider asking for recovery.

During the time of the investigation, the following is likely to occur:

- Overpayments continue. If not notified, the provider continues to bill inappropriately.
- The investigator's data is usually date specific and does not include claims after the data runs. This means that a second investigation is necessary for any time period after the determination of the overpayment.
- The investigator is dealing with other cases and their time constraints. This causes administrative delay in completing the investigation.
- The time involved after sending a recovery letter and dealing with administrative appeal further increases the recovery time and ongoing overpayments.
- At a hearing or upon contact with the provider as a result of the recovery letter, the investigator may find the problem is not one that is recoverable and thus the time spent developing the case was wasted (due to misinformation given by other staff, ambiguous, poorly written or weak medical policies, etc.)
- The process tends to create an adversarial relationship between Program Integrity and the provider.

Benefits From a Provider Self-Audit Approach:

- The approach tends to be less confrontational.
- It permits more recovery cases to be initiated per analyst.
- The provider may stop the incorrect billing process upon receipt of the self-audit letter while reviewing the issue. This creates loss avoidance.

- The provider's investigation may exceed the bound of the problem known to the analyst. This could mean a larger repayment.
- The provider is more likely to refund all overpayments rather than the money overpaid for a set time period. Thus, only one investigation is required.
- The analyst may use the self-audit results to identify other providers with similar problems.
- While the majority of information sent to a provider is about verified problems, a self-audit approach may permit the sharing of an anonymous allegation. Notifying the provider/Compliance Officer could alert them to investigate an area that might be difficult for Program Integrity to initiate without specific evidence.
- The provider's incentive to cooperate is good because the alert could help them avoid problems such as a whistleblower suit if they fail to identify incorrect problem billing procedures.

Self Audit Procedures for the Provider Review Unit:

The self-audit method should not be used if fraud and abuse are suspected.

1. Consult with the Associate Director of the provider review to decide whether self-audit protocol is appropriate for your review.
2. When the self audit is a result of a provider review audit, in most situations the self-audit letter and forms should be mailed with the recoupment letter.
3. Develop an introductory letter to the provider to explain the general details of the review and process which should be followed. The letter should set a date to reply as to whether they will select the option for self-audit and include the following disclaimer: "Recoupment of overpayments does not alleviate the possibility of further review by Program Integrity in this or future reviews, and does not affect in any manner the government's ability to pursue criminal, civil, or administrative remedies or to obtain additional damages, penalties, or fines for the matters which are subject to this recoupment".
4. The self-audit letter should also include the following:
 - a. The specific issues and codes to be identified in the self-audit
 - b. A detailed explanation of all the overpayment issues identified
 - c. The date range of our completed review
 - d. The inclusive dates of the requested self-audit
 - e. The type of sampling (100% vs random, etc)

NOTE: Reference to random sample should be deleted from the letter and 100% review specified, if random sample is not appropriate for your review
 - f. Include the form titled Notification of Intent to Conduct Self-Audit and give a deadline of 10 working days to return the form
 - g. A deadline to complete the self-audit
 - h. Clear instructions for sending self-audit results and the refund. An SPR (control number) should be given to include with the refund check
 - i. Include the form titled Self-Audit Documents to send to Program Integrity asking for:
 - A summary overview of the issues or problems identified
 - Time period identified by the review
 - Type of sampling (100%, random, etc)
 - Error percentage rate (if applicable)

- Corrective action implemented to assure that the errors do not recur
 - Explanation of format for the information to be returned so the incorrect claims can be validated. This should include recipient name and Medicaid ID, date of service, procedure code billed in error, ICN, amount billed, amount paid, and amount to be repaid to Medicaid
- j. Instructions to send the results and refund to the attention of the Director of Program Integrity
5. Monitor the 10 days to return the Notice of Intent to Conduct Self-Audit form and send a second notice if the provider does not respond to the self-audit request.
 6. In most situations, the review will remain open until the self-audit is completed.
 7. The analyst will review a sampling of self-audit results to validate accuracy of the self-audit.
 8. Notify the Associate Director if the provider fails to respond to two self-audit letters, and further action may be taken.

Leigh Ann Hixon

Date

Associate Director, Provider Review

Approved: Jacqueline Thomas

Date

Director, Program Integrity

NOTIFICATION OF INTENT TO CONDUCT SELF-AUDIT

Provider Name: _____

Medicaid Provider Number: _____

Contact Person for your office: _____

Phone Number: _____ Fax Number: _____

Email: _____

Your estimated completion date: _____

Signature: _____ Date: _____

Title: _____

Complete and return in self-addressed envelope within 10 working days from the date of this letter to:

Jacqueline G. Thomas
Director, Program Integrity
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

SELF-AUDIT DOCUMENTS TO SEND TO PROGRAM INTEGRITY


1. Cover letter which summarizes:
 - a. Overview of the issues identified
 - b. Time period covered by the review (please evaluate the problem for the full time period for which it occurred)**
 - c. 100% of Medicaid services performed by (provider name)**
 - d. What has been implemented to assure that these errors do not recur
 - e. Reason for error
2. Individual recipient pages in electronic format, (preferably Excel spreadsheet), which contain:
 - a. Recipient name
 - b. Medicaid ID number
 - c. Date of service
 - d. Procedure code found billed in error
 - e. ICN
 - f. Amount billed
 - g. Amount paid
 - h. Paid date
 - i. Amount to be repaid to Alabama Medicaid
 - j. SPRXXXX (control number)

SEND REFUND CHECK, WITH DOCUMENTS LISTED ABOVE, TO:

Jacqueline G. Thomas
Director, Program Integrity
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

Make checks payable to: Medicaid Accounts Receivable

 **DO NOT SEND ANY OF THESE DOCUMENTS TO HP** 

 Acceptance of payment does not constitute agreement as to the amount of loss suffered by the Medicaid Program

State: Arizona

Director: Glenn Prager glenn.prager@azahccs.gov

Assistant:

Information/Link/Attachment:

**STATE OF ARIZONA
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
OFFICE OF THE INSPECTOR GENERAL**

Self-Disclosure Guidelines

February 2011



Director

Inspector General

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Introduction

The mission of the State of Arizona AHCCCS Office of the Inspector General (OIG) is to work with providers to advance the integrity of the Medicaid program, while concurrently ensuring access to services for members and maintaining a cost effective program for Arizona's taxpayers. We are committed to detecting potential fraud, waste and abuse within the AHCCCS program and recovering improper payments. As part of our multi-disciplinary approach to attaining these goals, we are making a concentrated effort to recognize providers who find problems within their own organizations, self-disclose those issues to the OIG, and return inappropriate payments.

The OIG recognizes that many improper payments are discovered during the course of a provider's internal review process. While providers who identify that they have received improper payments from the AHCCCS program are required to return the overpayments, we appreciate that it is essential to develop and maintain a fair, rational process that will be mutually beneficial for both the State of Arizona and the concerned provider. The OIG has developed this approach to encourage and offer incentives for providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds, whether intentional or unintentional, under the state's Medicaid program. By forming a partnership with providers through this self-disclosure approach, the OIG's overall efforts to eliminate fraud, waste and abuse will be enhanced, while concurrently offering providers a mechanism or method to reduce their legal and financial exposure.

This guidance and disclosure protocol establishes the process for participating in the OIG's Self-Disclosure Program. The OIG recognizes that situations which are subject to this policy could vary significantly; therefore, this protocol is written in general terms to allow providers the flexibility to address the unique aspects of the matters disclosed.

Matters related to an on-going audit/investigation of the provider are not generally eligible for resolution under this self-disclosure protocol. Unrelated matters disclosed during an on-going audit may be eligible for processing under the self-disclosure protocol assuming the matter has received timely attention. If the OIG is already auditing or investigating the provider, and the provider wishes to disclose an issue, in addition to submitting a disclosure under this protocol, the provider should bring the matter to the attention of the assigned investigator/auditor. If another outside agency is auditing or investigating the provider, and the provider seeks to disclose an issue to OIG, the provider should follow this guidance accordingly.

Because of the complexity of some issues surrounding self-disclosures, providers may want to consider obtaining the advice of experienced healthcare legal counsel or consultants. This guide is not intended to provide or offer legal advice.

Advantages of Self-Disclosure

Self-disclosing overpayments, in most circumstances, will result in a better outcome than if OIG staff had discovered the matter independently. While the specific resolution of self-disclosures depends upon the individual merits of each case, the OIG typically extends the following benefits to providers who, in good-faith, participate in a self-disclosure:

1. Forgiveness or reduction of interest payments (for up to five years)
2. Extended repayment terms
3. Waiver of some penalties and/or sanctions
4. Timely resolution of the overpayment
5. Recognition of the effectiveness of the provider's compliance and a decrease in the likelihood of imposition of an OIG Corporate Integrity Program
6. Possible preclusion of subsequently filed OIG Civil Monetary Penalty action based on the disclosed matters

Developing such a partnership with the OIG during the self-disclosure process may also lead to more thorough understanding of the OIG's audit and investigatory processes, which could benefit the provider in the future.

When to Disclose

Once an inappropriate payment is discovered that warrants self-disclosure, providers are encouraged to contact the OIG as early in the process as possible to maximize the potential benefits of self-disclosure. However, because of the wide variance in the nature, amount and frequency of overpayments that may occur over a wide spectrum of provider types, it is difficult to present an all-inclusive set of criteria by which to judge whether disclosure is appropriate. Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through the administrative billing process.

Each incident shall be considered on an individual basis. Factors that OIG will consider include, but are not limited to:

- The exact issue,
- the amount involved,
- any patterns or trends that the problem may demonstrate within the provider's system,
- the period of non-compliance,
- the circumstances that led to the non-compliance,
- the organization's history, and whether or not the organization has a corporate integrity agreement (CIA) in place.

Issues appropriate for self disclosure may include, but are not limited to:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of state and federal laws relating to the AHCCCS program

The OIG is not interested in fundamentally altering the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims. The OIG highly discourages providers from attempting to avoid the self-disclosure process when circumstances in fact warrant its use.

Disclosure Process

Once a provider makes the determination to disclose an incident, the following steps comprise an **initial** report:

1. The basis for the initial disclosure, including how it was discovered, the approximate time period covered, and an assessment of the potential financial impact;
2. The AHCCCS program rules potentially implicated;
3. Any corrective action taken to address the problem leading to the disclosure, the date the correction occurred and the process for monitoring the issue to prevent reoccurrence
4. The name and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or legal counsel but must be in an appropriate position to speak for the organization.
5. Contact the OIG with the above information by e-mail, fax or via formal letter to:

Office of the AHCCCS Inspector General
Attention: Provider Self-Disclosure MD-4500
701 E. Jefferson St.
Phoenix, AZ 85034
E-mail: OIGDISCLOSE@AZAHCCCS.Gov
Fax: 602-417-4102

Providers may also use the printable version of OIG's self-disclosure form, which is available at www.AZAHCCCS.GOV.

Assuming the provider acts in good-faith, the mere fact that the provider and OIG are unable to agree on an amount and resolve the disclosure will not automatically preclude

favorable repayment terms, particularly related to the portion of the matter to which the provider and OIG are able to agree.

After this initial reporting phase, the OIG will consult with the provider and determine the most appropriate process for proceeding. OIG staff will discuss the next steps, which may include requesting additional information. Ultimately, the provider should be prepared to present the following:

1. A summary of the identified underlying cause of the issue(s) involved and any corrective action taken;
2. Detailed list of claims paid that comprise the overpayments (in an electronic format and preferably in Excel spreadsheet format). Each claim should list the provider's AHCCCS ID number, member name and AHCCCS ID, dates of service(s), CPT codes, and the amount(s) billed and paid.
3. The names of individuals involved in any suspected improper or illegal conduct.

Assuming complete provider cooperation and timely response to information requests, the OIG expects that the vast majority of self-disclosures will be completed within three to four months of submission of information.

The OIG will consider the provider's involvement and level of cooperation throughout the disclosure process in determining the most appropriate resolution and the best mechanism to achieve that resolution. In the event that the provider and the OIG cannot reach agreement on the amount of overpayments identified, or if a provider fails to cooperate in good faith with the OIG to resolve the disclosure, the OIG may pursue the matter through established audit or investigation processes, and any less stringent repayment and/or sanction terms may no longer apply.

Upon review of the provider's disclosure and related information, the OIG may independently conclude that the disclosed matter warrants referral to the State of Arizona Attorney General's Medicaid Fraud Control Unit (MFCU). Alternatively, the provider may request the participation of a representative of the MFCU, DHHS-OIG, or The United States Attorney's Office in settlement discussions in order to resolve potential liability under the Federal False Claims Act or other laws.

Access to Information

Providers are expected to promptly comply with OIG requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The OIG also expects the provider to execute and provide business record affidavits whenever requested, in an acceptable form.

The OIG is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or

work-product protection. If the provider has retained legal representation, the OIG will cooperate with the provider's counsel to explore ways to gain access to factual or other non-protected information pertinent to the case.

The OIG will assess a provider's culpability and good-faith efforts in reaching the disposition of a self-disclosure. Cooperation will be measured by the extent to which a provider discloses relevant facts and evidence, not its waiver of the attorney-client privilege. A lack of information may make it difficult for OIG to determine the nature and extent of the conduct which caused the improper payment.

Restitution

All provider self-disclosures are subject to a thorough OIG assessment to determine whether the amount identified is accurate. While repayment is encouraged/accepted as early in the process as possible, and any repayment will be credited toward the final settlement amount, the OIG will not accept money as full and final payment for self-disclosures prior to finalizing the audit/investigatory process.

Following the review, OIG staff may consult with the provider's contracted health plan(s) to assist in determination of a repayment amount and explore the need to pursue any further administrative action. The OIG's determination will be based on several factors, including the nature of the problem, the effectiveness of the provider's compliance program, the dollar amounts involved, the time period, thoroughness and timing of the provider's disclosure, any potential harm to the health and safety of AHCCCS patients, and the provider's efforts to prevent the problem from recurring. Upon review of the provider's disclosure and related information, the OIG may at any time conclude that the disclosed matter warrants referral to the Arizona Attorney General's Medicaid Fraud Control Unit (MFCU). Once a repayment amount has been established, assuming full repayment has not previously been made, the OIG expects the provider to reimburse the State of Arizona for the full amount of the overpayment (state and federal share), by check or money order made payable to the AHCCCS Administration or enter into a repayment agreement. The OIG will work with providers to establish repayment terms, which may include some forgiveness of interest and/or extended repayment. Providers interested in extended repayment terms may be required to submit audited financial statements, at the sole discretion of the OIG, and/or other documentation to assist the OIG in making that determination. Once the repayment agreement has been finalized, the OIG will issue a settlement agreement indicating closure of the matter.

State Of Arizona
AHCCCS Office of the Inspector general
Part I – Provider Self Disclosure

DATE COMPLETED	
NAME OF INDIVIDUAL COMPLETING FORM	

Type of Self-Report Issue (select one or more by checking box)	
Billing Issues	<input type="checkbox"/>
Documentation/Records Issues	<input type="checkbox"/>
Quality of Care	<input type="checkbox"/>
Cost Report Issues	<input type="checkbox"/>
Claims for Services Not Provided	<input type="checkbox"/>
Facility Licensing	<input type="checkbox"/>
Falsification/Alteration of Records/Documents	<input type="checkbox"/>
Employee Licensure and/or Credentialing	<input type="checkbox"/>
Other:	<input type="checkbox"/>

Provider Information

Vendor/Facility Name:			
Provider First Name:		Last Name	
Provider Type		Provider Specialty	
AHCCCS ID No.		License No.	
Physical Address	Street		
	City		State
	Zip Code		
	Alternate Mailing Address		Street
	City		State
	Zip Code		
Telephone numbers must include the area code			
Work Telephone Number(s)			
Fax Number			
Cell Telephone Number			

Contact Information

PART II

First Name		Last Name		
Title				
Employer/Agency/Company				
Division/Unit				
Relationship to Organization		Employee:	Attorney:	
		Consultant:	Other:	
Other Information:		Street		
		City	State	Zip Code
		<i>Telephone numbers must include the area code</i>		
		Work Telephone Number		Ext.
		Cell Telephone Number		
		Email Address:		

You must provide written, detailed information about your self disclosure. This must include a description of the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s), the period involved, the person(s) involved, the legal and program authorities implicated, and the estimated fiscal impact. **(Please refer to the AHCCCS OIG self disclosure Guidance for additional information).**

Attach the written, detailed information and any additional relevant documentation to this form and mail the completed form and attachments to the address listed in the instructions above.

I certify that, to the best of my knowledge, the information in this self-report is truthful and is based on a good faith effort to assist the AHCCCS OIG in its' inquiry and verification of the disclosed matter.

Print Name

Signature

Date

Title

State: Arkansas

Director: Robin Raveendran

Assistant:

Information/Link/Attachment:

No self-disclosure information has been obtained from the state of Arkansas

State: California

Director: Bruce Lim bruce.lim@dhcs.ca.gov

Assistant: Bill Alameda bill.alameda@dhcs.ca.gov

Information/Link/Attachment:

Some California providers use the OIG self-disclosure process. Based upon the documentation provided, California determines whether it is adequate or not and whether the state needs to conduct additional verification that the self-disclosure is complete. California conduct audits at the provider's site if the state feels that not everything has been disclosed or the correction is not adequate.

Respondent	Number of respondents	Responses per respondent	Hours per response (minutes)	Total Burden hours
<p>Send comments to Susan G. Queen, Ph.D., HRSA Reports Clearance Officer, Room 14-33, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.</p> <p>Dated: October 23, 1998.</p> <p>Jane Harrison, Director, Division of Policy Review and Coordination. [FR Doc. 98-29111 Filed 10-29-98; 8:45am] BILLING CODE 4160-15-P</p> <p>DEPARTMENT OF HEALTH AND HUMAN SERVICES</p> <p>Health Resources and Services Administration</p> <p>Agency Information Collection Activities: Submission for OMB Review; Comment Request</p> <p>Periodically, the Health Resources and Services Administration (HRSA)</p>	3,600	560
<p>publishes abstracts of information collection requests under review by the Office of Management and Budget, in compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). To request a copy of the clearance requests submitted to OMB for review, call the HRSA Reports Clearance Office on (301) 443-1129.</p> <p>The following request has been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1995:</p> <p>Proposed Project: Application for NHSC Recruitment and Retention Assistance (in Use Without Approval)</p> <p>The National Health Service Corps (NHSC) of the HRSA's Bureau of Primary Health Care assists underserved communities through the development, recruitment, and retention of primary health care clinicians dedicated to serving people in health professional shortage areas.</p>				
<p>The Application for NHSC Recruitment and Retention Assistance submitted by sites or clinicians requests information on the practice site, sponsoring agency, recruitment contact, staffing levels, service users, site's 5-year infant mortality or low birth rate averages, and next nearest site. The information on the application is used for determining eligibility of sites and to verify the need for NHSC providers. Sites must submit applications annually or when they need a provider.</p> <p>Estimates of annualized reporting burden are as follows:</p>				

Type of report	Number of respondents	Responses per respondent	Hours per response	Total burden hour
Application	1,000		.75	750

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to: Wendy A. Taylor, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: October 23, 1998.

Jane Harrison,
Director, Division of Policy Review and Coordination.

[FR Doc. 98-29112 Filed 10-29-98; 8:45am]
BILLING CODE 4160-15-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Publication of the OIG's Provider SelfR Disclosure Protocol

AGENCY: Office of Inspector General

(OIG), HHS.

ACTION: Notice.

SUMMARY: This Federal Register notice sets forth the OIG's recently-issued Provider Self-Disclosure Protocol. This Self-Disclosure Protocol offers health care providers specific steps, including a detailed audit methodology, that may be undertaken if they wish to work openly and cooperatively with the OIG to efficiently quantify a particular problem and, ultimately, promote a higher level of ethical

and lawful conduct throughout the health care industry.

FOR FURTHER INFORMATION CONTACT: Ted Acosta, Office of Counsel to the Inspector General, (202) 619-2078.

SUPPLEMENTARY INFORMATION: The OIG has long stressed the role of the health care industry in combating health care fraud, and believes that health care providers can play a cooperative role in identifying and voluntarily disclosing program abuses. The OIG's use of voluntary self-disclosure programs, for example, is premised on a belief that health care providers must be willing to police themselves, correct underlying

Government to resolve these matters.

Based on insights gained from a pilot program undertaken as part of Operation Restore Trust, discussions with the provider community and the

growing need for an effective disclosure mechanism, the OIG has now developed a more open-ended process, or protocol, for making a disclosure and allowing a health care provider to cooperative work with the OIG. Unlike the previous voluntary disclosure pilot programs, this self-disclosure protocol gives detailed guidance to the provider on what information is appropriate to include as part of an investigative report and how to conduct an audit of the matter, while setting no limitations on the conditions under which a health care provider may disclose information to the OIG.

A reprint of the OIG's Provider Self-Disclosure Protocol follows.

Provider Self-disclosure Protocol

1. Introduction

The Office of Inspector General (OIG)

Health and Human Services (HHS) relies heavily upon the health care industry to help identify and resolve matters that adversely affect the Federal health care programs (as defined in 42 U.S.C. 1320a-7b(f)). The OIG believes that, as participants in the Federal health care programs, health care providers have an ethical and legal duty to ensure the integrity of their dealings with these programs. This duty includes an obligation to take measures, such as instituting a compliance program, to detect and prevent fraudulent, abusive and wasteful activities. It also encompasses the need to implement specific procedures and mechanisms to examine and resolve instances of non-compliance with program requirements. Whether as a result of voluntary self-assessment or in response to external forces, health care providers must be prepared to investigate such instances, assess the potential losses suffered by the Federal health care programs, and make full disclosure to the appropriate authorities. To encourage providers to make voluntary disclosures, the OIG issues this Provider Self-Disclosure Protocol (Protocol).

The concept of voluntary self-disclosure is not new to the OIG. For many years, the OIG has worked informally with providers and suppliers that came forward to cooperate with OIG to resolve billing, marketing or quality of care problems. In 1995, as part of the Demonstration Restore Trust Initiative, HHS and the

a pilot voluntary disclosure program, which embraced DIG's longstanding policy favoring voluntary self-disclosure. The demonstration program was developed in coordination with representatives of the OIG, DOJ, various United States Attorneys' Offices, the Federal Bureau of Investigation and the Health Care Financing Administration (HCFA). The pilot program was limited to five States (New York, Florida, Illinois, Texas and California) and four different types of providers (home health agencies, skilled nursing facilities, durable medical equipment suppliers, and hospice providers). It gave those qualifying entities a formal mechanism for disclosing and seeking the resolution of matters relating to the Medicare and Medicaid programs. In 1997, the pilot voluntary disclosure program was concluded. While there was limited participation in the pilot, the OIG gained valuable insight into the variables influencing the decision to make a disclosure to the Government.

The OIG believes it must continue encouraging the health care industry to conduct voluntary self-evaluations and

providing viable opportunities for self-disclosure. By establishing this Protocol, the DIG renews its commitment to promote an environment of openness and cooperation. The Protocol has no rigid requirements or limitations. Rather, it provides the DIG's views on what are the appropriate elements of an effective investigative and audit working plan to address instances of non-compliance. Providers that follow the Protocol expedite the DIG's verification process and thus diminish the time it takes before the matter can be formally resolved. Failure to conform to each element of the Protocol is not necessarily fatal to the provider's disclosure, but will likely delay the resolution of the matter.

The DIG's principal purpose in producing the Protocol is to provide guidance to health care providers that decide voluntarily to disclose irregularities in their dealings with the Federal health care programs. Because a provider's disclosure can involve anything from a simple error to outright fraud, the DIG cannot reasonably make firm commitments as to how a particular disclosure will be resolved or the specific benefit that will ensue to the disclosing entity. In our experience, however, opening lines of communication with, and making full disclosure to, the investigative agency at an early stage generally benefits the individual or company. In short, the Protocol can help a health care provider initiate with the OIG a dialogue directed at resolving its potential liabilities.

The decision to follow the DIG's suggested Protocol rests exclusively with the provider. While the DIG can offer only limited guidance on what is inherently a case-specific judgement, there are several considerations that should influence the decision. First, a provider that uncovers an ongoing fraud scheme within its organization immediately should contact the OIG, but should not follow the Protocol's suggested steps to investigate or quantify the scope of the problem. If the provider follows the Protocol in this type of situation without prior consultation with the OIG, there is a substantial risk that the Government's subsequent investigation will be compromised.

Second, the OIG anticipates that a provider will apply the Protocol's suggested steps only after an initial assessment substantiates there is a problem with non-compliance with program requirements. The initial identification of potential risk areas should be less intensive and need not conform to the Protocol's suggested procedures. Similarly, when the OIG

conducts a national review of a particular billing practice, providers should consider the option of conducting a limited assessment of the practice under DIG review, rather than incur the expense of a comprehensive audit. In such cases, an audit that conforms to the Protocol's guidelines may be appropriate only in instances where a preliminary assessment suggests the provider has in fact engaged in the practices under OIG scrutiny.

II. The Provider Self-Disclosure Protocol

Unlike the earlier pilot program, there are no pre-disclosure requirements, applications for admission or preliminary qualifying characteristics that must be met. The Provider Self-Disclosure Protocol is open to all health care providers, whether individuals or entities, and is not limited to any particular industry, medical specialty or type of service. While no written agreement setting out the terms of the self-assessment will be required, the DIG expects the commitment of the health care provider to disclose specific information and engage in specific self-evaluative steps relating to the disclosed matter. In contrast to the pilot disclosure program, the fact that a disclosing health care provider is already subject to Government inquiry (including investigations, audits or routine oversight activities) will not automatically preclude a disclosure. The disclosure, however, must be made in good faith. The OIG will not continue to work with a provider that attempts to circumvent an ongoing inquiry or fails to fully cooperate in the self-disclosure process. In short, the OIG will continue its practice of working with providers that are the subject of an investigation or audit, provided that the collaboration does not interfere with the efficient and effective resolution of the inquiry.

The Provider Self-Disclosure Protocol is intended to facilitate the resolution of only matters that, in the provider's reasonable assessment, are potentially violative of Federal criminal, civil or administrative laws. Matters exclusively involving overpayments or errors that do not suggest that violations of law have occurred should be brought directly to the attention of the entity (e.g., a contractor such as a carrier or an intermediary) that processes claims and issues payment on behalf of the Government agency responsible for the particular Federal health care program (e.g., HCFA for matters involving Medicare). The program contractors are responsible for processing the refund and will review the circumstances surrounding the initial overpayment. If

the contractor concludes that the overpayment raises concerns about the integrity of the provider, the matter may be referred to the OIG. Accordingly, the provider's initial decision of where to refer a matter involving non-compliance with program requirements should be made carefully.

The OIG is not bound by any findings made by the disclosing provider under the Provider Self-Disclosure Protocol and is not obligated to resolve the matter in any particular manner. Nevertheless, the OIG will work closely with providers that structure their disclosures in accordance with the Provider Self-Disclosure Protocol in an effort to coordinate any investigatory steps or other activities necessary to reach an effective and prompt resolution. It is important to note that, upon review of the provider's disclosure submission and/or reports, the OIG may conclude that the disclosed matter warrants a referral to DOJ for consideration under its civil and/or criminal authorities. Alternatively, the provider may request the participation of a representative of DOJ or a local United States Attorney's Office in settlement discussions in order to resolve potential liability under the False Claims Act or other laws. In either case, the OIG will report on the provider's involvement and level of cooperation throughout the disclosure process to any other Government agencies affected by the disclosed matter.

III. Voluntary Disclosure Submission

The disclosing provider will be expected to make a submission as follows.

A. Effective Disclosure

The disclosure must be made in writing and must be submitted to the Assistant Inspector General for Investigative Operations, Office of Inspector General, Department of Health and Human Services, 330 Independence Avenue, SW, Cohen Building, Room 5409, Washington, DC 20201. Submissions by telecopier, facsimile or other electronic media will not be accepted.

B. Basic Information

The submission should include the following-

1. The name, address, provider identification number(s) and tax identification number(s) of the disclosing health care provider. If the provider is an entity that is owned, controlled or is otherwise part of a system or network, include a description or diagram describing the

pertinent relationships and the names and addresses of any related entities, as well as any affected corporate divisions, departments or branches. Additionally, provide the name and address of the disclosing entity's designated representative for purposes of the voluntary disclosure.

2. Indicate whether the provider has knowledge that the matter is under current inquiry by a Government agency or contractor. If the provider has knowledge of a pending inquiry, identify any such Government entity or individual representatives involved. The provider must also disclose whether it is under investigation or other inquiry for any other matters relating to a Federal health care program and provide similar information relating to those other matters.

3. A full description of the nature of the matter being disclosed, including the type of claim, transaction or other conduct giving rise to the matter, the names of entities and individuals believed to be implicated and an explanation of their roles in the matter, and the relevant periods involved.

4. The type of health care provider implicated and any provider billing numbers associated with the matter disclosed. Include the Federal health care programs affected, including Government contractors such as carriers, intermediaries and other third-party payers.

5. The reasons why the disclosing provider believes that a violation of Federal criminal, civil or administrative law may have occurred.

6. A certification by the health care provider or, in the case of an entity, an authorized representative on behalf of the disclosing entity stating that, to the best of the individual's knowledge, the submission contains truthful information and is based on a good faith effort to bring the matter to the Government's attention for the purpose of resolving any potential liabilities to the Government.

C. Substantive Information

As part of its participation in the disclosure process, the disclosing health care provider will be expected to conduct an internal investigation and a self-assessment, and then report its findings to the DIG. The internal review may occur after the initial disclosure of the matter. The DIG will generally agree, for a reasonable period of time, to forego an investigation of the matter if the provider agrees that it will conduct the review in accordance with the Internal Investigation Guidelines and the Self-Assessment Guidelines set forth below.

IV. Internal Investigation Guidelines

All disclosures to the OIG under the Provider Self-Disclosure Protocol should include a report based on an internal investigation conducted by the health care provider. While a provider is free to discuss its preliminary findings with the DIG prior to completion of its investigation, the matter cannot be resolved until a comprehensive assessment has been completed pursuant to the following guidelines:

A. Nature and Extent of the Improper or Illegal Practice

A voluntary disclosure report should demonstrate that a full examination of the practice has been conducted. The report should contain a written narrative that-

1. Identifies the potential causes of the incident or practice (e.g., intentional conduct, lack of internal controls, circumvention of corporate procedures or Government regulations);

2. Describes the incident or practice in detail, including how the incident or practice arose and continued;

3. Identifies the division, departments, branches or related entities involved and/or affected;

4. Identifies the impact on, and risks to, health, safety, or quality of care posed by the matter disclosed, with sufficient information to allow the DIG to assess the immediacy of the impact and risks, the steps that should be taken to address them, as well as the measures taken by the disclosing entity;

5. Delineates the period during which the incident or practice occurred;

6. Identifies the corporate officials, employees or agents who knew of, encouraged, or participated in, the incident or practice and any individuals who may have been involved in detecting the matter;

7. Identifies the corporate officials, employees or agents who should have known of, but failed to detect, the incident or practice based on their job responsibilities; and

8. Estimates the monetary impact of the incident or practice upon the Federal health care programs, pursuant to the Self-Assessment Guidelines below.

B. Discovery and Response to the Matter

The internal investigation report should relate the circumstances under which the disclosed matter was discovered and fully document the measures taken upon discovery to address the problem and prevent future abuses. In this regard, the report should-

1. Describe how the incident or practice was identified, and the origin of the information that led to its discovery.

2. Describe the entity's efforts to investigate and document the incident or practice (e.g., use of internal or external legal, audit or consultative resources).

3. Describe in detail the chronology of the investigative steps taken in connection with the entity's internal inquiry into the disclosed matter including the following-

(a) A list of all individuals interviewed, including each individual's business address and telephone number, and their positions and titles in the relevant entities during both the relevant period and at the time the disclosure is being made. For all individuals interviewed, provide the dates of those interviews and the subject matter of each interview, as well as summaries of the interview. The health care provider will be responsible for advising the individual to be interviewed that the information the individual provides may, in turn, be provided to the OIG. Additionally, include a list of those individuals who refused to be interviewed and provide the reasons cited;

(b) A description of files, documents, and records reviewed *with* sufficient particularity to allow their retrieval, if necessary; and

(c) A summary of auditing activity undertaken and a summary of the documents relied upon in support of the estimation of losses. These documents and information must accompany the report, unless the calculation of losses is undertaken pursuant to the Self-Assessment Guidelines, which contain specific reporting requirements.

4. Describe the actions by the health care provider to stop the inappropriate conduct.

5. Describe any related health care businesses affected by the inappropriate conduct in which the health care provider is involved, all efforts by the health care provider to prevent a recurrence of the incident or practice in the affected division as well as in any related health care entities (e.g., new accounting or internal control procedures, increased internal audit efforts, increased supervision by higher management or through training).

6. Describe any disciplinary action taken against corporate officials, employees and agents as a result of the disclosed matter.

7. Describe appropriate notices, if applicable, provided to other Government agencies, (e.g. Securities and Exchange Commission and Internal

Revenue Service) in connection with the disclosed matter.

C. The internal investigation report must include a certification by the health care provider, or in the case of an entity an authorized representative on behalf of the disclosing health care provider, indicating that, to the best of the individual's knowledge, the internal investigation report contains truthful information and is based on a good faith effort to assist the OIG in its inquiry and verification of the disclosed matter.

V. Self-Assessment Guidelines

To estimate the monetary impact of the disclosed matter, the health care provider also should conduct an internal financial assessment and prepare a report of its findings. This self-assessment may be performed at the same time as the internal investigation, or commenced after the scope of the non-compliance with program requirements has been established. In either case, the OIG will verify a provider's calculation of Federal health care program losses and it is strongly recommended that, at a minimum, the review conform to the following guidelines.

A. Approach

The review should consist of either-(1) all of the claims affected by the disclosed matter for the relevant period; or (2) a statistically valid sample of the claims that can be projected to the population of claims affected by the matter for the relevant period. This determination should be based on the size of the population believed to be implicated, the variance of characteristics to be reviewed, the cost of the self-assessment, the available resources, the estimated duration of the review, and other factors as appropriate.

B. Basic Information

Regardless of which of these two approaches is used, the disclosing provider should submit to the OIG a work plan describing the self-assessment process. The OIG will review the proposal and, where appropriate, provide comments on the plan in a timely manner. At its option, the OIG may choose to carry out any necessary activities at any stage of the review to verify that the process is undertaken correctly and to validate the review findings. While the OIG is not obligated to accept the results of a provider's self-assessment, findings upon procedures which conform to the Protocol will be given substantial weight in determining any program overpayments. In addition, the OIG will use the validated provider self-assessment report in preparing a

recommendation to DOJ for resolution of the provider's False Claims Act or other liability. Among the issues that should be addressed in the plan are the following-

1. *Review Objective*-There should be a statement clearly articulating the objective of the review and the review procedure or combination of procedures applied to achieve the objective.

2. *Review Population*-The plan should identify the population, which is the group about which information is needed. In addition, there should be an explanation of the methodology used to develop the population and the basis for this determination.

3. *Sources of Data*-The plan should provide a full description of the source of the information upon which the review will be based, including the legal or other standards to be applied, the sources of payment data and the documents that will be relied upon (e.g., employment contracts, rental agreements, etc.).

4. *Personnel Qualifications*-The plan should identify the names and titles of those individuals involved in any aspect of the self-assessment, including statisticians, accountants, auditors, consultants and medical reviewers, and describe their qualifications.

C. Sample Elements

If the provider, in consultation with the OIG, determines that the financial review will be based upon a sample, the work plan should also include the sampling plan as follows-

1. *Sampling Unit*-The plan should define the sampling unit, which is any of the designated elements that comprise the population of interest.

2. *Sampling Frame*-The plan should identify the sampling frame, which is the totality of the sampling units from which the sample will be selected. In addition, the plan should document how the audit population differs from the sampling frame and what effect this difference has on conclusions reached as a result of the audit.

3. *Sample Size*-The size of the sample must be determined through the use of a probe sample. Accordingly, the plan should include a description of both the probe sample and the full sample. At a minimum, the full sample must be designed to generate an estimate with a ninety (90) percent level of confidence and a precision of twenty-five (25) percent. The probe sample must contain at least thirty (30) sample units and cannot be used as part of the full sample.

4. *Random Numbers*-Both the probe sample and the sample must be selected through random numbers. The source of

the _rg.ndom-R-uml:>eFS-used-must-J.:J sliOwn in the sampling plans. The OIG strongly recommends the use of its Office of Audit Services' Statistical Sampling Software, also known as "RAT-STATS," which is currently available free of charge through the "internet" at "www.hhs.gov/progo oas/ratstat.html".

5. *Sample Design*--Unless the disclosing provider demonstrates the need to use a different sample design, the self-assessment should use simple random sampling. If necessitated, the provider may use stratified or multistage sampling. Details about the strata, stages and clusters should be included in the description of the audit plan.

6. *Estimate of Review Time per Sample-Item*--The plan should estimate the time expended to locate the sample items and the staff hours expended to review a sample item.

7. *Characteristics Measure by the Sample*--The sampling plan should identify the characteristics used for testing each sample item. For example, in a sample drawn to estimate the value of overpayments due to duplicate payments, the characteristics under consideration are the conditions that must exist for a sample item to be a duplicate. The amount of the duplicate payment is the measurement of the overpayment. The sampling plan must also contain the decision rules for determining whether a sample item entirely meets the criterion for having characteristics or only partially meets the criterion.

8. *Missing Sample Items*--The sampling plan must include a discussion of how missing sample items were handled and the rationale.

9. *Other Evidence*--Although sample results should stand on their own in terms of validity, sample results may be combined with other evidence in arriving at specific conclusions. If appropriate, indicate what other substantiating or corroborating evidence was developed.

10. *Estimation Methodology*--Because the general purpose of the review is to estimate the monetary losses to the Federal health care programs, the methodology to be used must be variables sampling using the difference estimator. To estimate the amount implicated in the disclosed matter, the provider must use the mean point estimate. The statistical estimates must be reported using a ninety (90) percent confidence level. The use of RAT-STATS to calculate the estimates is strongly recommended.

11. *Reporting Results*--The sampling plan should indicate how the results will be reported at the conclusion of the review. In preparing the report, enough details must be provided to clearly indicate what estimates are reported.

D. Certification

Upon completion of the self-assessment, the disclosing health care provider, or in the case of an entity its authorized representative, must submit to the OIG a certification stating that, to the best of the individual's knowledge, the report contains truthful information and is based on a good faith effort to assist OIG in its inquiry and verification of the disclosed matter.

VI. OIG's Verification

Upon receipt of a health care provider's disclosure submission, the OIG will begin its verification of the disclosure information. The extent of the OIG's verification effort will depend, in large part, upon the quality and thoroughness of the internal investigative and self-assessment reports. Matters uncovered during the verification process, which are outside of the scope of the matter disclosed to the OIG, may be treated as new matters outside the Provider Self-Disclosure Protocol.

To facilitate the OIG's verification and validation processes, the OIG must have access to all audit work papers and supporting documents without the assertion of privileges or limitations on the information produced. In the normal course of verification, the OIG will not request production of written communications subject to the attorney-client privilege. There may be documents or other materials, however, that may be covered by the work product doctrine, but which the OIG believes are critical to resolving the disclosure. The OIG is prepared to discuss with provider's counsel ways to gain access to the underlying information without the need to waive the protections provided by an appropriately asserted claim of privilege;")

VII. Payments

information provide by a disclosing health provider. The need to verify the OIG will not accept payments of presurried overpayments determined by the health care provider prior to the completion of the OIG's inquiry. However, the provider is encouraged to place the overpayment amount in an interest-bearing escrow account to minimize further losses. While

the matter is under OIG inquiry, the disclosing provider must refrain from making payment relating to the disclosed matter to the Federal health care programs or their contractors

without the OIG's prior consent. If the OIG consents, the disclosing provider will be required to agree in writing that the acceptance of the payment does not constitute the Government's agreement as to the amount of losses suffered by the programs as a result of the disclosed matter, and does not affect in any manner the Government's ability to pursue criminal, civil or administrative remedies or to obtain additional fines, damages or penalties for the matters disclosed.

VIII. Cooperation and Removal from the Provider Self-Disclosure Protocol

The disclosing entity's diligent and good faith cooperation throughout the entire process is essential. Accordingly, the OIG expects to receive documents and information from the entity that relate to the disclosed matter without the need to resort to compulsory methods. If a provider fails to work in good faith with the OIG to resolve the disclosed matter, that lack of cooperation will be considered an aggravating factor when the OIG assesses the appropriate resolution of the matter. Similarly, the intentional submission of false or otherwise untruthful information, as well as the intentional omission of relevant information, will be referred to DOJ or other Federal agencies and could, in itself, result in criminal and/or civil sanctions, as well as exclusion from participation in the Federal health care programs.

Dated: October 21, 1998. June Gibbs Brown, *Inspector General*.

[FR Doc. 98-29064 Filed 10-29-98; 8:45am]

BILLING CODE 4150-(14-P)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute: Opportunities for Cooperative Research and Development Agreements (CRADAs) for the Joint Evaluation and Development of Methods to Generate and Expand In- Vitro Modified Dendritic Cell Populations in Order to Elicit Phenotype Specific Immune Responses

The NCI is looking for CRADA Collaborators to jointly develop this dendritic cell immunology technology.
AGENCY: National Cancer Institute, National Institutes of Health, PHS, DHHS.

State: Colorado

Director: Joanne Lindsay joanne.lindsay@state.co.gov

Assistant:

Information/Link/Attachment:

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1229571081495&ssbinary=true>

Auditing contractors

The State has contracted with two new vendors who will help support the proper use of Medicaid funds for the best, cost effective care to qualified low-income Coloradoans. The auditors' post payment auditing will help the State determine billing trends and practices, overpayment of funds, and fraud or abuse of the Medicaid program. The audits should improve current recovery efforts and help identify the need for:

- Additional educational support to providers and
- Possible Medicaid rule clarifications.

The audits are scheduled to begin after July 1, 2002. The contracted auditors will notify providers when audits are scheduled, are underway, or when post-payment reviews are completed. Audits may be desk audits, onsite audits or any combination of the two. The objectives are to:

- Audit credit balances for recovery of overpayments and return those funds to the Colorado Medicaid program,
- Support providers regarding Medicaid rules application,
- Identify billing practices that result in overpayment, and
- Identify and report trends in payment, billing and provider services, focusing on fraud or abuse of the Medicaid program.

During the audit, providers will be able to reach the contracted auditors by a toll free telephone number. Providers may discuss the audit process, any issues that appear, and any questions. In addition, the State contract managers will be available to assist providers:

Pam Kurth BSN, RN
HCPF Quality Improvement Section
Program Integrity Unit
303-866-2649

Nancy Pickett BSN, RN
HCPF Quality Improvement Section
Program Integrity Unit
303-866-2816

Margaret Mohan, BSN, RN HCPF Quality
Improvement Section Program Integrity Unit
Supervisor
303-866-5421

The State of Colorado Department of Health Care Policy and Financing (HCPF) is responsible for purchasing cost effective health care for qualified, low-income Coloradoans. Providers, clients, advocacy groups, vendors, counties, other local government units, taxpayers, the Governor's Office and General Assembly are important to our success.

New program to provide guidelines for compliance reviews

Colorado Medicaid is starting a pilot program to assist providers with Medicaid compliance. The program has three parts:

1. Provider Self-Disclosure,

2. Provider Self-Audit, and
3. Corrective

Action Plans. The program is a guide for providers to:

- Do their own reviews of record-keeping, claims submission procedures, and other compliance issues, and
- Complete a plan to correct identified problems.

The State may consider reductions in penalties or interest owed for providers who successfully participate in the pilot program.

Self-disclosure

Providers may be eligible for *self-disclosure* when they identify compliance errors during their own review. When providers find compliance errors, they should contact the Department of Health Care Policy and Financing (HCPF) - Program Integrity for instructions on *self-disclosure*.

Self-audit

If possible compliance errors are discovered through a State review, the provider may be asked to conduct a *self-audit*. The State will identify areas for review and send instructions on how to proceed with the *self-audit*.

Corrective action plan

The State may ask the provider to follow the self-disclosure or self-audit process with a *corrective action plan*. The

corrective action plan is the provider's response, with solutions, to the compliance issues identified by the State.

All self-disclosures, self-audits, and corrective action plans are subject to approval by the State. For more information, please contact:

Carol Strini
DHCPF Quality Improvement - Program
Integrity Unit at:
303-866-3148 or 1-
800-221-3943.

Please direct questions about Medicaid billing or the information in this
bulletin to
Medicaid Provider
Services at:
**303-534-0146 or
1-800-237-0757 (toll free Colorado).**

State: Connecticut

Director: John McCormick john.mccormick@ct.gov

Assistant:

Information/Link/Attachment: Link: <http://www.ct.gov/dss/lib/dss/pdfs/selfdisclosureform.pdf>

<http://www.ct.gov/dss/lib/dss/pdfs/selfdisclosureguidancemanual.pdf>

Introduction

The Mission of the Office of Quality Assurance (OQA) is to maximize the resources available to families and individuals that need assistance by assuring quality, accuracy, efficiency and effectiveness in the delivery of DSS programs. This mission is accomplished by ensuring that: adequate internal controls are in place and functioning; fraud is deterred and pursued; and overpayments to providers and clients are reduced or recouped; and unnecessary costs are avoided.

We are committed to detecting potential fraud, waste and abuse within the state's Medicaid program and recovering inappropriate payments. As part of our multi-disciplinary approach to attaining these goals, we are making a concerted effort to recognize providers who find problems within their own organizations, reveal (self-disclose) those issues to the OQA, and refund inappropriate payments.

The OQA recognizes that many improper payments are discovered during the course of a provider's internal review processes. While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments we appreciate that it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both the State of Connecticut and the provider involved. OQA has developed this approach to encourage and offer incentives for providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds—whether intentional or unintentional—under the state's Medicaid program. By forming a partnership with providers through this self-disclosure approach, OQA's overall efforts to eliminate fraud, waste and abuse will be enhanced, while simultaneously offering providers a mechanism or method to reduce their legal and financial exposure.

This guidance establishes the process for participating in the OQA's Self-Disclosure Program.

The intended use of this guidance is significantly more expansive in scope than the protocol of the federal Department of Health and Human Services (DHHS) Office of the Inspector General's (OIG), which focuses on potential violations of criminal, civil or administrative law. The OQA recognizes that situations which are subject to this guidance could vary significantly; therefore, this protocol is written in general terms to allow providers the flexibility to address the unique aspects of the matters disclosed.

Advantages of Self-Disclosure

Self-disclosing overpayments, in most circumstances, will result in a better outcome than if OQA staff had discovered the matter independently. While the specific resolution of self-disclosures depends upon the individual merits of each case, the OQA typically extends the following benefits to providers who, in good-faith, participate in a self-disclosure:

- Forgiveness or reduction of interest payments (for up to two years)
- Extended repayment terms
- Waiver of penalties and/or sanctions

- Timely resolution of the overpayment
- Recognition of the effectiveness of the provider's compliance and a decrease in the likelihood of imposition of an OQA Corporate Integrity Program
- Possible preclusion of subsequently filed Connecticut State False Claims Act qui tam actions based on the disclosed matters

Developing such a partnership with the OQA during the self-disclosure process may also lead to more thorough understanding of the OQA's audit and investigatory processes, which could benefit the provider in the future.

When to Disclose

Once an inappropriate payment is discovered that warrants self-disclosure, providers are encouraged to contact OQA as early in the process as possible to maximize the potential benefits of self-disclosure.¹ However, because of the wide variance in the nature, amount and frequency of overpayments that may occur over a wide spectrum of provider types, it is difficult to present a comprehensive set of criteria by which to judge whether disclosure is appropriate. Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes.² Each incident must be considered on an individual basis. Factors to consider include the exact issue, the amount involved, any patterns or trends that the problem may demonstrate within the provider's system, the period of non-compliance, the circumstances that led to the non-compliance problem, the organization's history, and whether or not the organization has a corporate integrity agreement (CIA) in place.

Issues appropriate for disclosure may include, but are not limited to:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of fraud and abuse laws³

¹ Matters related to an on-going audit/investigation of the provider are not generally eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an on-going audit may be eligible for processing under the self-disclosure protocol assuming the matter has received timely attention. If OQA is already auditing or investigating the provider, and the provider wishes to disclose an issue, in addition to submitting a disclosure under this protocol, the provider should bring the matter to the attention of the on-site audit staff. If another outside agency is auditing or investigating the provider, and the provider seeks to disclose an issue to OQA, the provider should follow this guidance accordingly.

² Because of the complexity of some issues surrounding self-disclosures, providers may want to consider obtaining the advice of experienced healthcare legal counsel or consultants

³ Upon review of the provider's disclosure and related information, the OQA may conclude that the disclosed matter warrants referral to the CT Attorney General's Medicaid Fraud Control Unit (MFCU). Alternatively, the provider may request the participation of a representative of the MFCU, DHHS OIG, the Department of Justice or a local United States Attorney's Office in settlement discussions in order to resolve potential liability under the False Claims Act or other laws.

OQA is not interested in fundamentally altering the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims. Providers should be aware that the OQA monitors both the number of occurrences and dollar amounts of voids and/or adjustments, as well as any patterns of voids and/or adjustments. The OQA highly discourages providers from attempting to avoid the self-disclosure process when circumstances in fact warrant its use.

The Process

Once a provider makes the determination to disclose a problem, the following steps comprise an **initial** report:

- At a minimum, gather the following information:
 - The basis for the initial disclosure, including how it was discovered, the approximate time period covered, and an assessment of the potential financial impact;
 - The Medicaid program rules potentially implicated;
 - Any corrective action taken to address the problem leading to the disclosure, the date the correction occurred and the process for monitoring the issue to prevent reoccurrence; and
 - The name and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or counsel but should, in any event, be in an appropriate position to speak for the organization.
- Contact the OQA with the above information by telephone or via formal letter to:

**State of Connecticut
Department of Social Services
Office of Quality Assurance
Attn: John McCormick
25 Sigourney Street
Hartford, CT 06106
860-424-5920**

Providers may also use the printable version of OQA's self-disclosure form, which is available at <http://www.ct.gov/dss/lib/dss/pdfs/selfdisclosureform.pdf>

After this initial reporting phase, the OQA will consult with the provider and determine the most appropriate process for proceeding. OQA staff will discuss the next steps, which may include requesting additional information. Ultimately, the provider should be prepared to present the following:

- A summary of the identified underlying cause of the issue(s) involved and any corrective action taken;

- Detailed list of claims paid that comprise the overpayments (in an electronic medium and preferably in an Excel spreadsheet format). Each claim should list the provider Medicaid ID number, client name and Medicaid ID, dates of service(s), rates or procedure codes, and the amount(s) paid by Medicaid; and
- The names of individuals involved in any suspected improper or illegal conduct.

Assuming complete provider cooperation and timely response to information requests, the OQA expects that the vast majority of self-disclosures will be completed within six months of submission of this information.

The OQA will consider the provider's involvement and level of cooperation throughout the disclosure process in determining the most appropriate resolution and the best mechanism to achieve that resolution. In the event that the provider and the OQA cannot reach agreement on the amount of overpayments identified, or if a provider fails to cooperate in good faith with the OQA to resolve the disclosure, the OQA may pursue the matter through established audit or investigation processes, and any less stringent repayment and/or sanction terms may no longer apply.⁴

Access to Information

Providers are expected to promptly comply with OQA requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The OQA also expects the provider to execute and provide business record affidavits whenever requested, in an acceptable form. The OQA is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or work-product protection. Discussions with the provider's counsel will explore ways to gain access to factual or other non-protected information pertinent to the case in the event that documents or other material contain thought processes or advice from the provider's legal counsel, without the need to waive the protection provided by an appropriately asserted claim of attorney-client privilege or attorney work product.⁵

Restitution

All provider self-disclosures are subject to a thorough OQA review to determine whether the amount identified is accurate. While repayment is encouraged/accepted as early in the process as possible, and any repayment will be credited toward the final settlement amount, the OQA will not accept money as full and final payment for self-disclosures prior to finalizing the audit/investigatory process.

⁴ Assuming the provider acts in good-faith, the mere fact that the provider and OQA are unable to agree on an amount and resolve the disclosure will not automatically preclude favorable repayment terms, particularly related to the portion of the matter to which the provider and OQA are able to agree.

⁵ The OQA will assess a provider's culpability and good-faith efforts in reaching the disposition of a self-disclosure. Cooperation will be measured by the extent to which a provider discloses relevant facts and evidence, not its waiver of the attorney-client privilege or work product protection. A lack of information may make it difficult for OQA to determine the nature and extent of the conduct which caused the improper payment.

Following the review, OQA staff will consult with the provider's respective state oversight agency to establish a repayment amount and schedule and explore the need to pursue any further administrative action. OQA's determination will be based on several factors, including the nature of the problem, the effectiveness of the provider's compliance program, the dollar amounts involved, the time period, thoroughness and timing of the provider's disclosure, any potential harm to the health and safety of Medicaid patients, and the provider's efforts to prevent the problem from recurring.

Once a repayment amount has been established, assuming full repayment has not previously been made, the OQA expects the provider to reimburse the State of Connecticut for the overpayment with a check for the full amount, made payable to the Connecticut Department of Social Services or enter into a repayment agreement. Repayments can occur through monthly payments to OQA or by having OQA withhold a portion of that provider's weekly reimbursement. The OQA will work with providers to establish repayment terms, which may include some forgiveness of interest and/or extended repayment. Providers interested in extended repayment terms will be required to submit audited financial statements, if available, and/or other documentation to assist the OQA in making that determination. Once the repayment has been finalized, the OQA will issue a letter indicating closure of the matter.

**State of Connecticut
Department of Social Services
Office of Quality Assurance**

Part 1 – Provider Self Disclosure

Date Completed	
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Type of Self-Report Issue (select one or more)	
Billing Issues	<input type="checkbox"/>
Documentation/Records Issues	<input type="checkbox"/>
Quality of Care	<input type="checkbox"/>
Cost Report Issues	<input type="checkbox"/>
Claims for Services Not Provided	
Reporting Health Insurance	
Licensing and/or Certificate of Need	
Falsification/Alteration of Records/Documents	
Employee Licensure and/or Credentialing	
Other: _____	

Provider Information					
Vendor/Facility Name					
Provider First Name		Last Name			
Provider Type		Provider Specialty			
Medicaid ID No.		License No.			
Physical Address	Street				
	City		State		Zip Code
Mailing/Alternate Add	Street				
	City		State		Zip Code
<i>Telephone numbers must include the area code</i>					
Work Telephone Number	()		Ext.		
Fax Number	()				
Cell Phone Number	()				

Contact Information						
First Name		Last Name				
Title						
Employer/Agency/Company						
Division						
Relationship to Organization	<input type="checkbox"/> Employee <input type="checkbox"/> Attorney <input type="checkbox"/> Consultant <input type="checkbox"/> Other _____					
Address	Street					
	City		State		Zip Code	
<i>Telephone numbers must include the area code</i>						
Work Telephone Number	()		Ext.			
Fax Number	()					
Cell Telephone Number	()					
E-mail Address						

Federal or State Agency Involvement						
State or Federal Agency and/or Law Enforcement Notified?	<input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> Law Enforcement					
Agency Notified						
Date Notified						
Contact/Person						
First Name		Last Name				
Title						
<i>Telephone numbers must include the area code</i>						
Work Telephone Number	()		Ext.			
Cell Telephone Number	()					

Part 2 – Other Information

Contractor/Sub Contractor Information (if applicable)						
Contractor Company Name						
Owner Name						
Company/Owner Address	Street					
	City		State		Zip Code	
<i>Telephone numbers must include the area code</i>						
Company/Owner Telephone Number	()		Ext.			

Client Information (if applicable)			
First Name *		Last Name	
Social Security Number		Date of Birth	
Medicaid Number			
Date of Service		Service Rate Code	
Amount Paid by Medicaid			

* If more than one client, attach a computer disk containing an Excel spreadsheet with the applicable data listed above.

Discovered Primary Payor Health Insurance Information (if applicable)					
Client Medicaid Number					
Insurance Company Name					
Insurance Company Address	Street				
	City		State		Zip Code
<i>Telephone numbers must include the area code</i>					
Work Telephone Number	()		Ext.		
Cell Telephone Number					
Policy Holder Name					
Policy Holder SSN					
Employer Name					
Group Number					
Insurance Eff. Date		Insurance Term. Date			

List below any family members that are on the Health Insurance Policy:	
1.	4.
2.	5.
3.	6.

You must provide written, detailed information about your self disclosure. This must include a description of the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s), the period involved, the person(s) involved, the legal and program authorities implicated, and the estimated fiscal impact. (Please refer to the OQA Self Disclosure Guidance for additional information.)

Attach the written, detailed information and any additional relevant documentation to this form and mail the completed form and attachments to the address listed in the instructions above.

I certify that, to the best of my knowledge, the information in this self-report is truthful and is based on a good faith effort to assist the OQA in its inquiry and verification of the disclosed matter.

Print Name

Signature

Date

Title

State: Delaware

Director: Linda Murphy linda.murphy@state.de.us

Information/Link/Attachments:

No information has been obtained from the state of Delaware regarding its self-disclosure protocol.

State: Florida

Director: Mike Blackburn blackbrm@ahca.myflorida.com

Assistant: Ken Yon Dana.Yon@ahca.myflorida.com

Information/Link/Attachment:

FLORIDA MEDICAID PROVIDER SELF AUDIT PROTOCOL

1. Introduction.

The purpose of this Protocol is to provide guidance to providers regarding self audits. Self audits may be performed either:

- (a) Voluntarily by a provider, unsolicited by the Agency for Health Care Administration (Agency); or
- (b) In response to a request by the Agency pursuant to an amnesty program under Section 409.913(25)(e), Florida Statutes (F.S.).

The Agency's process for validating a self audit shall be consistent regardless of the means by which the self audit was initiated. Self audits will be forwarded to the Office of Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI) for analysis, validation, and acceptance.

- a. **Voluntary self audits.** A provider has an obligation to ensure that claims submitted to the Medicaid program are proper. When a provider determines that payments made to the provider were in excess of the amount due from the Medicaid program, the provider is obligated to return the improper amounts to the state. Providers should return the improper amounts to the Agency along with supporting information that will allow OIG/MPI to validate the overpayment amount. Examples and an explanation of the necessary supporting information are set forth in this protocol.
- b. **Amnesty programs.** The Agency recognizes that by conducting a self-audit, a Medicaid provider has more control over the parameters of the audit; also, the process is generally more educational for the provider, which results in a greater likelihood of future compliance and less opportunity for future overpayments and sanctions; the expense of the audit process is generally less for the provider who conducts a self-audit as opposed to when the Agency conducts the audit and investigative costs are recovered.

Furthermore, Section 409.913, F.S., obligates the Agency to impose a sanction on providers when the Agency has discovered certain specified violations of Medicaid laws, including the laws governing the provider's profession. These sanctions are imposed in accordance with Rule 59G-9.070, F.A.C. (Administrative Sanctions of Providers, Entities and Persons). Section 409.913, F.S., however, also authorizes the Agency to institute amnesty programs, wherein Medicaid providers may repay an overpayment without sanctions being imposed.

Therefore, pursuant to Section 409.913(25)(e), F.S., the Agency may provide opportunities for providers to conduct self audits. Providers will receive notice from the Agency of a specific matter to be addressed via the self audit, along with other pertinent audit parameters (time period for review, specific claims to review, etc.) and will be afforded a specified period of time in which to conduct the self audit. Providers who avail themselves of this opportunity within the timeframe afforded by the Agency will benefit from the amnesty provisions. Providers who do not avail themselves of this opportunity will be subject to audit by the Agency, and will be

subject to sanctions that may follow as a result of violations discovered during the audit.

Additionally, self audits conducted on a voluntary basis, upon acceptance by the Agency, shall be included in an amnesty program pursuant to Section 409.913(25)(e), F.S.

2. Self Audit Submission.

In order to ensure that the Agency can validate the audit findings and properly document the overpayment as well as the provider's correction of the overpayment, the Agency needs the following information:

- a. Billing Provider information: (1) Name;
(2) Address;
(3) Provider type;
(4) Provider identification number(s); (5) Tax identification number(s);
(6) Name, address, and telephone number of the designated contact for the provider regarding the self audit.

- b. Claims information (for the claims reviewed): (1) Date of Service;
(2) Type of Service (e.g., procedure code; units of service); (3) Treating Provider;
(4) Recipient Name and ID number
(5) Internal control number (ICN);
(6) Description of the non-compliance¹;
(7) And any other information that would allow the Agency to verify the claim(s).

¹ Descriptions may include such issues as "services not rendered", "up-coding", "brand drugs for generics", "unqualified staff performing service", "incorrect dates of service", "incorrect recipient", "duplicate services", "unbundling", "services not documented", etc.

Self Audit submissions shall be directed to:

**Agency for Health Care Administration Bureau of
Medicaid Program Integrity Attention: Special Audit
Coordinator
2727 Mahan Drive, MS 6
Tallahassee, Florida 32308**

3. Agency Verification

The extent of the Agency's verification effort will depend, in large part, upon the quality and thoroughness of the internal investigative and self-audit reports. During the self-audit process, providers may have questions and concerns; the Agency will work closely with providers to answer any questions that they may have. Providers or their representatives that have questions regarding this

protocol may contact the provider self-audit coordinator, whose name and contact information is included in the letter that initiated the self-audit or was identified following the provider's notice of intent to submit a self audit.

Upon completion of the Agency's review of the self-audit, the audit will either be accepted or declined. Accepted audits will result in the issuance of a final agency action letter stating the amount of money to be repaid and providing repayment instructions.

Audits that are not accepted will be returned to the provider for corrections, with an explanation regarding why the audit could not be accepted.

Participation in a self audit does not eliminate the possibility of further review by the Agency and does not affect in any manner the Agency or other regulatory or law enforcement agencies ability to pursue criminal, civil, or administrative remedies.

Provider shall maintain copies of all self-audit information and documentation for future reference.

FLORIDA MEDICAID PROVIDER SELF AUDIT PROTOCOL

1. Introduction.

The purpose of this Protocol is to provide guidance to providers regarding self audits. Self audits may be performed either:

- (a) voluntarily by a provider, unsolicited by the Agency for Health Care Administration (Agency), or
- (c) in response to a request by the Agency pursuant to an amnesty program under Section 409.913(25)(e), Florida Statutes (F.S.).

The Agency's process for validating a self audit shall be consistent regardless of the means by which the self audit was initiated. Self audits will be forwarded to the Office of Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI) for analysis, validation, and acceptance.

- a. **Voluntary self audits.** A provider has an obligation to ensure that claims submitted to the Medicaid program are proper. When a provider determines that payments made to the provider were in excess of the amount due from the Medicaid program, the provider is obligated to return the improper amounts to the state. Providers should return the improper amounts to the Agency along with supporting information that will allow OIG/MPI to validate the overpayment amount. Examples and an explanation of the necessary supporting information are set forth in this protocol.
- b. **Amnesty programs.** The Agency recognizes that by conducting a self-audit, a Medicaid provider has more control over the parameters of the audit; also, the process is generally more educational for the provider, which results in a greater likelihood of future compliance, and less opportunity for future overpayments and sanctions; the expense of the audit process is generally less for the provider who conducts a self-audit, as opposed to when the Agency conducts the audit and investigative costs are recovered.

Furthermore, Section 409.913, F.S., obligates the Agency to impose a sanction on providers when the Agency has discovered certain specified violations of Medicaid laws, including the laws governing the provider's profession. These sanctions are imposed in accordance with Rule 59G-9.070, F.A. C. (Administrative Sanctions of Providers, Entities and Persons). Section 409.913, F.S., however, also authorizes the Agency to institute amnesty programs, wherein Medicaid providers may repay an overpayment without sanctions being imposed.

Therefore, pursuant to Section 409.913(25)(e), F.S., the Agency may provide opportunities for providers to conduct self audits. Providers will receive notice from the Agency of a specific matter to be addressed via the self audit, along with

other pertinent audit parameters (time period for review, specific claims to review, etc.) and will be afforded a specified period of time in which to conduct the self audit. Providers who avail themselves of this opportunity within the timeframe afforded by the Agency will benefit from the amnesty provisions. Providers who do not avail themselves of this opportunity will be subject to audit by the Agency, and will be subject to sanctions that may follow as a result of violations discovered during the audit.

2. Notice of Intent to Conduct a Self Audit.

To assist the Agency in expediting its review and verification of a self audit providers are requested to first advise the Agency of the intent to conduct a self audit. Providers who are voluntarily conducting a self audit should first contact MPI to advise the Agency of the intent to conduct a self audit; all others should follow the instructions in the notice from the Agency. Unless otherwise agreed upon, submissions to OIG/MPI should be directed to:

Agency for Health Care Administration Bureau of
Medicaid Program Integrity Attention: Special Audit
Coordinator
2727 Mahan Drive, MS 6
Tallahassee, Florida 32308

3. Self Audit Work Plan.

Following the notice of intent to conduct a self audit, a provider should submit an audit work plan for review by the Agency. An audit work plan advises the Agency regarding whether the provider intends to conduct a review of particular issues or all aspects of the provider's practice. The work plan specifies the methodology by which the provider will conduct the audit and the timeframe within which the provider expects to complete the audit. By submitting the work plan prior to conducting the audit, the provider can coordinate with the Agency to develop an acceptable methodology prior to expending the time and resources to conduct the audit.

Self audits should consist of either a 100 percent claim review (a census review) or a review utilizing sampling.

a. **Option 1 (100 Percent Claim Review, a Census Review):** A provider may identify actual inappropriate payments by performing a 100 percent review of claims.

b. **Option 2 (Sampling):** A provider may identify and project inappropriate payments pursuant to a detailed work plan submitted to the Agency for approval. The review may consist of a statistically valid random sample of the claims that can be projected to a population of claims affected by the audit findings for the relevant period. The provider may use simple random sampling, cluster sampling,

or two-stage cluster sampling, as appropriate. If the provider generates the data, it must be consistent with the criteria utilized by the Agency in conducting audits, must be presented in a fashion that is readily reviewable by the Agency and must be compatible with Agency systems. Further explanation regarding sampling can be obtained by contacting the OIG/MPI Special Audit Coordinator. *A confidence level of 95 percent must be used.* Additionally, the provider may coordinate with OIG/MPI to use OIG/MPI programs to generate the sample.

The work plan should identify:

- a. The subject of the review (e.g., audit period and claims/procedure codes under review);
- b. The population of claims or recipients that will be reviewed with an explanation of the methodology used to develop the population and the basis for this determination;
- c. The point of contact (including contact information) for questions by the Agency regarding statistics (if utilized) and clinical/medical issues.

If the review will be based upon a sample, the work plan should also include the sampling plan as follows:

- d. Sample Size: Include a description of the sample, indicating the number of recipients and number of claims in the sample, and the total amount of the payments received for all claims in the sample. The minimum sample size is as follows and should only be deviated from in consultation with OIG/MPI:
 - i. Cluster samples: 40 or greater, with at least 150 claims in the clusters.
 - ii. Two-stage cluster samples: 30 or greater, with at least 250 claims in the clusters.
 - iii. Simple random samples: at least 150 claims.
- e. Sample Design: The work plan should describe the method of sampling (simple random sample, cluster, two-stage cluster), with a brief statement indicating why that method was selected.
- f. Characteristics Measured in the Sample: Identify the characteristics to be measured for each sample item. In a sample drawn to estimate the value of overpayments due to duplicate payments, the characteristic to be measured is the overpayment resulting from a duplicate payment. Criteria must be established to form the basis for determining when an overpayment exists. If a duplicate payment exists, the amount of the duplicate payment is the amount of the overpayment. The plan must contain decision rules to be used in determining whether the sample element meets the criteria wholly, in part or not at all.

The final overpayment calculation may not use apparent underpayments to reduce or offset overpayments owed to the Agency.

4. Self Audit Submission.

In order to ensure that the Agency can validate the audit findings and properly document the overpayment as well as the provider's correction of the overpayment, the Agency needs the following information:

- a. Provider information: (1) Name;
(2) Address;
(3) Provider type;
(4) Provider identification number(s); (5) Tax identification number(s);
(6) Name, address, and telephone number of the designated contact for the provider regarding the self audit.
- b. Claim information (for the claims reviewed; either all claims in a 100 percent review or the claims in the sample):
 - (1) Date of Service;
 - (2) Type of Service (e.g., procedure code); (3) Treating

Provider;

- (4) Pay-to-provider;
- (5) Date the claim was paid;
- (6) Internal control number (ICN);
- (7) Description of the non-compliance¹;
- (8) and, any other information that would allow the Agency to verify the claim(s).

c. Audit methodology:

The provider should submit a detailed description regarding the audit methodology that was actually used. [Note: the work plan detailed the *intended* methodology; the audit submission should detail the *actual* methodology] If the review was based upon a sample, the report should also include the following:

- (1) Sample Size: (see above for further details);
- (2) Random Numbers: The sample must be selected through random numbers and include a description of how the random numbers were generated;
- (3) Sample Design: (see above for further details);

¹ Descriptions may include such issues as “services not rendered”, “up-coding”, “brand drugs for generics”, “unqualified staff performing service”, “incorrect dates of service”, “incorrect recipient”, “duplicate services”, “unbundling”, “services not documented”, etc.

- (4) Characteristics Measured in the Sample: (see above for further details);
- (5) Missing Sample Items: Where documentation for a sample item (claim) is not available, the claim can not be substituted and should be recorded as an overpayment.

d. Overpayment calculation:

The provider should submit a final overpayment amount that is due to the Agency along with a detailed explanation regarding how that amount was calculated. The final overpayment calculation may not use apparent underpayments to reduce or offset overpayments owed to the Agency. A self audit completed using sampling must include an overpayment extended to the population using generally accepted statistical methods. OIG/MPI will assist the provider in calculating the overpayment using the method of extending to the population used by OIG/MPI.

e. Certification:

Upon completion of the self-audit, the provider must submit to the Agency, a statement indicating that the report contains truthful information and is based on a good faith effort to assist the Agency in making a final overpayment determination.

5. **Agency Verification:**

The extent of the Agency’s verification effort will depend, in large part, upon the quality and thoroughness of the internal investigative and self-audit reports. During the self-audit process providers may have questions and concerns; the Agency will work closely with providers to answer any questions that they may have. Providers or their representatives that have questions regarding this protocol may contact the provider self-audit coordinator, whose name and contact information is included in the letter that initiated the self-audit or was identified following the provider’s notice of intent to submit a self audit.

Upon completion of the Agency’s review of the self-audit, the audit will either be accepted or

declined. Accepted audits will result in the issuance of a final agency action letter stating the amount of money to be repaid and providing repayment instructions.

Audits that are not accepted will be returned to the provider for corrections, with an explanation regarding why the audit could not be accepted. Audits that are declined more than once may result in the Agency conducting an independent comprehensive audit that may also result in the imposition of sanctions.

Participation in a self audit does not eliminate the possibility of further review by the Agency and does not affect in any manner the Agency or other regulatory or law enforcement agencies ability to pursue criminal, civil, or administrative remedies.

1. Introduction.

The purpose of this Protocol is to provide guidance to providers regarding self audits. Self audits may be performed either:

- (a) Voluntarily by a provider, unsolicited by the Agency for Health Care Administration (Agency); or
- (b) In response to a request by the Agency pursuant to an amnesty program under Section 409.913(25)(e), Florida Statutes (F.S.).

The Agency's process for validating a self audit shall be consistent regardless of the means by which the self audit was initiated. Self audits will be forwarded to the Office of Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI) for analysis, validation, and acceptance.

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- b. **Amnesty programs.** The Agency recognizes that by conducting a self-audit, a Medicaid provider has more control over the parameters of the audit; also, the process is generally more educational for the provider, which results in a greater likelihood of future compliance and less opportunity for future overpayments and sanctions; the expense of the audit process is generally less for the provider who conducts a self-audit as opposed to when the Agency conducts the audit and investigative costs are recovered.

Furthermore, Section 409.913, F.S., obligates the Agency to impose a sanction on providers when the Agency has discovered certain specified violations of Medicaid laws, including the laws governing the provider's profession. These sanctions are imposed in accordance with Rule 59G-9.070, F.A.C. (Administrative Sanctions of Providers, Entities and Persons). Section 409.913, F.S., however,

also authorizes the Agency to institute amnesty programs, wherein Medicaid providers may repay an overpayment without sanctions being imposed.

Therefore, pursuant to Section 409.913(25)(e), F.S., the Agency may provide opportunities for providers to conduct self audits. Providers will receive notice from the Agency of a specific matter to be addressed via the self audit, along with other pertinent audit parameters (time period for review, specific claims to review, etc.) and will be afforded a specified period of time in which

to conduct the self audit. Providers who avail themselves of this opportunity within the timeframe afforded by the Agency will benefit from the amnesty provisions. Providers who do not avail themselves of this opportunity will be subject to audit by the Agency, and will be subject to sanctions that may follow as a result of violations discovered during the audit.

Additionally, self audits conducted on a voluntary basis, upon acceptance by the Agency, shall be included in an amnesty program pursuant to Section 409.913(25)(e), F.S.

2. Self Audit Submission.

In order to ensure that the Agency can validate the audit findings and properly document the overpayment as well as the provider's correction of the overpayment, the Agency needs the following information:

- a. Billing Provider information: (1) Name;
(2) Address;
(3) Provider type;
(4) Provider identification number(s); (5) Tax identification number(s);
(6) Name, address, and telephone number of the designated contact for the provider regarding the self audit.
- b. Claims information (for the claims reviewed): (1) Date of Service;
(2) Type of Service (e.g., procedure code; units of service); (3) Treating Provider;
(4) Recipient Name and ID number
(5) Internal control number (ICN);
(6) Description of the non-compliance¹;
(7) And any other information that would allow the Agency to verify the claim(s).

Self Audit submissions shall be directed to: Agency for

**Health Care Administration
Bureau of Medicaid Program Integrity
Attention: Special Audit Coordinator
2727 Mahan Drive, MS 6
Tallahassee, Florida 32308**

3. Agency Verification

The extent of the Agency's verification effort will depend, in large part, upon the quality and thoroughness of the internal investigative and self-audit reports. During the self-audit process, providers may have questions and concerns; the Agency will work closely with providers to answer any questions that they may have. Providers or their representatives that have questions regarding this protocol may contact the provider self-audit coordinator, whose name and contact information is included in the letter that initiated the self-audit or was identified following the provider's notice of intent to submit a self audit.

Upon completion of the Agency's review of the self-audit, the audit will either be accepted or

declined. Accepted audits will result in the issuance of a final agency action letter stating the amount of money to be repaid and providing repayment instructions.

Audits that are not accepted will be returned to the provider for corrections, with an explanation regarding why the audit could not be accepted.

¹ Descriptions may include such issues as “services not rendered”, “up-coding”, “brand drugs for generics”, “unqualified staff performing service”, “incorrect dates of service”, “incorrect recipient”, “duplicate services”, “unbundling”, “services not documented”, etc.

Participation in a self audit does not eliminate the possibility of further review by the Agency and does not affect in any manner the Agency or other regulatory or law enforcement agencies ability to pursue criminal, civil, or administrative remedies.

Provider shall maintain copies of all self-audit information and documentation for future reference.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAIL No.: *

[Date]

Provider No: *
NPI No: *
License No.: * [If applicable]

[Provider Name]
[Provider Address]
[City, State Zip]

In Reply Refer to
SELF AUDIT FINAL AUDIT REPORT
C.I. No.: *

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed the review of your self audit for the Medicaid services specified below [make sure to list them below or amend the letter here to describe the services] for dates of service during the period * through *. Based upon a review of all documentation submitted, in the absence of fraud or misrepresentation, we concur that you were overpaid \$* for services that in whole, or in part, are not covered by Medicaid. [If you have received any funds you should indicate that here – We are in receipt of your check for \$ ___ as (full or partial) repayment of the amount due to the Agency.] Please note that the claims that were at issue during this review remain subject to further audit by the Agency. Furthermore, you are advised that you should continue to maintain documentation regarding these claims

in accordance with applicable provisions of law.

Please remit (additional) payment by check in the amount of \$* [If you have received any funds the amount due here should be only that amount that remains outstanding; include the word “additional” prior to “payment”]. The check must be payable to the **Florida Agency for Health Care Administration**. Questions regarding payment should be directed to Medicaid Accounts Receivable, (850) 412-3901. To ensure proper credit, be certain your provider number and the MPI file number are shown on your check.

2727 Mahan Drive, MS# 6
Tallahassee, Florida 32308



Visit AHCA online at
<http://ahca.myflorida.com>

[Provider or project name]

[Provider ID]

C.I. No.: *

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Please mail to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

Pursuant to section 409.913(27), F.S., if within 30 days following this notice you have not either repaid the alleged overpayment amount or entered into a satisfactory repayment agreement with the Agency, your Medicaid reimbursements will be withheld; they will continue to be withheld, even during the pendency of an administrative hearing, until such time as the overpayment amount is satisfied. Pursuant to section 409.913(30), F.S., the Agency shall terminate your participation in the Medicaid program if you fail to repay an overpayment or enter into a satisfactory repayment agreement with the Agency, within 35 days after the date of a final order which is no longer subject to further appeal. Pursuant to sections 409.913(15)(q) and 409.913(25)(c), F.S., a provider that does not adhere to the terms of a repayment agreement is subject to termination from the Medicaid program.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, Florida Administrative Code (F.A.C.), and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be **received by the Agency** within twenty-one (21) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.**

Questions should be directed to: <<investigator>>, <<title>>, **Agency for Health Care Administration, Office of Inspector General, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 412-4600.**

Sincerely,

<<Administrator>> AHCA
Administrator Office of
Inspector General
Medicaid Program Integrity

// Enclosure(s)

Copies furnished to:

[Provider's Attorney – as applicable with address]

Finance & Accounting
(Interoffice mail)

Health Quality Assurance
(E-mail)

[Licensing Entity, if applicable]
(E-mail) or other means as appropriate

NOTICE OF ADMINISTRATIVE HEARING AND MEDIATION RIGHTS

You have the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If you disagree with the facts stated in the foregoing Final Audit Report (hereinafter FAR), you may request a formal administrative hearing pursuant to Section 120.57(1), Florida Statutes. If you do not dispute the facts stated in the FAR, but believe there are additional reasons to grant the relief you seek, you may request an informal administrative hearing pursuant to Section 120.57(2), Florida Statutes. Additionally, pursuant to Section 120.573, Florida Statutes, mediation may be available if you have chosen a formal administrative hearing, as discussed more fully below.

The written request for an administrative hearing must conform to the requirements of either Rule 28-106.201(2) or Rule 28-106.301(2), Florida Administrative Code, and must be received by the Agency for Health Care Administration, by 5:00 p.m., no later than 21 days after you received the FAR. The address for filing the written request for an administrative hearing is:

Richard J. Shoop, Esquire
Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 3
Tallahassee, Florida 32308
Fax: (850) 412-3630

The request must be legible, on 8 ½ by 11-inch white paper, and contain:

1. Your name, address, telephone number, any Agency identifying number on the FAR, if known, and name, address, and telephone number of your representative, if any;
2. An explanation of how your substantial interests will be affected by the action described in the FAR;
3. A statement of when and how you received the FAR;
4. For a request for formal hearing, a statement of all disputed issues of material fact;
5. For a request for formal hearing, a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle you to relief;
6. For a request for formal hearing, whether you request mediation, if it is available;
7. For a request for informal hearing, what bases support an adjustment to the amount owed to the Agency;
and
8. A demand for relief.

A formal hearing will be held if there are disputed issues of material fact. Additionally, mediation may be available in conjunction with a formal hearing. Mediation is a way to use a neutral third party to assist the parties in a legal or administrative proceeding to reach a settlement of their case. If you and the Agency agree to mediation, it does not mean that you give up the right to a hearing. Rather, you and the Agency will try to settle your case first with mediation.

If you request mediation, and the Agency agrees to it, you will be contacted by the Agency to set up a time for the mediation and to enter into a mediation agreement. If a mediation agreement is not reached within 10 days following the request for mediation, the matter will proceed without mediation. The mediation must be concluded within 60 days of having entered into the agreement, unless you and the Agency agree to a different time period. The mediation agreement between you and the Agency will include provisions for selecting the mediator, the allocation of costs and fees associated with the mediation, and the confidentiality of discussions and documents involved in the mediation. Mediators

charge hourly fees that must be shared equally by you and the Agency.

If a written request for an administrative hearing is not timely received you will have waived your right to have the intended action reviewed pursuant to Chapter 120, Florida Statutes, and the action set forth in the FAR shall be conclusive and final.



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAIL RETURN RECEIPT NO. *

«Date»

Provider No: *

License No: *

«Provider Name»

«Provider Address»

«City, State Zip»

In Reply Refer to:

MPI File No: *

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI), is extending to you an opportunity to perform a self audit of your Medicaid claims for the dates of service «begin date» through «end date». According to [describe the policy or law that they are required to comply with]. A review of your claims reveals that this billing requirement [these billing requirements] may not have been followed. For compliance and other information you may refer to the [cite the appropriate handbook(s)].

If you have reason to believe the issue(s) being audited is not applicable to you please send us a written response immediately. If you choose not to perform the self audit, an audit will be performed by the Agency. If an audit is performed by the Agency, the Agency is entitled to recover investigative, legal and expert witness cost in accordance with Section 409.913(23)(a), Florida Statutes (F.S.), and the Agency will apply sanctions, which may include a fine, suspension, or termination for violations of federal and state laws, including Medicaid policy, in accordance with Sections 409.913(15), (16), and (17), F.S., and Rule 59G-9.070, Florida Administrative Code (F.A.C.).

2727 Mahan Drive, MS# 6
Tallahassee, Florida 32308



Visit AHCA online at
<http://ahca.myflorida.com>

Provider Name

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Enclosed you will find a two page summary document that describes self audits. This document is provided for informational purposes only. Additionally, OIG/MPI will assist you, upon your request, with claims sampling and the overpayment calculation.

The self audit results and documentation should be submitted to the Agency within 30 days of receipt of this letter. It should be noted the Agency may request additional information or documentation needed to complete the review of the audit findings.

Correspondence and the requested self audit documentation should be sent to the following address:

Attn: «Special Audit Coordinator OR your own name»
Agency for Health Care Administration
Medicaid Program Integrity
2727 Mahan Drive, Mail Stop #6
Tallahassee, FL 32308-5403

Any questions you may have about this matter should be directed to «insert name» at (850) 412-4600, or by fax at (850) 410-1972.

Sincerely,

<<Use AHC Administrator for CMU use or CMU Manager for Special Audit Coordinator>>
Office of Inspector General
Medicaid Program Integrity

Enclosure(s)

cc: «Self Audit Coordinator»

Provider Name

Page 3

State: Georgia

Director: Toni Prine tprine@dch.ga.gov

Assistant: Tara Burks tburks@dch.ga.gov

Information/Link/Attachment:

402.10 Self Disclosure-The Department of Community Health encourages providers to be active participants in ensuring the financial integrity of our healthcare programs. Providers are urged to self-audit in an effort to identify claims errors and overpayments. Upon identifying a claims error or overpayment, providers must alert the Department and work toward a resolution or refund.

Once a provider has identified claims that are potential overpayments, a self disclosure letter detailing the potential overpayments should be forwarded to the Program Integrity Unit within the Office of Inspector General. Any self disclosure submitted to the Department for consideration must include the following information:

1. Name and address of the affected provider
2. If the provider is an entity owned, controlled, or otherwise part of a system or network, include a description or diagram of the pertinent business/legal relationships, the names and addresses of any related entities, and affected corporate divisions, departments, or branches. The description should include the name and address of the disclosing entity's designated representative.
3. Provider Identification Number(s) and NPI number(s) associated with the claims;
4. Tax Identification number(s);
5. Payee Identification number(s);
6. Submit affected claims on the appropriate SDA Analysis Worksheet.
Use form SDA-1 for medical claims or form SDA-2 for pharmacy claims. Alternatively, claims submitted electronically may be submitted in Excel or Access and should include the same information found in the Form SDA-1 and SDA-2. Each provider must have a separate SDA Analysis Worksheet;
7. A report that includes a full description of the matter being disclosed the person who identified the overpayment and the manner in which the individual discovered it;
8. The self disclosure should include a detailed account of the provider's investigation of the overpayment. The account should include a list of all persons interviewed regarding the violation, documentation reviewed, and summarized any audit activity that was undertaken;
9. A statement disclosing whether the provider is under investigation by any government agency or contractor;
10. A statement detailing the providers' theory regarding the cause of the violation;
11. A certification that the information submitted to the Department is based upon a good faith effort to disclose a billing inaccuracy and is true and correct under penalty of perjury, and;
12. The methodology used by the provider in determining the amount of the overpayment (if overpayment amount was determined using a sampling method).

State: Illinois

Director: Bradley Hart bradley.hart@illinois.gov

Assistant: Tanya Dworkin Tayna.S.Dworkin@Illinois.gov

Information/Link/Attachment:

In Illinois, when a provider comes forth with a Self-Disclosure, the Self-Disclosure would proceed to an Assessment Committee to determine if an investigation/audit would need to follow. No formal policy or program for Self-Disclosures has been disclosed.

State: Indiana

Director: AGO- Greg Zoeller

Assistant:

Information/Link/Attachment:

http://www.in.gov/attorneygeneral/2820.htm?cof=FORID%3A10&ie=UTF-8&num=10&site=ATG&client=ATG&proxystylesheet=default_agency&proxyreload=1&getfields=State%2BAgency.IN%25252Egov%2BCategory&output=xml_no_dtd&entgr=1&q=self+disclsoure&cx=005966028202432817588%3Auawb_9tgkuu

The Indiana Medicaid Fraud Control Unit does not have formal requirements for self-disclosure, but we do look with favor on providers that self-disclose.

State: Kansas

Director: Krista Engel kengel@kdheks.gov

Assistant:

Information/Link/Attachment:

Below is a KMAP provider agreement and KS Administrative Regulations. On the KMAP application, beginning on page 26 - page 4 of 6, section #13 "Overpayment" addresses that the provider must repay within 30 days. KAR 30-5-59(8) states "refund any overpayment to the program within a period of time specified by the secretary or lose eligibility to participate."



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

HCBS APPLICATION CHECKLIST

Below is a checklist for your convenience to help ensure that all forms are completed in their entirety. **If any of the following items are not complete, do not contain original signatures, or are not dated, or if required items are not returned, your entire application will be returned.**

Sign the application in BLUE ink. This helps minimize any confusion regarding original signatures. Copies of signed forms and/or stamped signatures are not acceptable.

_____ **Kansas Medical Assistance Program (KMAP) provider application**
If a question is not applicable, mark N/A in the corresponding field.
Original signature and date are required.

_____ **Waiver listings with specialties**
Mark the specialty(ies) you wish to enroll in.
Attach required documents including license as specified.

_____ **Affiliate agreement (if required)**
Contact your area Community Developmental Disability Organization (CDDO) to obtain an affiliate agreement.

_____ **HCBS Provider Certification Statement**
Original signature and date required.

_____ **HCBS Provider Agreement Addendum**
Original signature and date required.

_____ **Disclosure of Ownership and Control Interest Statement**
Name, phone number, and address must be filled in.
All questions or boxes must be completed or checked.
Original signature and date required.

_____ **KMAP Provider Agreement**

All four boxes on the first page must be completed.
Original signature and date must be on page 6 of 6.

Note: If the effective date requested is prior to the signature date of the provider agreement, a claim showing services were rendered on or before the requested effective date must be attached.

_____ **W-9**

A copy of the W-9 is required.

_____ **Application fee, if applicable**

Refer to General Bulletin 11043 attached to this application.

Rev. 10/2011



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

Dear prospective provider:

Thank you for your interest in the Kansas Medical Assistance Program (KMAP).

The application materials listed below must be completed and returned to the fiscal agent so your enrollment can be processed. Submission of incomplete application materials will delay your enrollment.

- KMAP Application
- Specialty Listing
- The Ownership and Control Interest Disclosure Statement
- KMAP Provider Agreement
- A copy of your current license (if required)

In order to facilitate the assignment of a provider number, please complete and submit the application materials with ORIGINAL SIGNATURES. Please retain copies of your application materials for your records.

You will receive written notification upon approval or denial of your enrollment.

All claims must be received by the current fiscal agent within one year from the date of service. Claims not received in a timely manner (within one year from the date of service) will not be considered for reimbursement except for claims submitted to Medicare, claims determined to be payable by reason of appeal or court decision, or as a result of agency error.

Regulations regarding payment of services to out-of-state providers (more than 50 miles from the Kansas border) allow payment consideration for out-of-state services provided to KMAP beneficiaries if one of the following situations exist:

- An out-of-state provider may be reimbursed for covered services required on an emergency basis.
- An emergency is defined as those services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.
- In these situations, please contact the KMAP Prior Authorization department to receive authorization prior to services being rendered. Failure to contact the Prior Authorization department may result in denial of your claim.
- An out-of-state provider may be reimbursed for nonemergency services if the Prior Authorization department, on behalf of the Kansas Department of Health and Environment, Division of Health Care Finance, determines that the services are medically necessary. Failure to meet either of the above situations may result in denial of your claim.

If either situation presently exists or may exist, then please complete the enclosed application forms and be sure that all information requested is provided.

If you have questions concerning enrollment, please contact Provider Enrollment at P.O. Box 3571, Topeka, Kansas 66601 or by telephone at 785- 274-5914, between 8:00 a.m. and 4:30 p.m., Monday through Friday. If you have any questions regarding prior authorization, please call 1-800-285-4978.

Sincerely,

KMAP Provider Enrollment



November 2011

Provider Bulletin Number 11152

General Providers

Application Fee Update

Per CMS final rule 6028-F, state Medicaid programs must collect an application fee for new provider applications and all applications submitted as part of the provider revalidation. The following providers are exempt from the application fee:

- Individual providers or nonphysician practitioners
- Providers who enrolled with Medicare or another state Medicaid plan after March 25, 2011
- Providers who paid the application fee to either Medicare or another state Medicaid plan

The application fee for 2012 will be \$523.00. Payment must be made in the form of a bank-certified check or money order made out to the State of Kansas – Medicaid. This amount will go into effect for any application received on and after January 1, 2012.

Note: In order to waive the application fee, proof of enrollment or revalidation in Medicare or another state Medicaid plan is required and must be dated after March 25, 2011. For Medicare providers, a copy of your most recent Medicare explanation of benefits (EOB) is also acceptable proof of active enrollment. Proof of payment is a receipt or formal notification from Medicare or the other state Medicaid plan specifically indicating payment of the application fee.

If an application is received and deemed to require an application fee and one is not attached or payment is not in an acceptable format, the entire application will be returned to the provider requesting proper payment.

Information about the Kansas Medical Assistance Program (KMAP) as well as provider manuals and other publications is available at <https://www.kmap-state-ks.us>.

If you have any questions, please contact Customer Service at 1-800-933-6593 (in-state providers) or 785-274-5990 from 8:00 a.m. until 5:00 p.m., Monday through Friday.



Kansas Medical Assistance Program

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From the office of the Fiscal Agent

Choose One: New Enrollment Re-enrollment

Kansas Medical Assistance Program (KMAP) PROVIDER APPLICATION

This application must be completed in its entirety. Do not leave any questions blank. If a question is not applicable, indicate so with an N/A in the appropriate field. Incomplete applications will result in a delay in the processing of your application.

Section A

BUSINESS NAME OR PROVIDER NAME: _____

OR PROVIDER: _____
First Middle Last

PROVIDER'S SOCIAL SECURITY NUMBER: _____

PROVIDER'S TAX IDENTIFICATION NUMBER: _____

PROVIDER'S LICENSE/CERTIFICATION NUMBER: _____

LICENSE/CERTIFICATION EFFECTIVE AND EXPIRATION DATES: FROM _____ TO _____

PROVIDER'S NPI: _____ TAXONOMY CODE: _____
A copy of the letter or e-mail received from NPPES assigning the NPI is required.

DEA NUMBER: _____

GROUP NUMBER: _____
If a group number is not indicated, the provider will not be listed as a member of the group.

GROUP NPI: _____ GROUP TAXONOMY CODE: _____

WAS THE PREVIOUS PROVIDER ENROLLED IN THE KANSAS MEDICAL ASSISTANCE PROGRAM?

YES _____ NO _____

PREVIOUS KMAP PROVIDER NAME AND NUMBER:

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES:



Kansas Medical Assistance Program

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From the office of the Fiscal Agent

TYPE OF PRACTICE ORGANIZATION:

INDIVIDUAL PRACTICE PARTNERSHIP CORPORATION
 CHARITABLE PRIVATELY OWNED LLC
 HOSPITAL-BASED PHYSICIAN OTHER MUNICIPAL OR STATE-OWNED

PROVIDER'S PHYSICAL LOCATION (This is the practice or physical site location.)

ADDRESS _____
 CITY _____ STATE _____ COUNTY _____ ZIP CODE _____
 (nine digits)
 PHONE NUMBER _____ EXT _____ FAX NUMBER _____
 E-MAIL ADDRESS _____

PROVIDER'S MAIL TO ADDRESS (This is the address to which correspondence will be mailed.)

ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 (nine digits)
 PHONE NUMBER _____ EXT _____ NUMBER _____
 E-MAIL ADDRESS _____

PROVIDER'S PAY TO ADDRESS (This is the address to which payments will be mailed.)

PAYEE NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 (nine digits)
 PHONE NUMBER _____ EXT _____ FAX NUMBER _____
 E-MAIL ADDRESS _____

PROVIDER'S HOME OFFICE ADDRESS (This is the address of business home office.)

ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 (nine digits)
 PHONE NUMBER _____ EXT _____ FAX NUMBER _____
 E-MAIL ADDRESS _____



Kansas Medical Assistance Program

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From the office of the Fiscal Agent

SECTION B

For groups or professional associations only.

NAME OF GROUP: _____

EXISTING GROUP? YES _____ NO _____

EXISTING GROUP KMAP PROVIDER NUMBER: _____ NPI: _____
A copy of the letter or e-mail received from NPPES assigning the NPI is required.

GROUP SPECIALTY: _____ TAXONOMY CODE: _____

GROUP'S TAX IDENTIFICATION NUMBER: _____

If new group, effective date KMAP beneficiaries will be seen: _____

If a group, please list all members in the group:

<u>NAME</u>	<u>CREDENTIALS</u>	<u>KMAP PROVIDER ID</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

If additional space is needed, please use a separate sheet.

SECTION C

PROVIDER SPECIALTY/PRACTICE DATA

USING THE SPECIALTY LISTING ATTACHED, PLEASE INDICATE THE KMAP SPECIALTY BEING REQUESTED.

PRIMARY: _____ SECONDARY: _____

KANSAS SCHOOL DISTRICT (for physical location): _____



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

SECTION D

Are you a proprietor, investor, partner, superintendent, executive officer, business member, or consultant of any clinical lab, diagnostic or testing center, hospital, surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? YES: _____ NO: _____

If yes, please provide the following information:

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET.

NAME OF ORGANIZATION: _____

TAX IDENTIFICATION NUMBER: _____ TELEPHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____
(nine-digit)

TYPE OF ORGANIZATION: _____ SIZE OF ORGANIZATION: _____

PERCENT OF BUSINESS OWNED/INVESTED BY PRACTITIONERS OR HOSPITALS: _____

PERCENT OF BUSINESS OWNED/INVESTED BY APPLICANT: _____

NATURE OF BUSINESS INTEREST: _____
(for example, owner, partner, investor)

SECTION E

LABORATORY INFORMATION

The Clinical Laboratory Improvement Act (CLIA) of 1988 requires all providers at all locations performing laboratory testing, including in-office laboratories, to be registered with the CLIA program.

CLIA NUMBER: _____ EFFECTIVE DATE: _____ CANCELLATION DATE: _____



Kansas Medical Assistance Program

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Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

SECTION E

Kansas Medical Assistance Program Provider Binder

I certify, under penalty of perjury, that the information and statements on this application and on any accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the Kansas Medical Assistance Programs.

I understand that should I be enrolled as a provider of services under the Kansas Medical Assistance Programs, that it is my responsibility to notify the Kansas Medical Assistance Programs' fiscal agent of any change to the information on this application including but not limited to address, group affiliation, change of ownership, or tax identification number.
Provider Signature:

Authorized Signature: _____

By: _____

Title: _____

Date: _____

CONTACT PERSON FOR QUESTIONS PERTAINING TO THIS APPLICATION, NAME AND PHONE NUMBER:

Please mail completed application to:

**Provider Enrollment Department
P.O. Box 3571
Topeka, KS 66601-3571**

SPECIALTY LISTING – AUTISM (AU) WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

550 AUTISM SPECIALIST*(effective 01/01/2008)*

Master's degree, preferably in human services or education, and documentation of 2,000 hours of experience working with a child with autism spectrum disorder (ASD) OR a board-certified behavior analyst (BCBA) and documentation of 2,000 hours of experience working with a child with ASD; successfully pass Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid Registry, and Motor Vehicle screens. * Exception: A BCBA can request the program manager to waive 1,000 hours of the required experience if there is documentation indicating the hours of supervised experience working with a child with ASD. Does require a national provider identifier (NPI).

551 INTENSIVE INDIVIDUAL SUPPORTS-AU*(effective 01/01/2008)*

Bachelor's degree, preferably in human services or education, and documentation of 1,000 hours experience working with a child with ASD OR 60 college credit hours and documentation of 1,000 hours experience working with a child with ASD. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist. Does require an NPI.

552 RESPITE CARE-AU*(effective 01/01/2008)*

High school diploma or equivalent; 18 years of age or older; must reside outside of child's home. Respite care cannot be provided by a parent of the child. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist. Does not require an NPI.

553 PARENT SUPPORT-AU*(effective 01/01/2008)*

High school diploma or equivalent; 21 years of age or older; must have three years of direct care experience with a child with ASD or be the parent of a child three years of age or older with ASD. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must work under the direction of the autism specialist. Does require an NPI.

554 FAMILY ADJUSTMENT COUNSELING-AU*(effective 01/01/2008)*

Must hold a current license to practice as a licensed mental health professional (LMHP) by the State of Kansas Behavioral Sciences Regulatory Board. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Must maintain an ongoing collaborative relationship with the autism specialist beginning at the time of referral. Does require an NPI.

173 INTERPERSONAL COMMUNICATION THERAPY*(effective 01/01/2011)*

Must hold a current license to practice as a licensed speech/language pathologist with a certificate of clinical competence from the American Speech and Hearing Association, and have documentation of 1,000 hours experience working with a child with ASD. Must successfully pass KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens. Does require an NPI.

To meet documentation requirements, an applicant must include in his or her enrollment packet all of the items which are relevant to the identified service they are seeking to provide from the list below:

- Current license
- Certification for BCBA
- Certificate of clinical competence from the American Speech and Hearing Association
- Transcripts (if a transcript does not indicate autism specifically, must attach syllabi)
- Supervisor's statement and/or documentation on official letterhead verifying the hourly requirement
- Copy of master's degree, bachelor's degree, high school diploma or equivalent
- Resume
- Copy of records indicating KBI, APS, CPS, Nurse Aid Registry, and Motor Vehicle screens successfully passed

All documentation will be reviewed by the autism waiver program manager.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

SPECIALTY LISTING – FRAIL ELDERLY (FE) WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

410 ADULT DAY CARE

Kansas Department of Aging (KDOA) must license providers. Licensed entities for this service include freestanding adult day care facilities, nursing facilities, assisted living facilities, residential health care facilities, and home plus facilities.

441 ASSISTIVE TECHNOLOGY

Any business, agency, or company that furnishes assistive technology items or services is eligible to enroll. Companies chosen to provide adaptations to housing structures must be licensed or certified by the county or city and must perform all work according to existing building codes. If the company is not licensed or certified, a letter from the county or city must be provided stating licensure or certification is not required.

510 ATTENDANT CARE SERVICES - PROVIDER-DIRECTED LEVEL I

Service A includes: shopping, house cleaning, meal preparation, and laundry services only.

Service B includes: supervision of medication cueing and reminding, bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, and accompaniment to obtain necessary medical services.

For Service A only — Qualified providers include nonmedical resident care facilities licensed by the Kansas Department of Social and Rehabilitation Services (SRS). Entities not licensed by SRS, KDOA, or the Kansas Department of Health and Environment (KDHE) must be set up with Articles of Incorporation or Articles of Organization as a business filed with the secretary of state in the State of Kansas. If the corporation or limited liability company is in a jurisdiction outside the State of Kansas, written proof must be provided showing authorization to do business in the State of Kansas. Written proof of liability insurance or a surety bond must also be provided.

For Services A and B — Qualified providers include county health departments, boarding care homes licensed by KDOA, and the following entities licensed by KDHE: state-licensed home health agencies (HHAs) and Medicare-certified HHAs.

511 ATTENDANT CARE SERVICES - PROVIDER-DIRECTED LEVEL II

Service C includes: physical assistance or total support with bathing, grooming, dressing, toileting, transferring, walking/mobility, and eating, and accompaniment to obtain necessary medical services.

Service D includes: health maintenance activities (limitations apply).

For Services C and/or D — Qualified providers include county health departments and the following entities licensed by KDHE: state-licensed HHAs and Medicare-certified HHAs.

511 ATTENDANT CARE SERVICES - PROVIDER-DIRECTED LEVEL III *(effective 11/1/11)*

Service includes: supervision, physical assistance, or total support with shopping, house cleaning, meal preparation, laundry, bathing, grooming, dressing, toileting, transferring, walking/mobility, eating, accompaniment to obtain necessary medical services, and health maintenance activities (limitations apply).

Qualified providers include the following entities licensed by KDOA: home plus facilities, assisted living facilities, and residential health care facilities.

Continued on next page

Continued from previous page

518 COMPREHENSIVE SUPPORT - PROVIDER-DIRECTED (effective 08/1/2008)

Note: Previously Senior Companion Service from 08/01/2008 through 06/30/2009.

Qualified providers include county health departments and the following entities licensed by KDHE: state-licensed HHAs, Medicare-certified HHAs, and centers for independent living (CILs) recognized by SRS. Entities not licensed by KDHE must be set up with Articles of Incorporation or Articles of Organization as a business filed with the secretary of state in the State of Kansas. If the corporation or Limited Liability Company is in a jurisdiction outside the State of Kansas, it shall provide written proof of authorization to do business in the State of Kansas. Written proof of liability insurance or surety bond must also be provided.

530 FINANCIAL MANAGEMENT SERVICES (FMS) (effective 11/1/2011)

FMS provides administrative tasks and information and assistance tasks for those beneficiaries choosing to self-direct HCBS FE services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must also meet all of the requirements as specified in the *HCBS Financial Management Services Provider Manual*. Enrollment in FMS also requires enrollment in each of the following HCBS FE services that are allowable for self-direction:

- 511 ATTENDANT CARE – SELF-DIRECTED**
- 518 COMPREHENSIVE SUPPORT – SELF-DIRECTED**
- 513 SLEEP CYCLE SUPPORT**

531 HOME TELEHEALTH – INSTALLATION/TRAINING (effective 10/1/11)

This service can be provided by HHAs or county health departments with system equipment capable of monitoring beneficiary vital signs daily including, at a minimum, heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature. The equipment must also be capable of asking the beneficiary questions that are tailored to the beneficiary's diagnosis. The provider and equipment must have needed language options – e.g. English, Spanish, Russian, and Vietnamese.

532 HOME TELEHEALTH (effective 10/1/11)

This service can be provided by HHAs or county health departments with system equipment capable of monitoring beneficiary vital signs daily including, at a minimum, heart rate, blood pressure, mean arterial pressure, weight, oxygen saturation, and temperature. The equipment must also be capable of asking the beneficiary questions that are tailored to the beneficiary's diagnosis. The provider and equipment must have needed language options – e.g. English, Spanish, Russian, and Vietnamese. Does require a national provider identifier (NPI).

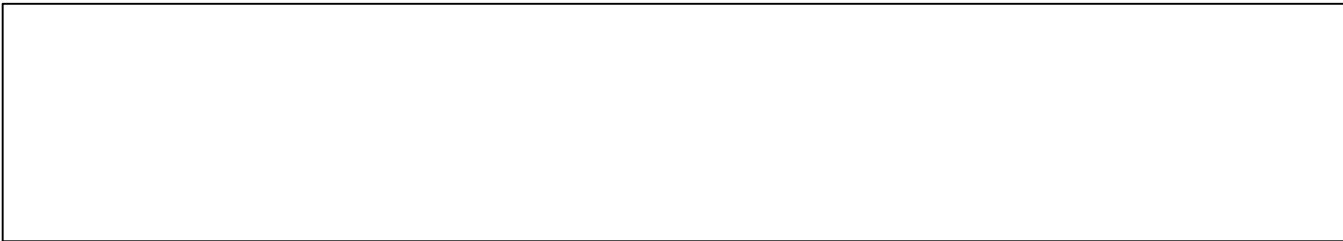
509 MEDICATION REMINDER (effective 5/16/2005)

Any company providing a medication reminder service is eligible to enroll. Adult care homes are excluded from enrolling to provide this service.

515 NURSING EVALUATION VISIT

Qualified providers include county health departments, self-employed registered nurses licensed in Kansas, the following entities licensed by KDHE: state-licensed HHAs and Medicare-certified HHAs, and the following entities licensed by KDOA: home plus facilities, assisted living facilities, and residential health care facilities. Does require a NPI.

Continued on next page



Continued from previous page

252 PERSONAL EMERGENCY RESPONSE — INSTALLATION

Any company providing personal emergency response systems is eligible to enroll.

253 PERSONAL EMERGENCY RESPONSE — RENTAL

Any company providing personal emergency response systems is eligible to enroll.

514 WELLNESS MONITORING

Qualified providers include county health departments, self-employed registered nurses licensed in Kansas, the following entities licensed by KDHE: state-licensed HHAs and Medicare-certified HHAs, and the following entities licensed by KDOA: home plus facilities, assisted living facilities, and residential health care facilities. Does require a NPI.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

Rev. 12/11

SPECIALTY LISTING – MR/DD WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

- ___ **268 MEDICAL ALERT RENTAL** Community developmental disability organization (CDDO) certificate or affiliate agreement. Does not require a national provider identifier (NPI).
- ___ **362 FAMILY/INDIVIDUAL SUPPORT** (*effective 08/01/1999 and ending 08/31/2009*) CDDO certificate or affiliate agreement. Does not require an NPI.
- ___ **364 RESIDENTIAL SUPPORT-MRDD** (*effective 07/01/1998*) For children – must be affiliated with the CDDO for area where operating and be licensed by the Kansas Department of Health and Environment (KDHE) as a child placing agency (K.A.R. 28-4-171). For adults – CDDO or affiliate agreement and be licensed by the Kansas Department of Social and Rehabilitation Services (SRS) to provide residential services. No more than eight adults in one home. Does not require an NPI.
- ___ **365 SUPPORTIVE HOME CARE-MRDD** CDDO certificate or affiliate agreement. Does not require an NPI.
- ___ **368 SLEEP CYCLE SUPPORT-MRDD** CDDO certificate or affiliate agreement. Does not require an NPI.
- ___ **369 SUPPORTED EMPLOYMENT SERVICES-MRDD** (*effective 03/15/2008*) CDDO certificate or affiliate agreement and licensed by SRS to provide this service. Does not require an NPI.
- ___ **370 PERSONAL ASSISTANT SERVICES-MRDD** (*effective 03/15/2008*) CDDO certificate or affiliate agreement. Does require an NPI.
- ___ **440 ASSISTIVE SERVICES** (*effective 03/15/2008*) CDDO or affiliate agreement. Does not require an NPI.
- ___ **512 RESPIRE CARE (Temporary)** (*ended 02/01/2010*) CDDO certificate or affiliate agreement. Does not require an NPI.
- ___ **512 RESPIRE CARE (Overnight)** For children – CDDO or affiliate agreement. Does not require an NPI.
- ___ **517 WELLNESS MONITORING** CDDO certificate or affiliate agreement along with a home health agency (HHA) license issued by KDHE or a registered nurse (RN) license issued by the Kansas State Board of Nursing. Does require an NPI.
- ___ **520 DAY SUPPORT-MRDD** (*effective 07/01/1998*) CDDO certificate or affiliate agreement and licensed by SRS to provide this service. Does not require an NPI.
- ___ **521 SPECIALIZED MEDICAL CARE – RN** (*effective 09/01/2009*) CDDO certificate or affiliate agreement. Must be licensed as an RN. Does require an NPI. If not associated with a HHA, must obtain written permission from the Mental Retardation Developmental Disabilities (MRDD) program manager.
- ___ **523 SPECIALIZED MEDICAL CARE – LPN** (*effective 09/01/2009*) CDDO certificate or affiliate agreement. Must be licensed as a licensed practical nurse (LPN). Does require an NPI. If not associated with a HHA, must obtain written permission from the MRDD program manager.
- ___ **530 FINANCIAL MANAGEMENT SERVICES (FMS)** (*effective 11/1/2011*) CDDO certificate or affiliate agreement. FMS provides administrative tasks and information and assistance tasks for those beneficiaries choosing to self-direct HCBS MRDD services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must also meet all of the requirements as specified in the *HCBS Financial Management Services Provider Manual*. Enrollment to provide FMS also requires enrollment to provide at least one of the services that can be self-directed on the HCBS MRDD waiver. Those services are Personal Assistant Services, Sleep Cycle Support, Overnight Respite, Specialized Medical Care RN, and Specialized Medical Care LPN. FMS providers will need to execute agreements with individual providers of these services.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

SPECIALTY LISTING - PHYSICAL DISABILITY (PD) WAIVER

Businesses/companies only

(Individuals may contract with any qualified provider agency or independent living counseling agency.)

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

_____ **500 ASSISTIVE SERVICES**

Contractors or companies chosen to provide adaptations to housing structures must be licensed by the county or city in which they work and all work must be performed to existing building codes. Durable medical equipment suppliers must be enrolled with Medicaid, meeting standards set in K.A.R. 30-5-108. Does not require a national provider identifier (NPI).

_____ **535 HOME-DELIVERED MEALS (HDM) (Effective 11/1/2011)**

Providers must have on staff or contract with a certified dietician to ensure compliance with Kansas Department on Aging (KDOA) nutrition requirements for programs under the Older Americans Act. Does not require a NPI.

_____ **509 MEDICATION REMINDER SERVICES (Effective 11/1/2011)**

Any provider who offers a scheduled reminder to a beneficiary indicating when the beneficiary is to take medications. The reminder may be a phone call, automated recording, automated alarm, or dispenser with an alarm, depending on the provider's system. The provider also offers installation of the medication dispenser. Does not require a NPI.

_____ **367 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**

Any company providing personal emergency response systems is eligible to enroll. Does not require a NPI.

_____ **367 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) INSTALLATION**

Any company providing personal emergency response systems with the ability to install the system is eligible to enroll. Does not require a NPI.

_____ **367 PERSONAL SERVICES (Choose Agency-Directed and/or Self-Directed) (Effective 11/1/2011)**

An adult beneficiary's spouse or a minor beneficiary's parents shall not be paid to provide this service unless granted an exception as outlined in K.A.R. 30-5-307. Does not require a NPI.

S5126 PERSONAL SERVICES – AGENCY-DIRECTED

Support staff must be at least 18 years of age and have training as recommended by the beneficiary, guardian/representative (if applicable), or medical provider. Agencies providing Personal Services must be licensed home health agencies and enrolled with the State's fiscal agent.

S5126 U6 PERSONAL SERVICES – SELF-DIRECTED

Support staff must be at least 18 years of age and have training as recommended by the beneficiary, guardian/representative (if applicable), or medical provider. Individual, nonenrolled providers of Personal Services must enter into an agreement with an enrolled provider of Financial Management Services (FMS).

_____ **367 SLEEP CYCLE SUPPORT (SCS)**

Support staff must be at least 18 years of age. Agencies providing Sleep Cycle Support must enroll with the State's fiscal agent. Individual, nonenrolled providers must enter into an agreement with an enrolled provider of FMS. Does not require a NPI.

_____ **530 FINANCIAL MANAGEMENT SERVICES (FMS) (Effective 11/1/2011)**

FMS provides administrative tasks and information & assistance tasks for those beneficiaries choosing to self-direct HCBS PD services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must meet all of the requirements as specified in the *HCBS FMS Provider Manual*. Enrollment to provide FMS also requires enrollment to provide Personal Services – Self-Directed and Sleep Cycle Support, the HCBS PD services that provide the option to self-direct. FMS providers will need to execute agreements with individual providers of these services.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

SPECIALTY LISTING – TARGETED CASE MANAGEMENT

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

Type 21

237 TARGETED CASE MANAGEMENT — FRAIL ELDERLY (FE)

A provider of Targeted Case Management (TCM) for the Frail Elderly (FE) services cannot also provide Home and Community Based (HCBS) FE waiver direct services including, but not limited to, self-direct/payroll agent services since this would create a conflict of interest. A targeted case manager employed by or under contract with a case management entity (CME) cannot also be employed by or under contract with any entity which creates a conflict of interest by providing HCBS-FE waiver services.

To meet documentation requirements, applicants must include copies of the following items in their enrollment packet:

- Current driver's license
- Resumé
- Master's degree, bachelor's degree, or high school diploma or equivalent
- Transcripts from four-year accredited college or university, if applicable
- Certificates of completion for TCM-FE on-line training and uniform assessment instrument (UAI) training
- Evidence of clear background checks from the Kansas Bureau of Investigation (KBI), Kansas Adult Protective Services (APS), and Motor Vehicle screen, each dated within 30 days of the date of application
- Licensed nurses must provide verification of no disciplinary action from the Kansas Board of Nursing
- Licensed social workers must provide verification of no disciplinary action from the Kansas Behavioral Sciences Regulatory Board
- Written proof of professional liability insurance with minimum proof coverage in an amount not less than \$200,000 per occurrence and \$600,000 annual aggregate
- Evidence of a national provider identifier (NPI)
- If applicable, current Kansas registered professional nurse license
- If applicable, verification of Articles of Incorporation or Articles of Organization as a business filed with the Kansas Secretary of State or, if the corporation or limited liability company is in a jurisdiction outside the state of Kansas, applicant shall provide written proof that it is authorized to do business in the state of Kansas
- If applicable, community mental health center license, issued in accordance with K.A.R. 30-60-1
- If Area Agency on Aging (AAA), verification from the secretary of the Kansas Department on Aging that the applicant meets the regulatory requirements for AAA designation as defined by K.A.R. 26-1-1

Targeted case managers for FE must meet the following qualifications:

Senior Case Manager

- An individual with a four-year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, or family studies, and at least one year experience in the geriatric services field; or
- A registered professional nurse licensed to practice in the state of Kansas with at least one year experience in the geriatric services field

Junior I Case Manager

- An individual with a high school or general education diploma and four years work experience in the human services field with an emphasis in aging services; or
- An individual with a combination of four years work experience in the human services field and post-secondary education, with one year of work experience substituting for one year of education

Note: A senior case manager must supervise a junior I case manager.

Junior II Case Manager

- An individual with a high school or general education diploma and one year work experience

Note: A senior case manager must supervise a junior II case manager.

Note: Individuals providing TCM services through an AAA as of April 1, 2008, are deemed as meeting education and experience requirements.

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237 TARGETED CASE MANAGEMENT — PHYSICALLY DISABLED (PD)

- Must have successfully completed the independent living counseling examination
- Must have at least six months personal experience with a disability as recognized by the Rehabilitation Act of 1973 (as amended) or have at least one year professional experience providing direct services to persons with a variety of disabilities
- Must have annual independent living philosophy training consisting of 12 hours of standardized training in history and philosophy of the National Independent Living Movement
- Must participate in all state-mandated HCBS-PD or independent living counseling training to ensure proficiency of the program, services, rules, regulations, policies, and procedures set forth by the state agency administering the program
- Must be a KMAP-enrolled provider of independent living counseling (TCM-PD)
- Does require an NPI

237 TARGETED CASE MANAGEMENT — TRAUMATIC BRAIN INJURY (TBI)

- Have at least six months experience with a disability as recognized by the Rehabilitation Act of 1973 or at least one year professional experience providing direct services, including case management, to a person or persons with a disability
- At least 12 hours of standardized training, annually, in the history and philosophy of the National Independent Living Movement
- Completion of a standard practicum to include observation of an assessment or assessments conducted by at least one qualified targeted case manager, and development of at least four assessments with monitoring and feedback provided by at least one qualified targeted case manager
- Completion of 40 hours of training regarding traumatic brain injury
- Annual demonstration of proficiency about the services, policies, rules, and procedures of the HCBS-TBI waiver program

Note: This is an agency responsibility and should be recorded in the TBI targeted case manager's personnel file.

- Does require an NPI

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

TARGETED CASE MANAGEMENT – MR/DD is located on the facility application.

SPECIALTY LISTING – TECHNOLOGY ASSISTED (TA) WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

- _____ **555 INDEPENDENT CASE MANAGEMENT-TA** *(effective 08/01/2008)*
- Advanced registered nurse practitioner (ARNP) or registered nurse (RN) with bachelor's degree and two-year clinical experience in the nursing field. Hold a current license to practice in the capacity of a nurse in the State of Kansas. Must include a copy of your license, degree, and resume. Does require a national provider identifier (NPI).
- _____ **556 SPECIALIZED MEDICAL CARE/MEDICAL RESPITE-TA** *(effective 08/01/2008)*
- Home health agency (HHA): Provider must be a RN or licensed practical nurse (LPN) trained with the medical skills necessary to care for and meet the medical needs of technology assisted (TA) beneficiaries. Must include a copy of your HHA license. Does not require a NPI. ***A home health application will need to be filled out as well.***
- _____ **557 LONG-TERM COMMUNITY CARE ATTENDANT (AGENCY-DIRECTED)-TA** *(effective 08/01/2008)*
- HHA: Medical service technician (MST), must be 18 years of age or older with a high school diploma or equivalent; must meet HHA's qualifications; must reside outside of beneficiary's home; must complete training and pass certification as regulated under K.A.Rs 28-39-165 or 28-51-100 by the State of Kansas licensing agency. Must include a copy of HHA license. Does not require a NPI. ***A home health application will need to be filled out as well.***
- _____ **558 LONG-TERM COMMUNITY CARE ATTENDANT (SELF-DIRECTED)-TA** *(effective 08/01/2008)*
- Must meet skill training delegated by parent and qualified medical provider; must reside outside of beneficiary's home. Providers must work under the direction of parent or legal guardian with the authority to direct services. Does not require a NPI.
- _____ **559 HOME MODIFICATION-TA** *(effective 08/01/2008)*
- Any individual or business licensed or certified as a contractor to provide home modifications, provide adaptation services to existing structures, or assistive technology equipment to assist TA beneficiaries with their home environments. All services provided must meet the local city, county, and state building codes. An exception of certification or licensure requirement may be granted with a letter from the city or county of beneficiary's residence declaring certification or licensure is not required. Must include copy of license or certification. Does not require a NPI.
- _____ **560 HEALTH MAINTENANCE MONITORING (TA)** *(effective 07/01/2011)*
- Local county health departments or HHAs licensed by KDHE: Provider must be a RN or LPN trained with the medical skills necessary to evaluate and monitor current and ongoing healthcare needs of TA beneficiaries. A LPN or RN performing this service under a KDHE-licensed HHA must comply with its licensing requirements. Must include a copy of your HHA license. Does require a NPI. ***A home health application will need to be filled out as well.***
- _____ **561 INTERMITTENT INTENSIVE MEDICAL CARE (TA)** *(effective 07/01/2011)*
- Local county health departments or HHAs licensed by KDHE: Provider must be a RN trained with the medical skills necessary to care for and meet the medical needs of TA beneficiaries as identified under the "Hydration/Specialty Care" elements of the MATLOC assessment. Must include a copy of your HHA license. Does require a NPI. ***A home health application will need to be filled out as well.***

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530 FINANCIAL MANAGEMENT SERVICES (FMS) *(effective 11/1/2011)*

FMS provides administrative tasks and information and assistance tasks for those beneficiaries choosing to self-direct HCBS TA services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must also meet all of the requirements as specified in the *HCBS Financial Management Services Provider Manual*. Providers of FMS must also select specialty type 558 in order to manage self-directed attendant services.

Providers of Specialized Medical Care, Medical Respite, and Long-Term Community Care Attendant (agency-directed) must be employed under a HHA and meet the licensing standards as regulated by the Kansas State Board of Nursing (KSBN) and/or the Kansas Department of Health and Environment (KDHE) as specified in K.S.A 65-5101 through K.S.A. 65-5117.

Providers of all services must provide appropriate certification and licensure, if applicable, and must maintain a clear background as documented through the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), KSBN, and Department of Motor Vehicles (DMV).

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

SPECIALTY LISTING – TRAUMATIC BRAIN INJURY (TBI) WAIVER

INDICATE THE SPECIALTIES YOU WISH TO ENROLL IN.

PLEASE BE SURE TO ENCLOSE COPIES OF THE REQUIRED LICENSURE/DOCUMENTATION AS SPECIFIED.

- ___ **503 ASSISTIVE SERVICES (Contractors or Durable Medical Equipment)**
Contractors must be licensed according to local and county codes in which they work. Durable medical equipment suppliers must be enrolled with Medicaid, meeting standards set in KAR 30-5-108.
- ___ **177 BEHAVIOR THERAPY**
Licensed by the Kansas Behavioral Sciences Regulatory Board and master's degree in a behavioral science field (such as psychology or social work) or Special Education. Forty hours of training or at least one year of experience in working with individuals who have sustained a traumatic brain injury (TBI).
- ___ **178 COGNITIVE THERAPY**
Licensed by the Kansas Behavioral Sciences Regulatory Board and master's degree in a behavioral science field (such as psychology or social work) or Special Education. Forty hours of training or at least one year of experience in working with individuals who have sustained a TBI.
- ___ **536 HOME-DELIVERED MEALS** (*Effective 11/1/2011*)
Providers of this service must have on staff or contract with a certified dietician to ensure compliance with Kansas Department on Aging (KDOA) nutrition requirements for programs under the Older Americans Act.
- ___ **509 MEDICATION REMINDER SERVICES** (*Effective 11/1/2011*)
Any company providing medication reminder services per industry standards is eligible to enroll. Services include a scheduled reminder (such as a phone call, automated recording, or automated alarm), medication dispenser with an alarm, and medication dispenser installation.
- ___ **171 OCCUPATIONAL THERAPY**
Licensed by the Kansas Board of Healing Arts. Forty hours of training or at least one year of experience and expertise in brain injury rehabilitation.
- ___ **170 PHYSICAL THERAPY**
Licensed by the Kansas Board of Healing Arts. Forty hours of training or at least one year of experience and expertise in brain injury rehabilitation.
- ___ **268 PERSONAL EMERGENCY RESPONSE SYSTEMS**
Any company providing personal emergency response systems.
- ___ **268 PERSONAL EMERGENCY RESPONSE SYSTEM INSTALLATION**
Any company providing personal emergency response systems with the ability to install the system.

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___ 363 PERSONAL SERVICES (choose Agency-Directed and/or Self-Directed)

Support staff must be at least 18 years of age and have training as recommended by the beneficiary, guardian/representative (if applicable), or medical provider. An adult beneficiary's spouse or a minor beneficiary's parents must not be paid to provide this service unless granted an exception as outlined in K.A.R. 30-5-307.

PERSONAL SERVICES – AGENCY-DIRECTED

Agencies providing Personal Services must be licensed home health agencies (HHAs) and enroll with the State's fiscal agent.

PERSONAL SERVICES – SELF-DIRECTED

Individual, nonenrolled providers of Personal Services must enter into an agreement with an enrolled provider of Financial Management Services (FMS).

___ 366 SLEEP CYCLE SUPPORT

Support staff must be at least 18 years of age. Agencies providing Sleep Cycle Support must enroll with the State's fiscal agent. Individual, nonenrolled providers must enter into an agreement with an enrolled provider of FMS.

___ 173 SPEECH/LANGUAGE THERAPY

Licensed by Kansas Department of Health and Environment (KDHE). Forty hours of training or at least one year of experience and expertise in brain injury rehabilitation.

___ 540 TRANSITIONAL LIVING SKILLS

Must be a center for independent living (CIL) or HHA. Individuals employed by the agency must have at least 28 hours of training in TBI, complete a mandatory curriculum, and score 80% or better on the corresponding test.

___ 530 FINANCIAL MANAGEMENT SERVICES (FMS) (Effective 11/1/2011)

FMS provides administrative tasks and information and assistance tasks for those beneficiaries choosing to self-direct HCBS TBI services. Qualified providers must submit a completed SRS/KDOA Provider Agreement. Providers must meet all of the requirements as specified in the *HCBS Financial Management Services Provider Manual*. Enrollment to provide FMS also requires enrollment to provide Personal Services –Self-Directed and Sleep Cycle Support, the HCBS TBI services that provide the option to self-direct. FMS providers will need to execute agreements with individual providers of these services.

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES _____

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Kansas Medical Assistance Program HCBS Provider Certification Statement (06/08)

As a KMAP HCBS provider, I agree to adhere to the standard of quality of service which is implied by my enrollment as a provider of these services.

I will be available for provision of services to eligible KMAP beneficiaries as prescribed in the individual beneficiary's plan of care.

I will agree to refuse no referrals for services, except under the following conditions:

- If the beneficiary, the beneficiary's family, or both substantially interferes with the provider's ability to deliver services, including refusing service and interfering with the completion of work
- If a possibility exists of the beneficiary physically harming the provider or where violence has been previously noted
- If the beneficiary or a member of the beneficiary's family makes sexual advances, demonstrates sexually inappropriate behavior, uses sexually inappropriate language in the presence of the provider or any combination of such actions

If services are to be terminated by the provider, written notice of termination shall be given to the beneficiary or the beneficiary's family, except in instances of death or institutionalization. The notice shall be served by delivering a copy of the notice to the beneficiary and the case manager or by mailing a copy of the notice to the beneficiary at the beneficiary's last known address. Notice shall be served at least 30 calendar days prior to the effective date of the termination, except in cases of violent or sexually inappropriate behavior. The notice shall include the reasons for and the effective date of the termination.

Signature of Provider:

Agreement to these provisions must be signed by the individual or by an officer of the business to be receiving payments for approved services.

Agreed by: _____

Date: _____

HCBS Provider Agreement Addendum – Expected Service Outcomes

Agencies providing Targeted Case Management (TCM) for Frail Elderly (FE):

1. Initial assessment of beneficiary needs shall occur within six working days of the request for services.
2. Each beneficiary obtaining services will be assigned a targeted case manager to coordinate the plan of care in a manner consistent throughout all service providers.
3. Completion of the plan of care and implementation of service provision shall occur within seven working days of the functional determination by the targeted case manager and the financial determination by SRS.
4. There shall be evidence of involvement by the beneficiary or beneficiary's representative in the development of the plan of care.
5. Ongoing evaluation and monitoring shall occur on a regular basis to assure services are being provided according to the plan of care.
6. TCM services are provided in an efficient manner.
7. Targeted case managers provide quality services to the FE beneficiaries.
8. Documentation accurately reflects beneficiary health status, service provision, choice of providers and coordination in accordance with the plan of care.
9. Documentation must adhere to state and federal rules, regulations and requirements.
10. The number of service units reimbursed per beneficiary shall not exceed 800 units per year for TCM.
11. Targeted case managers receive appropriate notification of financial KMAP eligibility from SRS and/or receive appropriate Kansas Department on Aging (KDOA) authorization of the plan of care prior to sending the notice of action.
12. At least 95 percent of beneficiaries receiving services shall report overall satisfaction with quality, access, and adequacy of services, to be identified by the state through a yearly beneficiary survey process.

Individuals or agencies, providing any HCBS service:

1. Services are provided according to the plan of care, in a quality manner, and as authorized on the notice of action.
2. Coordinate provision of services in a cost effective and quality manner.
3. Maintain beneficiary's independence and health where possible and in a safe and dignified manner.
4. Communicate beneficiary concerns, needs, changes in health status, etc., to the case manager within 48 hours including any ongoing reporting as required by KMAP.
5. Any failure or inability to provide services as scheduled in accordance with the plan of care must be reported immediately to the targeted case manager.
6. At least 95 percent of beneficiaries receiving services through the home health agency shall report overall satisfaction with access, quality, and adequacy of services, to be identified by the state through a yearly beneficiary survey process.

Signature _____

Date _____

HCBS Provider Agreement Addendum – Expected Service Outcomes

Agencies Providing Targeted Case Management (TCM) for Physically Disabled (PD):

1. Initial assessment of beneficiary needs will occur within five working days of the request for services.
2. Each beneficiary obtaining services will be assigned a case manager to coordinate the plan of care in a manner consistent throughout all service providers.
3. Completion of the plan of care and implementation of service provision will occur within 30 days from the date of offer of services or upon dismissal from institution or hospital. There will be evidence of involvement with the beneficiary or caregiver in the development of the plan of care.
4. Ongoing evaluation and monitoring will occur on a regular basis to ensure services are being provided according to the plan of care.
5. There will be a continual decrease in the number of unmet service needs experienced by the beneficiary through development of external resources in a cost-effective manner.
6. Documentation will accurately reflect beneficiary health status, service provision, choice of providers and coordination in accordance with the plan of care. Documentation will also adhere to state and federal rules, regulations and requirements.
7. The number of service units reimbursed per beneficiary will not exceed 120 hours (480 units) per year for TCM-PD.
8. At least 95 percent of beneficiaries receiving services will report overall satisfaction with quality, access, and adequacy of services, to be identified by the state through a yearly beneficiary survey process.

Individuals or agencies, providing any HCBS service:

1. Provide services according to the plan of care and in a quality manner.
2. Coordinate provision of services in a cost-effective and quality manner.
3. Maintain beneficiary's independence and health, when possible, in a safe and dignified manner.
4. Communicate beneficiary's concerns, needs, changes in health status, etc. to the case manager within 48 hours including any ongoing reporting as required by Kansas Medical Assistance Program.
5. Any failure or inability to provide services as scheduled in accordance with the plan of care must be reported immediately to the case manager.
6. At least 95 percent of beneficiaries receiving services through the home health agency will report overall satisfaction with access, quality, and adequacy of services, to be identified by the state through a yearly beneficiary survey process.

Signature _____

Date _____

Provider Compliance Attestation Form

This letter of attestation is being provided on behalf of the following individual or business entity:

Individual/Business Name and _____
Physical Address: _____

Telephone Number: _____

Contact Person: _____

1. Please indicate the type of building in which the business resides:
 - a. Free-standing building
 - b. Storefront (a store or other establishment that has frontage on a street or thoroughfare)
 - c. Professional office building with multiple office suites
 - d. Other (please specify): _____
2. Please indicate the business hours of operation: _____
3. What type of services are provided (medical, pharmaceutical, equipment/medical supplier, personal care, etc)? _____
4. Is the place of business closed for lunch and/or deliveries? Y N
5. Is the place of business ADA accessible? Y N
6. Is there a sign indicating the presence of the business clearly visible at the entrance? Y N

The provider agrees to comply with all state and federal laws, regulation, and professional standards applicable to services and professional activities provided to KMAP beneficiaries.

Under penalty of perjury, I certify by my signature the information provided is accurate. I also certify I am a duly authorized representative of the individual or business entity named above.

Provider Signature: _____

Printed Name: _____

Title: _____

Date: _____

Do you use a billing agent and/or clearinghouse for any Kansas Medicaid function? ____ Yes ____ No

If yes, provide the following information:

Billing Agent (if applicable)

Entity Name: _____

Entity Address: _____

Direct Contact Name: _____

Direct Contact Number: _____

Direct Contact Email Address: _____

Clearinghouse (if applicable)

Entity Name: _____

Entity Address: _____

Direct Contact Name: _____

Direct Contact Number: _____

Direct Contact Email Address: _____



K A N S A S

Kansas Medical Assistance Program

Provider Agreement

1. Provider's Name	2. Physical Address (street, city, state & zip)
3. Pay-to Name (if different than information given in No. 1)	4. Pay-to Address (street, city, state & zip)

Terms and Requirements

1. Rules, Regulations, Policies

The provider agrees to participate in the Kansas Medical Assistance Program (KMAP) and to comply with all applicable requirements for participation as set forth in federal and state statutes and regulations, and Program policies, within the authorities of such statutes and regulations, of the Kansas State Medicaid Agency (SMA) as published in the KMAP Provider Manuals and Bulletins. The provider also agrees to comply with all state and federal laws and regulations applicable to services delivered and professional activities.

The provider agrees that the KMAP General Provider Manuals and the Provider Manuals specific to the program and services, Provider Manual revisions and Provider Bulletins are a part of this agreement and are wholly incorporated by reference. The provider agrees to read them promptly. The Manuals represent Medicaid program limitations and requirements that providers must follow to receive payment and to continue participation in the Medicaid program under K.A.R. 30-5-59(c)(1). The Manuals are in addition to the requirements of the Medicaid Provider Agreement and any other contracts such as managed care contracts and contracts with other insurance carriers. The fiscal agent for the KMAP has prepared the Manuals for the SMA, but the requirements and limitations in the Manuals are the official requirements and limitations of the relationship between providers and the SMA. Please use the Manuals whenever billing or communicating with the KMAP.

The Manuals make available to Medicaid providers informational and procedural material needed for the prompt and accurate filing of claims for services rendered to KMAP consumers. The Manuals are not a complete description of all aspects of KMAP. Should a conflict occur between Manual material and laws and regulations regarding the KMAP, the latter takes precedence.

From time to time, program policies will change. The SMA will notify the provider in the form of bulletins and revised Manual pages published on the KMAP Website, and upon publication of those revised Manual pages, the contract between providers and the SMA is amended. It is important that all revisions be placed in the appropriate section of the Manual and obsolete pages removed when applicable. You may wish to keep obsolete Manual pages to resolve coverage questions for previous time periods.

The Manuals represent the official policy and interpretations of regulations of the SMA in the administration of the KMAP. No provider may claim, in any judicial or administrative proceeding or hearing, that the SMA modified or interpreted the Manuals based simply on an oral conversation unless such interpretation or modification was reduced to writing and signed by the Secretary of the SMA. The fiscal agent for the KMAP has no authority to modify or interpret the Manuals.

(Note: The provider must read the General Provider Manuals and all other applicable Provider Manuals before providing services to beneficiaries. Providers must follow documentation standards contained in the manuals beginning on the first date of service.)

2. Ownership Disclosure

The provider agrees that all required ownership and operating information is fully and truthfully disclosed on the Disclosure of Ownership and Control Interest Statement which is included as part of the Provider Application.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or the U.S. Department of Health and Human Services (HHS) full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or HHS full and complete information about any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or HHS a full and complete updated Disclosure of Ownership and Control Interest Statement.

3. Change of Ownership

The provider agrees to report and disclose all required changes in ownership and operating information and that any reported or unreported changes may affect the status of this provider agreement. The provider agrees to report such change of ownership to the fiscal agent for the KMAP within thirty-five (35) days. Changes of ownership or tax identification number terminate this agreement and the new owner or provider must reapply and submit an updated Disclosure of Ownership and Control Interest Statement.

Upon a change of ownership, the new provider must notify the SMA: (1) whether services provided to beneficiaries by the old provider will continue under the new ownership or whether the services will be transferred to another provider; and (2) where the old provider's records will be located.

4. Enrollment

An individually enrolled provider agrees that each provider performing services (except those services performed under the personal direction of an enrolled provider) must be individually enrolled in the KMAP and that if individual providers within a group fail to enroll separately, payment to the group for services rendered to Kansas Medical Assistance consumers by the non-enrolled provider will be denied or, if paid in error, recouped by KMAP.

5. Internal Revenue Service (IRS) Reporting

The provider agrees that the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) provided on the Provider Application Form is the correct number to report income to the IRS and that as a member of a group practice an individual provider, billing as an individual rather than as a member of a group, cannot use the FEIN of the group practice. The provider acknowledges that the KMAP will report income to the IRS using only the SSN or FEIN of the billing provider or payee and that no income will be reported using the SSN or FEIN of the performing provider.

6. License, Certification, Registration

The provider agrees to maintain required licensed, certified or registered status for all categories for which participation is sought.

7. Record Keeping and Retention

The provider agrees that standardized definitions, accounting, statistics and reporting practices which are widely accepted in the provider field shall be followed and that all records necessary to disclose fully the payments claimed and services rendered shall be accurately maintained in a manner which is retrievable for a period of five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. The provider agrees that this record keeping requirement is not a limit on the ability of the SMA to recoup overpayments; overpayments can be recouped beyond the five year limit.

8. Access to Records, Confidentiality and Routine Review

The provider agrees that routine reviews may be conducted by the Department of Health and Human Services, the SMA, or its designee of services rendered and payments claimed for KMAP consumers and that during such reviews the provider is required to furnish to the reviewers records and original radiographs and other diagnostic images which may be requested. If the required records are retained on machine readable media, a hard copy of the records must be made available when requested. The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto. Providers shall follow all applicable state and federal laws and regulations related to confidentiality.

9. Claims for Services Rendered

The provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to KMAP for payment. The provider agrees that the services listed on all claims are medically necessary for the health of the patient and are personally furnished by the provider or by the provider's employee under the provider's personal direction, the charges for such services are just, unpaid, and actually due according to federal and state statutes and regulations and Program policy, as announced in KMAP Provider Manuals and Bulletins and are not in excess of

regular fees; the information provided on the claim is true, accurate and complete; and the words “on file” or “signature on file” when placed on the KMAP claim refers to the provider’s signature on this document.

10. Timely Filing of Claims

The provider agrees that all claims must be received by the KMAP fiscal agent within twelve (12) months from the date the service was provided and that claims which are originally received within twelve (12) months from the date of service but are not resolved before the twelve (12) month limitation expires, may be corrected and resubmitted up to twenty-four (24) months from the date of service.

11. Payment

The provider agrees to accept as payment in full, subject to audit, the amount paid by the KMAP, with the exception of authorized co-payment and spenddown. The provider acknowledges that if funds budgeted for the fiscal year prove inadequate to meet all Program costs, payments may be pended or reduced and a payment plan as determined by the Secretary of the SMA will be developed within federal and state guidelines.

12. Billing the Consumer

The provider agrees that claims for covered services not submitted within twelve (12) months of the date of service, when the provider has knowledge of KMAP coverage, cannot be billed to the consumer and that claims which are timely filed and subsequently denied because of provider errors cannot be billed to the consumer if the provider fails to correct the errors and resubmit the claim. A provider may bill consumers for services not covered by KMAP if the provider notified the consumer of the non-coverage prior to the provision of services. The consumer must acknowledge the notification in writing.

13. Overpayment

The provider agrees that if it received payment for services or goods in an amount in excess of payment permitted by the KMAP that such overpayments may be deducted from future payments otherwise payable to the provider or the provider associated with the provider’s tax identification number or service location. The provider acknowledges that such remedy is not the only or exclusive remedy available to the SMA and that collection of the overpayment begins after its right to Administrative Review has been exhausted.

If funds have been overpaid or disallowed, the provider shall, within thirty (30) days of discovery by the provider or notification by the SMA or its agent, repay or make arrangements to repay on other terms approved by the SMA to the parties to this agreement. Failure to pay or make arrangements to repay any amount determined above may result in suspension from the Medicaid program as a provider of medical services and legal action by the SMA to recover such funds, including the legal rate of interest.

14. Fraud

The provider agrees that payment of claims is from federal or state funds, or both, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable federal or state laws. The provider acknowledges that he/she is accountable for claim information submitted personally by them or by their authorized employee regardless of the media by

which the provider submits claims. The provider acknowledges that the submission of a false claim, cost report, document or other false information, charging the recipient for covered services except for authorized spenddown and co-payment, and giving or taking of a kickback or bribe in relationship to covered services are crimes which are prosecutable under applicable federal and state laws. Among such applicable laws is K.S.A. 21-3844 et.seq. and amendments thereto (the Kansas Medicaid Fraud Control Act).

15. Termination

The provider agrees that the SMA may terminate a provider's participation in the Kansas Medical Assistance Program for noncompliance with one or more terms of this provider agreement or applicable state and federal laws and regulations. Among such applicable regulations are K.A.R. 30-5-60 and 42 CFR § 455 et. seq.

Upon a change of ownership, the new provider must notify the SMA: (1) whether services provided to beneficiaries by the old provider will continue under the new ownership or whether the services will be transferred to another provider; and (2) where the old provider's records will be located.

16. Civil Rights and 504 Compliance Assurances

The provider understands that the SMA policy is to comply with the applicable nondiscrimination, equal opportunity and affirmative action provisions of various federal and state laws, regulations and executive orders, and to require individuals and firms with whom it does business to comply with these laws, regulations and orders. The provider understands that this compliance policy covers employment policies, practices, services, benefit programs and activities. The provider understands that the SMA will not do business with any individual or firm whose employment or service delivery practices discriminate against any person on the basis of race, color, national origin, ancestry, religion, age, sex, disability or political affiliation.

The provider shall agree: (a) to observe the provisions of the Kansas Act Against Discrimination and to not discriminate against any person in the performance of work under this agreement because of the race, religion, color, sex, disability unrelated to such person's ability to engage in the particular work, national origin or ancestry; (b) in all solicitations or advertisements for employees, to include the phrase, "equal opportunity employer/service provider," or a similar phrase to be approved by the Kansas Human Rights Commission; (c) if the provider fails to comply with the manner in which the provider reports to the commission in accordance with the provisions of K.S.A. 44-1031, the provider shall be deemed to have breached this agreement and it may be canceled, terminated or suspended, in whole or in part, by the SMA; (d) if the provider is found to have committed a violation of the Kansas Act Against Discrimination under a decision or order of the Kansas Human Rights Commission that has become final, the provider shall be deemed to have breached this agreement and it may be canceled, terminated or suspended, in whole or in part, by the SMA; and (e) the provider shall include the provisions of paragraphs (a) through (d) inclusively of this paragraph in every subcontract or purchase order so that such provisions will be binding upon such subcontractor or vendor.

The provider assures that all services will be provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 to the end that no person shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, or national origin. The provider further assures that the United States has a right to seek judicial enforcement of this assurance. (Specific regulations are at 45 Code of Federal Regulations, Part 80.)

The provider assures that all services will be provided in compliance with the provisions of Section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of

disability. (Specific regulations found at 45 Code of Federal Regulations, Part 84.) The provider assures that all services will be provided in compliance with the provisions of the Americans With Disabilities Act of 1990, which prohibits discrimination on the basis of disability. (Specific regulations are at 29 Code of Federal Regulations, Part 1630.)

The provider assures that all services will be provided in compliance with the provisions of the Age Discrimination in Employment Act of 1975, which is designed to prohibit discrimination on the basis of age. (Specific regulations are at 45 Code of Federal Regulations, Part 90.)

17. Professional Standards

The provider agrees to comply with all state and federal laws, regulations, and professional standards applicable to services and professional activities provided to KMAP consumers

18. Provider Agreement Term and Effective Date

This Provider Agreement shall be continuous and ongoing as long as the provider meets the requirements for participation in the KMAP including periodic reenrollment as required by the SMA. The provider agrees that this Provider Agreement is effective if all requirements for enrollment are met on the date of signing by the provider, or may be effective no more than twelve (12) months prior to the signing if a claim for covered services has been received by the KMAP fiscal agent. If all requirements are not met, the date on which such requirements are met shall be the effective date of this Provider Agreement.

19. Signature of Provider:

I certify by my signature, under penalty of perjury, that I am the individual named in Box 1, page 1, or I am duly authorized by the person listed in Box 1, page 1, to bind such person to the terms of this Provider Agreement and that I have read and understand the Provider Agreement and all applicable Provider Manuals and Bulletins.

Provider signature:

By: _____

Printed Name: _____

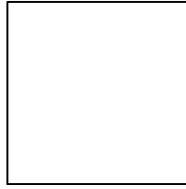
Title: _____

Date: _____

Acceptance by the Secretary of the State Medicaid Agency

By _____
Manager, Kansas Medical Assistance Program Provider Enrollment

Date _____



STATE OF KANSAS

Disclosure of Ownership and Control Interest Statement

Name of Entity/Individual	EIN/SSN	Date of Birth (if ind.)	NPI	Taxonomy
Address		City/ST		Zip Code

Questions 1 – 3 to be answered by fiscal agents and by all providers EXCEPT individual practitioners. If more space is needed, please provide the information on a separate piece of paper and attach to this document.

1. Provide the following information for each person (individual or corporation) with an ownership or control interest in the provider/fiscal agent/managed care entity or in any subcontractor in which the provider/fiscal agent has direct or indirect ownership of five percent or more.

Name	Address	Date of Birth (if individual)	Social Security Number (if individual)
A.			
B.			
C.			
D.			
E.			

1.a. For each corporation above, please provide the following:
NOTE: Designate the corporate entity in question #1 by using 1.A., 1.B., 1.C., etc.

Tax Identification Number	Primary Business Address

1.b. For each corporation above, please provide the following: <i>NOTE: Designate the corporate entity in question #1 by using 1.A., 1.B., 1.C., etc.</i>	
Every Business Location	Every P.O. Box Address

2. Is any person named in question #1 related to another as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). <i>NOTE: Designate relationship to each person listed in question #1 by using 1.A.,1.B.,1.C., etc.</i>		Yes No
Name	Relationship	

3. Does any person named in question #1 have an ownership or control interest in any other Medicaid provider or in any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act? If yes, give the name(s), address(es), and tax ID(s) of the Medicaid provider or entity. <i>NOTE: Designate relationship to each person listed in question #1 by using 1.A.,1.B.,1.C., etc.</i>			Yes No
Name	Address	Tax Identification Number	

Questions 4 – 14 to be answered by ALL providers. If more space is needed, please provide the information on a separate piece of paper and attach to this document.

4. Has the provider, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? If yes, please provide the following information below.
NOTE: A managing employee is a “general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency.”

Yes
No

Name	Description

5. Has the provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12-month period? If yes, give the information below for each subcontractor.

Yes
No

Name	Address	Date of Birth (if individual)	Social Security Number (if individual)
A.			
B.			
C.			
D.			
E.			

5.a. Provide the following for all persons with an ownership or control interest in each subcontractor named in question #5. <i>Note: Designate relationship to subcontractor listed above by using 5.A, 5.B, 5.C, etc.</i>			
Name	Address	Date of Birth	Social Security Number

6. Has the provider had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? If yes, give the information below for each wholly owned supplier or subcontractor.			Yes No
Name	Address	Description of Business Transaction	

7. Please provide the following information on all managing employees of the provider. <i>NOTE: Please see question #4 for the definition of a managing employee.</i>			
Name	Address	Date of Birth	Social Security Number
A.			
B.			
C.			
D.			
E.			

8. Have <u>any</u> of the individuals listed in questions #1 - 7 ever previously participated or currently participate as a provider in Kansas Medicaid or any other states' Medicaid program or Medicare? If yes, please provide the following information below.			Yes No
Name	Program	State	

8.a. Have any of the individuals in question #8 ever had their billing privileges revoked or had their participation in the program terminated for cause? If yes, please provide the following information below.			Yes No
Name	Program	State	

8.b. Do any of the individuals listed in question #8 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, please provide the following information below and attach documentation of the arrangements made to repay the debt.				Yes No
Name	Program	State	Amount of Debt	

<p>9. Does any family or household members of <u>any</u> of the individuals listed in questions #1 - 8 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, please provide the following information below and attach documentation of the arrangements made to repay the debt.</p> <p><i>NOTE: Designate relationship to each person listed in this question by using 1.A., 1.B., 5.A, 5.B., etc.</i></p>					<p>Yes No</p>
Name	Address	Date of Birth	Social Security Number	Program	Amount of Debt

<p>10. Have <u>any</u> of the individuals listed in questions #1 – 9 had any of the following healthcare related adverse legal actions imposed by Medicaid or any other Federal agency or program:</p> <ul style="list-style-type: none"> • Criminal Conviction • Program Exclusion • Civil Monetary Penalty • Program Debarment • Restitution Order • Pending Criminal Judgment • Administrative Sanction • Suspension of Payment • Assessment • Criminal Fine • Pending Civil Judgment • Judgment Pending Under False Claims Act <p>If yes, please provide the following information below and attach copy of the adverse legal action notification(s).</p>				<p>Yes No</p>
Name	Program	State	Action	

11. Have <u>any</u> of the individuals listed in questions #1 – 10 had any of the following non-healthcare related adverse legal actions: <ul style="list-style-type: none"> • Criminal Conviction • Program Exclusion • Civil Monetary Penalty • Program Debarment • Administrative Sanction • Suspension of payment • Assessment 			Yes No
If yes, please provide the following information below and attach copy of the adverse legal action notification(s).			
Name	Program	State	Action

12. Is the provider part of a provider or entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act? If yes, please provide the following below.			Yes No
Name of Provider or Entity	Address of Provider or Entity	Tax Identification Number of Provider or Entity	
13. Please provide the following information for the contact person for audit purposes.			
Name	Address	Phone Number	Title
14. Please provide the address for the physical location of the records required to be kept under K.A.R. 30-5-59. P.O. Boxes and drop boxes are not acceptable.			
Address	City/ST	Zip Code	

ANY DOCUMENTATION OR ANSWERS PROVIDED ON THIS APPLICATION, INCLUDING THE LACK OF DOCUMENTATION OR ANSWERS, MAY BE USED IN THE CONSIDERATION OF THIS APPLICATION FOR APPROVAL. THE STATE WILL ONLY CONSIDER APPROVAL OF APPLICANTS THAT IT DETERMINES TO HAVE MET THE FEDERAL, STATE AND AGENCY GUIDELINES FOR PROGRAM INTEGRITY AND PROVIDER ENROLLMENT.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE

THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY OF HEALTH AND HUMAN SERVICES AS APPROPRIATE.

Name of Application Preparer, if different than the Applicant _____

Name of Authorized Representative (Typed) _____

Signature of Authorized Representative _____

Title _____

Date _____

Submit Kansas Medical Assistance Program Claims Electronically

Benefits to submitting claims electronically include:

- Claims adjudicate within hours
- Cost savings in postage, paper, and ink
- Reduced time in claim preparation

Benefits to submitting electronic claims directly to the fiscal agent include:

- Submitters only need to contact the fiscal agent for submission problems; there are no intermediaries.
- Claim adjudication occurs within hours when submitting directly to the fiscal agent; intermediaries often transmit claims the next day.
- No fees are associated with submissions to the fiscal agent.

The fiscal agent offers two free solutions for electronic claims.

KMAP secure website – Claims can be filed online using the secure website. Claim adjudication occurs within seconds and allows any mistakes on a claim to be corrected and resubmitted. Beneficiary eligibility, claim status, prior authorization, pricing, and pharmacy NCPDP services are also available. Use of the KMAP secure website does not require an EDI application or an authorization test.

Provider Electronic Solutions – This batch billing software allows a batch of institutional or professional claims to be uploaded to the KMAP secure website. Claim adjudication occurs within hours. Beneficiary eligibility, claim status, prior authorization, and pharmacy NCPDP transactions can also be created. Use of batch billing software requires an EDI application and an authorization test. Call 1-800-933-6593 for details.

Other electronic claims solutions include:

Third-party software – A provider can select a software that meets his or her needs. An EDI application and authorization test are required before submitting claims for payment. The electronic claims clearinghouse (intermediary) must be authorized with the fiscal agent. Call 1-800-933-6593 for details.

For any questions regarding electronic claims or authorization testing, please contact the EDI Help Desk at 1-800-933-6593 or by e-mail at LOC-KSXIX-EDIKMAP@external.groups.hp.com.

RESOURCES

Provider Enrollment

785-274-5914

Provider Assistance Unit

785-274-5990

Toll Free: 800-933-6593

Beneficiary Assistance Unit

Toll Free: 800-766-9012

Adult Protective Services (Form ES-1021)

<http://www.srskansas.org/KEESM/Forms/Formstoc.htm>

Kansas Bureau of Investigation

<http://www.accesskansas.org/kbi/criminalhistory/>

Motor Vehicle Screen (Copy of driving record)

<http://www.ksrevenue.org/vehicle.htm>

National Provider Identifier

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

HCBS/FE policy manuals & Online Exams for Targeted Case Management

Frail Elderly (for TCM-FE enrollment only)

<http://www.aging.ks.gov/TCM/WebBasedTraining.html>

Kansas Department on Aging Uniform Assessment Instrument (UAI) Training

(for TCM-FE enrollment only)

<http://www.aging.ks.gov/TCM/TrainingCalendar.html>

Kansas Medical Assistance Programs



Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-

Electronic Funds Transfer (EFT)

The State of Kansas offers electronic deposit to providers who request this service. Electronic deposit provides the highest degree of certainty that payments will be delivered securely, without the delays that can occur with paper warrants.

To sign up for electronic deposit, an Authorization for Electronic Deposit of Vendor Payment form must be completed and returned to the Kansas Department of Health and Environment, Division of Health Care Finance.

*To request a form
be mailed or
faxed, please
call: Customer
Service
785-274-5990 (local) or 1-800-933-6593*

*If you have questions completing the form, please call:
Kansas Department of Health and Environment, Division of Health Care Finance
785-296-3981 (Ask for the finance department.)*

30-4-97 DEPARTMENT OF SOCIAL AND REHAB. SERVICES

39-708c; implementing K.S.A. 1996 Supp. 39-708c and K.S.A. 1996 Supp. 39-709 and K.S.A. 39-713d; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended April 1, 1990; amended Sept. 30, 1994; amended July 1, 1996; amended March 1, 1997; amended Oct. 1, 1997; revoked March 7, 2003.)

30-4-97. (Authorized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 1982 Supp. 39-708c, 39-709, K.S.A. 39-719b; effective May 1, 1981; amended, T-83-17, July 1, 1982; revoked, T-84-8, April 1, 1983; amended May 1, 1983; revoked, T-84-9, May 1, 1983; revoked May 1, 1984.)

30-4-93. Funeral assistance (FA) program. Assistance may be provided for funeral expenses upon the death of a recipient under the TAF, GA, or medical assistance program. (a) Funeral expenses. Funeral expenses shall include the cost of the following:

- (1)(A) The preparation of the body;
- (B) a minimal casket;

(C) the transportation of the body within the trade area; and

(D) a service; or

(2) a cremation.

(b) Application. Each request for funeral assistance shall be made within six months after either the date of death or the date on which the body is released by a county coroner.

(c) Treatment of resources.

(1) If a decedent, at the time of death, was not living with a child of the decedent who was under age 21, the spouse of the decedent, or an adult disabled child of the decedent, the total estate of the decedent shall be considered available. This provision shall not be applicable in situations in which there were separate living arrangements because of the need for institutional care. The estate shall not be allowed any exemptions.

(2) Eligibility for assistance shall be based on the assets owned by the family group at the time of decedent's death, under these circumstances:

(A) If, at the time of death, a decedent was living with a child of the decedent who was under

age 21, the spouse of the decedent, or an adult disabled child of the decedent, or if the decedent was a child under age 21 living with the parent of the decedent; or

(B) if there were living arrangements separate from one of the persons specified in paragraph

(c)(2)(A) because of the need for institutional care.

(3) The total amount of proceeds on any life insurance policy on the decedent shall be considered available if the policy was owned by the decedent, the spouse of the decedent, or, if the decedent was a child under age 21, the parent of the decedent.

(4) Death benefits from SSA, VA, railroad retirement, KPERS, and any other similar funds shall be considered available.

(d) Resource limit. If the value of the resources considered available in accordance with subsection (c) does not exceed \$2,000, assistance may be provided.

If the resource value exceeds \$2,000, the decedent shall be ineligible for assistance.

(e) Assistance provided. If the decedent is eligible, the amount of funeral assistance provided shall be \$680, except that the total cost of funeral expenses, including the \$680 payment, shall not exceed \$2500. If the total cost exceeds \$2500, no assistance shall be provided.

This regulation shall be effective on and after January 1, 2008. (Authorized by and implementing K.S.A. 39-708c and K.S.A. 39-713d; effective Aug. 11, 2006; amended Jan. 1, 2008.)

30-4-99, Reserved.

30-4-100. Payment standards for budgetary requirements in the TAF, GA, and foster care programs. The basic and shelter standards contained in K.A.R. 30-4-101 and 30-4-102, and the designated special requirements set forth in K.A.R. 30-4-120, shall be used in determining total budgetary requirements for the TAF, GA, and foster care programs. An applicant or recipient shall not be eligible to have a standard included in the computation of the applicant's or recipient's budgetary requirements if the agency or another state's assistance program has issued the applicant or recipient a payment for the same maintenance items in the same calendar month. (a) TAF and foster care program budgeting shall be predicated upon the total number of persons in the assistance plan.

(1) The basic standard and 100% of the shelter standard shall be used under the following circumstances:

(A) All persons in the home are in the same assistance plan;

(B) The only person in the home not in the plan is an SSI recipient to whom the 1/2 SSI reduction

is applied because the person lives in the household and receives support and maintenance in kind;

(C) There is a bona fide commercial landlord-tenant relationship between the family group and the other persons in the home; or

(D) All persons in the plan are in a specialized living, commercial board and room, or commercial room-only living arrangement.

(2) The basic standard, plus a percentage reduction of the shelter standard, shall be used when there are one or more persons residing in the home who are not included in the assistance plan, except as set forth in paragraphs (B), (C), and (D) above. The percentage reduction shall be as follows:

- (A) 60% reduction for one person in the plan;
- (B) 50% reduction for two persons in the plan;
- (C) 40% reduction for three persons in the plan;
- (D) 35% reduction for four persons in the plan;
- (E) 30% reduction for five persons in the plan; and
- (F) 20% reduction for six or more persons in the plan.

(b) GA program budgeting. Budgeting shall be predicated upon the total number of persons in the household. For purposes of budgeting, a "household" means one or more persons living as an economic unit and sharing in any of the maintenance items included in the basic standard or shelter standard.

(1) The budgetary standards, excluding the amount designated as an energy supplement, for each applicant or recipient shall equal 80% of the total budgetary requirements except for the following individuals:

- (A) Any person receiving care or supervision;
- (B) Any person who is participating in vocational rehabilitation program training; and
- (C) Any person residing in specialized living arrangements.

(2) The basic and shelter standards shall be used for each person living alone, maintaining a separate household, or residing in a specialized living, commercial board and room, or commercial room-only living arrangement.

(3) For each person residing in a living arrangement other than that specified in paragraph (2) above, the basic and shelter standards shall be computed as follows:

(A) The standards set forth in K.A.R. 30-4-101 shall be used to determine the basic and shelter

standards for the number of persons in the household, to a maximum of four persons.

(B) The applicable standard shall be divided by the number of persons in the household, to a maximum four persons. The result shall be multiplied by the number of persons in the assistance plan to establish the basic and shelter standards.

(c) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, T-84-8, April 1, 1983; amended May 1, 1983; amended, T-84-9, May 1, 1983; amended May 1, 1984; amended, T-86-19, July 1, 1985; amended May 1, 1986; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended July 1, 1989; amended March 1, 1997.)

30-4-100w. This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 359, Section 1; effective Dec. 30, 1994; revoked March 1, 1997.)

30.4.101. Standards for persons in own borne, other family home, specialized living, commercial board and room, or commercial room-only living arrangements. A monetary standard shall be deemed to address the costs of day-to-day expenses and certain special expenditures. (a) Basic standard. The basic standards shall be those set forth below. The basic standards include \$18.00 per person as an energy supplement.

PERSONS IN PLAN			
1	2	3	4
\$132.00	\$217.00	\$294.00	\$462.00

For each additional person, add \$61.00.

(b) Shelter standard. A standard has been established for shelter based on location in the state. The shelter standards shall be those set forth below for each county.

Standard.	Group I \$92.00		
Atlen	Bourbon	Cheyenne	
Anderson	Brown	Clark	
Atchison	Cham	Clay	
Barber	Chautauqua	Cloud	
Barton	Cherokee	Coffey	

Standard.	Group I \$92.00		
	Comanche	Jewell	Pratt
	Cowley	Keamy	Hawkins
	Crawford	Kingman	Republic
	Decatur	Lthette	Hooks
	Dickimon	lane	Rnsh
	Doniphan	Uncoln	Hussell
	Edwards	Unn	Saline Elk
		Logan	Scott
	Ellis	Lyon	Sheridan
	Ellsworth	Malion	Smith
	Finney	Marshall	Stafford
	Ford	Meade	Stanton
	Geary	Mitchell	Stevens
	Cove	Montgomery	Sumner
	Graham	Morris	lItomctS
	Gnmt	Nemaha	Trego
	Greeley	Neosho	"abaunsc
	Greenwood	Ness	Wallace
	Ilamillon	Norton	Washington
	Harper	Osborne	Wichita
	Haskell	Ottawa	Wilson
	Hodgman	llhillips	Woodson
	Jackson	Pottawatomic	
Standard.	Group II \$97.00	Gmull III \$109.00	Group IV \$135.00
	Franklin	Butler	Douglas
	Gray	Jefferson	Harvey
	Kiowa	L.F. Worth	Johnson
	Morton	McPherson	
	Pawnee	Miami	
	Seward	Osage	
	Sherman	Heno	
		Illice Ililey	
		Sedgwick	
		Shawnee	
		Wyandotte	

30-8-28-90, Aug. 30, 1990; amended, T-30-12-28-90, Dec. 28, 1990; amended April 1, 1991; amended, T-30-6-10-91, July 1, 1991; amended Oct. 28, 1991; amended, T-30-6-10-92, July 1, 1992; amended Oct. 1, 1992; amended Oct. 13, 1995; amended March I, 1997.)

30-4-102. Standards for children in foster care. The standards below shall be used for children in foster care. (a) The cost of care for any child placed in a care facility shall be an amount established by the secretill)'

(b) The foster care standards shall also be used to meet the maintenance needs of a child of a foster care recipient if the recipient and the child are living together in the same foster care living arrangement.

(c) This regulation shall take effect on and after March I, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 39-708c, amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended, T-84-8, April, 1983; amended, T-84-9, May 1, 1983; amended, T-84-11, July 1, 1983; amended May 1, 1984; amended, T-85-19, July 1, 1984; amended May I, 1985; amended, T-86-19, July 1, 1985; amended, T-86-42, Dec. 18, 1985; amended May I, 1986; amended, T-87-44, Jan. 1, 1987; amended, T-88-10, May I, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July I, 1989; amended, T-30-2-28-90, Jan. 2, 1990; amended May I, 1990; amended March I, 1997.)

30-4-103 and **30-4-104.** Reserved.

30-4-105. This regulation shall be revoked on and after March I, 1997. (Authorized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 1982 Supp. 39-708c, 39-709; effective May 1, 1981; amended May I, 1983; revoked March 1, 1997.)

30-4-105w. This rule and regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 285, Sections 5, 8, and 13; effective Dec. 30, 1994; revoked March I, 1997.)

30.4.106. General rules for consideration of resources, including real property, personal property, and income. (a) For purposes of determining eligibility for assistance,

(c) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Chapter 229, Section 104; implementing K.S.A. 1995 Supp. 39-709; effective May I, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-85-19, July 1, 1984; amended May 1, 1985; amended, T-86-19, July 1, 1985; amended, T-86-42, Jan. 1, 1986; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-88-2, Feb. I, 1987; amended May 1, 1987; amended, T-88-10, May I, 1987; amended, T-88-14, July 1, 1987; amended May I, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-5-1-90, May 1, 1990; amended, T-

ownership of property shall be determined by legal title. In the absence of a legal title, ownership shall be determined by possession.

(b) Resources, to be real, shall be of a nature that the value can be defined and measured. The value of resources shall be established by the objective measurements set forth in paragraphs (1) and (2) below.

(1) Real property. The value of real property shall be initially determined by the latest uniform statewide appraisal value of the property, which shall be adjusted to reflect current market value. If the property has not been appraised or if the market value as determined above is not satisfactory to the applicant or recipient or the agency, an estimate or appraisal of its value shall be obtained from a disinterested real estate broker. The cost of obtaining an estimate or appraisal shall be borne by the agency.

(2) Personal property. The market value of personal property shall be initially determined by a reputable trade publication. If a publication is not available, or if there is a difference of opinion regarding the value of the property between the applicant or recipient and the agency, an estimate from a reputable dealer shall be used. The cost of obtaining an estimate or appraisal shall be borne by the agency.

(c) Resources shall be considered available both when actually available and when the applicant or recipient has the legal ability to make them available. A resource shall be considered unavailable when there is a legal impediment that precludes the disposal of the resource. The applicant or recipient shall pursue reasonable steps to overcome the legal impediment unless it is determined that the cost of pursuing legal action would exceed the resource value of the property or that it is unlikely the applicant or recipient would succeed in the legal action.

(d) The resource value of property shall be that of the applicant's or recipient's equity in the property. Unless otherwise established, the proportionate share of jointly owned real property and the full value of jointly owned personal property shall be considered available to the applicant or recipient. Resources held jointly with a non-legally responsible person may be excluded from consideration if the applicant or recipient can demonstrate that the applicant or recipient has no ownership interest in the resource, that the applicant or recipient has not contributed to the resource, and that any access to the resource by the

applicant or recipient is limited to acting as an agent for the other person.

(e) Except as provided in subsection (h) and (1), non-exempt resources of all persons in the assistance plan and the nonexempt resources of persons who have been excluded from the assistance plan pursuant to K.A.R. 30-4-70(e)(3) and 30-4-90(a)(3) shall be considered.

(f) Except as provided in subsection (h), tire combined resources of husband and wife, if they are living together, shall be considered in determining the eligibility of either or both for assistance, unless otherwise prohibited by law. A husband and wife shall be considered to be living together if they are regularly residing in the same household. Temporal absences of one of the couple for education or training, working, securing medical treatment, or visiting shall not be considered to interrupt the couple's living together.

(g) Despite subsections (e) and (f), the resources of an SSI beneficiary shall not be considered in the determination of eligibility for assistance of any other person, except for funeral assistance.

(h) The resources of an alien sponsor and the sponsor's spouse shall be considered in determining eligibility for the alien.

(i) A conversion of real or personal property from one form of a resource to another shall not be considered as income for the applicant or recipient except for the proceeds from a contract for the sale of property.

(j) Income shall not be considered both as income and as property in the same month.

(k) Despite subsection (e) above, the resources of a child whose needs are met through foster care payments shall not be considered.

(l) This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Jan. 1, 1988; amended May 1, 1988; amended, T-89-13, April 26, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended March 1, 1997; amended Oct. 1, 1997.)

30-4-106w. This regulation shall be re-

voked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

30-4-107. Property exemption. (a) Each assistance family may own otherwise nonexempt real or personal property with an aggregate resource value not in excess of \$2,000.00. Ownership of property with a resource value in excess of this amount shall render the assistance family group ineligible for assistance. However, if there is ineligibility due to excess real property, assistance shall be provided for a period of up to nine months if the applicant or recipient is making a bona fide and documented effort to dispose of the property.

(b) This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, 39-709; effective May 1, 1981; amended May 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended, T-85-33, Dec. 19, 1984; amended May 1, 1985; amended Oct. 1, 1997.)

30-4-108. Real property. (a) Definitions.

(1) "Home" means the house or shelter in which the applicant or recipient is living or from which the applicant or recipient is temporarily absent, as well as the tract of land and contiguous tracts of land upon which the house and other improvements essential to the use or enjoyment of the home or located. Tracts of land shall be considered to be contiguous if lying side by side, except for streets, alleys, or other easements. The home shall not include pieces of property that touch only at the corners.

(2) "Other real property" means any of the following types of property:

- (A) real property other than a home;
- (B) a home from which an applicant or recipient has been temporarily absent for at least 12 months; or
- (C) a home to which an applicant or recipient will be unable to return.

(h) Treatment of real property. The equity value of non-exempt real property shall be considered as a resource.

(c) Exempted real property. The equity value of the following classifications of real property shall be exempt:

- (1) The home;
- (2) other real property that is essential for employment or self-employment; and

(3) other real property that is producing income consistent with its fair market value.

(d) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-19, Oct. 29, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1988; amended Sept. 26, 1988; amended March 1, 1997.)

30-4-109. Personal property. (a) Definitions.

(1) "Personal property" means all property, excluding real property.

(2) "Cash assets" means money, investments, cash surrender or loan values of life insurance policies, trust funds, and similar items on which a determinate amount of money can be realized.

(3) "Other personal property" means personal effects, household equipment and furnishings, home produce, livestock, equipment, vehicles, inventory, and other items from the sale of property, and similar items on which a determinate amount of money can be realized.

(b) Treatment of personal property. Personal property, unless exempted, shall be considered a resource.

(c) Exempted personal property. The resource value of the following classifications of personal property shall be exempt:

- (1) Personal effects;
- (2) household equipment and furnishings in use or only temporarily not in use;
- (3) tools in use and necessary for the maintenance of house or garden;
- (4) income-producing property, other than cash assets, that is essential for employment or self-employment or that is producing income consistent with its fair market value. Income-producing property may include tools, equipment, machinery, and livestock;
- (5) the stock and inventory of any self-employed person that are reasonable and necessary in the production of goods or services;
- (6) items for home consumption, which shall consist of the following:

(A) produce from a small garden consumed from day to day and any excess that may be canned or stored; and

(B) a small flock of fowl or livestock that is used to meet the food requirements of the family;

(7) one vehicle for each assistance family. Additional vehicles may be exempt if used over 50% of the time for employment or self-employment, if used as the family's home, or if specially equipped for use by a handicapped person;

(8) cash assets that are traceable to income exempted as income and as a cash asset;

(9) proceeds from the sale of a home if the proceeds are conserved for the purchase of a new home and the funds so conserved are expended or committed to be expended in the month received or in the following month;

(10) burial plots and funeral agreements that meet conditions established by the secretary of health and human services and approved by the secretary of social and rehabilitation services;

(11) any contract for the sale of property, if the proceeds from the contract are considered as income;

(12) escrow accounts established for families participating in the family self-sufficiency program through the deprivation of housing and urban development. Interest earned on the accounts shall also be exempted as income; and

(13) the cash value of any life insurance policy.

(d) This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended Oct. 1, 1992; amended March 1, 1997; amended Oct. 1, 1997.)

30-4-109w. This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 8; effective Dec. 30, 1994; revoked March 1, 1997.)

30-4-IIO. Income, (a) Definitions.

(1) "Earned income" means income, in cash or in kind, that an applicant or recipient currently earns, through the receipt of wages, salary, or profit, from activities in which the individual engages as an employer or as an employee with responsibilities that necessitate continuing activity on the individual's part.

(2) "Unearned income" means all income not earned.

(3) "Lump sum" means a nonrecurring payment.

(b)(1) The following TCS of income shall be excluded from total income:

(A) Income-producing costs of the self-employed listed in K.A.R. 30-4-111(d);

(B) the income of a child received from a youth program funded by the job training partnership act of 1982, as specified in K.A.R. 30-4-111(j); and

(C) the earned income of a child as defined in K.A.R. 30-4-70(a)(2) who is a student in elementary or secondary school or who is working towards attainment of a G.E.D.

(2) For purposes of this regulation, total income shall be regarded as the sum of all earned income, or adjusted gross income of the self-employed, with no exemptions, all nonexempt, unearned income and nonexempt, current support payments received and reported by the child support enforcement office.

(c) Treatment of income.

(1) A prospective or income-average budgetary method shall be used to determine eligibility and the amount of the assistance payment for persons with income.

(2) Prospective budgeting shall be used to determine initial eligibility and the amount of the assistance payment in each calendar month. The budget estimate shall reflect the income received and the income expected to be received.

(3) Intermittent income or income from self-employment shall be considered and averaged. Intermittent income shall be divided by the proper number of months to establish the monthly amount. For self-employed persons with monthly income, the income average shall be based on the income earned during two or more representative months.

(d) This regulation shall be effective on and after October 1, 2003. (Authorized by K.S.A. 39-708c; implementing K.S.A. 39-708c and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended March

1, 1997; amended July 1, 1997; amended July 1, 1998; amended Oct. 1, 2003.)

30-4-IIOW. This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

30-4-III. Applicable income. (a) "Applicable income" means the amount of earned and unearned income to be subtracted from the budgetary requirements in determining the budgetary deficit.

(b) Applicable earned income for persons included in the assistance plan shall equal gross earned income or the adjusted gross earned income from self-employment, less the following items:

- (1) Ninety dollars for each employed person;
- (2) the earned income disregard of 40 percent of the remaining income, for the following persons in a TAF or foster care assistance plan:

(A) Each applicant who had received assistance in one of the four preceding months; and

(B) each recipient; and

(3) reasonable expenses for child care or expenses for the care of an incapacitated person. The amount of deductible dependent care shall not exceed \$200.00 per month per person for persons under age two or \$175.00 per month per person for persons age two or older. The dependent shall be included in the family group before the deduction is allowed.

(c) For self-employed persons, adjusted gross earned income shall equal gross earned income less costs of the production of the income. Income-producing costs shall include only those expenses directly related to the actual production of income. A standard deduction of 25% of gross earned income shall be allowed for these costs. If the person wishes to claim actual costs incurred, the following guidelines shall be used by the agency in calculating the cost of the production of the income.

(1) The public assistance program shall not be used to pay debts, set up an individual in business, subsidize a nonprofit activity, or treat income on the basis of internal revenue service (IRS) policies.

(2) If losses are suffered from self-employment, the losses shall not be deducted from other income, nor may a net loss of a business be considered an income-producing cost.

(3) If a business is being conducted from a lo-

cation other than the applicant's or recipient's home, the expenses for business space and utilities shall be considered income-producing costs.

(4) If a business is being conducted from a person's own home, shelter and utility costs shall not be considered income-producing costs unless they are clearly distinguishable from the operation of the home.

(5) If payments increase the equity in equipment, vehicles, or other property, the payments shall not be considered income-producing costs.

(6) If equipment, vehicles, or other property are being purchased on an installment plan, the actual interest paid may be considered an income-producing cost.

(7) Depreciation on equipment, vehicles, or other property shall not be considered an income-producing cost.

(8) Insurance payments on equipment, vehicles, or other property shall be allowed if the payments directly relate to the business.

(9) Expenses for inventories and supplies that are reasonable and required for the business shall be considered income-producing costs.

(10) Wages and other mandated costs related to wages paid by the applicant or recipient shall be considered income-producing costs.

(d) The applicable income for a person in the home whose income is required to be considered and who is not included in the assistance plan shall equal all nonexempt, unearned income and gross earnings, or adjusted gross earnings of the self-employed, without the application of any income disregards, unless otherwise prohibited by law.

(e) The income of an alien's sponsor and the sponsor's spouse shall be considered in determining eligibility and the amount of the assistance payment for the alien.

(f) All net unearned income of persons included in the assistance plan shall be applicable unless exempted. Net unearned income shall equal gross unearned income less the costs of the production of the income. Income-producing costs shall include only those expenses directly related to the actual production of income. The principles set forth in subsection (c) of this regulation regarding the calculation of income-producing costs shall be applicable.

(g) This regulation shall take effect on and after January 1, 1999. (Authorized by K.S.A. 1997 Supp. 39-708c; implementing K.S.A. 1997 Supp. 39-708c and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May

1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Oct. 1, 1989; amended Jan. 2, 1990; amended May 1, 1991; amended, T-30-11-16-93, Dec. 1, 1993; amended Jan. 3, 1994; amended March 1, 1997; amended July 1, 1997; amended July 1, 1998; amended Jan. 1, 1999.)

30-4-111w. This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 265, Section 13; effective Dec. 30, 1994; revoked March 1, 1997.)

30-4-112. Income exempt from consideration as income and as a cash asset. The following income shall be exempt, except as provided in K.A.R. 30-4-110(b):

- (a) Grants and scholarships provided for educational purposes;
- (b) the value of benefits provided under the food stamp program;
- (c) the value of the U.S. deprimment of agii-culture donated foods;
- (d) the value of supplemental food assistance received under the child nutiltion act of 1966, as amended, and the special food service program for children under the national school lunch act, as amended;
- (e) benefits received under title V, community services employment program, or title VII, nutrition program for the elderly, of the older Americans act of 1965, as amended;
- (f) Indian funds dishibuted or held in trust, including interest and investment income accmed on such funds while held in trust and initial-purchases made with such funds;
- (g) distributions to natives under the Alaska native claims settlement act;
- (h) payments provided to individual volunteers serving as foster grandparents, senior health aides, and senior companions, and to persons setving in the setvice cmps of retired executives and active cotps of executives under titles II and III of the domestic service act of 1973;
- (i) payments to individual volunteers under title I, sec. 404(g) of Public Law 93-113 when the director of ACTION determines that the value of such payments, adjusted to reflect the number of hours such' volunteers are serving, is less than the federal minimum wage;
- (j) payments received under the uniform relocation assistance and real property acquisition policies act of 1970;
- (k) death benefits from SSA, VA, railroad retirement, or other bmiial insurance policy when the benefit is used toward the cost of burial;
- (l) a one-time payment or a portion of a one-time payment from a cash settlement for repair or replacement of property or for legal services, or medical costs or other required obligations to a third pmtly, if the payment is expended or committed to be expended for the intended purpose within sLx months of its receipt;
- (m) money that VA determines may not be used for subsistence needs held in trust by VA for a child;
- (n) retroactive conective assistance payments in the month received or in the following month;
- (o) income directly provided by vocational rehabilitation;
- (p) benefits from special government programs at the discretion of the secretary, including energy assistance programs.
- (q) cash donations that are based on need, do not exceed \$300 in any calendar quarter, and are received from one or more private, nonprofit, charitable organizations;
- (r) reimbursements for out-of-pocket expenses in the month received and the following month;
- (s) proceeds from any bona fide loan requiring repayment;
- (t) payments granted to certain U.S. citizens of Japanese ancestry and resident Japanese· aliens under Title ■ of Public Law 100-383;
- (u) payments granted to certain Aleuts under Title ■ of Public Law 100-383;
- (v) agent orange settlement payments;
- (w) foster care and adoption support payments;
- (x) the amount of any emned income tax credit received. Such credit shall not be regarded as a cash asset in the month of receipt and the following month;
- (y) federal major disaster and emergency assistance and comparable disa<;ter assistance provided by state or local government or by disaster assistance organizations in conjunction with a presidentially declared disaster;
- (z) payments granted to the Aroostook Band of Micmac Indians under Public Law 102-171;
- (aa) payments from the radiation exposure

compensation trust fund made by the department of justice; and

(bb) special federal allowances paid monthly to children of Vietnam veterans who are born with spina bifida.

This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended May 1, 1991; amended July 1, 1991; amended Jan. 2, 1992; amended Oct. 1, 1992; amended Oct. 1, 1993; amended Dec. 30, 1994; amended Oct. 1, 1997.)

30-4-112w. This regulation shall be revoked on and after March 1, 1997. (Authorized by and implementing K.S.A. 39-708c and L. 1994, Chapter 26.5, Section 5; effective Dec. 30, 1994; revoked March 1, 1997.)

304-113. Income exempt as applicable income. The following types of income shall be exempt as applicable income in the determination of the budgetary deficit: (a) earned income of a child who is under the age of 19 years if the child is a student in elementary or secondary school or is working towards attainment of a G.E.D.

(b) lump sum income;

(c) irregular, occasional, or unpredictable monetary gifts that do not exceed \$50.00 per month per family group;

(d) income-in-kind;

(e) shelter cost participation payments. In shared living arrangements in which two families contribute toward the shelter obligations, any cash paid toward the shared shelter obligation by one family to the second family in the shared arrangement shall not be considered as income to the second family. This exemption shall not be applicable in a bona fide, commercial landlord-tenant arrangement;

(f) tax refunds and rebates, except for earned income tax credits in accordance with K.A.R. 30-4-112(y);

(g) incentive payments received by renal dialysis patients;

(h) home energy assistance furnished on the basis of need by a federally regulated or state-regulated entity whose revenues are primarily derived on a rate-of-return basis, by a private, non-profit organization, by a supplier of home heating oil or gas, or by a municipal utility company that provides home energy;

(i) income received from the job training partnership act of 1982. However, earnings received by individuals who are participating in on-the-job training programs shall be countable unless the individual is a child;

(j) housing assistance from federal housing programs;

(k) assistance payments in the month received;

(l) support payments received following the effective date of the assignment of support rights to the agency. However, a support refund disbursed by the agency to the recipient or repaid current support that, if prospectively treated as non-exempt income, would result in ineligibility, shall not be exempt income;

(m) up to \$2,000.00 per year of income received by an individual Indian that is derived from leases or other uses of an individually owned trust or restricted lands;

(n) veterans administration (VA) aid and attendance and housebound allowances;

(o) VA payments resulting from unusual medical expenses;

(p) interest income that does not exceed \$50.00 per month per family group;

(q) the amount of any child support pass through payment; and

(r) the amount of any child support arrearage payment.

This regulation shall take effect on and after October 1, 1997. (Authorized by K.S.A. 1996 Supp. 39-708c; implementing K.S.A. 1996 Supp. 39-708c, and 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-84-11, July 1, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended, T-87-15, July 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended May 1, 1991; amended July 1, 1991; amended Sept. 30, 1994; amended Dec. 30, 1994; amended March 1, 1997; amended July 1, 1997; amended Oct. 1, 1997.)

30-4-113w. This regulation shall be revoked on and after March 1, 1997. (Authmized by and implementing K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

30-4-114 to 30-4-119. Reserved.

30-4-120. Special needs for applicants and recipients of TAF. (a) The expenses for the following special needs shall be added to the basic and shelter standards as outlined in K.A.R. 30-4-100 to compute the budgetary requirements for applicants and recipients under the conditions as specified.

(1) Temporry out-of-home care for children. The Cost of tempormy, out-of-home care may be allowed under the following conditions:

(A) The child is -tempormily absent from the home due to the illness of another member of the household or the incarceration of the caretaker relative;

(B) the tempormy absence is only for a pmtion of a calendar month; and

(C) there is an approved setvice plan. The amount to be allowed shall be the foster care standard.

(2) Consetvator or personal representative expense. The fee of the legally appointed conseruator for conservatorship or the personal representative fee for senrice shall be allowed under the following conditions:

(A) The conseJVator or personal representative charges for t110se services; and

(B) the consetvator or personal representative is not the spouse, parent, or child of the incapacitiated person. The amount allowed by t11e court, or the conseiVator's or personal representative's charge, shaH be allowed to a maximum of five percent of the person's cash payment or \$8.00, whichever is greater.

(3) Special household and childrearing expenses. Costs for special household and childrearing expenses may be allowed in an amount that does not exceed the highest allowable basic and shelter standard, as outlined in K.A.R. 30-4-100. Payment for these expenses shall be derived from donor funds that m-e eannarked for the famUy or otherwise designated to the family by a donor. The following expenses may be covered under this provision:

(A) Repair or replacement of household items;

(B) replacement of essential clothing;

(C) special needs related to pregnancy or new-hom child;

(D) special school expenses for children; and

(E) other essential household expenses or expenses resulting from a catastrophe.

(b) This regulation shall take effect on and after March 1, 1997. (Authmized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104, K.S.A. 1995 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended, T-84-25, Sept. 19, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-33, Dec. 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended Oct. 1, 1989; amended, T-30-3-29-90, April 1, 1990; amended, T-30-7-2-90, Aug. 1, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Jan. 7, 1991; amended May 1, 1991; amended Aug. 1, 1995; amended Jan. 1, 1997; amended March 1, 1997.)

30-4-120w. This regulation shall be revoked on and after March 1, 1997. (Authmized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective Dec. 30, 1994; amended August 1, 1995; amended Jan. 1, 1997; revoked March 1, 1997.)

30-4-121. This regulation shall be revoked on and after July 1, 1996. (Authmized by K.S.A. 1983 Supp. 39-708c; implementing K.S.A. 1983 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-84-30, Nov. 2, 1983; amended May 1, 1984; revoked July 1, 1996.)

30-4-122. (Authmized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 39-719b, K.S.A. 1982 Supp. 39-708c, 39-709; effective May 1, 1981; amended, T-83-9, April 29, 1982; revoked May 1, 1983.)

30-4-122a. This regulation shall be revoked on and after March 1, 1997. (Authmized by and implementing K.S.A. 1992 Supp. 39-708c, implementing K.S.A. 1992 Supp. 39-708c, 39-709, as amended by 1993 SB 317; effective, T-84-9, March 29, 1983; effective May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended June 1, 1993; amended, T-30-9-16-93,

Sept. 16, 1993; amended Nov. 8, 1993; revoked March 1, 1997.)

:JO-4-12:1. (Authorized by K.S.A. 1982 Supp. 39-708c; implementing K.S.A. 1982 Supp. 39-708c, 39-709, K.S.A. 19-1015, 39-719b; effective May 1, 1981; amended, T-83-17, July 1, 1982; revoked, T-84-8, April 1, 1983; amended May 1, 1983; revoked, T-84-9, May 1, 1983; revoked May 1, 1984.)

:JO-4-124 to 30-4-129. Reserved,

30-4-1:10. Types of payments. Public assistance payments shall be issued in accordance with the provisions set forth below. (a) Money payment. Payments shall be available through the state electronic benefit transfer system or, in certain circumstances, by check or warrant immediately redeemable at par. Payments shall be made with no restriction on the use of the funds. All payments shall be money payments, except for the following types of payments:

- (1) Payments pursuant to the foster care programs;
- (2) work program support costs and transitional expenses in accordance with K.A.R. 30-4-64 (c) and (d);
- (3) protective payments; and
- (4) subsistence allowances for CA clients residing in specialized living arrangements in which there is a current approved provider agreement with the secretary.

(b) Who may receive money payments. The following persons may receive money payments:

- (1) a caretaker;
- (2) a recipient;
- (3) a personal representative; or
- (4) substitute payee.

A minor shall not receive a money payment unless emancipated.

(c) Protective payments in the TAF and GA programs.

(1) If any caretaker persistently mismanages the money payment to the detriment of any child for whom assistance is claimed and if an approved service plan is on file, a protective payment, in lieu of a money payment to the caretaker, shall be issued to a substitute payee.

(2) If a substitute payee is unavailable, a protective vendor payment shall be issued.

(3) If the caretaker has been removed and all reasonable efforts to identify a suitable protective

payee have failed, protective payments shall not be required.

(d) Substitute payee.

(1) Appointment and dismissal. Each substitute payee shall be appointed as assisted by the agency. The payee may be terminated by the agency if the payee's services are no longer needed or if the payee is not giving satisfactory service. A payee shall be removed only after a careful evaluation of the payee's performance has been made.

(2) (A) Who may be substitute payee. An individual selected to be a substitute payee may be a relative, friend, neighbor, or member of a religious or community organization. The following persons shall not serve as substitute payees:

- (i) the agency's area director;
- (ii) the supervisor of the agency worker;
- (iii) the agency's worker determining financial eligibility;
- (iv) the agency's special investigative or resource staff;
- (v) the staff handling the fiscal process for the client; or
- (vi) the landlord, grocers, or vendors of goods or services dealing directly with the client.

(B) Exception. Payments may be made to a foster parent on behalf of a minor living in a foster care home with the minor's child in order to provide TAF for the child. Such a foster care home shall be licensed or approved as meeting licensing standards. This provision shall not be used in any other kind of public assistance case and may continue until the minor is released from custody of the agency or becomes emancipated.

(3) Criteria for selection. Each substitute payee shall demonstrate the following characteristics:

(A) An interest and concern for the welfare of the family;

(B) the ability to help the family with ordinary budgeting, experience in purchasing food, clothing and household equipment within a limited income, and knowledge of effective household practices;

(C) the ability to establish and maintain a positive relationship;

(D) the ability to maintain close contacts with the caretaker and child by virtue of living near the caretaker or having transportation available; and

(E) responsibility and dependability.

(4) Payee-recipient relationship. Each payee may make decisions about the expenditure of the

assistance payment. The payee may expend the payment in any of the following ways:

- (A) spend the money for the family;
 - (B) supervise the recipient's use of the money;
- or
- (C) give a portion of the money to the recipient to spend for certain expenses and pay for other expenses of the recipient.

(5) Payee-agency relationship. Each payee shall assure the agency that the money is spent for the children's benefit. The payee's responsibility to the agency shall be set forth in writing with one copy for the payee and one for the agency.

(A) This written agreement shall cover the following areas:

- (i) the plans for accounting;
- (ii) use of the assistance funds; and
- (iii) reporting on the general progress made.

(B) The agreement shall be supplemented by the following:

- (i) discussions of the payee's responsibility;
- (ii) a statement of the purpose of the plan;
- (iii) a description of the nature and frequency of reports;
- (iv) a statement of the rights of the recipient; and
- (v) a statement of the confidential nature of the relationship.

(6) Periodic review of cases. Each money payment mismanagement case shall be reviewed at least every six months to determine which of the following actions will be taken:

(A) Restore the recipient to regular money payment status;

(B) continue the recipient on protective payment status; or

(C) develop another plan for the care of the child or children if necessary, including any of the following options:

- (i) placement with another relative;
- (ii) seeking appointment of a guardian; or
- (iii) placement in a foster home.

(7) Discontinuance of protective payments. Protected payments shall be discontinued when the caretaker has demonstrated an ability to manage the money/ayment or after a period of two years has lapse, whichever comes first. Payment may continue for any additional time reasonably necessary to complete a substitute plan for the care of the child.

(e) Special personal representative. A petition for the appointment of a personal representative shall be filed by the agency only if the need for an

appointment is clearly established, and the agency has counseled with the applicant or recipient concerning the money management problems. Confidential reports shall be filed by the agency with the appropriate court as requested.

(1) Appointment of personal representative. A person who meets the following qualifications shall be recommended to the court as a personal representative by the agency.

(A) The person shall not be an employee of the agency.

(B) The person shall not benefit directly from the assistance payment.

(C) The person shall meet the criteria set forth in paragraph (d)(2)(A) of this regulation.

(2) Dismissal of personal representative. A recommendation to the court to dismiss a personal representative shall be made by the agency if the client demonstrates that the client no longer requires a personal representative, or if the personal representative is failing to execute the responsibilities set forth in this regulation, in which instance a substitute personal representative shall be recommended by the agency.

(3) Responsibility of personal representative. Each personal representative shall be responsible to the court, the agency, and the recipient. Each personal representative shall make an annual accounting to both the court and the agency. A more frequent accounting may be required by the agency or the court in the form and at the times prescribed by the agency or the court. Each personal representative shall maintain a confidential relationship with the applicant or recipient and shall consult with the applicant or recipient concerning the applicant's or recipient's requirements, resources, and the use of the money payment.

(4) Periodic review. The necessity of continuing the appointment of a personal representative shall be reviewed semiannually. Consideration shall be given to whether or not the recipient's ability to manage personal affairs has improved or if other changes in the recipient's circumstances or living arrangements make it possible for the recipient to manage without the help of a personal representative.

(f) This regulation shall take effect on and after March 1, 1997. (Authorized by K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; implementing K.S.A. 59-2801 *et seq.*, K.S.A. Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104 and K.S.A. 1995 Supp. 39-709; effective

May 1, 1981; amended May 1, 1983; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-6-10-91, July 1, 1991; amended Oct. 1, 1993; amended July 1, 1996; amended March 1, 1997.)

30-4-130w. This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 39-708c; implementing K.S.A. 59-2801 et seq., K.S.A. 39-708c; effective Dec. 30, 1994; revoked March 1, 1997.)

30-4-131 to 30-4-139. Reserved,

30-4-140. Payments. (a) **Help** amounts. Assistance payments shall equal the budgetary deficit, which shall be rounded down to the nearest dollar, except as set forth below.

(1) Payments for the month of application shall equal the budgetary deficit, which shall be prorated beginning with the date of application through the end of the month. This amount shall be rounded down to the nearest dollar.

(2) A payment shall not be made if the amount of the budgetary deficit is less than \$10.00. When a payment is not made under this provision, recipient status shall continue.

(b) **Underpayments**. Underpayments shall be promptly corrected.

(c) **Overpayments**. Overpayments shall be promptly corrected. Recovery procedures shall not be initiated by the agency, pending the disposition of a welfare fraud referral. Overpayments may be recovered by voluntary repayment, administrative recoupment, or legal action. The assistance payment shall be reduced for recoupment as follows:

(1) For fraud claims, by the greater of 20% of the applicable need standard or \$ 0.00 per month; and

(2) for non-fraud claims, by the greater of 10% of the applicable need standard or \$10.00 per month.

(d) **Disqualification penalties**.

(1) Each individual who is found to have committed fraud, either through an administrative disqualification hearing or by a court of appropriate jurisdiction, or who has signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in any

case referred for prosecution, shall be ineligible for assistance as set forth below.

(A) If the individual is found to have made a fraudulent statement or representative with respect to the identity or place of residence of the individual in order to receive multiple benefits simultaneously, the individual shall be ineligible for a period of 10 years.

(B) For all other fraudulent acts, the individual shall be ineligible for one of the following periods of time:

- (i) 12 months for the first violation;
- (ii) 24 months for the second violation; and
- (iii) permanently for the third violation.

A court may impose an additional 18-month disqualification period for the first and second convictions on criminal cases only. If a court fails to impose a disqualification period, the disqualification periods outlined above shall be imposed, unless they are contrary to the court order.

(2) Upon determination of fraud, an applicant shall be denied assistance. A recipient shall be terminated from assistance no later than the first day of the second month following the month the notice of disqualification is sent.

(e) **Discontinuance of assistance payments**. Assistance payments shall be discontinued when the recipient no longer meets one or more of the appropriate eligibility factors.

(J) This regulation shall take effect on and after July 1, 1998. (Authorized by K.S.A. 1997 Supp. 39-708c; implementing K.S.A. 39-719b, K.S.A. 1997 Supp. 39-708c; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended, T-83-38, Nov. 23, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended July 1, 1989; amended May 1, 1992; amended March 1, 1997; amended July 1, 1998.)

30-4-140w. This regulation shall be revoked on and after March 1, 1997. (Authorized by K.S.A. 39-708e; implementing K.S.A. 39-719b and 39-708c; effective Dec. 30, 1994; amended August 1, 1995; revoked March 1, 1997.)

Article 5.-PROVIDER PARTICIPATION,
SCOPE OF SERVICES, AND
REIMBURSEMENTS FOR THE
MEDICAID (MEDICAL ASSISTANCE)
PROGRAM

30-5-1. (Authorized by K.S.A. 39-709, K.S.A. 1975 Supp. 39-708c; effective Jan. 1, 1967;

amended Jan. 1, 1968; amended Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

30-5-2. (Authorized by KSA 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1971; amended, E-71-34, Aug. 11, 1971; amended Jan. 1, 1972; amended Jan. 1, 1974; revoked May 1, 1976.)

30-5-3. (Authorized by KSA 1969 Supp. 39-708; effective Jan. 1, 1967; amended, E-70-9, Dec. 4, 1969; revoked Jan. 1, 1971.)

30-5-4 to 30-5-9. (Authorized by KSA 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 1971.)

30-5-10. (Authorized by KSA 1967 Supp. 39-708; effective Jan. 1, 1967; amended Jan. 1, 1968; revoked Jan. 1, 197L)

30-5-11 and 30-5-12. (Authorized by KSA 1965 Supp. 39-708; effective Jan. 1, 1967; revoked Jan. 1, 197L)

30-5-13. (Authorized by KSA 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1971; amended Jan. 1, 1973; amended Jan. 1, 1974; amended, E-76-10, Jan. 23, 1975; amended May 1, 1975; revoked May 1, 1976.)

30-5-14. (Authorized by KSA 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1969; revoked May 1, 1976.)

30-5-15. (Authorized by KSA 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1974; revoked May 1, 1976.)

30-5-16. (Authorized by KSA 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1969; amended, E-70-37, Aug. 5, 1970; amended Jan. 1, 1971; amended Jan. 1, 1974; revoked May 1, 1976.)

30-5-17. (Authorized by KSA 1975 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; revoked May 1, 1976.)

30-5-18. (Authorized by KSA 1975 Supp. 39-708c; effective Jan. 1, 1967; revoked May 1, 1976.)

30-5-19. (Authorized by KSA 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1,

1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended, E-72-3, Nov. 5, 1971; amended Jan. 1, 1972; amended, E-72-12, March 31, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended Feb. 15, 1977; amended, E-78-19, July 8, 1977; amended, E-79-1, Feb. 1, 1978; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

30-5-20. (Authorized by K.S.A. 1980 Supp. 39-708e; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; **amended, E-72-3, Nov. 5, 1971; amended Jan. 1, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended, E-78-19, July 8, 1977; amended, E-79-1, Feb. 1, 1978; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)**

30-5-21. (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended, E-77-36, July 1, 1976; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-25, Aug. 27, 1980; revoked May 1, 198L)

30-5-22. (Authorized by K.S.A. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended, E-70-37, Aug. 5, 1970; amended Jan. 1, 1971; revoked, E-72-23, July 28, 1972; revoked Jan. 1, 1973.)

30-5-23. (Authorized by K.S.A. 1978 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; revoked, E-79-20, Aug. 17, 1978; revoked May 1, 1979.)

30-5-24. (Authorized by K.S.A. 1976 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; revoked Feb. 15, 1977.)

30-5-25. (Authorized by K.S.A. 1980 Supp.

39-708e; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1981.)

30-5-26. (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended, E-70-9, Dec. 4, 1969; amended, E-70-37, Aug. 5, 1970; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended, E-77-36, July 1, 1976; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-11, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

30-5-27. (Authorized by K.S.A. 1971 Supp. 39-708; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-37, Aug. 5, 1970; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; revoked, E-72-23, July 28, 1972; revoked Jan. 1, 1973.)

:10-5-28. (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1967; amended Jan. 1, 1968; amended Jan. 1, 1974; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

30-5-29. (Authorized by K.S.A. 1970 Supp. 39-708; effective Jan. 1, 1967; amended Jan. 1, 1968; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; revoked Jan. 1, 1974.)

30-5-30. (Authorized by K.S.A. 1970 Supp. 39-708; effective Jan. 1, 1967; revoked, E-70-9, Dec. 4, 1969; revoked Jan. 1, 1971.)

:10-5-31. (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jnl. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended, E-72-3, Nov. 5, 1971; amended Jan. 1, 1972; amended, E-72-12, March 31, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended Feb. 15, 1977; amended, E-78-19, July 8, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended, E-79-30, Nov. 21, 1978; amended May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

:10-5-32. (Authorized by K.S.A. 1980 Supp. 39-708c; effective Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972;

amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended, E-78-19, July 8, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended, E-79-30, Nov. 21, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

30-5-33. (Authorized by K.S.A. 1980 Supp. 39-708e; effective Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended Jan. 1, 1972; amended Jnl. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

30-5-34. (Authorized by K.S.A. 1980 Supp. 39-708e, 75-3304; effective Jan. 1, 1969; amended, E-70-9, Dec. 4, 1969; amended Jan. 1, 1971; amended, E-72-1, Oct. 1, 1971; amended, E-72-3, Nov. 5, 1971; amended, E-72-12, March 31, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

30-5-35. (Authorized by K.S.A. 1970 Supp. 39-708; effective Jan. 1, 1969; revoked, E-70-9, Dec. 4, 1969; revoked Jan. 1, 1971.)

:10-5-36. (Authorized by K.S.A. 75-5321; effective Jan. 1, 1974; revoked May 1, 1981.)

:10-5-37 anti 30-5-38. (Authorized by K.S.A. 75-5321, 75-5375(s), K.S.A. 1980 Supp. 39-708c, 39-748; effective, E-78-19, July 8, 1977; effective May 1, 1978; revoked May 1, 1981.)

30-5-39. (Authorized by K.S.A. 75-5321, K.S.A. 1980 Supp. 39-708c, 39-748; effective, E-78-19, July 8, 1977; amended, E-79-1, Feb. 1, 1978; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

30-5-40. (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-78-19, July 8, 1977; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

30-5-41. (Authorized by K.S.A. 75-5321, 75-5375(s), K.S.A. 1980 Supp. 39-708c, 39-748;

effective, E-78-19, July 8, 1977; amended, E-79-1, Feb. 1, 1978; effective May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; revoked May 1, 1981.)

30-5-42. (Authorized by K.S.A. 75-5321, K.S.A. 1980 Supp. 39-708c, 39-748; effective, E-79-1, Feb. 1, 1978; effective May 1, 1978; revoked May 1, 1981.)

30-5-43. (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-30, Nov. 21, 1978; effective May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

30-5-44. (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-31, Dec. 20, 1978; effective May 1, 1979; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

30-5-45. (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-30, Nov. 21, 1978; effective May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-25, Aug. 27, 1980; revoked May 1, 1981.)

30-5-46. (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-30, Nov. 21, 1978; effective May 1, 1979; amended, E-81-19, July 16, 1980; revoked May 1, 1981.)

30-5-47. (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-79-30, Nov. 21, 1978; effective May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

30-5-43 to 30-5-50. (Authorized by K.S.A. 1980 Supp. 39-708c; effective May 1, 1980; revoked May 1, 1981.)

30-5-51 to 30-5-54. Reserved.

30-5-55 to 30-5-57. (Authorized by K.S.A. 1980 Supp. 39-708c; effective, E-80-13, Aug. 8, 1979; effective May 1, 1980; revoked May 1, 1981.)

30-5-53. Definitions. The following words and terms, when used in this article, shall have the following meanings, unless the context clearly indicates otherwise.

provider will accept the medicare-allowed payment rate as payment in full for services provided to a recipient.

(b) "Accrual basis accounting" means that revenue of the provider is reported in the period in which it is earned, regardless of when it is col-

lected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(c) "Acquisition cost" means the allowable reimbursement price for each covered drug, supply, or device as determined by the secretary in accordance with federal regulations.

(d) "Admission" means entry into a hospital for the purpose of receiving inpatient medical treatment.

(e) "Agency" means the department of social and rehabilitation services.

(f) "Ambulance" means a state-licensed vehicle equipped for emergency transportation of injured or sick recipients to facilities where medical services are rendered.

(g) "Arm's-length transaction" means a transaction between unrelated parties.

(h) "Border cities" means those communities outside of the state of Kansas but within a 50-mile range of the state border.

(i) "Capitated managed care" means a type of managed care plan that uses a risk-sharing reimbursement method whereby providers receive fixed periodic payments for health services rendered to plan members. Capitated fees shall be set by contract with providers and shall be paid on a per person basis regardless of the amount of services rendered or costs incurred.

(j) "Capitation reimbursement" means a reimbursement methodology establishing payment rates, per program consumer or eligible individual, for a designated group of services.

(k) "Case conference" means a scheduled, face-to-face meeting involving two or more persons to discuss problems associated with the treatment of the facility's patient or patients. Persons involved in the case conference may include treatment staff, or other department representatives of the client or clients.

(l) "Change of ownership" means a change that involves the following:

(1) An arm's-length transaction between unrelated parties; and

(2) (A) The dissolution or creation of a partnership when no member of the dissolved partnership or the new partnership retains ownership interest from the previous ownership affiliation;

(B) a transfer of title and property to another party if the property is owned by a sole proprietor;

(C) the change or creation of a new lessee acting as a provider of pharmacy services; or

(D) a consolidation of two or more corpora-

tions that creates a new corporate entity. The transfer of participating provider corporate stock shall not in itself constitute a change of ownership. A merger of one or more corporations with a participating provider corporation surviving shall not constitute a change of ownership.

(m) "Common control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(n) "Common ownership" means that an entity holds a minimum of five percent ownership or equity in the provider facility and in the company engaged in business with the provider facility.

(o) "Comparable outpatient service" means a service that is provided in a hospital and that is comparable to a service provided in a physician's office or ambulatory surgical center.

(p) "Concurrent care" means services rendered simultaneously by two or more eligible providers.

(q) "Consultation" means an evaluation that requires another examination by a provider of the same profession, a study of records, and a discussion of the case with the physician primarily responsible for the patient's care.

(r) "Contract loss" means the excess of contract cost over contract income.

(s) "Cost and outlier accounting information" means adequate data, including source documentation, that is accurate, current, and in sufficient detail to accomplish the purposes for which it is intended. Source documentation, including petty cash payout memoranda and original invoices, shall be valid only if it originated at the time and near the place of the transaction. In order to provide the required cost data, financial and statistical records shall be maintained in a consistent manner. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedure.

(t) "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(u) "Cost outlier" means a general hospital inpatient stay with an estimated cost that exceeds the cost outlier limit established for the respective diagnosis-related group.

(v) "Cost outlier limit" means the maximum cost of a general hospital inpatient stay established

according to a methodology specified by the secretary for each diagnosis-related group.

(w) "Cost-related reimbursement" means reimbursement based on analysis and consideration of the historical operating costs required to provide specified services.

(x) "Costs not related to patient care" means costs that are not appropriate, necessary, or proper in developing and maintaining the facility's operations and activities. These costs shall not be allowed in computing reimbursable costs under cost-related reimbursement.

(y) "Costs related to patient care" means all necessary and proper costs arising from arm's-length transactions in accordance with generally accepted accounting principles that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.

(z) "Covered service" means a medical service for which reimbursement will be made by the Medicaid/Medicaid program. Coverage may be limited by the secretary through prior authorization requirements.

(aa) "Day outlier" means a general hospital inpatient length of stay that exceeds the day outlier limit established for the respective diagnosis-related group.

(bb) "Day outlier limit" means the maximum general hospital inpatient length of stay established according to a methodology specified by the secretary for each diagnosis-related group.

(cc) "Diagnosis-related group" or "DRG" means the classification system that organizes medical diagnoses into mutually exclusive groups.

(dd) "Diagnosis-related group adjustment percent" or "DRG adjustment percent" means a percentage assigned by the secretary to a diagnosis-related group for purposes of computing reimbursement.

(ee) "Diagnosis-related group daily rate" or "DRG daily rate" means the dollar amount assigned by the secretary to a diagnosis-related group for purposes of computing reimbursement when a rate per day is required.

(ff) "Diagnosis-related group reimbursement system" or "DRG reimbursement system" means a reimbursement system in the Kansas Medicaid/Medicaid program for general hospital inpatient services that uses diagnosis-related groups for determining reimbursement on a prospective basis.

(gg) "Diagnosis-related group weight" or "DRG weight" means the numeric value assigned

to a diagnosis-related group for purposes of computing reimbursement.

(hh) "Discharge" means release from a hospital. A discharge shall occur when the consumer leaves the hospital or dies. A transfer to another unit within a hospital, except to a swing bed, and a transfer to another hospital shall not be a discharge.

(ii) "Discharging hospital" means, in instances of the transfer of a consumer, the hospital that discharges the consumer admitted from the last transferring hospital.

(oj) "Dispensing fee" means the reimbursement rate assigned to each individual pharmacy provider for the provision of pharmacy services involved in dispensing a prescription.

(kk) "Disproportionate share hospital" means a hospital that has the following:

(1) Either a low-income utilization rate exceeding 25 percent or a medicaid/medikan hospital inpatient utilization rate of at least one standard deviation above the mean medicaid/medikan inpatient utilization rate for hospitals within the state borders of Kansas that are receiving medicaid/medikan payments; and

(2) at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to medicaid/medikan eligible individuals. In a hospital located in a rural area, the obstetrician may be any physician with staff privileges at the hospital who performs nonemergency obstetric procedures. The only exceptions to this requirement shall be the following:

(A) A hospital with inpatients who are predominantly under 18 years of age; or

(B) a hospital that did not offer nonemergency obstetric services as of December 21, 1987.

(ll) "Drug, supply, or device" means the following:

(1) Any article recognized in the official United States Pharmacopoeia, another similar official compendium of the United States, an official national formulary, or any supplement of any of these publications;

(2) any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings;

(3) any article intended to affect the structure or any function of the bodies of human beings; and

(4) any article intended for use as a component of any article specified in paragraphs (1), (2), or (3) above.

(nn) "Durable medical equipment" or "DME" means equipment that meets these conditions:

(1) Withstands repeated use;

(2) is not generally useful to a person in the absence of an illness or injury;

(3) is primarily and customarily used to serve a medical purpose;

(4) is appropriate for use in the home; and

(5) is rented or purchased as determined by designees of the secretary.

(oo) "Election period" means the period of time for the receipt of hospice care, beginning with the first day of hospice care as provided in the election statement and continuing through any subsequent days.

(pp) "Election statement" means the revocable statement signed by a consumer that is filed with a particular hospice and that consists of the following:

(1) Identification of the hospice selected to provide care;

(2) acknowledgment that the consumer has been given a full explanation of hospice care;

(3) acknowledgment by the consumer that other medicaid services are waived;

(4) the effective date of the election period; and

(5) the consumer's signature or the signature of the consumer's legal representative.

(qq) "Emergency services" means those services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Serious jeopardy to the patient's health;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(rr) "Estimated cost" means the cost of general hospital inpatient services provided to a consumer, as computed using a methodology set out in the Kansas medicaid state plan.

(ss) "Formulary" means a listing of drugs, supplies, or devices.

(tt) "Free-standing inpatient psychiatric facility" means an inpatient psychiatric facility licensed to provide services only to the mentally ill.

(uu) "General hospital" means an establishment that provides an organized medical staff of physicians, permanent facilities that include inpatient

- beds, and medical services. The medical services provided by the hospital shall include the following:
- (1) Physician services;
 - (2) continuous registered professional nursing services for 24 hours each day; and
 - (3) diagnosis and treatment for nonrelated patients who have a variety of medical conditions.
- (uu) "General hospital group" means the category to which a general hospital is assigned for purposes of computing reimbursement.
- (w) "General hospital inpatient beds" means the number of beds reported by a general hospital on the hospital and hospital health care complex cost report form, excluding those beds designated as skilled nursing facility or intermediate care facility beds. For hospitals not filing the hospital and hospital health care complex cost report form, the number of beds shall be obtained from the provider application for participation in the Kansas Medicaid/Medicaid program form.
- (v.w) "Generally accepted accounting procedures" means generally accepted accounting principles, except as otherwise specifically indicated by Medicaid/Medicaid program policies and regulations. These principles shall not supersede any specific regulation or policy of the Medicaid/Medicaid program.
- (xx) "Group reimbursement rate" means the dollar value assigned by the secretary to each general hospital group for a diagnosis-related group weight of one.
- (yy) "Health maintenance organization" means an organization of providers of designated medical services that makes available and provides these medical services to eligible enrolled individuals for a fixed periodic payment determined in advance and that limits referral to outside specialists.
- (zz) "Historical cost" means actual allowable costs incurred for a specified period of time.
- (aaa) "Hospice" means a public agency, private organization, or a subdivision of either, that primarily engages in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospices, and has enrolled to provide hospice services as provided in K.A.R. 30-5-59.
- (bbb) "Hospital located in a rural area" means a facility located in an area outside of a metropolitan statistical area as defined in paragraph (sss).
- (ccc) "Independent laboratory" means a laboratory that performs laboratory tests ordered by a physician and that is in a location other than the physician's office or a hospital.
- (ddd) "Ineligible provider" means a provider who is not enrolled in the Medicaid/Medicaid program because of reasons set forth in K.A.R. 30-5-60, or because of commission of civil or criminal fraud in another state or another program.
- (eee) "Interest expense" means the cost incurred for the use of borrowed funds on a loan made for a purpose related to patient care.
- (fff) "Kan Be Healthy program participant" means an individual under the age of 21 who is eligible for Medicaid, and who has undergone a Kan Be Healthy medical screening in accordance with a specified screening schedule. The medical screening shall be performed for the following purposes:
- (1) To ascertain physical and mental defects; and
 - (2) to provide treatment that corrects or ameliorates defects and chronic conditions that are found.
- (ggg) "Kan Be Healthy dental-only participant" means an individual under the age of 21 who is eligible for Medicaid, and has undergone only a Kan Be Healthy dental screening in accordance with a specified screening schedule. The dental screening shall be performed for the following purposes:
- (1) To ascertain dental defects; and
 - (2) to provide treatment that corrects or ameliorates dental defects and chronic dental conditions that are found.
- (hhh) "Kan Be Healthy vision-only participant" means an individual under the age of 21 who is eligible for Medicaid, and who has undergone only a Kan Be Healthy vision screening in accordance with a specified screening schedule. The vision screening shall be performed for the following purposes:
- (1) Ascertain vision defects; and
 - (2) provide treatment that corrects or ameliorates vision defects and chronic vision conditions that are found.
- (iii) "Length of stay as an inpatient in a general hospital" means the number of days an individual remains for treatment as an inpatient in a general hospital from and including the day of admission, to and excluding the day of discharge.
- (iiij) "Lock-in" means the restriction, through limitation of the use of the medical identification card to designated medical providers, of a con-

sumer's access to medical services because of abuse.

(kkk) "Low-income utilization rate for hospitals" means the rate that is defined in accordance with section 1923 of the social security act, codified at 42 U.S.C. 1396r-4, as amended by section 1(a)(6) of the consolidated appropriations act, 2001 P.L. 106-554, which enacted into law Section 701 of H.R. 5661, the medicare, medicaid, and SCHIP benefits improvement and protection act of 2000, effective December 21, 2000, which is adopted by reference.

(lll) "Managed care" means a system of managing and financing health care delivery to ensure that services provided to managed care plan members are necessary, efficiently provided, and appropriately priced.

(mmn) "Managerial capacity" means the authority of an individual, including a general manager, business manager, administrator or director, who performs the following functions:

(1) Exercises operational or managerial control over the provider; or

(2) directly or indirectly conducts the day-to-day operations of the provider.

(nnn) "Maternity center" means a facility licensed as a maternity hospital that provides delivery services for normal, uncomplicated pregnancies.

(ooo) (1) "Medical necessity" means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

(A) "Authority." The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.

(B) "Purpose." The health intervention has the purpose of treating a medical condition.

(C) "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

(D) "Evidence." The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph (ooo)(3). For existing interventions, effectiveness shall be determined as provided in paragraph (ooo)(4).

(E) "Value." The health intervention is cost-effective for this condition compared to alternative

interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

(2) The following definitions shall apply to these terms only as they are used in this subsection (ooo);

(A) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(B) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this regulation's definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

(C) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.

(D) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

(E) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.

(F) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magni-

tude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

(G) "Secretary's designee" means a person or persons designated by the secretary to assist in the medical necessity decision-making process.

(H) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.

(I) "Treating physician" means a physician who has personally evaluated the patient.

(3) Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph (ooo)(4).

(4) The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

(ppp) "Medical necessity in psychiatric situations" means that there is medical documentation that indicates either of the following:

(1) The person could be harmful to himself or herself or others if not under psychiatric treatment; or

(2) the person is disabled in time, place, or person.

(qqq) "Medical supplies" means items that meet these conditions:

(1) Are not generally useful to a person in the absence of illness or injury;

(2) are prescribed by a physician; and

(3) are used in the home and certain institutional settings.

(rrr) "Mental retardation" means any signifi-

cant limitation in present functioning that meets these requirements:

(1) Is manifested during the period of birth to age 18;

(2) is characterized by significantly subaverage intellectual functioning as reflected by a score of two or more standard deviations below the mean, as measured by a generally accepted, standardized, individual measure of general intellectual functioning; and

(3) exists concurrently with deficits in adaptive behavior, including related limitations in two or more of the following areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

(sss) "Metropolitan statistical area" or "MSA" means a geographic area designated as such by the United States executive office of management and budget as set out in the 64 Fed. Reg. 202, pp. 56628-56644, October 20, 1999, and 65 Fed. Reg. 249, pp. 82228-82238, December 27, 2000 which are adopted by reference.

(ttt) "Necessary interest" means interest expense incurred on a loan made to satisfy a financial need of the facility. A loan that results in excess funds or investments shall not be considered necessary.

(uuu) "Net cost" means the cost of approved educational activities, less any reimbursements from the following:

(1) Grants;

(2) tuition; and

(3) specific donations.

(vvv) "Non-covered services" means services for which Medicaid/medicaid will not provide reimbursement, including services that have been denied due to the lack of medical necessity.

(www) "Occupational therapy" means the provision of treatment by an occupational therapist registered with the American occupational therapy association. The treatment shall meet these requirements:

(1) Be rehabilitative and restorative in nature;

(2) be provided following physical debilitation due to acute physical trauma or physical illness; and

(3) be prescribed by the attending physician.

(xxx) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of business. These costs shall be considered intangible assets because they represent expenditures for rights and privileges that

have value to the enterprise. Because the services inherent in organization extend over more than one accounting period, the costs shall be amortized over a period of not less than 60 months from the date of incorporation for the purposes of computing reimbursable costs under a cost-related reimbursement system.

(yy) "Orthotics and prosthetics" means devices that meet these requirements:

- (1) Are reasonable and necessary for treatment of an illness or injury;
- (2) are prescribed by a physician;
- (3) are necessary to replace or improve functioning of a body part; and
- (4) are provided by a trained orthotist or prosthetist.

(zz) "Other developmental disability" means a condition or illness that meets the following criteria:

- (1) Is manifested before age 22;
- (2) may reasonably be expected to continue indefinitely;
- (3) results in substantial limitations in any three or more of the following areas of life functioning:
 - (A) Self-care;
 - (B) understanding and the use of language;
 - (C) learning and adapting;
 - (D) mobility;
 - (E) self-direction in setting goals and undertaking activities to accomplish those goals;
 - (F) living independently; or
 - (G) economic self-sufficiency; and
- (4) reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of extended or lifelong duration and are individually planned and coordinated.

(aaa) "Out-of-state provider" means any provider that is physically located more than 50 miles beyond the border of Kansas, except those providing services to children who are wards of the secretary. The following shall be considered out-of-state providers if they are physically located beyond the border of Kansas:

- (1) Nursing facilities;
- (2) intermediate care facilities;
- (3) community mental health centers;
- (4) partial hospitalization service providers; and
- (5) alcohol and drug program providers.

(bbb) "Outpatient treatment" means services provided by the outpatient department of a hos-

pital, a facility that is not under the administration of a hospital, or a physician's office.

(ccc) "Over-the-counter" means any item available for purchase without a prescription order.

(ddd) "Owner" means a sole proprietor, member of a partnership, or a corporate stockholder with five percent or more interest in the corporation. The term "owner" shall not include minor stockholders in publicly held corporations.

(eee) "Partial hospitalization program" means an ambulatory treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and daily living skills treatment modalities, based upon a treatment plan.

(fff) "Participating provider" means any individual or entity that presently has an agreement with the agency to furnish Medicaid services.

(ggg) "Pharmacy" means the premises, laboratory, area, or other place meeting these conditions:

(1) Where drugs are offered for sale, the profession of pharmacy is practiced, and prescriptions are compounded and dispensed;

(2) that has displayed upon it or within it the words "pharmacist," "pharmaceutical chemist," "pharmacy," "apothecary," "drugstore," "druggist," "drugs," "drug sundries," or any combinations of these words or words of similar import; and

(3) where the characteristic symbols of pharmacy or the characteristic prescription sign "Rx" are exhibited. The term "premises" as used in this subsection refers only to the portion of any building or structure leased, used, or controlled by the registrant in the conduct of the business registered by the board at the address for which the registration was issued.

(hhh) "Pharmacist" means any person duly licensed or registered to practice pharmacy by the state board of pharmacy or by the regulatory authority of the state in which the person is engaged in the practice of pharmacy.

(iii) "Physical therapy" means treatment that meets these criteria:

(1) Is provided by a physical therapist registered in the jurisdiction where the service is provided or by the Kansas board of healing arts;

(2) is rehabilitative and restorative in nature;

(3) is provided following physical debilitation due to acute physical trauma or physical illness; and

(4) is prescribed by the attending physician.

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- (iiij) "Physician extender" means a person registered as a physician's assistant or licensed advanced registered nurse practitioner in the jurisdiction where the service is provided, and who is working under supervision as required by law or administrative regulation.
- {kkkk} "Practitioner" means any person licensed to practice medicine and surgery, dentistry, or podiatry, or any other person licensed, registered, or otherwise authorized by law to administer, prescribe, and use prescription-only drugs in the course of professional practice.
- (llll) "Prescribed" means the issuance of a prescription order by a practitioner.
- {mmmm} "Prescription" means either of the following:
- (1) A prescription order; or
 - (2) a prescription medication.
- (nnnn) "Prescription medication" means any drug, supply, or device that is dispensed according to a prescription order. If indicated by the context, the term "prescription medication" may include the label and container of the drug, supply, or device.
- {oooo} "Prescription-only" means an item available for purchase only with a prescription order.
- {pppp} "Primary care case management" or "PCCM" means a type of managed care whereby a beneficiary is assigned a primary care case manager who manages costs and quality of services by providing case assessment, primary services, treatment planning, referral, and follow-up in order to ensure comprehensive and continuous service and coordinated reimbursement.
- {qqqq} "Primary diagnosis" means the most significant diagnosis related to the services rendered.
- (rrrr) "Prior authorization" means the approval of a request to provide a specific service before the provision of the service.
- (ssss) "Program" means the Kansas Medicaid program.
- (tttt) "Proper interest" means interest incurred at a rate not in excess of what a prudent borrower would have had to pay under market conditions existing at the time the loan was made.
- (uuuu) "Prospective, reasonable, cost-related reimbursement" means present and future reimbursement, based on analysis and consideration of historical costs related to patient care.
- {vvvv} "Qualified Medicare beneficiary" or "QMB" means an individual meeting these requirements:
- (1) Who is entitled to Medicare hospital insurance benefits under part A of Medicare;
 - (2) whose income does not exceed a specified percent of the official poverty level as defined by the United States executive office of management and budget; and
 - (3) whose resources do not exceed twice the supplemental security income resource limit.
- (ww.vv) "Readmission" means the subsequent admission of a consumer as an inpatient into a hospital within 30 days of discharge as an inpatient from the same or another DRG hospital.
- (xxxx) "Related parties" means two or more parties to a transaction, one of which has the ability to influence the other or others in a way in which each party to the transaction might fail to pursue its own separate interests fully. Related parties shall include those related by family, business, or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations. Transactions or agreements that are illusory or a sham shall not be recognized.
- (yyyy) "Related to the community mental health center" means that the agency or facility furnishing services to the community mental health center meets any of these requirements:
- (1) Is directly associated or affiliated with the community mental health center by formal agreement;
 - (2) governs the community mental health center; or
 - (3) is governed by the community mental health center.
- (zzzz) "Residence for the payment of hospice services" means a hospice consumer's home or the nursing facility in which a hospice consumer is residing.
- (aaaaa) "Revocation statement" means the statement signed by the consumer that revokes the election of hospice service.
- (bbbbb) "Sampling" means the review process of obtaining a stratified random sample of a subset of cases from the universe of claims submitted by a specific provider. The sample shall be used to project the review results across the entire universe of claims for that provider to determine an overpayment.
- (ccccc) "Speech therapy" means treatment provided by a speech pathologist who has a cer-

tificate of clinical competence from the American speech and hearing association. The treatment shaH meet these requirements:

- (1) Be rehabilitative and restorative in nature;
- (2) be provided following physical debilitation due to acute physical trauma or physical illness; and

(3) be prescribed by the attending phvskian.
 (ddddd) "Standard diagnosis-related group amount" or "standard DRG amount" means the amount computed by multiplying the group re imbursement rate for the general hospital by the diagnosis-related group weight.

(eeee) "Statc operated hospital" means an es tablishment operated by the state of Kansas that provides diagnosis and treatment for nom-elated patients and includes the following:

- (1) An organized mediC'al staff of physicians;
- (2) permanent facilities that include inpatient beds; and
- (3) medical services that include physician services and continuous registered professional nursing services for 24 hours each day.

(ffff) "Stay as an inpatient in a general hospi- tal" means the peliod of time spent in a general hospital from admission to discharge.

(ggggg) "Swing bed" means a hospital bed that can be used interchangeably as a hospital, skilled nursing facility, or intennediate care facility bed, with reimbursement based on the specific type of care provided.

(hhhhh) "Targeted case management services" means those services that assist medicaid consum- ers in gaining access to medically necessary care. The services shall be provided by a case manager \with credentials specified by the secretary.

(iilli) "Terminally ill" means that an individual has a life expectancy of six months or less as de- termined by a physician.

(jjjjj) "Timely filing" means the receipt by the agency or its fiscal agent of a claim for payment filed by a provider for services provided to a med- icaid program consumer not later than 12 months after the date the claimed services were provided.

(kkkkk) "Transfer" means the movement of an individual receiving general hospital inpatient services from one hospital to another hospital for additional, rela_ted inpatient care after adission to the previous hospital or hospitals.

(Ulll) "Transfening hospital" means the hospi- tal that transfers a consumer to another hospital. There may be more than one transfening hospital for the same consumer until discharge.

(mmmmm) "Uncollectable overpayment to an out of business provider" means either of the following:

- (1) Any amount that is due from a provider of medical services who has ceased all practice or operations for any medical services as an individ ual, a pmtnership, or a corporate identity, and who has no assets capable of being applied to any ex- tent toward a medicaid ovelpayment; or

(2) any amount due that is less than its collec- tion and processing costs.

(nnnnn) "Urgent" means that a situation re- quires medical treatment within two days of onset, but not through the emergency room. (Author- ized by and implementing K.S.A. 39-708c; effec- tive May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amende Jan. 2, 1989; amended July 1, 1989; amended Jan. 2, 1990; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Aug. 1, 1990; amended Jan. 7, 1991; amended, T- 30-3-1-91, March 1, 1991; amended July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended Apdl1, 1992; amended May 1, 1992; anlended July 31, 1992; amended May 3, 1993; amended Oct. 1, 1993; amended July 1, 1994; amended April 1, 1995; amended Sept. I, 1995; amended March 1, 1996; amended July 1, 1996; amended July 1, 1997; amended July 6, 2001.)

30-5-59. Provider l>at:icipation require- ments. The following shall be prerequisites for participation in and payment from the medicaid! medikan program. Any provider of services to foster care consumers, adoption supp0lt consumers, Kan Be Healthy consumers, or other consumers who have special needs may be excluded from these prerequisites if the secretary determines that a medically necessary item of durable medical equipment or a medically necessaaly sewice can be cost-efficiently obtained only from a provider not othem>ise eligible to be enrolled within the current program guidelines. (a) Enrollment. Each participating provider shall perform the following:

- (1) Submit an application for participation in the medicaidlmedikan program on forms pre- scribed by the secretary of the Kansas departmen- of social and rehabilitation services;
- (2) obtain and maintain professional or depart

ment-specified credentials determined by the secretary in the jurisdiction where the service is provided and for the time period when the service is provided and, if applicable, be certified, licensed, or registered by the appropriate professional credentialing authority;

(3) notify the Kansas department of social and rehabilitation services if any of the original information provided on the application changes during the term of participation in the medicaid/medikan program;

(4) after completing the necessary application forms and receiving notice of approval to participate from the department, enter into and keep a provider agreement with the Kansas department of social and rehabilitation services;

(5) notify the Kansas department of social and rehabilitation services when a change of provider ownership occurs, submit new ownership information on forms for application for participation in the medicaid/medikan program, and receive approval from the department for participation as a new provider before reimbursement for services rendered to medicaid/medikan program consumers is made;

(6) locate a consumer service representative who is available 24 hours per day and a business in Kansas or a border city that is accessible, in accordance with the applicable Americans with disabilities act guidelines, to the general public between the hours of 9:00 a.m. and 5:00 p.m. at a minimum, excluding weekends and state and federal holidays, if applying to be a durable medical equipment or medical supply provider. Any pharmacy located in Kansas or a border city that has a medical provider number may enroll as a durable medical equipment provider even if no storefront is present; and

(7) be located in Kansas or a border city if applying to be a pharmacy, unless the pharmacy is providing services to children in the custody of the secretary of the Kansas department of social and rehabilitation services or to program consumers in emergency situations. The only exceptions to this requirement shall be the following:

(A) A pharmacy that is an approved contractor with the Kansas department of health and environment as a supplier of intravenous blood fraction products. This exception shall apply only to reimbursement for the intravenous blood fraction products; and

(B) a mail order pharmacy that serves medicaid

consumers with a primary payor other than medicaid.

(b) Denial of application. If an application for participation in the medicaid/medikan program is denied, the applicant shall be notified in writing by the department.

(c) Continuing participation. Each participating provider shall perform the following:

(1) Comply with applicable state and federal laws, regulations, or other program requirements;

(2) comply with the terms of the provider agreement;

(3) submit accurate claims or cost reports;

(4) submit claims only for covered services provided to consumers;

(5) engage in ethical and professional conduct;

(6) provide goods, services, or supplies that meet professionally recognized standards of quality;

(7) submit a new application for participation in the medicaid/medikan program if a claim has been submitted for payment and if at least 18 months have elapsed since a previous claim for payment was submitted; and

(8) refund any overpayment to the program within a period of time specified by the secretary or lose eligibility to participate.

(d) Recordkeeping. Each participating provider shall perform the following:

(1) Maintain and furnish within the time frame specified in a request an information for five years from the date of service that the Kansas department of social and rehabilitation services, its designee, or any other governmental agency acting in its official capacity may request to ensure proper payment by the medicaid/medikan program, to substantiate claims for medicaid/medikan program payments, and to complete determinations of medicaid/medikan program overpayments. This information shall include the following:

(A) Fiscal, medical, and other recordkeeping systems;

(B) matters of the provider's ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;

(C) documentation of asset acquisition, lease, sale, or other action;

(D) franchise or management arrangements;

(E) matters pertaining to costs of operation;

(F) amounts of income received; by source and purpose; and

(G) a statement of changes in financial position;

(2) use standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the provider's field;

(3) permit the Kansas department of social and rehabilitation services, its designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the medicare program; and

(4) agree to repay overpayment determinations resulting from the use of sampling techniques.

(e) Payment. Each participating provider shall meet the following conditions:

(1) Accept as payment in full, subject to audit when applicable, the amount paid by the medicare program for covered services;

(2) not assign medicare program claims or grant a power of attorney over or otherwise transfer right to payment for these claims except as set forth in 42 CFR 447.10, revised July 24, 1996, which is adopted by reference;

(3) not charge medicare program consumers for services denied for payment by the medicare program because the provider has failed to meet a program requirement including prior authorization;

(4) not charge any medicare program consumer for noncovered services unless the provider has informed the consumer, in advance and in writing, that the consumer is responsible for noncovered services;

(5) not charge medicare program consumers for services covered by the program, with the exception of claims liable to copayment or copayment;

(6) submit claims for payment on claim forms approved and prescribed by the secretary; and

(7) be subject to the payment limitations specified in K.A.R. 30-5-70.

(f) Provider participation in the medicare program may be disallowed for any of the reasons set forth in K.A.R. 30-5-60. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended Jan. 7, 1991; amended May 1, 1992; amended May 3, 1993; amended Dec. 30, 1994;

amended April 1, 1995; amended Oct. 1, 2000; amended Jan. 1, 2004; amended Dec. 10, 2004.)

30-5-60. Provider termination/suspension. (a) Any provider's participation in the medicare program may be terminated for one or more of the following reasons:

(1) Voluntary withdrawal of the provider from participation in the program;

(2) non-compliance with applicable state laws, administrative regulations, or program issuances concerning medical providers;

(3) non-compliance with the terms of a provider agreement;

(4) non-compliance with the terms and certification set forth on claims submitted to the agency for reimbursement;

(5) assignment, granting a power of attorney over, or otherwise transferring right to payment of program claims except as set forth in 42 U.S.C. 1396a (32), revised July 18, 1984, which is adopted by reference;

(6) pattern of submitting inaccurate billings or cost reports;

(7) pattern of submitting billings for services not covered under the program;

(8) pattern of unnecessary utilization;

(9) unethical or unprofessional conduct;

(10) suspension or termination of license, registration, or certification;

(11) provision of goods, services, or supplies harmful to individuals or of an inferior quality;

(12) civil or criminal fraud against medicare, the Kansas medicare or social service programs, or any other state's medicare or social service programs;

(13) suspension or exclusion by the secretary of health and human services from the title XVIII or title XIX programs;

(14) direct or indirect ownership or controlling interest of five percent or more in a provider institution, organization or agency by a person who has been found guilty of civil or criminal fraud against the medicare program or the Kansas medicare or social service programs or any other state's medicare or social service programs;

(15) employment or appointment by a provider of a person in a managerial capacity or as an agent if the person has been found guilty of civil or criminal fraud against the medicare program or the Kansas medicare or social service programs or any other state's medicare or social service programs;

(16) insolvency; or

(17) other good cause.

(b) Termination, unless based upon civil or criminal fraud against the program, suspension or exclusion by the secretary of health and human services, shall remain in effect until the agency determines that the reason for the termination has been removed and that there is a reasonable assurance that it shall not recur. Terminations based upon civil or criminal fraud shall remain in effect for such time period as deemed appropriate by the agency. Termination based upon suspension or exclusion by the secretary of health and human services (HHS) shall remain in effect no less than the time period specified in HHS' notice of suspension.

(c) Prior to the termination of a provider from the program; the provider shall be sent a written notification by the agency of the proposed termination and the reasons. The notice shall state whether payment liability to the provider has been suspended pending further proceedings. The notice shall further advise the provider that an appearance before the section may be permitted at a specified time, not less than five days nor more than 15 days from the date the notice is mailed to or served upon the provider. At the appearance the provider may present any relevant evidence and have an opportunity to be heard on the question of continuing eligibility in the program. All evidence presented, including that of the provider, shall be considered by the agency. If the decision is to terminate, a written order of termination shall be issued, setting forth the effective date of the termination and the basic underlying facts supporting the order.

(d) Any provider found not to be in compliance with one or more requirements set forth in K.A.R. 30-5-59 may be subject to suspension of payment or other remedies in lieu of termination. The effective date of this regulation shall be May 3, 1993. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by L. 1992, Chapter 322, Sec. 5; effective May 1, 1981; amended May 1, 1986; amended July 1, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended May 3, 1993.)

30-5-61. (Authorized by K.S.A. 1979 Supp. 39-708c; effective May 1, 1981; amended, T-84-11, July 1, 1983; revoked May 1, 1984.)

30-5-61a. Withholding of payments to

medical providers. (a) Payments otherwise authorized to be made to medical providers shall be withheld, in full or in part, by the agency when:

(1) The agency has determined that the provider to whom payments are to be made has been overpaid;

(2) the agency has reliable evidence, although additional evidence may be needed for a determination, that an overpayment exists or that the payment to be made may not be correct; or

(3) the agency has been instructed by the department of health and human services (HHS) to withhold all or part of the federal share from payment to a medical provider.

(b) A withholding action shall become effective immediately unless a later date is set forth in the letter of notification. The agency, no later than the effective date of the withholding action, shall send written notification of the withholding and the reasons therefor to the affected medical provider.

(c) A withholding action shall remain in effect until:

(1) The overpayment is recouped from the amount withheld or is otherwise recovered;

(2) the agency enters into an agreement with the provider for recovery of the over payment;

(3) the agency, on the basis of subsequently acquired evidence or otherwise, determines that there is no overpayment; or

(4) the agency is otherwise notified by HHS if the withholding action is pursuant to federal instructions. No payment for the withheld federal share shall be made to any medical provider unless the agency receives notification from HHS to do otherwise.

(d) Whenever payments to a medical provider are withheld pursuant to paragraph (a)(2), the agency shall take timely action to obtain any additional evidence the agency may need to make a determination as to whether an overpayment exists or whether payments should be made. The agency shall make all reasonable efforts to expedite the determination. As soon as the determination has been made, the provider shall be informed and, when appropriate, the withholding action shall be rescinded or adjusted to take into account the determination. If not rescinded, the withholding action shall remain in effect as specified in paragraph (c) above. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1984.)

30-5-61b. Suspension of payment liability

ity to medical providers. (a) Suspension of payment liability because of determination by the secretary of health and human services. The agency shall suspend payment liability for services provided by any medical provider during any time period in which payments may not be made to the provider under titles XVIII or XIX of the social security act because of a determination by the secretary of health and human services pursuant to 42 U.S.C.A. 1395y(d)(1) and (e)(1), clause (C)(ii), (D), (E) or (F) of 42 U.S.C.A. 1395cc (b)(2). The suspension shall be effective upon receipt of the notification of the determination by the department of health and human services (HHS) and shall remain in effect until the agency is otherwise notified by HHS. The agency, no later than the effective date of the suspension, shall send written notification of the suspension and the reasons therefore to the affected medical provider. No payment shall be made to any medical provider for services provided by the medical provider during the time period of suspension unless the agency receives notification from HHS to do otherwise.

(b) Suspension of payment liability upon notification of proposed termination.

(1) Payment liability may be suspended by the agency upon notification to a provider of a proposed termination if the provider may no longer legally provide services or for other good cause. No payment shall be made to a provider for services rendered after the provider receives notification of the suspension.

(2) If payment liability is suspended to an adult care home, payment liability for those program recipients who are living in the home at the time of the suspension may be continued, for a period not to exceed 30 days, to facilitate the orderly transfer of the recipients to another facility or to alternate care. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1984.)

30-5-62. Reinstatement of a provider previously terminated from the medicaid/medicaid program. A request for reinstatement by a provider terminated from participation in the medicaid/medicaid program shall not be considered for a period of 60 days following the effective date of the order of termination. As a prerequisite for reinstatement in the program one or more of the following conditions may be imposed by the agency: (a) Implementation and documentation of

corrective action taken by the provider to comply with program policies and to reasonably insure that the reason for the termination shall not recur;

(b) probationary period not to exceed one year;

(c) attendance at provider education sessions;

(d) prior authorization of services;

(e) peer supervision; and

(f) other conditions as the specific situation may warrant. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.)

30-5-63. Medical necessity. Except as specifically set forth in program policy, the agency shall not reimburse a provider for the provision of a covered service to a program recipient unless the provision of the service was medically necessary. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.)

30-5-64. (Authorized by K.S.A. 39-708c(b) and K.S.A. 2004 Supp. 39-7,120; implementing K.S.A. 2004 Supp. 39-7,120 and 39-7,121a; effective May 1, 1981; amended May 1, 1983; amended May 1, 1986; amended May 1, 1992; amended July 1, 1994; amended March 1, 1995; amended March 1, 1996; amended July 1, 1996; amended July 1, 1997; amended Jan. 1, 1999; amended April 1, 2000; amended Oct. 1, 2000; amended Oct. 1, 2001; amended Dec. 6, 2002; amended Feb. 21, 2003; amended May 9, 2003; amended July 11, 2003; amended Aug. 8, 2003; amended Nov. 14, 2003; amended Dec. 29, 2003; amended May 28, 2004; amended Oct. 29, 2004; amended Jan. 7, 2005; amended April 1, 2005; amended May 27, 2005; revoked Oct. 28, 2005.)

30-5-65. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990; amended May 1, 1992; amended July 1, 1994; revoked July 13, 2007.)

30-5-66. Effective date of administrative regulations in relationship to provider cost reporting periods. The administrative regulations in effect at the beginning of a cost reporting period shall govern the treatment of costs that accrue during said period unless otherwise provided. (Authorized by and implementing

K.S.A. 1980 Supp. 39-708c; effective May 1, 1981.)

30-5-67. Disallowance of claims for services generated by providers ineligible for participation in the medicaid/medikation program. The agency shall disallow payment, except for emergency services, if the service set forth on a claim was generated by a provider ineligible to participate in the medicaid/medikation program. (Authorized by and implementing K.S.A. 1985 Supp. 39-708c; effective May 1, 1981; amended May 1, 1986.)

30-5-68. Consultants to the medicaid/medikation program. Consultants to the medicaid/medikation program may be reimbursed if under contract with the Kansas department of social and rehabilitation services. The payment rate for consultants shall be a mutually negotiated amount. The effective date of this regulation shall be August 1, 1990. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1986; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1, 1990.)

30-5-69. Volume purchase and negotiated contracts for medical services. The agency may procure medical services from a single or multiple source through competitive bidding or negotiated fee. The agreed upon reimbursement shall supersede the usual reimbursement methodology for the service. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982.)

30-5-70. Payment of medical expenses for eligible recipients. (a) Payment for covered services shall be made only to those providers participating in the program pursuant to K.A.R. 30-5-59. The only exceptions shall be pursuant to K.A.R. 30-5-65.

(b) Each program recipient shall be eligible for the payment of specific medical expenses as follows:

(1) Payment of Medicare (title XVIII) premiums and deductibles and co-insurance amounts for services covered in the medicaid program. Recipients who are ineligible for program coverage because they have a spenddown shall be eligible for the payment of the Medicare (title XVIII) premium expense. For cash recipients, including SSI recipients, who are age 65 or older, payment of

the Medicare (title XVIII) premium shall begin with the month of approval for medicaid, excluding any months of prior eligibility. For recipients under age 65 who are eligible for Medicare after receiving retirement and survivor's disability insurance for 24 consecutive months, payment of the Medicare (title XVIII) premium shall begin with the 25th month. For all other recipients, payment of the Medicare (title XVIII) premium shall begin with the second month following the month of approval for medicaid, excluding any months of prior eligibility;

(2) payment of premiums of health maintenance organizations that are approved by the agency or premiums of group health plans offered by the recipient's employer if the agency has determined that this plan is cost-effective;

(3) payment of other allowable medical expenses incurred in the current eligibility base period in excess of any co-pay or spenddown requirements;

(4) payment for services rendered to a person who is mandated to receive inpatient treatment for tuberculosis and who is not otherwise eligible for participation in the program. Coverage shall be limited to services related to the treatment for tuberculosis;

(5) payment for services in excess of medicaid/medikation program limitations for foster care and adoption support recipients, when approved by the agency; and

(6) payment for covered medical services provided to an individual participating in the KanVork program. A monthly cost-sharing amount for medical services shall be paid by each individual participating in the KanVork program when required.

(c) The scope of services provided to recipients and the payment for those services shall be as set forth in articles 5 and 10 of this chapter, subject to the following limitations.

(1) Payment for a particular medical expense shall be denied if it is determined that any one of these conditions is met:

(A) The recipient failed to utilize medical care available through other community resources, including public institutions, veterans administration benefits, and those laboratory services that are available at no charge through the state department of health and environment.

(B) A third party liability for the medical expense has been established and is available.

(C) The recipient fails to make a good faith effort to establish a third party liability for the medical expense or fails to cooperate with the agency in establishing the liability. Payment of a medical expense may be delayed pending the outcome of a determination concerning third party liability.

(D) The expense is not covered or is only partially covered by an insurance policy because of an insurance program limitation or exclusion.

(E) The recipient failed to notify the provider of services of the recipient's eligibility for the program.

(F) The service is cosmetic, pioneering, or experimental, or is a result of complications related to these procedures.

(G) The service is related to transplant procedures that are not covered by the medicaid/medicaid program.

(H) The service was provided by a provider not designated as a lock-in provider for any recipient who is locked into designated providers due to abuse, unless the provider has a written referral from a designated provider or unless the service was an emergency service.

(I) The service was provided by a provider not designated as the primary care case manager for any recipient who is enrolled in the primary care case manager program, unless the provider has a written referral from the designated provider or unless the service was an emergency service.

(J) The service was covered in a health maintenance organization plan for any recipient enrolled in a health maintenance organization.

(K) The service was provided by an unlicensed, unregistered, or noncertified provider when licensure, registration, or certification is a requirement to participate in the medicaid/medicaid program.

(L) The service exceeds the limitations defined by the program policies.

(2) Payment for out-of state services shall be limited to the following:

(A) Payment on behalf of recipients if medical services are normally provided by medical vendors that are located in the bordering state and within 50 miles of the state border, except for community mental health center services, alcohol and drug abuse services, or partial hospitalization services;

(B) emergency services rendered outside the state;

(C) nonemergency services for which prior approval by the agency has been given. Authorization

from the agency shall be obtained before making arrangements for the individual to obtain the out of state services;

(D) services provided by independent laboratories; and

(E) medical services provided to foster care recipients and medical services in excess of the limitations of the state of residence, when approved by the Kansas department of social and rehabilitation services and within the scope of the adoption agreement for those for whom Kansas has initiated adoption support agreements.

(3) The scope of services for adult non medicaid (non-title XIX) program recipients shall be limited as set forth in K.A.R. 30-5-150 through 30-5-172.

(d) Payment for medical services shall be made, at the discretion of the secretary, when it has been determined that an agency administrative error has been made.

(e) This regulation shall take effect on and after October 1, 1998. {Authorized by and implementing K.S.A. 1997 Supp. 39-708c and K.S.A. 1997 Supp. 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-87-44, Jan. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended May 3, 1993; amended July 19, 1996; amended Oct. 1, 1998.)

30-5-71. Copayment requirements. (a) Except as set forth in subsection (b) of this regulation, program recipients shall be obligated to the provider for the following copayment charges.

(1) The copayment for inpatient general hospital and freestanding psychiatric facility services shall be \$48.00 per admission.

(2) The copayment for outpatient general hospital services shall be \$1.00 per non-emergency visit in place of a doctor's office visit.

(3) The copayment for other medical services subject to copayment shall be based upon the following ranges:

average medicaid/medicaid payment for services	maximum copayment chargeable to recipient
\$10.00 or less	\$.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

(4) The copayment for other medical services subject to copayment shall be a standard amount based upon the average medicaid payment for the services, calculated on an annual basis. The average medicaid payment shall be calculated by dividing the cost of the services in aggregate by the total number of claims paid in the previous fiscal year. Any change in copayment shall be published in the Kansas Register on or before December fifteenth to be effective January first of each year. (5) Other medical services subject to copayment shall include the following:

(A) Ambulatory surgical center services, for each date of service;

(B) audiological services, excluding batteries, for each date of service;

(C) community mental health center services, for each individual psychotherapy visit;

(D) durable medical equipment, prosthetics, and orthotics, for each claim, excluding the rental of durable medical equipment;

(E) home health services, for each skilled nursing visit, excluding the rental of durable medical equipment;

(F) non-emergency ambulance services, for each date of service;

(G) optometric or ophthalmologist services, for each date of service;

(H) outpatient general hospital surgery, for each date of service;

(I) prescribed drugs, for each new or refilled prescription;

(J) physician or physician extender services, for each office visit;

(K) podiatric services, for each office visit;

(L) psychological services, for each office visit; (M) dietitian services, for each date of service;

(N) dental services, for each date of service;

(O) federally qualified health center services, for each encounter; and

(P) rural health clinic services, for each encounter.

(b) The provisions of subsection (a) shall not apply to services provided as follows:

(1) To residents in nursing facilities, including swing beds, intermediate care facilities for the

mentally retarded, nursing facilities for mental health, and to recipients participating in the home- and community-based services programs;

(2) to inpatients in a state psychiatric hospital who meet both of the following conditions:

(A) Have reached the age of 18 but are not yet 22 years of age; or

(B) are at least 65 years of age;

(3) to recipients under age 18;

(4) to recipients in the custody of the juvenile justice authority or secretary of social and rehabilitation services who are at least 18 years old but under age 21 and who are in out-of-home placements;

(5) to recipients enrolled in a medicaid-funded health maintenance organization;

(6) for family planning purposes;

(7) for medical services relating to an injury incurred on the job during a community work experience project;

(8) for services related to pregnancy; and

(9) for emergency services. (Authorized by and implementing

K.S.A. 39-708c; effective May 1, 1981; amended May 1, 1982; amended, T-83-38, Nov. 23, 1982; amended May 1, 1983; amended, T-84-36, Jan. 1, 1984; amended May 1, 1984; amended May 1, 1986; amended, T-87-20, Sept.

1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-12-28-89, Jan. 1, 1990; amended, T-30-2-28-90, Feb. 28, 1990; amended Aug. 1,

1990; amended Dec. 31, 1992; amended Sept. 27, 1993; amended Dec. 30, 1994; amended, T-30-6-28-95, July 1, 1995; amended Sept. 1, 1995; amended July 1, 1997; amended Sept. 3, 2004.)

30-5-72. Medical contracts; funding. All medical contracts shall be subject to federal and state funding conditioned by appropriations made by congress and the state legislature. (Authorized by and implementing K.S.A. 1980 Supp. 39-708; effective May 1, 1981.)

30-5.73. Requirements for facilities to participate. (a) Medical services provided in community mental health centers, free-standing psychiatric facilities, state-operated hospitals, and general hospitals to be reimbursed by the medicaid/medicaid program shall be under the effective control of a physician as determined by the agency.

(b) Community mental health centers, free-standing psychiatric facilities, state-operated hospitals, and general hospitals providing medical

Revised 02/2012

State: Michigan

Director: Michele Warstler wastlerM@michigan.gov

Assistant:

Information/Link/Attachment:

No information regarding self-disclosures has been obtained from the state of Michigan.

State: Minnesota

Director: Ronald Nail ron.nail@state.mn.us

Assistant:

Information/Link/Attachment:

Minnesota does not have any set policy at this time on provider self-disclosure. The issues and the amount of disclosure seem to dictate the degree Minnesota vets the disclosure. Minnesota verifies the audit logic, and runs a query to see if claims information coincides with the provider's logic. All providers remain subject to further audit of any issues disclosed.

State: Mississippi

Director: Otis J Washington otis.washington@mediciad.ms.gov

Information/Link:

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Effective Date: 01/01/11
Section: General Policy	Section: 7.04	
Subject: Fraud and Abuse	Pages: 4 Cross Reference: DOM Addresses and Telephone Numbers 1.05	

Title XIX of the Social Security Act, the implementing federal regulations 42 CFR Part 455, and the Mississippi Code of 1972, Title 43 Chapter 13 as amended, set forth the state Medicaid agency's requirements for control of fraud and abuse in the Medicaid program. The Division of Medicaid (DOM) employs detailed methods and procedures to prevent, detect, investigate, report, identify, and collect all improper payments, and impose administrative measures for the control of fraud, abuse, and over utilization practices by providers and beneficiaries. The Mississippi Code of 1972, Title 43 Chapter 13 as amended, describes the penalties related to fraud in the Medical Assistance Program. Suspected fraud/abuse regarding a provider or beneficiary should be addressed to the DOM Bureau of Program Integrity. When a provider identifies any overpayments made by Medicaid caused by billing errors, system errors, human error, etc., he/she should notify the DOM Bureau of Program Integrity in writing within 30 days of the discovery. Refer to Provider Policy manual section 1.05 for DOM address and telephone contact information.

Self Disclosure:

The Division of Medicaid encourages providers to be active participants in ensuring the financial integrity of our healthcare programs. Providers are urged to self-audit in an effort to identify claim errors and overpayments. Providers have an ethical and legal duty to promptly return inappropriate payments they have received from the Medicaid Program. The DOM will accept reimbursement for inappropriate payments without penalty in the event that such inappropriate payments are disclosed voluntarily and in good faith, and that the acts that led to the inappropriate payments were not the result of fraudulent or abusive conduct. Upon identifying claims errors or overpayment, providers must alert DOM's Bureau of Program Integrity and work toward a resolution or refund. Once a provider has identified claims that are potential overpayments, the Medicaid Provider Self Disclosure Form detailing the potential overpayments should be forwarded to the Program Integrity Bureau within 30 days of the discovery. Any self disclosure submitted to DOM for consideration must include the following information:

- a. Name and address of the affected provider;
- b. If the provider is an entity owned, controlled, or otherwise part of a system or network, include a description or diagram of the pertinent business/legal relationships, the names and addresses of any related entities, and affected corporate divisions, departments, or branches. The description should include the name and address of the disclosing entity's designated representative.
- c. Provider Identification Number(s) associated with claims;
- d. Tax Identification number(s);
- e. Payee Identification number(s);
- f. Submit affected claims in Excel or Access and should include the following information beneficiary name, claim TCN, procedure code, service from/to date, billed amount, paid amount, paid date, refund amount. (Providers are encouraged to contact the Program Integrity Bureau prior to submitting reports to insure acceptance of information being submitted)
- g. A report that includes a full description of the matter being disclosed, the person who identified the overpayment and the manner in which the individual discovered it;
- h. The self disclosure should include a detailed account of the provider's investigation of the

State: Mississippi

Director: Otis J Washington otis.washington@mediciad.ms.gov

Information/Link:

- i. A statement disclosing whether the provider is under investigation by any government agency or contractor;
- j. A statement detailing the provider's theory regarding the cause of the violation;
- k. A certification that the information submitted to the DOM is based upon a good faith effort to disclose a billing inaccuracy and is true and correct and;
- l. The methodology used in determining the amount of the overpayment (if overpayment amount was determined using a sampling method additional detailed information may be required).

Documentation should be sent to the address listed in Section 1.05 of this manual.

The Bureau of Program Integrity reserves the right to verify the financial impact of the disclosed matter. Accordingly, the DOM expects to receive documents and information from the entity that relate to the disclosed matter without the need to resort to compulsory methods. Matters uncovered during the verification process which are outside the scope of the self disclosure may be treated as new matters subject to further investigation.

To the extent that payments can be returned through the claims payment adjustment process, the claims adjustment process will be followed. Otherwise, providers should send refund checks, made payable to The DOM at the address listed in Section 1.05 of this manual within 60 days of the overpayment discovery.

Please note that self disclosure will not absolve the provider of criminal culpability.

Corrective Action Plans:

In an effort to correct deficiencies noted during an investigation, the DOM can require the submission of a Corrective Action Plan. Corrective Action Plans must be specific and must, at a minimum, include provisions aimed toward correction of the deficiencies, indicate reasonable completion dates, fully describe the methodology used to accomplish complete and permanent corrective action, and describe methods for ensuring full compliance with the corrective action plan. The Corrective Action Plan shall be subject to review by the DOM to ensure compliance. Violation of the Corrective Action Plan, including failure to implement as directed, will subject the provider to further adverse actions and may be based upon both the initial investigation and the Corrective Action Plan.

Overpayments

When it is established through audit or investigation that an overpayment has been made to a provider, the DOM shall begin collection of any overpayment to a provider 60 days after issuance of the demand for repayment. The overpayment may be recovered by any legitimate methods which may include any of the following methods:

1. Lump sum payment by the provider.
2. Offset against current payments due to the provider.
3. A repayment agreement executed between the provider and DOM.
4. Any other method of recovery available to and deemed appropriate by the DOM.

An offset against current payments shall continue until one of the following occurs:

- a. The overpayment is recovered;
- b. The DOM enters into an agreement with the provider for repayment of overpayments.
- c. The DOM determines, as a result of hearing proceedings or review of information that there is no overpayment.

Any recovered overpayment that is subsequently determined to have been erroneously collected shall be promptly refunded to the provider.

Suspension of Payments

In section 6402(h) of the Affordable Care Act, the Congress amended section 1903(i)(2) of the Act to provide the Federal Financial Participation (FFP) in the Medicaid program shall not be made with respect to any amount expended for items or services (other than an emergency item or service, not including

items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State in accordance with these regulations, unless the State determines in accordance with these regulations that good cause exists not to suspend such payments.

Basis for suspending payments to Providers

The Division of Medicaid may suspend payments in whole or in part to a provider when there is a pending investigation of a credible allegation of fraud unless the state determines that good cause exists not to suspend such payments. Examples of good cause are the following:

- Specific requests by law enforcement that DOM not suspend (or continue to suspend) payment.
- DOM has determined that other available remedies exist that could effectively or quickly protect Medicaid funds than would implementing (or continuing) a payment suspension.
- DOM determines that a payment suspension is not in the best interests of the Medicaid program.
- DOM determines that a payment suspension would have an adverse effect on beneficiary access to necessary items or services.
- Law enforcement declines to cooperate in certifying that a matter continues to be under investigation.

DOM may suspend payments without first notifying the provider of its intention to suspend such payments as allowed under state and/or federal laws and regulations.

The Medicaid Fraud Control Unit (MFCU) can refer to the Division of Medicaid any provider against which there is pending an investigation of credible allegation of fraud for purposes of payment suspension. Referrals from MFCU must be in writing and include information adequate to enable the Division of Medicaid to identify the provider and a brief explanation forming the grounds for the payment suspension.

The Division of Medicaid shall make a formal, written suspected fraud referral to MFCU for each instance of a payment suspension as the result of a Division of Medicaid preliminary investigation of a credible allegation of fraud.

Notice of payment suspension to Providers

The Division of Medicaid must send notice of payment suspension to providers within five (5) days of taking such action. Exception to the five (5) day notice period occurs when the Division of Medicaid receives a written request by law enforcement to delay notification to a provider. Law enforcement can request up to a 90 day notification of delay.

The payment notice must set forth the general allegations as to the nature of the suspension of payments, but does not require disclosure of any specific information regarding the ongoing investigation. The notice must:

- State the payments are being suspended in accordance with 42 CFR Section 455.23.
- State that the suspension is for a temporary period and cite the circumstances under which the payment suspension will be terminated.
- Indicate, when appropriate, which type or types of Medicaid claims will be suspended.
- Inform the provider of the right to submit written evidence for consideration by the Division of Medicaid.

Duration of Suspension of Payments to Providers

All suspension of payments will be temporary and will not continue after:

- The Division of Medicaid or the prosecuting authorities determines that there is insufficient evidence of fraud.

-
-
- Legal proceedings related to the provider's alleged fraud are completed.

Recovery Audit Contractors (RACs) Program

In accordance with Section 6411 of the Affordable Care Act the Division of Medicaid has established a program to comply with these requirements. The Division of Medicaid will contract with one or more Medicaid RACs for the purpose of identifying underpayments, overpayments and recouping overpayments under the State Plan and under any waiver of the State Plan with respect to all services. Payments to RAC contractors for the identification of overpayments will only be made from amounts recovered. Contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. This program may be adjusted pursuant to future regulation/guidance promulgated by CMS.

Through its procurement process the State will establish the following:

- a. Qualifications of Medicaid RACs;
- b. Required personnel;
- c. Contract duration;
- d. RAC responsibilities;
- e. Timeframes for completion of audits/recoveries;
- f. Audit look-back periods;
- g. Coordination with other contractors and law enforcement;
- h. Appeals process for RACs to follow;
- i. Contingency fee considerations;
- j. other terms and conditions as necessary.

Medicaid Provider Self Disclosure Form

Provider Name: _____ Provider Number: _____

Address: _____ City _____

State: _____ ZIP Code: _____

Related entities, affected corporate divisions, departments or branches:

Provider Identification Number(s) associated with claims: _____

Tax ID number(s): _____

Description of the matter being disclosed: _____

Person who identified the overpayment: _____

How it was discovered: _____

Summary of provider's review of the overpayment: _____

Is the provider under investigation by any government agency or contractor? Yes _____ No _____

I certify that the information submitted on this form and any other documentation related to this disclosure submitted to DOM is based upon a good faith effort to disclose a billing inaccuracy and is true and correct.

Signature _____ Date _____

Mail or fax form to: Division of Medicaid, Bureau of Program Integrity, Suite 1000, Walter Sillers building, 550 High Street, Jackson, MS 39201, (601) 576-4162, Fax (601) 576-4161

State: Montana

Director: Jennifer Irish jirish@mt.gov

Assistant:

Information/Link/Attachment: Link: <http://medicaidprovider.hhs.mt.gov/pdf/selfaudit.pdf>

State of Montana DPHHS

Quality Assurance Division

SURS Policy: Updated 03.05.08

MONTANA MEDICAID PROVIDER SELF-AUDIT PROTOCOL

I. Background:

Description

Provider self-auditing is an administrative method that may be useful in a Surveillance Utilization Review Section (SURS) office setting. It is best applied to investigation of overpayment issues that do not involve fraud or abuse. It's an administrative process that modifies the internal review and recovery processes from a Department of Public Health and Human Services (DPHHS) initiated recovery process to a provider involved recovery process. In addition it changes the SURS reviewer's responsibility from "auditor" to validating the provider selfaudit and initiating appropriate follow-up action.

Current SURS Process

In the usual SURS review process, the reviewer detects a problem, initiates requests for data or claims, determines an amount of overpayment for the time period under review and then sends a letter to the provider asking for recovery. During the time of the SURS review the following is likely to occur:

- Overpayments continue. If not notified, the provider continues to bill inappropriately.
- The reviewer's data is usually date specific and does not include claims after the data runs. This means that a second review is necessary for any time period after the determination of the overpayment amount.

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- The reviewer is dealing with other cases and their time constraints. This

causes administrative delay in completing the review

- The time involved after sending a recovery letter and dealing with administrative appeal further increases the recovery time and ongoing overpayments.
- At a hearing or upon contact with the provider as a result of the recovery letter, the reviewer may find the problem is not one that is recoverable and thus the time spent developing the case was wasted. (e.g. due to misinformation given by other staff; ambiguous, poorly written or weak medical policies, etc).
- The process tends to create an adversarial relationship between SURS and the provider.

Benefits From A Provider "Self-Audit" Approach

- The approach tends to be less confrontational.
- It permits more recovery cases to be initiated per reviewer
- The provider may stop the incorrect billing process upon receipt of the self-audit letter while reviewing the issue. This creates loss avoidance.
- The provider's review may exceed the bounds of the problem known to the SUR reviewer. This could mean a larger repayment.
- The provider is more likely to refund all overpayments rather than the money overpaid for a set time period. Thus, only one review is required.
- The SUR reviewer may use the self-audit results to identify other providers with similar problems.
- While the majority of information sent to a provider is about verified problems, a self-audit approach may permit the sharing of an anonymous allegation. Notifying the provider could alert them to investigate an area that might be difficult for SUR to initiate without more specific evidence.

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- The provider's incentive to cooperate is good because the alert could help them avoid problems if they fail to identify incorrect problem billing procedures such as a whistleblower suit.

A provider's self-audit may be initiated under either of the following

circumstances:

- A provider contacts the Department and self discloses a billing error
- A probe (a.k.a. discovery sample) is completed by SURS which demonstrates a percentage of billing errors
- Other circumstances identified by DPHHS.

II. Introduction

The Department of Public Health and Human Service (Hereinafter, the Department or DPHHS) relies upon the health care industry to assist in the identification and resolution of matters that adversely affect the State Medicaid Program, and believes that a cooperative effort in this area will serve our common interest of protecting the financial integrity of Medicaid (MA) and ensuring proper payments to providers. The Department encourages MA providers to implement necessary policies, processes, and procedures to ensure compliance with federal and state laws, regulations, and policies relating to the MA Program. As part of these policies and procedures, the Department recommends that providers conduct periodic audits to identify instances where services reimbursed by the MA Program are not in compliance with Program requirements.

With this policy the Department encourages all provider types to voluntarily come forward to disclose any overpayments or improper payments (herein referred to as inappropriate payments) of MA funds. Previously the Department has had no formal mechanism or process for such self audits, but rather, considered and evaluated each disclosure on an individual basis. To ensure uniformity of audits

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submitted for purposes of self disclosure SURS has established a protocol for self audits by MA providers that participate in the fee-for-service environments. While providers have a legal duty to promptly return inappropriate payments that they have received from the MA Program (ARM 37.85.406(10)), use of the protocol is voluntary. The protocol simply provides guidance to providers on the preferred methodology to return inappropriate payments to the Department. This voluntary protocol does not in any way affect the requirements of the Single Audit

Act (such as A-113 Audits) or other independent audit requirements. In establishing this protocol, the Department recognizes that it must encourage MA providers to conduct self audits and to provide viable opportunities for disclosure. The flexibility built into this protocol reflects both the desire of the Department to encourage voluntary disclosure and our commitment to openness and cooperation.

The Department's Self-Audit Protocol is intended to facilitate the resolution of matters that, in the provider's reasonable assessment, potentially violate state administrative law, regulation, or policy governing the MA Program, or matters exclusively involving overpayments or errors that do not suggest violations of law. It is possible that the Department may, upon review of information submitted by the provider or upon further investigation, determine that the matter implicates state criminal or federal law. In such instances, the Department will refer the matter to the appropriate state or federal agency.

When, either in the course of regular business or by using one of the options specified below, providers believe that they have been inappropriately paid, they should promptly contact the Program Integrity Bureau – Surveillance Utilization Review Section (SURS) to expedite the return of the inappropriate payment.

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This protocol is equally applicable to both fee-for-service and managed care providers. Inappropriate payments made by managed care organizations (MCOs) to providers within their networks inflate the costs of providing care to MA recipients, and DPHHS retains its right and responsibility to identify and recover payments or take any other action available under law. While the Department will return to the applicable MCO any payments identified through this protocol, providers must make the self disclosure directly to the Department. The Department recommends that MCOs under contract with the agency educate their contracted providers on this protocol, and encourage them to use it. The Department will notify the respective MCO of the repayment and will work together with the MCO to expedite the return of the payment. Again, when a provider properly identifies an inappropriate payment and the acts underlying

such conduct are not fraudulent, DPHHS will accept repayment without interest penalty.

III. Provider Options for Self Audits

Providers have several options for conducting the self audits and expediting the return of inappropriate payments to the Department:

Option 1 - 100 Percent Claim Review

A provider may identify actual inappropriate payments by performing a 100 percent review of claims. This option is recommended in instances where a case-by-case review of claims is administratively feasible and cost-effective.

To the extent that payments can be returned through the claim adjustment process, the provider should follow the claim adjustment instructions in the applicable provider manual. Otherwise, providers should send refund checks made payable to the "Department of Public Health and Human Services" to the following address:

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Department of Public Health and Human Services
Quality Assurance Division

Supervisor, Surveillance Utilization Review

P.O. Box 202953

Helena, MT 59620-2953

Provider's who wish to submit refund checks by overnight delivery, should direct their mail to the SURS building address:

Department of Public Health and Human Services
Quality Assurance Division

Supervisor, Surveillance Utilization Review

2401 Colonial Drive

Helena, MT 59601

Refund checks should be accompanied by a cover letter that provides:

- an overview of the issues identified,
- the time period covered by the review, (including the reason for the time period selected), and,

- the actions that have been or will be taken to assure that these errors do not reoccur in the future.

Note that providers may be asked to work with the Department to ensure that correct paid claims information is maintained. Acceptance of payment by the Department does not constitute agreement as to the amount of loss suffered.

Option 2 - Provider-Developed Audit Work Plan for DPHHS-QAD Approval When it is not administratively feasible or cost effective for the provider to conduct a 100 percent claim review, a provider may identify and project inappropriate payments pursuant to a detailed work plan submitted to the Department for 7

approval. A provider that wishes to use this option should submit his/her proposal in writing to the Department at the above address.

The proposed work plan should also include an overview of the issues identified, the proposed time period of the review, including the reason for the time period selected, and the corrective action taken to ensure that the errors do not reoccur in the future. DPHHS will, as it has in the past, review the submission and advise the provider accordingly.

Once the proposed plan has been approved by the Department, the audit should be conducted and inappropriate payment(s) projected. Providers should send refund checks to the address specified in Option 1. Again, acceptance of payment by the Department does not constitute agreement as to the amount of loss suffered.

Option 3 – Utilize the Office of Inspector General’s (OIG) Self Disclosure Policy

A provider may find this policy on the OIG’s website.

<http://oig.hhs.gov/fraud/selfdisclosure.html>

Option 4 - DPHHS Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SVRS) A provider may identify and project inappropriate payment amounts by conducting a self audit in accordance with the Department preapproved methodology as set forth in Attachment A (below). If a provider chooses this method, the provider need not obtain prior approval of the audit

work plan.

- NOTE: The Department recognizes that the methodology set forth in Attachment A (below) does not lend itself to all circumstances or provider types. To the extent that the use of Attachment A is not feasible, a provider should notify the Department of the inappropriate payment, and subsequently work with the Department to develop a pre-approved work plan.

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Providers should send refund checks to the address specified in Option 1. Refund checks should be accompanied by:

- a cover letter that provides an overview of the issues identified,
- the time period covered by the review, including the reason for the time period selected, and
- the actions that have or will be taken to assure that these errors do not reoccur in the future.

Acceptance of payment by the Department does not constitute agreement as to the amount of loss suffered.

IV. Examples of Inappropriate Payments Suitable for Self Audits

Over the years, DPHHS – QAD Program Integrity Bureau has identified hundreds of situations involving inappropriate payments to MA providers. Many involve failing to maintain records in accordance with applicable regulations (ARM 37.85.414), performing or providing inappropriate or unnecessary services (ARM 37.85.410), or billing for services that were not rendered. A few more specific violations include the following:

- Billing more than the allowable number of units
- Unbundling bundled codes
- Unqualified person providing services

V. Provider Inquiries

The Department recognizes that application of this protocol to all of the various inappropriate payment situations may raise numerous questions and concerns.

DPHHS is determined, however, to make this process work and will work closely

with providers to answer any questions that they may have.

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Providers or their representatives that have questions regarding this protocol may contact the Department's SURS Unit at (406) 444-4586 to discuss this protocol with the SURS Supervisor.

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Attachment A

**** Attachment A IS TO BE USED BY PROVIDERS WHO SELECT OPTION 4 ONLY ****

Statistically Valid Random Sample (SVRS) Projected Inappropriate Payment(s) under the State of Montana Medical Assistance Provider Self-Audit Protocol
I. Initial Notification to DPHHS and Request for Universe of Claims to be Reviewed

The provider should include a statement identifying the reason for its decision to perform a self audit, including at a minimum the following information:

1. A description of the events that prompted the provider to decide that a self audit would be conducted.
2. The reasons that separate analyses should be performed for different subsets (strata) of billing codes or for different time periods. For example, based upon a hospital's internal audit review, there could be a concern that bundling/unbundling issues might be relevant for laboratory billings during a two year period while there might be a concern that upcoding may have occurred for emergency room billings during a one year time period. This would suggest two sample strata for review (a two year analysis for relevant laboratory codes and a one year analysis for relevant emergency room codes).
3. Basic Information:
 - o The name, address, and Provider Identification Number(s) of the disclosing MA provider. Additionally, provide the name, address, title, and phone number of the disclosing entity's designated representative for purposes of the self audit.

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- A statement of whether the provider has knowledge that the matter is under current inquiry by a government agency or contractor.
- A full description of the nature of the matter being disclosed, including the type of claim, transaction or other conduct giving rise to the matter, and the relevant periods involved.
- The type of health care provider and any provider billing numbers associated with the matter disclosed.
- The reasons why the disclosing provider believes that a violation of state, civil, or administrative law may have occurred.
- A certification by the health care provider, or in the case of an entity, an authorized representative on behalf of the disclosing entity stating that, to the best of the individual's knowledge, the submission contains truthful information and is based on a good faith effort to bring the matter to the state's attention for the purpose of resolving any potential liabilities to the state.

4. The disclosure should be sent to:

Department of Public Health and Human Services

Quality Assurance Division

Supervisor, Surveillance Utilization Review

P.O. Box 202953

Helena, MT 59620-2953

II. Information to be Used by Provider

There are two options for providers to obtain data to complete their SVRS.

A. DPHHS Generated Data

1. DPHHS can, upon request, generate electronic paid claims file(s), which will then be sent to the provider. The paid claims file(s) will be in a format

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specified by DPHHS. If the audit involves a network provider for a MCO under contract with the Department, the Department will work with the relevant MCO to obtain the specific claim information. Discussions will be conducted between DPHHS and providers to determine the format of the

paid claims file and the fields of information required for each claim in the file.

2. DPHHS will generate summary data related to the paid claims file(s). For each stratum of paid claims, DPHHS will report the total number of paid claims and the total amount paid by DPHHS to the provider. For example, depending on the information requested by the provider, DPHHS might generate specific paid claims and summary information such as: 10,000 claims totaling \$300,000 were paid for procedure codes 80000-89999 for the period 7/1/03 to 6/30/06, and 5,000 claims totaling \$500,000 were paid for procedure codes 70000-79999 for the period 7/1/03 to 6/30/06.

3. Providers must assign a sequence number to each claim provided by DPHHS and generate a random number sequence that must be used in sampling the paid claims files. For each stratum of claims under investigation, the provider will generate a sequence of 600 random numbers, which will determine the items to be reviewed as part of each sample. If, in the course of the analysis, it is determined that more than 600 items must be included in a stratum sample, provider must supplement the initial 600 random numbers with additional random numbers.

B. Provider Generated Data

If the provider generates the data, it must meet the SVRS criteria established in II.A. and be compatible with DPHHS systems.

III. The Review Process to be Used

A. For each sample stratum, an initial "probe" sample will be identified by selecting claims with sequence numbers matching the random numbers

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generated by the provider. Claims will be added to the probe sample in the order of the random numbers.

1. The number of claims to be included in the probe sample will be the greater of:

A. 30 claims; or

B. 30 claims plus those claims added in increments of five (i.e., 35, 40, 45, etc.), until a minimum of 15 claims with inappropriate payment amounts are identified.

2. For each claim in the probe sample, beginning with the claim whose sequence number corresponds to the first random number, the provider will determine whether available documentation supports the claim as paid.

A. After a review of relevant documentation, a determination will be made as to the amount, which should have been paid for each claim analyzed.

B. For each claim, an "overpayment" amount will be calculated. The overpayment amount is equal to the greater of:

The amount actually paid minus the amount that "should have been" paid.

Zero (there will not be a credit for underpayments as part of the self-disclosure process – if claims with underpayments are identified through the self-disclosure in a timely manner, the provider may submit claim adjustments to obtain additional payment as provided by applicable law). Refer to the provider handbook for instructions and time frames for submitting claims and claim adjustments.

C. If documentation to support the claim cannot be located for a sampled claim, all payments made by DPHHS for the claim will be treated as overpayments. There can be no substitution of a

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different claim because documentation of the selected claim is not available.

3. At this point the results from the probe sample can be reviewed to assess whether it may be appropriate to modify the stratum under analysis. For example, if the original stratum selected for analysis was all billings for CPT codes between 80000-89999 and the analysis of the probe sample

showed that all errors were associated with only one of those CPT codes, it might be appropriate to narrow the focus of the review to only that one CPT code.

- If it is determined that the stratum should be modified, the provider must document that decision process for inclusion in the selfdisclosure report. The provider must then return to outline step II.A.3 (above) and proceed with a new analysis (including a new probe sample) of only the more focused universe of claims now under review.
- If it is determined that the stratum does not need to be modified, the probe sample will be used to determine the number of claims to be included in the full sample for each stratum using the process illustrated in Exhibit 1 (below).

B. Once the number of claims to be reviewed as part of the full sample has been determined, enough claims should be added to the probe sample to yield the necessary full sample size. Claims will continue to be added to the probe sample in the order of the random numbers until the full sample size is obtained.

- Claims should be added to the probe sample based upon the random numbers generated by provider and the sequence numbers, which were assigned to the paid claims by the provider.

- For each claim in the full sample, the provider will determine whether available documentation supports the claim as paid. Inappropriate payments will be determined for each claim in the full sample by the same

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method as was used to determine overpayments or inappropriate payments for each claim in the probe sample.

- The full sample will be used to determine the estimated repayment amount for each stratum using the process illustrated in Exhibit 2 (below).

IV. The Self-Disclosure Report

A. The report must include the identification of the provider and the Provider MA Identification Number that is the subject of the self disclosure.

B. The report must include the identification of the entity that performed the review and provide the following:

- Identify whether the review was performed by an outside firm or by internal personnel.
- If the review was performed by an outside firm, indicate whether the outside firm performed all aspects of the review. If not, indicate other parties (such as internal personnel) that performed some components of the review (such as determinations of medical necessity).

C. The report must identify the issues which were reviewed on each claim/procedure, and specifically identify whether the following issues were reviewed:

Although providers may submit a claim adjustment during the required time frames for inappropriate payments, the following list of violations is the primary focus of a self-audit process.

- Billing for services not rendered. This includes the obvious and failure to submit a claim adjustment when returning medication to stock or billing for cancelled appointments or no shows.
- Billing for misrepresented service in which a provider received inappropriate payments. This violation includes up coding of procedures, billing brand drugs for generics, services provided by unqualified staff, incorrect dates of service, up coding inpatient ICD-9-CM diagnosis(es) and procedures and, reporting incorrect discharge status codes for inpatient admissions.
- Billing for duplicate services. This could also include billing two different sources for the same service.
- Billing contrary to DPHHS payment conditions such as unbundling laboratory and radiology services to receive higher compensation and billing for non-covered services.
- Serious record keeping violations. This includes falsified records, or no medical or fiscal records available.

- It would be appropriate for the self disclosure to include a copy of the work program review process to document exactly what was (and therefore what was not) reviewed for each claim.

D. The report must disclose, for each stratum analyzed, the following information:

- The time period under analysis.
- The procedure codes under analysis.
- The total amount of payments received from DPHHS and number of claims paid by DPHHS (this is the summary data report generated by DPHHS as a result of the providers' initial request for information for the self-disclosure audit).
- The total number of claims included in the probe sample.
- The total number of claims included in the full sample. If the full sample includes probe samples, specifying the number of claims obtained from the probe sample.
- The repayment amount calculated based on analysis of the full sample (with the associated precision interval at a 90% confidence level). An example of this calculation is given in Exhibit 2 (below).

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E. For each stratum analyzed, the following information should be included as appendices or additional schedules to the report.

- A list of all claims analyzed as part of the probe sample. For each claim in the probe sample the information shown on Exhibit 3 (below) should be provided.
- A schedule detailing the calculations performed to determine the appropriate number of claims to be included in the full sample based on information obtained through analysis of the probe sample.
- A list of all claims analyzed as part of the full sample. For each claim in the full sample the information shown on Exhibit 3 (below) should be provided.
- A schedule detailing the calculations performed to determine the appropriate repayment amount and associated precision interval (at a 90% confidence level) based on information obtained through analysis of

the full sample. An example of this calculation is given in Exhibit 2 (below).
F. The report must be signed and dated and should include a statement that all information included in the report is true and accurate and, the self-disclosure audit was conducted in accordance with the State of Montana Department of Public Health and Human Services Medicaid Provider Self-Audit Protocol.

Exhibit 1

Draft Protocol For Self-Audit Reporting - Analysis of Probe Sample

Claim No Amount That Amount That Overpayment Claims With

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Was Actually

Paid by DPHHS

Should Have Been

Paid by DPHHS

Amount Overpayment

Amounts

1	\$70.00	\$70.00	\$ 0.00	0
2	\$70.00	\$24.00	\$46.00	1
3	\$70.00	\$24.00	\$46.00	2
4	\$70.00	\$70.00	\$ 0.00	0
5	\$70.00	\$70.00	\$ 0.00	0
6	\$70.00	\$70.00	\$ 0.00	0
7	\$24.00	\$70.00	\$ 0.00	0
8	\$70.00	\$24.00	\$46.00	3
9	\$24.00	\$24.00	\$ 0.00	0
10	\$70.00	\$24.00	\$46.00	4
11	\$70.00	\$70.00	\$0.00	0
12	\$70.00	\$70.00	\$ 0.00	0
13	\$24.00	\$24.00	\$ 0.00	0
14	\$70.00	\$24.00	\$46.00	5
15	\$24.00	\$24.00	\$ 0.00	0
16	\$70.00	\$70.00	\$ 0.00	0

17 \$70.00 \$24.00 \$46.00 6
18 \$70.00 \$70.00 \$ 0.00 0
19 \$70.00 \$70.00 \$ 0.00 0
20 \$24.00 \$70.00 \$ 0.00 0
21 \$70.00 \$24.00 \$46.00 7
22 \$24.00 \$24.00 \$ 0.00 0
23 \$70.00 \$24.00 \$46.00 8
24 \$70.00 \$70.00 \$ 0.00 0
25 \$70.00 \$24.00 \$46.00 9
26 \$70.00 \$70.00 \$ 0.00 0
27 \$24.00 \$70.00 \$ 0.00 0
28 \$70.00 \$24.00 \$46.00 10
19
29 \$70.00 \$24.00 \$46.00 11
30 \$24.00 \$24.00 \$ 0.00 0
31 \$70.00 \$24.00 \$46.00 12
32 \$70.00 \$24.00 \$46.00 13
33 \$70.00 \$24.00 \$46.00 14
34 \$70.00 \$70.00 \$ 0.00 0
35 \$24.00 \$24.00 \$ 0.00 0
36 \$70.00 \$24.00 \$46.00 15
37 \$24.00 \$24.00 \$ 0.00 0
38 \$70.00 \$24.00 \$46.00 16
39 \$70.00 \$70.00 \$ 0.00 0
40 \$70.00 \$70.00 \$ 0.00 0

Standard Deviation \$22.54

Determine the number of claims to be in the full sample based upon the following:

- The standard deviation of overpayments in probe sample is 22.54 (from previous page)
- Assume that the total number of provider's claims at issue which were

paid by DPHHS is: 11,500

- The desired confidence level for estimated overpayment is equal to 90%.

The factor for a confidence level of 90% is 1.645.

- Assume that the total payments by DPHHS to the provider for the claims at issue are: \$500,000

- Desired preclusion interval for estimated overpayment is equal to 5% of DPHHS payments: 5% of \$500,000 = \$25,000

The formula for determining the full sample size is:

20

(Standard Deviation of Probe Sample Overpayments) ²
Times

(Total Number of Provider's Claims Paid by DPHHS) ²
Times

(Factor Related to Desired Confidence Level) ²

Divided by

(Desired Precision Interval) ²

Using the values from this example, results in the following full sample size:

$$(22.54)^2 \times (11,500)^2 \times (1.645)^2 / (25,000)^2 =$$

$$(508) \times (132,250,000) \times (2.71) / (625,000,000) = 291$$

Exhibit 2

Draft Protocol For Self-Audit Reporting

Analysis of Full Sample

Continuing the example from Exhibit 1.

- Since 40 claims had already been analyzed as part of the probe sample and since the full sample size was determined to be 291, an additional 251 claims must be selected (251=291-40). If the full sample size calculated from Exhibit 1 had been less than the number of claims in the "probe" sample, then no additional claims would need to be selected and the "probe" sample could be used as the "full" sample.

- Calculate overpayments for each of the claims in the full sample.

- Determine the average overpayment amount for the claims in the full

sample (equals total of all 291 claims' overpayment amounts divided by 291). Assume, for this example, that the total overpayment amount for all 21

291 claims was \$5,336. Then the average overpayment amount for the claims in the full sample would be \$18.34 ($\$18.34 = 5,336 / 291$).

- Determine the estimated amount for repayment to DPHHS (equals the average overpayment amount from Step 3 above times the total number of claims paid by DPHHS). For this example the calculation would be \$18.34 (per claim overpayment amount) times 11,500 (number of claims paid by DPHHS from paid claims file generated by DPW). The example calculation would yield a repayment amount of \$210,910.

- Determine the actual precision interval obtained by the full sample. Although the full sample was designed to result in a confidence level of 90% and a precision interval of plus or minus 5% of the total DPHHS payments under analysis, the actual results of the full sample might be somewhat different. To determine the actual precision interval obtained at a 90% confidence level, perform the following calculations:

- Standard Deviation of Full Sample Overpayments times
- Total Number of Claims Paid By DPHHSW times
- Factor Related to Desired Confidence Level times
- Square Root of Number of Claims in Full Sample

For the example, assume that the standard deviation of the full sample's overpayments was 23, then the calculated precision interval for the \$290,910 overpayment at a 90% confidence level would be:

$(23) \text{ times } (11,500) \text{ times } (1.645) \text{ divided by } (\text{square root of } 291) = 23 \times 11,500 \times 1.645 / 17.06 = \$25,504$

This means that statistical analysis indicates that we can be 90% certain that the provider's actual overpayment is \$210,910 plus or minus \$25,504 (or somewhere between \$236,414 and \$185,406).

Exhibit 3

Protocol for Self-Audit Reporting

Information to Be Included In Audit Report for Each Claim Reviewed

22

1. The sequence number assigned to the claim as part of the electronic paid claims file generated by DPHHS for the self-audit process.
2. The claim's ICN number (Individual Claim Number) or adjusted ICN, if applicable, including the ICN Line Number.
3. The Provider Identification Number (PIN) of the provider who billed and received the inappropriate payment, if other than the provider conducting the self audit.
4. The Date of Service (DOS).
5. The procedure code actually billed to DPHHS for the service.
6. The selected diagnosis(es) or Diagnosis Related Group (DRG), if applicable to the self audit.
7. The amount the provider charged/billed DPHHS for the service.
8. The amount actually paid by DPHHS for the service.
9. The procedure code which should have been billed based on the review of the claim performed as part of the self-audit process.
10. The amount which should have been paid by DPHHS based on the review of the claim performed as part of the self-audit process.
11. The amount of inappropriate payment associated with the claim for each procedure code identified.
12. The specific individual(s) that performed the review of the claim.

APPROVALS

ADMINISTRATOR _____ DATE _____

Jeff Buska

23

BUREAU CHIEF _____ DATE _____

Russ Hill

SURS SUPERVISOR _____ DATE _____

Jennifer Irish

State: Nebraska

Director: Anne Harvey Anne.Harvey@nebraska.gov

Assistant: Jennifer Barber Jennifer.Barber@nebraska.gov

Information/Link/Attachment: Link: http://dhhs.ne.gov/medicaid/Pages/med_pi_fraud.aspx

The Nebraska form is based on other states and the OIG form and process. The process was made more formal because it needed to be available during Medicaid RAC activities. Most providers use this form now, but others still submit the information through another party (law firm, auditor, and statistician). When the form is received, an initial review is done to assess the amount of money involved. If the amount is \$10,000 or greater or the error is particularly questionable, the information is forwarded to the Nebraska MFCU for review. If the disclosure doesn't go to the MFCU or the MFCU does not want to investigate, Program Integrity staff investigates the disclosure to determine if the provider's assessment of claims and money is close.

Nebraska Medicaid Program

Program Integrity


Reporting Medicaid Fraud

- To report suspected **Medicaid Provider Fraud** or possible abuse, neglect or financial exploitation of patients in Medicaid facilities, contact the Medicaid Fraud and Patient Abuse Unit of the Attorney General's Office at (402) 471-3549 or toll free at 1-800-727-6432, 1221 N Street, Suite 500, Lincoln, NE 68509-8920, or by e-mail

ago.medicaid.fraud@Nebraska.gov



[Incident Report/Case Referral](#).

- To report Nebraska Medicaid provider self-disclosure, contact Nebraska Medicaid Program Integrity, PO Box 95026, Lincoln, NE 68509 or toll free at 1-877-255-3092 or by e-mail at DHHS.MedicaidProgramIntegrity@nebraska.gov  [MLTC-61](#), "Self-Disclosure Form"
- To report suspected **Medicaid Client Fraud**, contact the [Special Investigation Unit](#) in the Department of Health and Human Services Division of Public Health:

Phone: for Lincoln and greater Nebraska (402) 471-9407

Or in Omaha: (402) 595-3789

Email:

Investigations.SIU@dhhs.ne.gov

Written complaints

may be submitted in Lincoln

to:

Joyce DeLay
DHHS Division of Public Health Investigations
1033 O Street, Suite 500
Lincoln, NE 68508

Written complaints

may be submitted in Omaha

to:

Janet Blackman
DHHS Division of Public Health Investigations
1215 S 42nd Street
Omaha, NE 68105



Nebraska Medicaid Provider Self-Disclosure Statement

Date Form Completed _____

Type of Self-Report Issue (Select one of more)

- Billing Issue
- Documentation/Records Issue
- Quality of Care
- Cost Report Issue

- Claims for Services Not Provided
- Reporting Health Insurance
- Facility Licensing
- Falsification/Alteration of Records/Documents
- Employee Licensure and/or Credentialing
- Other _____

Facility Information

Facility Name

Provider First Name Last Name

Provider Type Provider Speciality

NE Medicaid provider number NPI License #

Street Address City State Zip

Mailing/Alternate Address City State Zip

Office Phone Fax Alternate Phone

Contact information - person completing form. Leave fields blank if not applicable

First Name Last Name

Job Title Employer/Agency/Company Division

Relationship to Provider
 Employee Attorney Consultant Staff Other

Street Address City State Zip

Office Phone Fax Alternate Phone

E-mail Address

State/Federal Agency or Law Enforcement Notification. Leave fields blank if not applicable

Agency

--	--

Incident Report / Case Referral

Notified

Date Notified Contact First Name Last Name Job Title Phone

--	--	--	--	--	--

Self-Disclosure Details

Date of Referral: _____

You must provide written, detailed information about your self-disclosure in the space below. This must include a description of the facts and circumstances surrounding the errors and inappropriate payments, the time period involved, the person(s) involved, claim details (procedure codes, diagnoses, place of service, etc), relevant Medicaid regulations and estimate of the overpayment. Please provide specific Medicaid claim numbers.

If you have a spreadsheet or listing of the claim details, please send a copy in a secure manner (encrypted as an e-mail attachment with password under separate cover or on a CD).

--

Certification Statement

Self-disclosure offers providers the opportunity to minimize the potential cost and disruption of a full scale audit and investigation and to negotiate a fair monetary settlement. Self-disclosure will not absolve the provider of criminal or civil culpability. If a law enforcement agency determines that a crime was committed, any information shared with the Department will be forwarded to the appropriate agency.

I certify that, to the best of my knowledge, the information in this self report is truthful and is based on a good faith effort to assist Nebraska Medicaid Program Integrity in its inquiry and verification of this disclosed matter.

Print Name

--

Signature

Date

--	--

Job Title

--

Phone Number

Allegation / Concern:

Describe the suspected fraudulent or abusive activities (including background, persons involved, events, dates and locations). Be sure to include the who, what, when, where, why and how of the situation. Please provide as much information as possible.

Other Agencies Notified: City Police County Sheriff Health & Human Services

Other: _____

State: Nevada

Director: Marta Stagliano marta.stagliano@dhcp.nv.gov

Assistant/Contact: Michelle Campbell michelle.campbell@dhcp.nv.gov

Information/Attachment/Link:

When Nevada receives a self disclosure the state will follow up with the provider to determine the amount of the overpayment. If it appears that it is something that may happen again the state will usually keep the case open so it can follow up at a later date. If the state believes the self-disclosure is a one-time occurrence the state gives the provider the benefit of the doubt since they self disclosed. Unless the state receives additional complaints or information the case remains closed after the overpayment is recovered. Nevada does not have a formal self-disclosure protocol.

State: New Jersey

Director: Marc Wallace Marc.Wallace@OSC.state.nj.us

Assistant:

Information/Link/Attachment:

www.nj.gov/njomig/disclosure/

The mission of the New Jersey Office of the State Comptroller - Medicaid Fraud Division (MFD) is to mitigate fraud and abuse in the Medicaid program resulting in cost effectiveness to New Jersey's taxpayers. As part of our multi-disciplinary approach to attaining these goals, we support providers who find problems within their own organizations, reveal (self-disclose) those issues to the MFD, and return inappropriate payments.

The Affordable Care Act of 2010 imposes new federal requirements on Medicaid providers to have a more proficient and time-sensitive process for identifying errors and overpayments received under the Medicaid program, and disclosing and repaying the Medicaid program for amounts that providers received in error. Under changes set forth in the ACA, providers are obligated to report, explain, and repay overpayments within 60 calendar days of identification. See ACA Sec. 6402, expected to be codified at 42 U.S.C. Sec. 1320a-7k(d)(2). Those that fail to disclose, explain, and repay the overpayment in a timely manner may be subject to liability under the New Jersey and federal False Claims Acts.

The MFD recognizes that many improper payments are discovered during the course of a provider's internal review processes. While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments, it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both New Jersey and the provider involved. In order to encourage self-disclosure, MFD offers incentives for providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds-whether intentional or unintentional-under the state's Medicaid program. By forming a partnership with providers through this self-disclosure approach, MFD's overall efforts to eliminate fraud, waste and abuse will be enhanced, while simultaneously offering providers a mechanism or method to reduce their legal and financial exposure.

The MFD recognizes that situations which are subject to this guidance could vary significantly; therefore, this protocol is written in general terms to allow providers the flexibility to address the unique aspects of the matters disclosed.

Advantages of Self-Disclosure

Self-disclosing overpayments, in most circumstances, will result in a better outcome than if MFD staff had discovered the matter independently. While the specific resolution of self-disclosures depends upon the individual merits of each case, the MFD will extend the following benefits to providers who, in good-faith, participate in a self-disclosure:

- Avoidance of False Claims penalties if reported within 60 days of identification
- Forgiveness or reduction of interest payments (for up to two years)
- Extended repayment terms
- Waiver of penalties and/or sanctions
- Timely resolution of the overpayment
- Decrease in the likelihood of imposition of an MFD Corporate Integrity Program

Developing such a partnership with the MFD during the self-disclosure process may also lead to more thorough understanding of the MFD's audit and investigatory processes, benefitting the provider in the future.

When to Disclose

Section 1128J (d)(2) of the Social Security Act requires a provider to self disclose an overpayment within 60 days of the overpayment being identified or the date any corresponding cost report is due, if applicable. Under subsection (3) of the statute, failure to report the overpayment in a timely manner, makes the claims comprising the overpayment subject to the penalties described in the False Claims Act (not less than \$5,000 a per claim line nor more than \$11,500 per claim line plus three times the amount of damages). Matters related to an on-going audit/investigation of the provider are not generally eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an on-going audit may be eligible for processing under the self-disclosure protocol assuming the matter has received timely attention. If MFD is already auditing or investigating the provider, and the provider wishes to disclose an issue, in addition to submitting a disclosure under this protocol, the provider should bring the matter to the attention of the on-site audit staff. If another outside agency is auditing or investigating the provider, and the provider seeks to disclose an issue to MFD, the provider should follow this guidance accordingly. However, because of the wide variance in the nature, amount and frequency of overpayments that may occur over a wide spectrum of provider types, it is difficult to present a comprehensive set of criteria by which to judge whether disclosure is appropriate. Providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes. Because of the complexity of some issues surrounding self-disclosures, providers may want to consider obtaining the advice of experienced healthcare legal counsel or consultants.

Each incident must be considered on an individual basis. Factors to consider include the exact issue, the amount involved, any patterns or trends that the problem may demonstrate within the provider's system, the period of non-compliance, the circumstances that led to the non-compliance problem, the organization's history, and whether or not the organization has a corporate integrity agreement (CIA) in place.

Issues appropriate for disclosure may include, but are not limited to:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of fraud and abuse laws

MFD is not interested in fundamentally altering the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims. Providers should be aware that the MFD monitors both the number of occurrences and dollar amounts of voids and/or adjustments, as well as any patterns of voids and/or adjustments. The MFD highly discourages providers from attempting to avoid the self-disclosure process when circumstances in fact warrant its use.

The Process

Once a provider determines to disclose a problem, an initial report should be prepared which includes gathering the following information:

- The basis for the initial disclosure, including how it was discovered, the approximate time period covered, and an assessment of the potential financial impact;
- The Medicaid program rules potentially implicated;
- Any corrective action taken to address the problem leading to the disclosure, the date the correction occurred and the process for monitoring the issue to prevent reoccurrence; and
- The name and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or counsel but should, in any event, be in an appropriate position to speak for the organization.

Contact the MFD with the above information by telephone or via formal letter to The Office of the Medicaid Fraud Division, P.O. Box 025, Trenton, New Jersey 08625-025. Providers may also use the printable version of MFD's self-disclosure form, which is available at <http://nj.gov/comptroller/divisions/medicaid/>.

After this initial reporting phase, the MFD will consult with the provider and determine the most appropriate process for proceeding. MFD staff will discuss the next steps, which may include requesting additional information. Ultimately, the provider should be prepared to present the following:

- A summary of the identified underlying cause of the issue(s) involved and any corrective action taken;
- A CD containing an Excel file containing a detailed list of claims paid that comprise the overpayments. Each claim should list the provider Medicaid ID number, client name and Medicaid ID, dates of service(s), rates or procedure codes, and the amount(s) paid by Medicaid;
- The names of individuals involved in any suspected improper or illegal conduct and whether they are still employed by the provider, the names of the individuals who found the problem, and the names of the individuals involved in rectifying the problem;
- The nature and extent of any investigation or audit conducted to identify and determine the amount of overpayment;
- An attestation of accuracy and completeness; and

- The name, correspondence address, email address, and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or counsel but should, in any event, be in an appropriate position to speak for the organization.

Assuming a provider completely cooperates and responds promptly to information requests, the MFD expects that the vast majority of self-disclosures will be completed within six months of submission of this information.

The MFD will consider the provider's involvement and level of cooperation throughout the disclosure process in determining the most appropriate resolution and the best mechanism to achieve that resolution. In the event that the provider and the MFD cannot reach agreement on the amount of overpayments identified, or if a provider fails to cooperate in good faith with the MFD to resolve the disclosure, the MFD may pursue the matter through established audit or investigation processes, and any less stringent repayment and/or sanction terms may no longer apply. Upon review of the provider's disclosure and related information, the MFD may conclude that the disclosed matter warrants referral to the New Jersey Attorney General's Medicaid Fraud Control Unit (MFCU). Alternatively, the provider may request the participation of a representative of the MFCU, DHHS OIG, the Department of Justice or a local United States Attorney's Office in settlement discussions in order to resolve potential liability under the False Claims Act or other laws.

Access to Information

Providers are expected to promptly comply with MFD requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The MFD also expects the provider to execute and provide business record affidavits whenever requested, in a form acceptable to the MFD.

The MFD is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or work-product protection. Discussions with the provider's counsel will explore ways to gain access to factual or other non-protected information pertinent to the case in the event that documents or other material contain thought processes or advice from the provider's legal counsel, without the need to waive the protection provided by an appropriately asserted claim of attorney-client privilege or attorney work product. Assuming the provider acts in good-faith, the mere fact that the provider and MFD are unable to agree on an amount and resolve the disclosure will not automatically preclude favorable repayment terms, particularly related to the portion of the matter to which the provider and MFD are able to agree.

Restitution

All provider self-disclosures are subject to a thorough MFD review to determine whether the amount identified is accurate. The MFD will not accept any payment for self-disclosures prior to reviewing the provider's submission, and confirming the accurate amount of the overpayment.

Following the review, MFD staff will consult with the provider's respective state oversight agency to establish a repayment amount and schedule and explore the need to pursue any further administrative action. MFD's determination will be based on several factors, including the nature of the problem, the effectiveness of the provider's compliance program, the dollar amounts involved, the

time period, thoroughness and timing of the provider's disclosure, any potential harm to the health and safety of Medicaid recipients, and the provider's efforts to prevent the problem from recurring.

Once a repayment amount has been established, assuming full repayment has not previously been made, the MFD expects the provider to reimburse the State of New Jersey for the overpayment with a check for the full amount, or enter into a repayment agreement. Repayments can occur through monthly payments to MFD or by having MFD withhold a portion of that provider's weekly reimbursement. The MFD will work with providers to establish repayment terms, which may include some forgiveness of interest and/or extended repayment. Providers interested in extended repayment terms will be required to submit audited financial statements, if available, and/or other documentation to assist the MFD in making that determination. The MFD will assess a provider's culpability and good-faith efforts in reaching the disposition of a self-disclosure. Cooperation will be measured by the extent to which a provider discloses relevant facts and evidence, not its waiver of the attorney-client privilege or work product protection. A lack of information may make it difficult for MFD to determine the nature and extent of the conduct which caused the improper payment. Once the repayment has been finalized, the MFD will issue a letter indicating closure of the matter.

State: New Mexico

Director: Everet Apodaca everet.apodaca@state.nm.gov

Assistant:

Information/Link/Attachment:

New Mexico has an [Inspector General](#) for all programs administered under the Human Services Department, including Medicaid. New Mexico has a Program Integrity Unit within its [Quality Assurance Bureau](#) of the Human Services Department. Other than a recent [CMS Report](#) on the program, very little information about this program was found on New Mexico's website. The CMS Report states that New Mexico has a "self-audit program" to capture improper payments, but no information about this program could be found online.

State: New York

Director: James Cox (james.cox@omig.ny.gov)

Assistant: Information/Link/Attachment:

<http://www.omig.ny.gov/data/content/blogsection/25/208/>

The New York State Office of Medicaid Inspector General (OMIG) originally issued self-disclosure guidance for Medicaid providers on March 12, 2009. OMIG developed the self-disclosure guide in consultation with health care providers and industry professionals to give providers an easy-to-use method for disclosing overpayments. OMIG designed this approach to encourage providers to investigate and report matters that involve possible fraud, waste, abuse or inappropriate payment of funds that they identify through self-review, compliance programs, or internal controls that affect the state's Medicaid program. This guide is designed to help the provider through the process, point out advantages of self-disclosure, offer a user-friendly mechanism, and make providers aware of regulatory compliance requirements.

Since its inception, the Self-Disclosure Program has been successful and utilized extensively by providers, benefiting both the providers and the Medicaid program. As a result of the OMIG Self-Disclosure Unit's experience and feedback, the agency has made enhancements and had added resources to the process.

The function is now supplemented by utilizing the OMIG\HMS PORTal, a Web-based site maintained by OMIG's contracted agent, HMS, Inc. The PORTal is an online mechanism used by OMIG\HMS to issue various projects and process recoveries in a simple, effective, and user-friendly electronic medium. OMIG has revised this guide to reflect the consolidation of the self-disclosure function within the agency to better serve the providers and the New York State Medicaid program.

Regulatory Authority

OMIG's Self-Disclosure Program, is in accordance with OMIG's enabling legislation: *[T]o, in conjunction with the commissioner, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. The provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action.* N.Y. PUB. HEALTH LAW § 32(18).

Self-disclosure and repayment of overpayments within 60 days of identification has become mandatory for Medicare and Medicaid providers under section 6402(a) of the Affordable Care Act (ACA) of 2010 and a mandatory part of New York's compliance programs under 18 NYCRR 521.

When to Disclose

Providers should self-disclose **after** they fully investigate and confirm that an overpayment exists. OMIG's self-disclosure protocol assists and enables providers in

making disclosures directly to OMIG or through its contracted agent HMS, which maintains the online OMIG PORTal. Through this process, providers who identify that they received reimbursement to which they were not entitled, whether caused by mistake, fraud, or accident, must disclose the parameters of the problem, cause, and its potential Medicaid financial impact in accordance with the self-disclosure guidelines. In addition, the federal Affordable Care Act requires providers to identify, self-disclose, explain, and repay overpayments within 60 calendar days of identification of the overpayment regardless of the financial threshold of participation in the Medicaid program.

The statute at 42 U.S.C. §1320a-7k(d)(1), requires a person who has received an overpayment to:

1. **report and return** the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
2. **notify** the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

Failure to timely report and return any Medicare and Medicaid overpayment can have severe consequences, including potential liability under the False Claims Act, as well as the imposition of civil monetary penalties and exclusion from the Medicare and Medicaid programs.

Overpayment Reporting should occur when the following conditions are met:

1. Overpayment is NOT included in another, separate review or an audit being conducted by OMIG, vendors, or OIG.
2. Overpayment is NOT related to a broader state-initiated rate adjustment, cost settlement, or other broader payment adjustment mechanisms. (These include retroactive rate adjustments, charity care, cost reporting, etc.)

The repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims.

The Process

Prior to contacting OMIG, the provider should fully investigate and determine the issue and prepare the disclosure including all the required information and documentation. Once an inappropriate payment is discovered, providers must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes. Each incident must be considered on an individual basis. Factors to consider include: identification of the exact issue, the amount involved, any patterns or trends that the problem may demonstrate within the provider's billing system, the extent of the period affected, the circumstances that led to the overpayment and whether or not the organization has an **OMIG corporate integrity agreement (CIA)** which requires self-disclosure.

The providers may choose to self-disclose using one of two methods:

1. Following the Self-Disclosure Submission Guidelines (see Attachment 1); or
2. Using the OMIG PORTal for electronic submission (see Attachment 2).

After receipt of the self-disclosure, the OMIG/HMS staff will consult with the provider and determine the most appropriate process for proceeding. OMIG/HMS staff will

discuss the next steps which may include requesting additional information, verification of the overpayments and any regulatory clarification needed.

In the event that the provider is unable to determine if the self-disclosure issue resulted in non-compliance overpayments or has difficulty identifying the overpayments, OMIG staff can possibly assist the provider in the disposition of the issue. The provider, or its designated agent, may request data for the sole purpose of quantifying and validating a potential overpayment (see Attachment 3 – Data Request from Providers).

The use of **statistical sampling** must be approved by OMIG and all documentation related to the review and extrapolation must be submitted to OMIG for review and approval. Data may be provided by OMIG to establish the appropriate universe and sampling method upon request and approval by OMIG.

To submit a self-disclosure or request data to develop same please send to:
Via letter:

The Office of the Medicaid Inspector General
Attention: Self-Disclosure Unit
800 North Pearl Street
Albany, NY 12204

Via Email:
SelfDisclosures@omig.ny.gov

Access to Information

Providers are expected to promptly comply with OMIG requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. The OMIG is committed to working with providers in a cooperative manner to obtain relevant facts and evidence without interfering with the attorney-client privilege or work-product protection. Discussions with the provider's compliance officer, counsel, or other staff may be necessary to obtain information and agreement to complete the disclosure in a timely manner.

Access to Data

All documentation and data must be protected for confidentiality under the Health Insurance Portability and Accountability Act (HIPAA) by the provider and its representatives (staff, lawyer, or contractor). The US Department of Health and Human Services' HIPAA guidance states that: The "Privacy Rule" requires that a covered entity obtain satisfactory assurances from its business associate that the business associate will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity. **The satisfactory assurances must be submitted in writing to OMIG, whether in the form of a contract or other agreement between the covered entity and the business associate.**

Restitution

All provider self-disclosures are subject to a thorough OMIG/HMS review to determine whether the amount identified is accurate. While repayment is encouraged and accepted as early in the process as possible, and will be credited toward the final settlement amount, the OMIG will not accept money, voids, and adjustments as full and final payment for self-disclosures prior to finalizing the review process.

Once a repayment amount has been established, assuming full repayment has not previously been made, the OMIG expects the provider to reimburse the State of New

York for the overpayment. Providers interested in extended repayment terms due to hardship will be required to submit audited financial statements and/or other documentation to assist the OMIG in making that determination. Once the repayment has been finalized, the OMIG will issue a letter indicating closure of the matter.

Self-disclosure limitations

The OMIG Self-Disclosure Program is designed to report and recover overpayments due back to the Medicaid program. Depending on the nature of the issue, the OMIG's staff may refer the matter through established audit or investigation processes or to other state agencies.

NYS Office of Medicaid Inspector General (OMIG)

Self-Disclosure Submission Guidelines

A self-disclosure submission requires both a letter and a claim file(s) of impacted Medicaid claims.

Submission Letter

Complete description of circumstances surrounding the disclosure including:

- Provider name
- Medicaid MMIS ID and NPI number of the billing provider
- The error that occurred
- How the error was found
- Any relevant facts including total amount billed and amount of overpayment by Medicaid
- Identify the time period the claims error encompasses
- Actions taken to stop the error and prevent recurrence
- Personnel involved in the error occurrences, those who discovered the problem, and those involved in rectifying the problem

- Legal and Medicaid program rules implicated
- Disclosure contact person name, phone number, and both correspondence and email addresses

File of claims

Enclose a CD containing an encrypted, password-protected Access, Excel, or tab delimited txt (with file

structure) file of claims billed to Medicaid. Please notify OMIG of the password via email or phone call. Do not e-mail the data.

Data needed for each claim line is as follows:

- Claim Reference Number (CRN) or Transaction Control Number (TCN)
- Medicaid MMIS ID
- NPI number of billing provider
- Medicaid group ID number (applicable if only submitted on claim)
- Last name of Medicaid patient
- First name of Medicaid patient
- Medicaid ID of patient (CIN - 8 characters)
- If applicable, Patient Account Number
- If applicable, Medical Record Number

- Date of service (not the date billed)
- Rate or Procedure code
- Amount paid to provider by Medicaid
- Amount overpaid by Medicaid

Please do not send a check for overpayment or void/adjust your claims

After OMIG reviews all disclosure submission material, you will receive a final letter indicating the overpayment

dollar amount and the procedure for remitting payment. If the submitted claim data does not materially match

OMIG's payment data, you will be contacted before a final letter is issued.

All self-disclosure correspondence and claim files claims should be sent to:

NYS Office of Medicaid Inspector General

Self-Disclosure Unit

800 North Pearl St.

Albany, NY 12204-1822

If you have any questions, please email to SelfDisclosures@omig.ny.gov or call 518-473-3782 for assistance

State: Ohio

Director: Lisa Coss lisa.coss@jfs.ohio.gov

Assistant:

Information/Link/Attachment: Link:

<http://codes.ohio.gov/oac/5101%3A3-1-25>

Below is Section F from the link; Lisa Coss stated this was the only policy/document on Self audit disclosure.

F) ODJFS may waive interest when repayment is made in full and the amount of interest owed by any single provider is less than fifty dollars. ODJFS may waive interest when voluntary repayment of individual claims is made by a provider before any notification by ODJFS that an overpayment has occurred.

State: Oklahoma

Director: Cindy Roberts cindy.roberts@okhca.org

Assistant: Kristen Edwards Kristen.Edwards@okhca.org

Information/Link/Attachment

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER



MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

OHCA 2011-24

May 4, 2011

Re: Self-Disclosure of errors and overpayments

Dear Provider,

This letter is to inform you of new federal policy related to the handling of errors and overpayments. Public Law 111-148, expected to be codified at 42 U.S.C. Sec. 1320a-7k(d)(2) requires Medicaid contracted providers to have a proficient and time-sensitive process for identifying errors and overpayments. Providers are obligated to report, explain, and repay overpayments within 60 calendar days of identification. Those providers that fail to disclose, explain, and repay the overpayment in a timely manner may be subject to liability under the Federal False Claims Acts.

We recognize that varying types of improper payments are discovered during the course of a provider's internal review process. When a provider notes an improper payment, the provider must determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes. Either process requires repayment within 60 days of identification.

The Oklahoma Health Care Authority (OHCA) is not interested in fundamentally altering the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayments should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims.

Each incident must be considered on an individual basis. Factors to consider include the exact issue, the amount involved, any patterns or trends that the problem may demonstrate within the provider's system, the period of non-compliance, and the circumstances that led to the non-compliance problem. Issues appropriate for disclosure may include, but are not limited to:

- substantial routine errors
- systematic errors
- patterns of errors
- potential violation of fraud and abuse laws.

To assist providers, OHCA has developed HCA-47 "Provider Self-Disclosure form" available on the website at www.okhca.org/providers/forms. If you have questions regarding the information provided in the letter, please contact Kristin Edwards at (405) 522-7069 or via e-mail at kristin.edwards@okhca.org.

Thank you for the services that you provide to our SoonerCare and Insure Oklahoma members.

Sincerely,

A handwritten signature in black ink, appearing to read "Garth L. Splinter, MD". The signature is fluid and cursive, with a distinct loop at the end.

Garth L. Splinter, MD
State Medicaid Director

Oklahoma Health Care Authority Provider Self Disclosure Form

Provider Information	
Provider Name	
Provider ID	
Address	
Contact Information	
Contact Person	
Phone Number	

Description of matter being disclosed:

Date discovered:	_____
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How it was discovered:

Summary of provider's review of the overpayment:

Amount of Overpayment:	_____
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It should be noted that participation in the self disclosure program does not alleviate the possibility of further review of the OHCA in this or future reviews, and does not affect in any manner the government's ability to pursue criminal, civil or administrative remedies for the matters which are the subject of the self disclosure.

I certify that the information submitted on this form and any other documentation related to this disclosure submitted to OHCA is based upon a good faith effort to disclose a billing inaccuracy and is true and correct.

Signature _____ **Date** _____

Mail this form to: Oklahoma Health Care Authority, Program Integrity & Accountability Unit, 2401 N.W. 23rd St, Suite A-1, Oklahoma City, OK 73107

State: Oregon

Director: Fritz Jenkins fritz.jenkins@state.or.us

Assistant

Information/Link/Attachment:

Oregon is working on procedures/policies for Providers self disclosure.

State: Pennsylvania

Director: Laurie Rock lrock@state.pa.us

Assistant:

Information/Link/Attachment:

Link:

http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicalassistanceproviderselfauditprotocol/S_001151

I. Introduction

The Department of Public Welfare (DPW) relies upon the health care industry to assist in the identification and resolution of matters that adversely affect the Medical Assistance (MA) Program, and believes that a cooperative effort in this area will serve our common interest of protecting the financial integrity of the MA Program and ensuring proper payments to providers. DPW encourages MA providers to implement necessary policies, processes, and procedures to ensure compliance with federal and state laws, regulations, and policies relating to the MA Program. As part of these policies and procedures, the DPW recommends that providers conduct periodic audits to identify instances where services reimbursed by the MA Program are not in compliance with Program requirements.

Over the years, DPW has encouraged all provider types to voluntarily come forward and disclose any overpayments or improper payments (herein referred to as inappropriate payments) of MA funds. DPW has had no formal mechanism or process for such self audits, but rather, has considered and evaluated each disclosure on an individual basis. Upon review of recent disclosures and supporting audits, DPW has become concerned about the lack of uniformity of audits submitted for purposes of self disclosure.

In light of these concerns, DPW decided to establish a protocol for self audits by MA providers that participate in both the fee-for-service and managed care environments. While providers have a legal duty to promptly return inappropriate payments that they have received from the MA Program, use of the protocol is voluntary. The protocol simply provides guidance to providers on the preferred methodology to return inappropriate payments to DPW. This voluntary protocol does not in any way affect the requirements of the Single Audit Act or other independent audit requirements.

In establishing this protocol, DPW recognizes that it must continue to encourage MA providers to conduct self audits and to provide viable opportunities for disclosure. Toward that end, DPW renews its commitment to promote an environment of openness and cooperation. The flexibility built into this protocol reflects both our desire to encourage voluntary disclosure and our commitment to openness and cooperation.

DPW's Self-Audit Protocol is intended to facilitate the resolution of matters that, in the provider's reasonable assessment, potentially violate state administrative law, regulation, or policy governing the MA Program, or matters exclusively involving overpayments or errors that do not suggest violations of law. It is possible that the Department may, upon review of information submitted by the provider or upon further investigation, determine that the matter implicates state criminal or federal law. In such instances, the Department will refer the matter to the appropriate federal or state agency.

When, either in the course of regular business or by using one of the options specified below, providers believe that they have been inappropriately paid, they should promptly contact the Bureau of Program Integrity (BPI) to expedite the return of the inappropriate payment. Providers benefit from self audits in several ways. By coming forward and identifying instances of possible noncompliance, the provider, rather than DPW, is conducting the review of his/her records. Further, and perhaps most importantly, when the provider properly identifies an inappropriate payment and reports it to DPW, and the acts underlying such conduct are not fraudulent, **DPW will not seek double damages, but will accept repayment without penalty.**

While voluntary disclosures were traditionally made by providers operating under the fee-for-service system, this protocol is equally applicable to managed care providers. Inappropriate payments made by managed care organizations (MCOs) to providers within their networks inflate the costs of providing care to MA recipients, and DPW retains its right and responsibility to identify and recover payments or take any other action available under law. While DPW will return to the applicable MCO any payments identified through this protocol, providers must make the self disclosure directly to DPW. We recommend that MCOs under contract with DPW educate their contracted providers on this protocol, and encourage them to use it. DPW will notify the respective MCO of the repayment and will work together with the MCO to expedite the return of the payment. Again, when a provider properly identifies an inappropriate payment and the acts underlying such conduct are not fraudulent, DPW will not seek double damages but will accept repayment without penalty.

II. Provider Options for Self Audits

Providers have several options for conducting the self audits and expediting the return of inappropriate payments to the Department:

Option 1 - 100 Percent Claim Review - A provider may identify actual inappropriate payments by performing a 100 percent review of claims. This option is recommended in instances where a case-by-case review of claims is administratively feasible and cost-effective.

To the extent that payments can be returned through the claim adjustment process, the provider should follow the claim adjustment instructions in the applicable provider manual. Otherwise, providers should send refund checks made payable to the "Commonwealth of Pennsylvania" to the following address:

Department of Public Welfare
Office of Administration
Director, Bureau of Program Integrity
P.O. Box 2675
Harrisburg, PA 17105-2675

Providers who wish to submit refund checks by overnight delivery, please have mail directed to the Bureau's building address:

Department of Public Welfare
Office of Administration
Bureau of Program Integrity
Petry Building, #17, 3rd Floor
DGS Annex Complex
116 East Azalea Drive
Harrisburg, PA 17110-3594

Refund checks should be accompanied by a cover letter that provides an overview of the issues identified, the time period covered by the review, including the reason for the time period selected, and the actions that have been or will be taken to assure that these errors do not reoccur in the future. Note that providers may be asked to work with DPW to ensure that we maintain correct paid claims information. Acceptance of payment by the MA Program does not constitute agreement as to the amount of loss suffered.

Option 2 - Provider-Developed Audit Work Plan for BPI Approval - When it is not administratively feasible or cost effective for the provider to conduct a 100 percent claim review, a provider may identify and project inappropriate payments pursuant to a detailed work plan submitted to DPW for approval. A provider that wishes to use this option should submit his/her proposal in writing to BPI at the above address.

The proposed work plan should also include an overview of the issues identified, the proposed time period of the review, including the reason for the time period selected, and the corrective action taken to ensure that the errors do not reoccur in the future. BPI will, as it has in the past, review the submission and advise the provider accordingly.

Once the proposed plan has been approved by DPW, the audit should be conducted and inappropriate payment(s) projected. Providers should send refund checks to the address specified in Option 1. Again, acceptance of payment by the MA Program does not constitute agreement as to the amount of loss suffered.

Option 3 - DPW Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SVRS) - A provider may identify and project inappropriate payment amounts by conducting a self audit in accordance with the DPW pre-approved methodology as set forth in Attachment A (below). If a provider chooses this method, the provider need not obtain prior approval of the audit work plan.

- NOTE: DPW recognizes that the methodology set forth in Attachment A (below) does not lend itself to all circumstances or provider types. To the extent that the use of Attachment A is not feasible, a provider should notify DPW of the inappropriate payment, and subsequently work with DPW to develop a pre-approved work plan.

Providers should send refund checks to the address specified in Option 1. Refund checks should be accompanied by a cover letter that provides an overview of the issues identified, the time period covered by the review, including the reason for the time period selected, and the actions that have or will be taken to assure that these errors do not reoccur in the future. Acceptance of payment by the MA Program does not constitute agreement as to the amount of loss suffered.

III. Examples of Inappropriate Payments Suitable for Self Audits

Over the years, DPW's Bureau of Program Integrity has identified hundreds of situations involving inappropriate payments to MA providers. Many involve failing to maintain records in accordance with applicable regulations (55 Pa. Code §1101.51), performing or providing inappropriate or unnecessary services, or billing for services that were not rendered. A few of the more specific violations identified include the following:

- A provider (e.g., pharmacy, medical supplier, laboratory, home health agency, EPSDT service provider) bills MA with an incorrect prescriber's license number. This, in effect, misrepresents the prescriber of the service.
- A behavioral health rehabilitation services provider bills for more units of service, e.g. Therapeutic Staff Support (TSS), Behavioral Specialist Consultant (BSC), and/or Mobile Therapist (MT), than were prescribed in the Psychiatric/ Psychological evaluation for the client.
- A behavioral health rehabilitation services provider discovers that an employee providing TSS, BSC, and/or MT services was not qualified to provide the services billed.
- An inpatient hospital provider (provider type 11) includes outpatient services in the inpatient billings, resulting in an incorrect DRG payment.
- A psychiatric inpatient hospital provider (provider type 01) bills and received payment for primary Drug and Alcohol services not payable to a psychiatric hospital or hospital psychiatric unit.
- A hospital outpatient laboratory provider (provider type 01) bills both CPT Codes #87040 (aerobic and anaerobic) and #8076 (anaerobic) when CPT Code #87040 should have been the only code billed because it includes both the aerobic and anaerobic components.
- Two or more physicians (provider type 31) involved in rendering an inpatient service bills different procedure codes for the same service.
- A methadone maintenance provider (provider type 08, specialty 084) bills for services provided prior to the clinic supervisory physician's examination/evaluation and/or treatment plan.
- A hospital outpatient radiology provider (provider type 01) bills individual diagnostic radiology codes separately for hand-wrist procedures when appropriate combination codes were available.
- An inpatient physician provider bills Procedure Code 99233 without meeting at least two of the three required components.
- A pharmacy provider (provider type 24) identifies claim adjustments that have not been made when recipient(s) have not picked up their prescriptions.

- An inpatient psychiatric and rehabilitation hospital or unit (provider type 01) bills and receives payments for more than two therapeutic leave days per calendar month.
- An inpatient residential treatment facility (provider type 56) bills and receives full per diem reimbursement for days when residents were hospitalized at acute care facilities, private psychiatric hospitals, or psychiatric units (provider type 01). These days should be billed as hospital reserved bed days and paid one-third the facility's per diem rate up to the maximum fifteen days per calendar year.
- A psychiatric partial hospitalization program (provider type 11, specialty 113 and 114) bills for time spent transporting the client to and/or from the partial program or for time spent in activities away from the licensed site.
- A psychiatric outpatient clinic (provider type 08, specialty 110) bills for a medication administration visit when no medication was administered, or bills for services provided away from the licensed site (e.g. services provided in the schools).
- A laboratory provider (provider type 28) bills for drug screens of clients at drug and alcohol clinics (provider type 08). Diagnostic laboratory services used to detect the clinic patient's use of drugs are included in the Drug and Alcohol clinic visit fee.
- A hospice provider (provider type 06) incorrectly billed the Department without the required Certification of Terminal Illness.
- An inpatient hospital provider (provider type 01) incorrectly uses ICD-9-CM V30 codes and receives improper DRG cost outlier payments.

IV. Provider Inquiries

DPW recognizes that application of this protocol to all of the various inappropriate payment situations may raise numerous questions and concerns. DPW is determined, however, to make this process work and will work closely with providers to answer any questions that they may have.

Providers or their representatives that have questions regarding this protocol may contact the Department's Bureau of Program Integrity at (717) 772-4606 to discuss this protocol with the Provider Self-Audit Protocol Coordinator.

Attachment A

****** Attachment A IS TO BE USED BY PROVIDERS WHO SELECT OPTION 3 ONLY ******

Statistically Valid Random Sample (SVRS) Projected Inappropriate Payment(s) under the Pennsylvania Medical Assistance Provider Self-Audit Protocol

I. Initial Notification to DPW and Request for Universe of Claims to be Reviewed

The provider should include a statement identifying the reason for its decision to perform a self audit, including at a minimum the following information:

1. A description of the events that prompted the provider to decide that a self audit would be conducted.
2. The reasons that separate analyses should be performed for different subsets (strata) of billing codes or for different time periods. For example, based upon a hospital's internal audit review, there could be a concern that bundling/unbundling issues might be relevant for laboratory billings during a two year period while there might be a concern that upcoding may have occurred for emergency room billings during a one year time period. This would suggest two sample strata for review (a two year analysis for relevant laboratory codes and a one year analysis for relevant emergency room codes).
3. Basic Information:
 - The name, address, and Medical Assistance Identification Number(s) (MAID) of the disclosing MA provider. Additionally, provide the name, address, title, and phone number of the disclosing entity's designated representative for purposes of the self audit.
 - A statement of whether the provider has knowledge that the matter is under current inquiry by a government agency or contractor.
 - A full description of the nature of the matter being disclosed, including the type of claim, transaction or other conduct giving rise to the matter, and the relevant periods involved.
 - The type of health care provider and any provider billing numbers associated with the matter disclosed.
 - The reasons why the disclosing provider believes that a violation of state, civil, or administrative law may have occurred.
 - A certification by the health care provider, or in the case of an entity, an authorized representative on behalf of the disclosing entity stating that, to the best of the individual's knowledge, the submission contains truthful information and is based on a good faith effort to bring the matter to the state's attention for the purpose of resolving any potential liabilities to the state.
4. The disclosure should be sent to:

Commonwealth of PA Department of
Public Welfare Director, Bureau of
Program Integrity P.O. Box 2675
Harrisburg, PA 17105-2675

II. Information to be Used by Provider

There are two options for providers to obtain data to complete their SVRS.

A. DPW Generated Data

1. DPW can, upon request, generate electronic paid claims file(s), which will then be sent to the provider. The paid claims file(s) will be in a format specified by DPW. If the audit involves a network provider for a MCO under contract with the Department, the Department will work

with the relevant MCO to obtain the specific claim information. Discussions will be conducted between DPW and providers to determine the format of the paid claims file and the fields of information required for each claim in the file.

2. DPW will generate summary data related to the paid claims file(s). For each stratum of paid claims, DPW will report the total number of paid claims and the total amount paid by DPW to the provider. For example, depending on the information requested by the provider, DPW might generate specific paid claims and summary information such as: 10,000 claims totaling \$300,000 were paid for procedure codes 80000-89999 for the period 7/1/97 to 6/30/98, and 5,000 claims totaling \$500,000 were paid for procedure codes 70000-79999 for the period 7/1/96 to 6/30/99.
3. Providers must assign a sequence number to each claim provided by DPW and generate a random number sequence that must be used in sampling the paid claims files. For each stratum of claims under investigation, the provider will generate a sequence of 600 random numbers, which will determine the items to be reviewed as part of each sample. If, in the course of the analysis, it is determined that more than 600 items must be included in a stratum sample, provider must supplement the initial 600 random numbers with additional random numbers.

B. Provider Generated Data

If the provider generates the data, it must meet the SVRS criteria established in II.A. and be compatible with DPW systems.

III. The Review Process to be Used

A. For each sample stratum, an initial "probe" sample will be identified by selecting claims with sequence numbers matching the random numbers generated by the provider. Claims will be added to the probe sample in the order of the random numbers.

1. The number of claims to be included in the probe sample will be the greater of:
 - A. 50 claims
2. For each claim in the probe sample, beginning with the claim whose sequence number corresponds to the first random number, the provider will determine whether available documentation supports the claim as paid.
 - A. After a review of relevant documentation, a determination will be made as to the amount, which should have been paid for each claim analyzed.
 - B. For each claim, an "overpayment" amount will be calculated. The overpayment amount is equal to either:
 - The amount actually paid minus the amount that "should have been" paid.
 - Zero
 - C. **If documentation to support the claim cannot be located for a sampled claim, all payments made by DPW for the claim will be treated as overpayments. There can be no substitution of a different claim because documentation of the selected claim is not available.**
3. At this point the results from the probe sample can be reviewed to assess whether it may be appropriate to modify the stratum under analysis. For example, if the original stratum selected for analysis was all billings for CPT codes between 80000-89999 and the analysis of the probe sample showed that all errors were associated with only one of those CPT codes, it might be appropriate to narrow the focus of the review to only that one CPT code.
 - If it is determined that the stratum should be modified, the provider must document that decision process for inclusion in the self-disclosure report. The provider must then return to outline step II.A.3 (above) and proceed with a new analysis (including a new probe sample) of only the more focused universe of claims now under review.
 - If it is determined that the stratum does not need to be modified, the probe sample will be used to determine the number of claims to be included in the full sample for each stratum using the process illustrated in Exhibit 1 (below).

B. Once the number of claims to be reviewed as part of the full sample has been determined, enough claims should be added to the probe sample to yield the necessary full sample size. Claims will continue to be added to the probe sample in the order of the random numbers until the full sample size is obtained.

- Claims should be added to the probe sample based upon the random numbers generated by provider and the sequence numbers, which were assigned to the paid claims by the provider.
- For each claim in the full sample, the provider will determine whether available documentation supports the claim as paid. Inappropriate payments will be determined for each claim in the full sample by the same method as was used to determine overpayments or inappropriate payments for each claim in the probe sample. The full sample will be used to determine the estimated repayment amount for each stratum using the process illustrated in Exhibit 2 (below).

IV. The Self-Disclosure Report

A. The report must include the identification of the provider and the Provider MA Identification Number that is the subject of the self disclosure.

B. The report must include the identification of the entity that performed the review and provide the following:

- Identify whether the review was performed by an outside firm or by internal personnel.
- If the review was performed by an outside firm, indicate whether the outside firm performed all aspects of the review. If not, indicate other parties (such as internal personnel) that performed some components of the review (such as determinations of medical necessity).

C. The report must identify the issues which were reviewed on each claim/procedure, and specifically identify whether the following issues were reviewed:

Although providers may submit a claim adjustment during the required time frames for inappropriate payments, the following list of violations is the primary focus of a self-audit process.

- Billing for services not rendered. This includes the obvious and failure to submit a claim adjustment when returning medication to stock or billing for cancelled appointments or no shows.

- Billing for misrepresented service in which a provider received inappropriate payments. This violation includes up coding of procedures, billing brand drugs for generics, services provided by unqualified staff, incorrect dates of service, up coding inpatient ICD-9-CM diagnosis(es) and procedures and, reporting incorrect discharge status codes for inpatient admissions.
- Billing for duplicate services. This could also include billing two different sources for the same service.
- Billing contrary to DPW payment conditions such as unbundling laboratory and radiology services to receive higher compensation and billing for non-covered services.
- Serious record keeping violations. This includes falsified records, or no medical or fiscal records available.
- It would be appropriate for the self disclosure to include a copy of the work program review process to document exactly what was (and therefore what was not) reviewed for each claim.

D. The report must disclose, for each stratum analyzed, the following information:

- The time period under analysis.
- The procedure codes under analysis.
- The total amount of payments received from DPW and number of claims paid by DPW (this is the summary data report generated by DPW as a result of the providers' initial request for information for the self-disclosure audit).
- The total number of claims included in the probe sample.
- The total number of claims included in the full sample. If the full sample includes probe samples, specifying the number of claims obtained from the probe sample.
- The repayment amount calculated based on analysis of the full sample (with the associated precision interval at a 90 percent confidence level). An example of this calculation is given in Exhibit 2 (below).

E. For each stratum analyzed, the following information should be included as appendices or additional schedules to the report.

- A list of all claims analyzed as part of the probe sample. For each claim in the probe sample the information shown on Exhibit 3 (below) should be provided.
- A schedule detailing the calculations performed to determine the appropriate number of claims to be included in the full sample based on information obtained through analysis of the probe sample.
- A list of all claims analyzed as part of the full sample. For each claim in the full sample the information shown on Exhibit 3 (below) should be provided.
- A schedule detailing the calculations performed to determine the appropriate repayment amount and associated precision interval (at a 90 percent confidence level) based on information obtained through analysis of the full sample. An example of this calculation is given in Exhibit 2 (below).

F. The report must be signed and dated and should include a statement that all information included in the report is true and accurate and, the self-disclosure audit was conducted in accordance with the Pennsylvania Medical Assistance Provider Self-Audit Protocol.

Exhibit 1
Draft Protocol For Self-Audit Reporting - Analysis of Probe Sample

Claim No	Amount That Was Actually Paid by DPW	Amount That Should Have Been Paid by DPW	Overpayment Amount	Claims With Overpayment Amounts
1	\$70.00	\$70.00	\$ 0.00	0
2	\$70.00	\$24.00	\$46.00	1
3	\$70.00	\$24.00	\$46.00	2
4	\$70.00	\$70.00	\$ 0.00	0
5	\$70.00	\$70.00	\$ 0.00	0
6	\$70.00	\$70.00	\$ 0.00	0
7	\$24.00	\$70.00	\$ 0.00	0
8	\$70.00	\$24.00	\$46.00	3
9	\$24.00	\$24.00	\$ 0.00	0
10	\$70.00	\$24.00	\$46.00	4
11	\$70.00	\$70.00	\$0.00	0
12	\$70.00	\$70.00	\$ 0.00	0
13	\$24.00	\$24.00	\$ 0.00	0
14	\$70.00	\$24.00	\$46.00	5
15	\$24.00	\$24.00	\$ 0.00	0
16	\$70.00	\$70.00	\$ 0.00	0

17	\$70.00	\$24.00	\$46.00	6
18	\$70.00	\$70.00	\$ 0.00	0
19	\$70.00	\$70.00	\$ 0.00	0
20	\$24.00	\$70.00	\$ 0.00	0
21	\$70.00	\$24.00	\$46.00	7
22	\$24.00	\$24.00	\$ 0.00	0
23	\$70.00	\$24.00	\$46.00	8
24	\$70.00	\$70.00	\$ 0.00	0
25	\$70.00	\$24.00	\$46.00	9
26	\$70.00	\$70.00	\$ 0.00	0
27	\$24.00	\$70.00	\$ 0.00	0
28	\$70.00	\$24.00	\$46.00	10
29	\$70.00	\$24.00	\$46.00	11
30	\$24.00	\$24.00	\$ 0.00	0
31	\$70.00	\$24.00	\$46.00	12
32	\$70.00	\$24.00	\$46.00	13
33	\$70.00	\$24.00	\$46.00	14
34	\$70.00	\$70.00	\$ 0.00	0
35	\$24.00	\$24.00	\$ 0.00	0
36	\$70.00	\$24.00	\$46.00	15
37	\$24.00	\$24.00	\$ 0.00	0
38	\$70.00	\$24.00	\$46.00	16
39	\$70.00	\$70.00	\$ 0.00	0
40	\$70.00	\$70.00	\$ 0.00	0

Standard Deviation \$22.54

Determine the number of claims to be in the full sample based upon the following:

- The standard deviation of overpayments in probe sample is 22.54 (from previous page)
- Assume that the total number of provider's claims at issue which were paid by DPW is: 11,500
- The desired confidence level for estimated overpayment is equal to 90 percent. The factor for a confidence level of 90 percent is 1.645.
- Assume that the total payments by DPW to the provider for the claims at issue are: \$500,000
- Desired preclusion interval for estimated overpayment is equal to 5 percent of DPW payments: 5 percent of \$500,000 = \$25,000

The formula for determining the full sample size is:

(Standard Deviation of Probe Sample Overpayments)²
Times

(Total Number of Provider's Claims Paid By DPW)²
Times

(Factor Related To Desired Confidence Level)²
Divided by

(Desired Precision Interval)²

Using the values from this example, results in the following full sample size:

$$(22.54)^2 \times (11,500)^2 \times (1.645)^2 / (25,000)^2 =$$

$$(508.05) \times (132,250,000) \times (2.71) / (625,000,000) = 291$$

Exhibit 2
Draft Protocol For Self-Audit Reporting
Analysis of Full Sample

Continuing the example from Exhibit 1.

- Since 40 claims had already been analyzed as part of the probe sample and since the full sample size was determined to be 291, an additional 251 claims must be selected (251=291-40). If the full sample size calculated from Exhibit 1 had been less than the number of claims in the "probe" sample, then no additional claims would need to be selected and the "probe" sample could be used as the "full" sample.
- Calculate overpayments for each of the claims in the full sample.
- Determine the average overpayment amount for the claims in the full sample (equals total of all 291 claims' overpayment amounts divided by 291). Assume, for this example, that the total overpayment amount for all 291 claims was \$5,336. Then the average overpayment amount for the claims in the full sample would be \$18.34 ($\$5,336 / 291$).
- Determine the estimated amount for repayment to DPW (equals the average overpayment amount from Step 3 above times the total number of claims paid by DPW). For this example the calculation would be \$18.34 (per claim overpayment amount) times 11,500 (number of claims paid by DPW from paid claims file generated by DPW). The example calculation would yield a repayment amount of \$210,910.
- Determine the actual precision interval obtained by the full sample. Although the full sample was designed to result in a confidence level of 90 percent and a precision interval of plus or minus 5 percent of the total DPW payments under analysis, the actual results of the full sample might be somewhat different. To determine the actual precision interval obtained at a 90 percent confidence level, perform the following calculations:
 - Standard Deviation of Full Sample Overpayments times
 - Total Number of Claims Paid By DPW times
 - Factor Related to Desired Confidence Level times
 - Square Root of Number of Claims in Full Sample

For the example, assume that the standard deviation of the full sample's overpayments was 23, then the calculated precision interval for the \$290,910 overpayment at a 90% confidence level would be:

$(23) \text{ times } (11,500) \text{ times } (1.645) \text{ divided by } (\text{square root of } 291) = 23 \times 11,500 \times 1.645 / 17.06 = \$25,504$

This means that statistical analysis indicates that we can be 90 percent certain that the provider's actual overpayment is \$210,910 plus or minus \$25,504 (or somewhere between \$236,414 and \$185,406).

Exhibit 3
Draft Protocol For Self-Audit Reporting
Information To Be Included In Audit Report For Each Claim Reviewed

1. The sequence number assigned to the claim as part of the electronic paid claims file generated by DPW for the self-audit process.
2. The claim's ICN number (Internal Control Number) or adjusted ICN, if applicable, including the ICN Line Number.
3. The Medical Assistance Identification Number (MAID) of the provider who billed and received the inappropriate payment, if other than the provider conducting the self audit.
4. The Date of Service (DOS).
5. The procedure code actually billed to DPW for the service.
6. The selected diagnosis(es) or Diagnosis Related Group (DRG), if applicable to the self audit.
7. The amount the provider charged/billed DPW for the service.
8. The amount actually paid by DPW for the service.
9. The procedure code which should have been billed based on the review of the claim performed as part of the self-audit process.
10. The amount which should have been paid by DPW based on the review of the claim performed as part of the self-audit process.
11. The amount of inappropriate payment associated with the claim for each procedure code identified.
12. The specific individual(s) that performed the review of the claim.

State: Tennessee

Director: Dennis J Garvey dennis.j.garvey@tn.gov

Assistant:

Information/Link/Attachment: <http://www.tn.gov/tenncare/programintegrity.shtml>

Providers shall perform self-audit and report overpayment and, when it is applicable, return overpayment to TennCare within 60 days from the date the overpayment is identified. Overpayments that are not returned within 60 days from the date the overpayment was identified can trigger a liability under the False Claims Act.

TENNCARE POLICY MANUAL

Policy No: Subject: Approval:

PURPOSE:

The purpose of this policy is to describe the procedures to be followed by TennCare contractors and providers in implementing the requirements of Section 6402 of the Affordable Care Act with respect to "Reporting and Returning of Overpayments."

BACKGROUND:

Section 6402 of the Affordable Care Act contains new obligations for health care providers regarding reporting and returning overpayments from the Bureau of TennCare or one of its contractors. **Overpayments that are not returned within 60 days from the date the overpayment was identified can trigger a liability under the False Claims Act.** The overpayment will be considered an "obligation," as this term is defined at 31US Code§ 3729(b)(3). The False Claims Act subjects a provider to a fine and treble damages if he knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay money to the federal government.

POLICY:

Overpayments to providers and to TennCare Managed Care Contractors (MCCs) must be returned within 60 days from the date the overpayment is identified.

For purposes of this policy, the following definitions are used:

1. **Managed Care Contractor (MCC).** An entity that contracts with TennCare for the delivery of certain services to TennCare enrollees. The entities included in this category are as follows:
 - Managed Care Organizations (AMERIGROUP, BlueCare, UnitedHealthcare, and TennCare Select)
 - Pharmacy Benefits Manager (SXC)
 - Dental Benefits Manager (TennDent)
2. **State Agency.** A State agency that is under contract with TennCare to provide certain services to certain TennCare enrollees. The entities included in this category are as follows:
 - Department of Children’s Services (DCS)
 - Department of Intellectual and Developmental Disabilities (DIDD)
3. **Contract provider.** A provider that delivers TennCare services under contract to one of the MCCs or State Agencies. Contract providers are paid by the entity with which they are contracted, rather than being paid directly by TennCare.
4. **Fee-for-service provider.** A provider that delivers services outside the managed care program and that is reimbursed directly by TennCare. Providers in this category include the following:
 - Intermediate Care Facilities for persons with Mental Retardation (ICFs/MR)
 - Providers of Medicare crossover services

This category also includes providers that were formerly contracted with TennCare but whose contracts have ended and providers that were contracted with an MCC that is no longer active in TennCare.

The procedures for returning overpayments vary depending on what entity made the overpayment and what entity received the overpayment. These procedures are outlined below.

Group 1: MCCs and State Agencies Paid by TennCare

~~If an MCC or a State Agency (as defined above) identifies an overpayment made to that entity by TennCare, the MCC or State Agency may retain the overpayment but must send a letter to TennCare containing the following information:~~

- An explanation of how and when the overpayment was identified
- Evidence that the next invoice to TennCare has been reduced by the amount of the overpayment

The letter must be sent to the following

address: Casey Dungan
 Chief Financial Officer
 Bureau of TennCare
 310 Great Circle Road
 Nashville, TN 37243

Group 2: Contract Providers Paid by Contract Agencies

If a contract provider (as defined above) identifies an overpayment made to him by an MCC or a State Agency, the provider must send a letter to the MCC or State Agency that made the overpayment containing the following:

- A check to the MCC or State Agency for the amount of the overpayment
- Relevant claims data so that the MCC or State Agency can identify where the problem occurred
- An explanation of how and when the overpayment was identified

The letter must be sent to the appropriate address below and copied to TennCare.

Entity Returning the Overpayment	Address to Which the Overpayment Should be Returned	Address for Copy of Letter Accompanying the Returned Overpayment
AMERIGROUP providers ¹	Taj-Malik Hinton Tennessee Market Recovery Audit Analyst Amerigroup Community Care P. O. Box 933657 Atlanta, GA 31139-3657 Phone: 757-473-2737, ext. 33267	Dennis J. Garvey Director of Program Integrity Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
BlueCare providers	Volunteer State Health Plan Attention: Claims Refund Department 1 Cameron Hill Circle, Suite 0040 Chattanooga, TN 37402-0040	Dennis J. Garvey Director of Program Integrity Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
UnitedHealthcare providers	UnitedHealthcare of the River Valley Lockbox 88825 Chicago, Illinois 60603	Dennis J. Garvey Director of Program Integrity Bureau of TennCare 310 Great Circle Road Nashville, TN 37243

TennCare Select providers	Volunteer State Health Plan Attention: Claims Refund Department 1 Cameron Hill Circle, Suite 0040 Chattanooga, TN 37402-0040	Dennis J. Garvey Director of Program Integrity Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
SXC providers	SXC Health Solutions 2441 Warrenton Road	Dennis J. Garvey Director of Program Integrity

¹ AMERIGROUP has a special form that should be used in return of overpayments. Providers may contact Mr. Hinton at the address provided for a copy of the form.

Entity Returning the Overpayment	Address to Which the Overpayment Should be Returned	Address for Copy of Letter Accompanying the Returned Overpayment
	Suite 610- Provider Relations Lisle, IL 60532	Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
TennDent providers	TennDent P.O. Box 281078 Nashville, TN 37228-1078	Dennis J. Garvey Director of Program Integrity Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
Department of Children's Services (DCS) providers	Mohamed El-Kaissy Fiscal Division Department of Children's Services 7 th floor, Cordell Hull Building 436 6 th Avenue North Nashville, TN 37243-1290	Dennis J. Garvey Director of Program Integrity Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
Department of Intellectual and Developmental Disabilities (DIDD) providers	Stephen Beaty Fiscal Director Department of Intellectual and Developmental Disabilities Andrew Jackson Building, 13 th floor 500 Deaderick Street Nashville, TN 37243	Dennis J. Garvey Director of Program Integrity Bureau of TennCare 310 Great Circle Road Nashville, TN 37243

The MCC or State agency receiving the overpayment from a provider then has certain obligations with respect to TennCare.

Group 2.1. At-Risk MCCs

The at-risk MCCs (AMERIGROUP, BlueCare, and UnitedHealthcare) may retain the overpayment that the provider returned to them. Since these entities are at risk, there is no need for them to

return the overpayment to TennCare. However, they must send a letter with the following items to TennCare:

- An explanation of how and when the overpayment was identified
- The date on which the encounter data was adjusted to reflect the recovery

The letter must be send to the following

address: Casey Dungan
Chief Financial Officer
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Group 2.2 Non-Risk or Partial Risk MCCs and State Agencies

The non-risk or partial risk MCCs (TennCare Select, SXC, and TennDent) and the State Agencies (DCS and DIDD) may retain the provider overpayment that a provider has returned to them, but they must send a letter with the following items to TennCare:

- An explanation of how and when the overpayment was identified
- Evidence that the next invoice to TennCare will be reduced by the amount of the overpayment
- The date on which the encounter data was adjusted to reflect the recovery

This information should be sent to the following

address: Casey Dungan
Chief Financial Officer
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

**Group 3: Fee-for-Service Providers Paid by
TennCare**

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If any fee-for-service provider, as that term is defined above, has received an overpayment from TennCare or from an MCC that is no longer active in TennCare, the provider must send a letter to TennCare containing the following:

- A check to the Bureau of TennCare for the overpayment
- An explanation of how and when the overpayment was identified

The address where the check and the letter must be sent is provided

below: Casey Dungan
Chief Financial Officer

Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

DEFINITION

S:

Knowing and knowingly. Descriptive words meaning that a person, with respect to information, has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.²

Obligation. “An established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.”³

Overpayment. Any funds that a person receives or retains under TennCare to which the person, after applicable reconciliation, is not entitled under TennCare. (A “person” means a provider of services, supplier, or TennCare MCC. It does not include a beneficiary.)⁴

OFFICES OF PRIMARY RESPONSIBILITY:

Division of Internal Audit and Program Integrity
Division of Fiscal Budget
Office of Managed Care Networks

REFERENCE

S:

Affordable Care Act, Section 6402
Social Security Act, Section 1128J(d)
Fraud Enforcement Recovery Act of 2009

Original: 06/11/11:

SB Rev. 1: 10/03/11:

² 31 U.S. Code § 3729(b)(1).

³ 31 U.S. Code § 3729(b)(3).

⁴ Affordable Care Act, § 6402.

**RULES OF
TENNESSEE DEPARTMENT OF FINANCE
AND ADMINISTRATION BUREAU OF
TENNCARE**

**CHAPTER 1200-13-18
TENNCARE ADMINISTRATIVE ACTIONS
AND PROVIDER APPEALS**

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1200-13-18-.01 SCOPE AND AUTHORITY.

- (1) An approved provider of TennCare services may appeal the following administrative actions:
- (a) An administrative action for recovery against a person other than an enrollee, recipient or applicant brought by the Bureau of TennCare upon written request of the Attorney General pursuant to the Tennessee Medicaid False Claims Act;
 - (b) An action proposed or taken by the Bureau of TennCare or its audit contractor to recover, recoup or withhold payment from a provider, as a result of any audit performed by or on behalf of the Centers for Medicare and Medicaid Services or the Bureau pursuant to state or federal law;
 - (c) A Bureau of TennCare determination to suspend payments to a provider due to a credible allegation of fraud for which an investigation is pending;
 - (d) A denial of eligibility for or a determination of the amount of an incentive payment pursuant to the federal Medicaid Electronic Health Record Incentive Program (EHR-IP); or,
 - (e) Termination of an approved provider's Tennessee Medicaid Provider Number by the Bureau, except when federal law mandates exclusion of the provider.
- (2) A provider of services may not appeal the following administrative actions:
- (a) An MCC's refusal to contract with the provider;

- (b) A decision by the Bureau to decline coverage of prescriptions not written by a provider with prescribing authority; or,
 - (c) Termination or exclusion from the Program as required by federal law.
- (3) In order to exercise the right to a hearing, a provider must submit his appeal and request for a hearing in writing to the Bureau. The notice of the Bureau action shall contain specific instructions concerning the right to appeal and the address for filing an appeal.
 - (4) Any request for an appeal must be received at the address contained in the notice of action no later than 35 days following the date of the notice.
 - (5) Provider appeals shall be conducted as contested case hearings by the Tennessee Department of State, Administrative Procedures Division, pursuant to the Tennessee Uniform Administrative Procedures Act (APA).
 - (6) The Uniform Rules of Procedure for Hearing Contested Cases Before State Administrative Agencies, Chapter 1360-04-01, promulgated under the APA, are adopted by the Bureau and incorporated by reference herein. The Uniform Rules shall govern the conduct of a provider appeal except where a specific contrary provision is adopted by the Bureau in this Chapter.
 - (7) For purposes of issuing an initial order, a contested case hearing shall be conducted by an administrative judge hearing the case alone.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.02 DEFINITIONS.

- (1) Administrative Judge. An employee or official of the Office of the Secretary of State who is licensed to practice law and authorized by law to conduct contested case proceedings.
- (2) Administrative Procedures Act (APA). The Tennessee Uniform Administrative Procedures Act, as amended, codified at T.C.A. §§ 4-5-301, et seq.
- (3) Approved Provider. A provider of health care services who has registered with and been approved by the Bureau and has been issued a Tennessee Medicaid Provider Number.
- (4) Audit. The systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria and communicating the results to interested parties. Audits are conducted in accordance with AICPA (American Institute of Certified Public Accountants) auditing or attestation engagement standards. For purposes of this chapter, audits are conducted of health care provider records, financial information, and statistical data according to principles of cost reimbursement to determine the reasonableness and allowance of costs reimbursable under the Program.
- (5) Bureau of TennCare (Bureau). The division of the Tennessee Department of Finance and Administration, the single state Medicaid agency, that administers the TennCare Program. For purposes of this Chapter, the Bureau shall represent the State of Tennessee.

- (6) Civil Penalty. A monetary penalty assessed by the Bureau against a provider in an amount of not less than \$1,000 nor more than \$5,000 for each violation of the Tennessee Medicaid False Claims Act. T.C.A. § 71-5-183(h)(3).
- (7) Claim. Any request or demand for money, property, or services made to any employee, officer, or agent of the state, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded was issued from, or was provided by, the State.
- (8) Commissioner. The chief administrative officer of the Tennessee Department where the Bureau is administratively located.
- (9) Commissioner's Designee. A person authorized by the Commissioner to review appeals of initial orders and to enter final orders pursuant to T.C.A. § 4-5-315, or to review petitions for stay or reconsideration of final orders.
- (10) Contested Case. An administrative proceeding in which the legal rights, duties or privileges of a party are required by any statute or constitutional provision to be determined by an agency after an opportunity for a hearing.
- (11) Credible Allegation of Fraud. Information which has been verified by the Bureau through judicious case-by-case review and found to contain indicia of reliability. This information may be from any source, including but not limited to hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, or law enforcement investigations.
- (12) Department. The Tennessee Department of Finance and Administration.
- (13) Electronic Health Record Incentive Program (EHR-IP). The provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) that provide for incentive payments to eligible professionals (EPs) and eligible hospitals (EHs), including acute care, children's and critical access hospitals (CAHs) participating in Medicare and Medicaid programs that adopt, implement or update a certified system and successfully demonstrate meaningful use of certified electronic health record (EHR) technology as required by federal regulations.
- (14) Enrollee. An individual eligible for and enrolled in the TennCare program.
- (15) Error Rate. The percentage of claims in a sample population that was not billed properly and is actionable. Error rates can be applied to entire populations if the sample was the result of statically valid random sampling. The use of the term "error" does not indicate the intent of the person or entity submitting the claim.
- (16) Findings of Fact. The factual findings issued by the Administrative Judge or Commissioner's Designee following an administrative hearing. The factual findings are enumerated in the initial and/or final order. An order must include a concise and explicit statement of the underlying facts of record to support the findings.
- (17) Final Agency Decision. A Final Order.
- (18) Final Order. An initial order becomes a final order without further notice if not timely appealed, or if the initial order is appealed pursuant to T.C.A. § 4-5-315, the Commissioner or Commissioner's Designee may render a final order. A statement of the procedures and time limits for seeking reconsideration or judicial review shall be included with the issuance of a final order.

- (19) Good Cause Not to Suspend Payment. The Bureau may determine not to suspend payment or not to continue suspension of payment to a provider being investigated due to a credible allegation of fraud if:
- (a) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;
 - (b) Other available remedies implemented by the State more effectively or quickly protect Program funds;
 - (c) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed;
 - (d) Enrollee access to items or services would be jeopardized by a payment suspension because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of enrollees within a HRSA-designated medically underserved area;
 - (e) Law enforcement declines to certify that a matter continues to be under investigation;
or
 - (f) The Bureau determines that payment suspension is not in the best interests of the Program.
- (20) Good Cause to Suspend Payment Only in Part. The Bureau may determine to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to a provider being investigated due to a credible allegation of fraud if:
- (a) Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of recipients within a HRSA-designated medically underserved area;
 - (b) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part;
 - (c) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider, and the Bureau determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid;
 - (d) Law enforcement declines to certify that a matter continues to be under investigation;
or
 - (e) The Bureau determines that payment suspension only in part is in the best interests of the Program.

- (21) Hearing. A contested case proceeding.
- (22) Indicia of Reliability. Factors which the Bureau will examine in determining whether a credible allegation of fraud exists, requiring the suspension of payments to a provider, including but not limited to:
- (a) Firsthand knowledge; (b) Corroborating witness;
 - (c) Witness conflict (disgruntled employee); (d) Prior bad acts;
 - (e) Pattern of bad acts; (f) Documentary proof;
 - (g) Admission by provider; (h) Expert opinion; or
 - (i) Indictment by a court of competent jurisdiction.
- (23) Initial Order. The decision issued by the administrative judge following a hearing. The initial order shall contain the decision, findings of fact, conclusions of law, the policy reasons for the decision and the remedy prescribed. It shall include a statement of the procedure for filing an appeal of the initial order as well as a statement of any circumstances under which the initial order may, without further notice, become a final order. A statement of the procedures and time limits for seeking reconsideration or other administrative relief and the time limits for seeking judicial review shall be included.
- (24) Notice of Action. The document or letter sent by the Bureau to a provider detailing the action the Bureau intends to take against the provider. The notice shall include a statement of the reasons and authority for the action as well as a statement of the provider's right to appeal the action, if applicable.
- (25) Notice of Hearing. The pleading filed with the Administrative Procedures Division by the Bureau upon receipt of an appeal. It shall contain a statement of the time, place, nature of the hearing, and the right to be represented by counsel; a statement of the legal authority and jurisdiction under which the hearing is to be held, referring to the particular statutes and rules involved; and, a short and plain statement of the matters asserted, in compliance with the APA.
- (26) Program. See TennCare.
- (27) Provider with Prescribing Authority. A health care professional authorized by law or regulation to order prescription medications for her patients and who:
- (a) Participates in the provider network of the MCC in which the beneficiary is enrolled; or
 - (b) Has received a referral of the beneficiary, approved by the MCC, authorizing her to treat the beneficiary; or,
 - (c) In the case of a TennCare beneficiary who is also enrolled in Medicare, is authorized to treat Medicare patients.
- (28) RAT-STATS. A widely accepted statistical software tool designed to assist the user in conducting statistically valid random sampling and evaluating audit results.
- (29) Standard of Proof. A preponderance of the evidence.
- (30) Statistically Valid Random Sampling. A method for determining error rates in healthcare billings using extrapolation. Typically used for large numbers of suspect claims

or patients, a random sample of claims from a chosen population is selected using RAT-STATS or a similar program. That sample is then analyzed for errors. If the sample is the result of statistically valid random sampling, the error rate in the sample can be extrapolated to the entire population of claims.

- (31) TennCare. The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee.
- (32) Tennessee Medicaid Provider Number. The identifying number issued by the Bureau to an approved provider for the purpose of receiving payment in exchange for rendering services to TennCare enrollees.
- (33) Tennessee Medicaid False Claims Act (Act). T.C.A. §§ 71-5-181, *et seq.*
- (34) Termination. The deactivation of a provider's Tennessee Medicaid Provider Number and the cessation of the provider's TennCare billing privileges.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.03 ADMINISTRATIVE ACTION FOR RECOVERY UNDER THE TENNESSEE MEDICAID FALSE CLAIMS ACT.

- (1) The Attorney General, following an investigation of an approved provider's claims, may determine that certain provider actions are appropriate for administrative action by the Bureau, pursuant to the Act. The Attorney General may refer any such matters to the Bureau Director, or his designee, along with the investigative file and a recommendation for action.
- (2) The Attorney General shall not refer matters originally brought under T.C.A. § 71-5-183(b) or if any person has the right to participate in or recover from the proceeding pursuant to T.C.A. § 71-5-183(c)(5).
- (3) Upon receipt of a written request from the Attorney General, the Bureau may commence a contested case proceeding on behalf of the State for recovery under the Act against any person other than an enrollee, recipient or applicant.
- (4) The Bureau may initiate the recovery process by notice of action to the provider setting out:
 - (a) The assessment of damages, civil penalties and related costs;
 - (b) The name and contact information of an individual within the Bureau with knowledge of the claim(s) and the assessment who is authorized to discuss the matter with the provider; and
 - (c) A statement of the right of the provider to appeal the assessment and the manner in which an appeal must be filed.
- (5) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

- (6) The Bureau may recover actual damages in an amount no greater than ten thousand dollars (\$10,000). The amount of actual damages may be based upon a statistically valid random sample utilizing a software tool such as RAT-STATS.
- (7) In addition to and not limited by the amount of actual damages, the Bureau may recover:
- (a) Civil penalties of not less than one thousand dollars (\$1,000) nor more than five thousand dollars (\$5,000) for each claim found to be in violation of the Act;
 - (b) Costs of the administrative action; and
 - (c) Treble the amount of actual
- damages. (8) Any action for recovery shall not be brought:
- (a) More than six (6) years following the date on which the violation of the Act is committed; or
 - (b) More than three (3) years after the date when facts material to the right of action are known or reasonably should have been known by the state official charged with responsibility to act in the circumstances, but in no event not more than ten (10) years after the date the violation was committed, whichever occurs last.
- (9) A subpoena issued by an administrative judge pursuant to the APA requiring the attendance of a witness at a hearing may be served by certified mail at any place in the United States.
- (10) For purposes of rendering a final order pursuant to the APA, the Bureau is designated as the agency to review initial orders and issue final agency decisions. Orders issued by the Bureau shall have the effect of a final order pursuant to the APA.
- (11) Judgment. A final order issued by the Bureau under this rule may be enforced as a final judgment, as follows:
- (a) A notarized copy of the final order must be filed in the office of the Clerk of the Chancery Court of Davidson County;
 - (b) Upon filing with the Clerk, a final order shall be considered as a judgment by consent of the parties on the same terms and conditions as those recited in the order;
 - (c) The judgment shall be promptly entered by the Court;
 - (d) The judgment shall become final on the date of entry; and
 - (e) A final judgment shall have the same effect, is subject to the same procedures and may be enforced or satisfied in the same manner as any other judgment of a court of record of the State of Tennessee.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

**1200-13-18-.04 RECOUPMENT OR
WITHHOLD.**

- (1) The Bureau is required by state and federal law to protect the integrity of the Medicaid program. This is accomplished in part by causing audits of provider claims to be conducted. Audit findings are reported to the Bureau for the purpose of recovering incorrect payments, by recoupment or withhold.
- (2) The Bureau shall notify a provider of its intent to recoup or withhold based upon audit findings by issuing a notice of action. Each notice of action sent to a provider shall contain the proposed recovery action and the following information:
 - (a) The name and contact information of an individual knowledgeable about the audit findings and who is authorized to discuss the proposed recovery action with the provider;
 - (b) The manner by which the provider may submit additional information to support his disagreement with the proposed recovery action;
 - (c) A statement that the provider has the right to appeal the proposed recovery action and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.
- (4) The audit and the audit findings are not subject to appeal. (See *NHC v. Snodgrass*, 555 S.W.2d 403 (Tenn. 1977)).

(Rule 1200-13-18-.04, continued)

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

**1200-13-18-.05 SUSPENSION OF
PAYMENT.**

- (1) Pursuant to 42 C.F.R. § 447.90, the Bureau is prohibited by federal law from receiving federal financial participation (FFP) for payment to a provider of medical items or services with respect to which there is a pending investigation of a credible allegation of fraud, absent good cause not to suspend payment or good cause to suspend payment only in part.
- (2) The Bureau must provide written notice to the provider of a suspension of payments:
 - (a) Five (5) days after suspending payments unless a law enforcement agency has submitted a written request to delay the notice; or
 - (b) Thirty (30) days after suspending payments when a delay was properly requested by law enforcement, except the delay may be renewed twice in writing not to exceed ninety (90) days.
- (3) Written notice of suspension of payment must contain:

- (a) A statement that payments are suspended according to this rule and federal regulation;
 - (b) The general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation;
 - (c) A statement that the suspension is temporary and the circumstances under which it will be terminated;
 - (d) If applicable, state the type(s) of TennCare/Medicaid claims to which suspension is effective;
 - (e) A statement that the provider has the right to submit written evidence for consideration by the Bureau; and
 - (f) A statement that the provider has the right to appeal the suspension and the manner in which an appeal must be filed.
- (4) Any appeal of a notice of suspension of payment shall be conducted according to rule .01 of this chapter.
- (5) Any suspension of payment shall be temporary and shall not continue after:
- (a) The Bureau or prosecuting authority determines there is insufficient evidence of fraud by the provider; or
 - (b) Legal proceedings related to the provider's alleged fraud are completed.
- (6) The Bureau must document in writing the termination of a suspension of payment. Such document must include any applicable appeal rights available to the provider.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.06 ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM (EHR-IP).

- (1) An approved provider of TennCare services, upon receipt of a notice of action, may appeal the following issues related to the EHR-IP:
- (a) Denial of an incentive payment;
 - (b) Incentive payment amount;
 - (c) Determination of eligibility for an incentive payment, including but not limited to measurement of patient volume;

- (d) Determination of efforts to adopt, implement or upgrade to certified EHR technology during the first year of the EHR-IP or meaningful use of certified EHR technology in subsequent years;
 - (e) Whether the provider is hospital-based;
 - (f) Whether the provider is practicing predominantly in an FQHC or RHC; (g) Whether a hospital qualifies as an acute care or children's hospital; or,
 - (h) Whether the provider is already participating in the Medicare incentive program or in the Medicaid incentive program of another state and therefore is ineligible for duplicate TennCare incentive program payments.
- (2) Each notice of action sent to a provider of a determination of any matter listed in paragraph (1) shall contain the following:
- (a) The contact information to reach an individual knowledgeable about the EHR-IP who is authorized to discuss the determination with which the provider disagrees;
 - (b) The manner by which the provider may submit additional information to support his disagreement with the determination; and
 - (c) A statement that the provider has the right to appeal the determination with which he disagrees and the manner in which an appeal must be filed.
- (3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.07 TERMINATION OR EXCLUSION OF A PROVIDER FROM PROGRAM PARTICIPATION.

- (1) A provider may be terminated or excluded from participation in the TennCare program.
- (2) Federal Mandatory Exclusion. The Bureau is required by federal law to exclude a provider from participation in the TennCare program upon notice from HHS or CMS under the following circumstances:
 - (a) Conviction of program-related crimes;
 - (b) Conviction relating to patient abuse;
 - (c) Felony conviction relating to health care fraud; or
 - (d) Felony conviction relating to controlled substance.
- (3) Federal Permissive Exclusion. Pursuant to federal law, the Bureau may exclude a provider from participation in the TennCare program under the following circumstances:

(Rule continued)

1200-13-18-.07,

- (a) Conviction related to fraud;
 - (b) Conviction related to obstruction of an investigation or audit;
 - (c) Misdemeanor conviction related to controlled substance;
 - (d) License revocation or suspension;
 - (e) Exclusion or suspension under federal or state health care program;
 - (f) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services;
 - (g) Fraud, kickbacks, and other prohibited activities;
 - (h) Entities controlled by a sanctioned individual;
 - (i) Failure to disclose required information;
 - (j) Failure to supply requested information on subcontractors and suppliers;
 - (k) Failure to supply payment information;
 - (l) Failure to grant immediate access;
 - (m) Failure to take corrective action;
 - (n) Default on health education loan or scholarship obligations;
 - (o) Individuals controlling a sanctioned entity; or
 - (p) Making false statements or misrepresentation of material facts.
- (4) When a provider exclusion is mandatory, the notice of action shall state that the provider has no right to appeal the termination from program participation.
- (5) When a provider exclusion is permissive, the notice of action shall include a statement that the provider has the right to appeal the termination from program participation and the manner in which an appeal must be filed.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.08 PROVIDER SANCTIONS.

- (1) Pursuant to the authority granted by T.C.A. § 71-5-118 to the Commissioner to impose sanctions against providers, the Commissioner, through the Bureau, may take the following actions against a provider upon a finding that such actions will further the purpose of the Tennessee Medical Assistance Act:

- (a) Subject providers to stringent review and audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim;
 - (b) Refuse to issue or terminate a Tennessee Medicaid Provider Number if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the U.S. Title XX Services Program;
 - (c) Refuse to issue or terminate a Tennessee Medicaid Provider Number if a determination is made that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the U.S. Title XX Services Program since the inception of these programs;
 - (d) Refuse to issue or terminate a Tennessee Medicaid Provider Number if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification;
 - (e) Refuse to issue or terminate a Tennessee Medicaid Provider Number upon notification by the U.S. Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation;
 - (f) Suspend or withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance; or,
 - (g) Recover from a provider any payments made by a recipient and/or his family for a covered service when evidence of recipient billing by the provider is determined by the Bureau and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from the Bureau to make repayment. If a provider knowingly bills a recipient and/or family for a TennCare covered service, in total or in part, except as otherwise permitted by State rules, the Bureau may terminate the provider from participation in the program.
- (2) In addition to the grounds for sanctions set out in T.C.A. § 71-5-118, activities or practices which justify sanctions against a provider and may include recoupment of monies incorrectly paid shall include but not be limited to:
- (a) Noncompliance with contractual terms;
 - (b) Billing for a service in a quantity which is greater than the amount provided;
 - (c) Billing for a service which is not provided or not documented;
 - (d) Knowingly providing incomplete, inaccurate, or erroneous information to TennCare or its agent(s);
 - (e) Continued provision of poor record keeping or inappropriate or inadequate medical care;

- (f) Medical assistance of a quality below recognized standards;
- (g) Suspension from the Medicare or Medicaid program(s) by the authorized U.S. enforcement agency;
- (h) Partial or total loss (voluntary or otherwise) of a provider's federal Drug Enforcement Agency (DEA) dispensing or prescribing certification;
- (i) Restriction to or loss of practice by a state licensing board action;
- (j) Acceptance of a pretrial diversion, in state or federal court, from a Medicaid or Medicare fraud charge or evidence from such charge;
- (k) Violation of the responsible state licensing board license or certification rules;
- (l) Conviction of any felony, any offense under state or federal drug laws, or any offense involving moral turpitude;
- (m) Dispensing, prescribing, or otherwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical or mental infirmity or disease;
- (n) Dispensing, prescribing, or otherwise distributing to any person a controlled substance or other drug if such person is addicted to the habit of using controlled substances without making a bona fide effort to cure the habit of such patient;
- (o) Dispensing, prescribing or otherwise distributing any controlled substance or other drug to any person in violation of any law of the state or of the United States of America;
- (p) Engaging in the provision of medical or dental service when mentally or physically unable to safely do so;
- (q) Billing TennCare an amount that is greater than the provider's usual and customary charge to the general public for that service;
- (r) Falsifying or causing to be falsified dates of service, dates of certification or recertification or back dating any record which results in or could result in an inappropriate cost to TennCare;
- (s) Fragmentation or submitting claims separately on the component parts of a procedure instead of claiming a single procedure code which includes the entire procedure or all component parts, when such approach results in TennCare paying a greater amount for the components than it would for the entire procedure; or,
- (t) Submitting claims for a separate procedure which is commonly carried out as a component part of a larger procedure, unless it is performed alone for a medically justified specific purpose.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109. **Administrative History:** Original rule filed May 18, 2011; effective August 16, 2011.

State: Texas

Director: Jason Nelson jason.nelson@tx.us

Assistant:

Information/Link/Attachment:

http://oig.hhsc.state.tx.us/ProviderSelfReporting/Self_Reporting.aspx

Introduction

The HHSC Office of Inspector General "OIG" is issuing this Provider Self-Reporting Guidance to encourage providers to voluntarily investigate and report matters involving the possible fraud, waste, abuse, or inappropriate payment of funds under state administered programs. Recipients of funds administered through the state's health and human services programs, including the Medicaid program, have an ethical and legal duty to insure the integrity of their dealings with such programs. Title 1, Texas Administrative Code (TAC), Chapter 371. This duty includes an obligation to take measures to detect and prevent fraudulent, abusive, and wasteful activities, as well as circumstances that result in the incorrect payment of funds, and to report those activities when discovered. It also promotes the OIG's expectation that providers implement specific procedures and mechanisms to examine and resolve instances of non-compliance with program requirements. Because the circumstances that could be subject to this Guidance can vary significantly, the OIG has intentionally kept this Guidance general to allow it to be flexible depending on the unique aspects of a particular matter. It is the OIG's intention to endeavor to work collaboratively, and not adversarially, with providers who choose to proceed in accordance with the letter and spirit of this Guidance.

The OIG's Provider Self-Reporting Guidance is intended to facilitate the resolution only of matters that, in the provider's reasonable assessment, potentially violate criminal or civil laws and/or material violations of the administrative rules governing the state's health and human services programs, including Medicaid. Matters involving overpayments or errors that do not suggest violations of civil or criminal laws or material violations of administrative rules should be brought directly to the attention of the claims administrator that processes claims and issues payments for the particular program. (e.g. for Medicaid, the Texas Medicaid & Healthcare Partnership (TMHP)). The claims administrator will process the refund and will review the circumstances surrounding the overpayment. If the claims administrator concludes that the overpayment raises concerns about the provider's integrity, the matter may be referred to the OIG.

With regard to matters that are self-reported to OIG, the disclosing provider may not make payments to the claims administrator without the OIG's prior consent. If given, the OIG's consent does not constitute agreement as to the amount of losses suffered by the program as a result of the disclosed matter, and does not affect the OIG's ability to pursue criminal, civil, or administrative remedies or to obtain additional recoupment of overpayments, damages, or penalties for the matters disclosed. The OIG will not make firm commitments as to how a particular self-report will be resolved or the specific benefit to the self-reporting provider, nor is the OIG bound by any findings made by a provider through its compliance program. However, making full disclosure of non-compliance to the OIG at an early stage will generally allow the provider to work with the OIG toward a better result for the provider than if the OIG discovered the matter independently. One potential benefit is the possibility of avoiding or decreasing penalties. The disclosure to the OIG must be made in good faith.

A provider who self-reports is not eligible for any monetary award provided by state or federal law or rule to include, but not limited to, the Texas Human Resources Code, Chapter 36 and 1 TAC §371.1611.

Provider Self-Reporting

The OIG encourages each provider to maintain an active compliance program that includes, among other elements, auditing and monitoring designed to prevent, detect and remedy program abuses. A provider that learns of suspected non-compliance may take initial steps to validate whether there is potential fraud, waste or abuse. The OIG expects, however, that a provider that validates suspected or actual fraud, waste, abuse, or other circumstances involving inappropriate payments and a potential violation of criminal or civil laws or material violations of administrative rules will follow this Guidance and make an initial report to the OIG. If a provider identifies an ongoing violation, it should immediately contact the OIG prior to continuing any internal review or investigation. Disclosure at this point in such circumstances avoids compromising any subsequent review or investigation deemed necessary by the OIG. After receiving an initial report, the OIG will determine the most appropriate process for proceeding and establish communication with the provider regarding the next steps. The OIG's decision in that regard will be based on factors such as the nature of the issue, the existence and effectiveness of the provider's compliance program, the amounts involved, the time period, the thoroughness of the provider's disclosure, and the potential harm to the safety of individuals. The OIG will consider the provider's involvement and level of cooperation throughout the reporting process in determining the appropriate resolution of the matter and the best avenue to achieve that resolution. The OIG will not work with a provider that attempts to circumvent an ongoing inquiry or fails to fully cooperate in the self-reporting process. The disclosing entity's diligent and good faith cooperation throughout the entire process is essential.

Upon receipt of a health care provider's initial report, the OIG may conduct a review, audit, or investigation as deemed appropriate. A matter uncovered during such a process that was not disclosed may be treated as a new matter unrelated to the disclosure. The OIG may also ask the provider to conduct an internal review or to take other measures during the pendency of the matter.

The OIG will not accept money for presumed overpayments as full and final payment prior to the completion of any OIG review, audit, or investigation. Further, the OIG is required by law to conduct an integrity review of issues brought to its attention and, if warranted, to refer the matter to the Texas Attorney General's Office, U.S. Attorney's Office, or other appropriate authority.

The OIG may request, and expects to promptly receive, all documents and information from the provider that materially relate to the disclosed matter without the need to resort to compulsory methods. The OIG will generally expect the provider to execute and provide business records affidavits whenever requested by the OIG in a form acceptable to the OIG. The OIG will generally expect the provider to provide OIG with access to all records and information, including, if requested, audit working papers and other supporting documents, without the assertion of privileges or limitations on the information produced. A provider must comply with required access to premises and records as specified in 1 TAC §371.1643(f).

To the extent documents or other materials contain thought processes or advice from a provider's legal counsel, and the OIG believes the documents or materials may also contain factual or other information that is critical to resolving the disclosed matter, the OIG is prepared to discuss with provider's counsel ways to gain access to the underlying information without the need to waive the protections provided by an appropriately asserted claim of attorney client privilege or attorney work product. If a provider fails to work in good faith with the OIG to resolve the disclosed matter, that lack of cooperation will be considered an aggravating factor and may provide the basis for the OIG to decide to aggressively pursue the matter as if the provider had not chosen the route of voluntary disclosure. A determination of lack of cooperation may be made based on, among other things: (1) submission of false or otherwise untruthful information, (2) omission of relevant information, or (3) tampering with witnesses or evidence. In addition, the OIG may refer any such intentional lack of cooperation to the Texas Attorney General's Office, U.S. Attorney's Office, or other appropriate authority. A lack of cooperation could therefore result in criminal prosecution, civil sanctions, or both, including possible exclusion from participation in all state or federally funded health and human services programs.

Self-Reporting Mechanism

A provider must self-report by sending written notification of the possible fraud, waste, abuse, or inappropriate payment of state or federal funds to the OIG's Chief Counsel's Office at the address below:

Texas Health and Human Services Commission
Office of Inspector General Chief Counsel's Mail
Code I-1350
P. O. Box 85200
Austin, Texas 78708

To obtain a printable version of the required form to be used in providing the written notification, click [HERE](#).

The written notification must include a complete description of the circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment, including the relevant facts, persons involved, and the legal and Medicaid program authorities implicated. The notification must also include the full name and telephone number of the individual reporting the information on behalf of the provider. By submitting a self-report, the provider certifies that, to the best of the provider's knowledge, the report contains truthful information and is based on a good faith effort to assist the OIG in its inquiry and verification of the disclosed matter.

For questions regarding the OIG's self-reporting process, contact Fread Houston, Director of Sanctions, at (512) 491-4076.

Related Authority

- Texas Government Code, §531.102
- Title 1, Texas Administrative Code, Chapter 371

State: Vermont VT

Director: Ron Clark ron.clark@ahs.state.vt.us

Assistant:

Information/Link/Attachment:

Vermont has no formal policies or procedures regarding provider self-disclosures.

State: West Virginia

Director: Tammy Hypes tammy.g.hypes@wv.gov

Assistant/Contact: Erika Young Erika.h.young@wv.gov

Information/Attachment/Link:

Below are copies of letters and forms utilized when BMS OQPI requests a self-audit or when a provider notifies of a self-disclosure. The last attachment is an excerpt from West Virginia's manual relating to self-disclosure. When the state receives a self-disclosure it reviews the disclosure against other data available to determine if there may be other issues for further review and follow-up. Policy-**800.6.3** **SELF-AUDIT/SELF-DISCLOSURE**

Health care providers have an ethical and legal duty to ensure the integrity of their partnership with the Medicaid program. This duty includes an obligation to examine and resolve instances of noncompliance with program requirements through self-assessment and voluntary disclosures of improper use of state and federal resources. If a provider suspects improper billing in an attempt to defraud WV Medicaid, or an ongoing fraud scheme within its organization, it should immediately contact BMS' OQPI. If a provider performs a self-disclosed self-audit, interest will not be imposed to the reimbursement amount unless the provider's payments are not made by the BMS specified payment dates. OQPI may request that a provider perform a self-audit as a result of a specific area of questionable billing. When a self-audit is assigned, a self-audit letter is sent to the provider. The self-audit letter details the format in which the provider is to report their findings along with their options of repayment.

Forms-

Provider Name: **XXXXXXXXXXXXXXXXXXXX** Overpayment Amount: **\$XXX.XX**
Provider Number: **000000000** Amount Remitted: _____
Case Number: **XXXXXX** Check Number: _____

Make checks payable to: **DHHR**

Please mail to: **DHHR-Bureau for Medical Services**
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3710

INSURE ACCURATE PROCESSING
PLEASE INCLUDE THE **CASE NUMBER** ON YOUR CHECK
AND ENCLOSE THIS VOUCHER WITH YOUR CHECK

West Virginia Medicaid Standard Repayment Provision for All Overpayment Notifications

Provider Name:

Provider Number:

Case Number:

Principal Amount of Repayment: \$

Please select which of the following options you wish to use to repay the above overpayment. Sign, date and return this form.

- Payment within sixty (60) days after notification of the overpayment.
- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment.
- A recovery schedule of up to a 12 month period, through:
 - Monthly payments or;
 - The placement of a lien against future payments

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as an image transaction. For inquiries, please call 1-866-243-9010.

When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution.

This form must be returned to Paula Duff, Office of Quality and Program Integrity, West Virginia Department of Health and Human Resources, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3710 no later than thirty (30) days after the date of this notification. If it is not returned, the Bureau for Medical Services will establish a lien against all future Medicaid payments until the overpayment is recovered with interest accruing sixty (60) days after the original notification and take any other necessary actions to assure recovery. Checks should be made payable to the Department of Health and Human Resources.

Signature

Date

Updated 9/11/12



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bureau for Medical Services

350 Capitol Street, Room 251

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

DATE

PROVIDER NAME Case Number: *XX-XXX-X*

Attention: *DIRECTOR'S NAME*

ADDRESS

CITY, STATE ZIP CODE

Dear *DIRECTOR NAME*:

Thank you for your *TYPE OF CONTACT* on *DATE OF CONTACT* in which you informed us that you had identified a billing error related to *TYPE OF SERVICE*.

Enclosed is an example of the format you are to follow when reporting your findings, a standard repayment agreement, and a remittance voucher to be returned if you decide to repay the amount in one lump sum payment. All correspondence should reference case number XX-XXX-X and be forwarded directly to my attention. The findings must be received in our office within 30 calendar days of receipt of this letter.

If you have any questions regarding this request, you may contact me at (304)558-1700.

Sincerely,

Sam Stout
Office of Quality and Program Integrity

REVIEWER NAME, Program Specialist

REVIEWER INITIALS:pjd

Attachments



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bureau for Medical Services

350 Capitol Street, Room 251

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

DATE

PROVIDER NAME
Attention: *DIRECTOR'S NAME*
ADDRESS
CITY, STATE ZIP

Case Number: XX-XXX-

Dear *DIRECTOR'S NAME*:

The West Virginia Department of Health and Human Resources is responsible for assuring that Medicaid dollars are spent on services that are medically necessary, appropriate in quality and quantity, and provided in conformance with service definitions contained in the West Virginia State Medicaid Manuals and Program Instructions.

DESCRIBE THE ISSUE THAT HAS BEEN DISCOVERED.

Please perform a self-audit of your billings from *DATE* through *DATE*, and correct any billing errors. Enclosed is an example of the format to use when reporting your findings, as well as a remittance voucher and repayment form to be returned. All correspondence should reference case number *XX-XXX-X* and be forwarded directly to my attention.

The findings, as well as the other documents, must be received in our office within 30 days after receipt of this letter. If additional time is required to complete this review, please call me to discuss an extension.

Please ensure Protected Health Information (PHI), as defined within the Health Insurance Portability and Accountability Act of 1996 (HIPAA), contained in this letter is not used or disclosed in any way that will compromise the privacy, security, or confidentiality of the patient/recipient to whom the information pertains.

If you have any questions regarding this letter, you may contact me at 304-558-1700.

Sincerely,

REVIEWER NAME, Program Specialist
Office of Quality and Program Integrity
REVIEWER INITIALS:pjd

THE WEST VIRGINIA MEDICAID SELF-REPORT FORM

THIS FORM MAY BE FILLED OUT AND RETURNED AT THE COMPLETION OF YOUR REVIEW. IF YOU CHOOSE NOT TO USE THIS FORM, PLEASE SET UP A TEMPLATE WHICH INCLUDES ALL THE INFORMATION SHOWN IN THE CHART BELOW.

PROVIDER NAME: PROVIDER NUMBER:
COMPLETED BY:

TIME PERIOD REVIEWED: DATE COMPLETED:

Recipient Name	Medicaid ID	Date of Service	Procedure Code	Amount Billed	Amount Paid	Paid Date	Refund Amount	Reason for Error

PLEASE SEND THE COMPLETED FORM, ALONG WITH ANY OTHER DOCUMENTATION OR REFUND TO THE FOLLOWING ADDRESS:

BUREAU FOR MEDICAL SERVICES
OFFICE OF QUALITY AND PROGRAM INTEGRITY
350 CAPITOL STREET, ROOM 251
CHARLESTON, WV 25301-3710

State: Wisconsin

Director: Alan White alan.white@wisconsin.gov

Assistant:

Information/Link/Attachment:

CR 10-003

**ORDER OF DEPARTMENT OF HEALTH SERVICES TO
ADOPT RULES**

The Wisconsin Department of Health Services proposes to create ch. DHS 19, relating to reduction or waiver of penalties for voluntary self-disclosure by a small business of actual or potential violations of rules or guidelines, and affecting small businesses.

SUMMARY OF PROPOSED RULE

Statute interpreted: Section 895.59, Stats.

Statutory authority: Sections 227.11 (2) and 895.59 (2), Stats.

Explanation of agency authority:

The rules created under s. 895.59 (2) Stats., are required to include a reduction or waiver of penalties for voluntary disclosure by a small business of actual or potential violations of rules or guidelines. Section 895.59 (2) Stats., further requires that the rule specify when the use of discretion in the enforcement of a rule or guideline against a small business will not be allowed. Section 895.59 (2), Stats., includes a list of circumstances under which discretion is not allowed. These circumstances must also be included in the rule. The rules may include consideration of a violator's ability to pay when determining the amount of any monetary penalty, assessment, or surcharge.

Related statute (s) or rule (s):

Section 895.59 Stats.

Plain language analysis:

The Department proposes to create a rule consistent with the requirements of s. 895.59, Stats., by indicating when the Department may use discretionary enforcement concerning small businesses and when discretionary enforcement concerning small businesses is prohibited.

Summary of, and comparison with, existing or proposed federal regulation:

There appear to be no proposed or existing federal regulations that are intended to address the activities to be regulated by the proposed rule.

Comparison with rules in adjacent states:

Illinois:

There appear to be no rules in Illinois that are similar to the proposed rules.

Iowa:

There appear to be no rules in Iowa that are similar to the proposed rules.

Michigan:

There appear to be no rules in Michigan that are similar to the proposed rules.

Minnesota:

There appear to be no rules in Minnesota that are similar to the proposed rules.

Summary of factual data and analytical methodologies:

The Department reviewed statutes that authorize enforcement to determine whether discretionary enforcement could be used and the extent of that discretion.

Analysis and supporting documents used to determine effect on small business or in preparation of economic impact report:

Entities that may be affected by the proposed rules include the following: Emergency Medical and Ambulance Service Providers; Asbestos & Lead Abatement Providers, Consultants, and Trainers; Hotels and Motels; Bed and Breakfast Establishments; Tourist Rooming Houses; Recreational and Educational Campgrounds; Restaurants (including mobile restaurants); Tattoo and Body Piercing Establishments; Tanning Bed Facilities; Public Pools; Vending Machine Operators; WIC Vendors; persons subject to licensing and regulation under ch. DHS 157; other entities regulated by the Department's Division of Public Health; and certain Medical Assistance providers regulated by the Department's Division of Health Care Access and Accountability.

Section 895.59, Stats., is applicable only to small businesses that are not covered under s. 48.685 or 50.065, Stats. Because the rule requires a reduction or waiver of a penalty for voluntary disclosure of a violation, it is likely that the rule will have a positive fiscal effect on those businesses that receive a waiver or reduction.

Effect on small business:

The proposed rules will have a direct impact on a substantial number of small businesses that are not covered under s. 48.685 or 50.065, Stats. The economic impact on the businesses affected by this rule is indeterminate.

Agency contact person:

Rosie Greer
Department of Health Services
1 W. Wilson Street, Room 650
Madison, WI 53707
608-226-1279
greerrj@dhfs.state.wi.us

Place where comments are to be submitted and deadline for submission:

A public hearing will be held on February 18, 2010, 1:00 p.m. to 3:00 p.m. at the Wilson Street State Office Building, 1 W. Wilson St., Rm. 638A, Madison, WI. Comments may be submitted to the agency contact person listed above or to the Wisconsin Administrative Rules Website at www.adminrules.wisconsin.gov until February 18, 2010, 4:30 p.m.

TEXT OF PROPOSED RULE

SECTION 1. Chapter DHS 19 is created to read:

Chapter DHS 19 DISCRETIONARY ENFORCEMENT OF RULES AND GUIDELINES AGAINST SMALL BUSINESSES

DHS 19.01 Authority and purpose.

DHS 19.02 Applicability.

DHS 19.03 Definitions.

DHS 19.04 Use of discretion in enforcement.

DHS 19.05 Limitations on the use of discretion.

DHS 19.01 Authority and purpose. This chapter is promulgated under the authority of s. 895.59, Stats., to describe the discretion the department may exercise in enforcement actions against small businesses regulated by the department.

DHS 19.02 Applicability. This chapter applies to the department and small businesses regulated by the department.

DHS 19.03 Definitions. In this chapter:

(1) “Department” means the department of health services.

(2) “Small business” has the meaning given in s. 895.59 (1) (b), Stats.

Note: Under s. 895.59, Stats., and this chapter a small business does not include an entity as defined in s. 48.685 (1) (b) or 50.065 (1) (c), Stats., which is subject to the caregiver law.

19.04 Use of discretion in enforcement. (1) The department may waive or reduce a penalty otherwise applicable to a small business that voluntarily discloses an actual or potential violation of a department rule or guideline and requests a waiver or reduction as a small business, if the department is not prohibited under s. DHS 19.05 from reducing or waiving the penalty.

(2) In exercising discretion under sub. (1), the department will follow the applicable department rule or guideline when taking an enforcement action against a small business, except that, on a case-by-case basis, the department may use discretion to reduce or waive a penalty based on consideration of the history of violations, the type of business, the severity of the violation and its impact on the public’s health safety and welfare, state or federal statutory requirements for enforcement, and any other relevant factor.

(3) (a) A reduction or waiver of any penalty may not be inconsistent with any requirements established by state or federal statute or regulation.

(b) In determining a reduction in a monetary penalty, the department may consider the small business’s ability to pay.

DHS 19.05 Limitations on the use of discretion. The department may not exercise discretion under s. DHS 19.04 (1) in the enforcement of a rule or guideline under any of the

following circumstances:

- (1) The department discovers the violation before the small business discloses the violation.
- (2) The violation is disclosed after a department audit or inspection of the small business has been scheduled.
- (3) The violation was identified as part of the monitoring or sampling requirements that are consistent with the requirements under an existing permit, certificate, or license.
- (4) The violation results in a substantial economic advantage for the small business.
- (5) The small business has repeatedly violated the same statute, rule or guideline.
- (6) The violation may result in imminent endangerment to the environment or to public health or safety.
- (7) A state or federal statute, federal regulation or department rule prohibits the department's exercise of discretion.
- (8) The business is operating without a certificate, permit, or license.
- (9) The business fails to provide the department with credible and verifiable information that it is a small business.
- (10) The violation was willful.

SECTION 2. EFFECTIVE DATE. This rule shall take effect on the first day of the month following publication in the Wisconsin administrative register, as provided in s. 227.22 (2), Stats.

Wisconsin Department of Health Services

Dated: April 13, 2010

Karen E. Timberlake, Secretary

SEAL:

State: Wyoming

Director: Christine Bates Christine.bates@health.wyo.gov

Assistant:

Information/Link/Attachment:

Wyoming does not have a standard process.