7

7 Understanding Your Rights and Responsibilities as a Provider

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

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

7.1 Provider Responsibilities

Medicare and Medicaid authorize payment only when the items or services are medically necessary. Medical necessity is determined on a case by case basis and consistent with the criteria outlined in section 7.1.1 “Medical Necessity/ Medically Necessary Care”. Providers who agree to accept Medicaid payment must agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, (such as, epidurals or spinal anesthetic) these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. Medicaid covers these services. Providers may not bill Medicaid recipients they have accepted as patients for covered labor and delivery-related pain management services.

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

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

7.1.1 Medical Necessity/Medically Necessary Care

Medical Necessity" or "Medically Necessary Care" means any health care service, intervention, or supply (collectively referred to as "service") that a physician (or psychologist, when applicable), exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, [including mental illnesses and substance use disorders], injury, disease, condition, or its symptoms, in a manner that is:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, disease, or condition;
- in accordance with medical necessity "guidelines/references" in Agency's Administrative Code, State Plan, and Provider Manual;
- not primarily for the convenience of the patient or Provider;
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, disease, or condition.
- the service is not contraindicated; and
- the Provider's records include sufficient documentation to justify the service.

For these purposes, "generally accepted standards of medical practice" means:

- Standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community are required when applicable; or
- Alternatively, may consider physician specialty society recommendations [clinical treatment guidelines/guidance] and/or the general consensus of physicians practicing in relevant clinical areas.

Application of medical necessity is unique with regard to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit/services. All full benefit eligible Medicaid enrollees under age twenty-one (21) may receive EPSDT benefit/services in accordance with sections 1905(a) and 1905(r) of the Social Security Act. Included are services identified as a result of a comprehensive screening visit or an inter-periodic screening, regardless of whether or not they are ordinarily covered for all other Medicaid Enrollees. Additionally, all services necessary to correct or ameliorate a physical or mental illness or condition are included.

The fact that a Provider has prescribed, recommended, or approved services does not, in itself, make such services medically necessary, a medical necessity, or a Covered Service.

At Agency's request, the Provider must submit the written documentation to comply with "generally accepted standards of medical practice" as defined within the medical necessity definition.

Experimental and cosmetic procedures are only allowed in limited circumstances as outlined in Agency's Administrative, Code Chapter 6, Rule No. 560-X-6-.13 Covered Services: Details on Selected Services.

7.1.2 Maintenance of Provider Information

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

DXC Provider Enrollment

P.O. Box 241685

Montgomery, AL 36124-1685

7.1.3 Reporting Change of Ownership Information

Medicaid requires the owner of a Medicaid enrolled facility to report any change of ownership or closure to Medicaid as soon as Medicare has been notified.

Currently enrolled providers are required to complete the Change of Ownership Information form and mail to the Enrollment and Sanctions Unit, Program Integrity Division, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103. This form can be obtained by accessing Medicaid's website at www.medicaid.alabama.gov.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

7.1.4 Retention of Records

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

> *Alabama Medicaid providers will keep detailed records in Alabama, of such quality, sufficiency, and completeness except as provided in subparagraph (5) Rule No. 560-X-16-*

> *.02, that will fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients. These records will be retained for a period of three (3) years plus the current year.*

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

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

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

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

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

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

7.1.5 Release of Confidential Information

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

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

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

7.1.6 Compliance with Federal Legislation

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

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

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

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

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

7.1.7 Utilization Control – General Provisions

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

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

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

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

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

7.1.8 Provider Certification

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

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

Offering incentives and advertising discounts.

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

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

Medicaid payment can never be made directly to recipients.

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

laws." The requirements for this certification may be found in 42 Code of Federal Regulations §447.18.

Services must be reasonable and medically necessary.

Medicaid is continuously evaluating and updating medical necessity for claims payment. In an effort to ensure accurate coding and payment of claims, diagnosis/procedure code criteria is applied. The correct use of a CPT, ICD-9 or ICD-10 code alone does not guarantee coverage of a service. All services must be reasonable and necessary in the specific case and must meet the criteria of specific governing policies. Medical record documentation must support coding utilized in claim and/or prior authorization submission.

7.1.9 Billing Recipients

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

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

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

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

7.1.10 Payment Adjustment for Provider Preventable Conditions (PPC's)

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

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

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

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

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

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

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

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

AdverseEvents@medicaid.alabama.gov.

Providers that do not currently have a password for the Adverse Event reporting may require one by contacting Jerri Jackson at Jerri.Jackson@medicaid.alabama.gov or via phone at 334-242-5630.

Reportable OPPCs include but are not limited to:

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

The following information is required for reporting:

- Recipient first and last name
- Date of Birth
- Medicaid number

- Date event occurred
- Event type

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

7.1.11 340 B Entities

The Veterans Health Care Act of 1992 enacted section 340 B of the Public Health Services Act, "Limitation on Prices of Drugs Purchased by Covered Entities". This Section provides that a manufacturer who sells covered outpatient drugs to eligible 340B entities must sign a pharmaceutical pricing agreement with the Secretary of Health and Human Services in which the manufacturer agrees to charge to Medicaid a price for covered outpatient drugs that will not exceed the average manufacturer price decreased by a rebate percentage.

Eligible 340B entities are defined in 42 U.S.C. § 256b(a)(4).

When an eligible 340B entity, other than a disproportionate share hospital, a children's hospital excluded from the Medicare prospective payment system, a free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital, submits a bill to the Medicaid Agency for a drug purchased by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus the dispensing fee established by the Medicaid Agency.

A disproportionate share hospital, children's hospital excluded from the Medicare prospective payment system, free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital may bill Medicaid the total charges for the drug. As manufacturer price changes occur, the entities must ensure that their billings are updated accordingly.

Eligible 340B entities are identified on the Department of Health and Human Service's website. These entities shall notify Medicaid of their designation as a 340B provider.

Audits of the eligible 340B entities' (claims submissions and invoices) will be conducted by the Medicaid Agency. Eligible 340B entities, other than the providers listed above, must be able to verify acquisition costs through review of actual invoices for the time frame specified. Charges to Medicaid in excess of the actual invoice costs will be subject to recoupment by the Medicaid Agency in accordance with Chapter 33 of the Administrative Code.

7.2 Provider Rights

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

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

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

7.2.1 Administrative Review and Fair Hearings

The Alabama Medicaid Agency is responsible for mandating and enforcing the Title XIX Medical Assistance State Plan. The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims by providers of medical care, services, and equipment authorized under the provisions of the Alabama Title XIX State Plan. The present fiscal agent contract is with DXC Technology (DXC), PO Box 244032, Montgomery, AL 36124-4032. Their toll free telephone is 800-688-7989.

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

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

7.2.2 Claims Denials and the Appeals Process

Denials fall into one of three categories which are:

- Outdated Claims
- Medical Utilization (Example: Denials for exceeding maximum units, separate and distinct service provided that is being billed, etc.)
- National Correct Coding Initiative (NCCI)

The process for appealing denials for each of the categories is as follows:

Outdated Claim Denial Appeal Process

Step 1: Administrative Review

When a denial of payment is received for an outdated claim, the provider may request an Administrative Review of the claim. A request for an administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated.** The request must be received on a Request for Administrative Review of Outdated Medicaid Claims (form 404) which is available in Appendix E of the Provider Manual. In addition the request should include the following:

- A clean claim printed on a red line drop out form (CMS Form UB04 or 1500)
- Supporting documentation such as a remittance advices or any correspondence with DXC or the Agency.

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

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

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

NOTE:

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

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

Medical Utilization Denial Appeal Process

Step 1: Redetermination Request

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

When a claim is denied for Medical Utilization, the provider may request a redetermination as long as the claim is within the timely filing limit. A *redetermination* is an examination of a claim and operative notes/medical justification by DXC personnel. The request for Redetermination must include:

- Completed Medical Utilization Redetermination Review Form 401
- Corrected, completed, red drop out, clean claim (applicable CMS form UBO4 or 1500) for only the procedure codes that denied. The corrected claim must include the applicable modifier(s)
- All relevant RAs and previous correspondence with DXC or the Agency

- Medical documentation (Operative Notes, Medical Justification, Medical Records, Supportive reports, etc.)

Documentation must be sent in on single sided paper, double sided copies are not allowed and will be returned without being processed.

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

DXC Technology
Request for Medical Utilization Redetermination
PO Box 244032
Montgomery, AL 36124-4034

DXC will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. A letter will NOT be sent to the provider.

Step 2: Medical Utilization Administrative Review

When the redetermination request results in a denial by DXC, the provider may request an *administrative review* of the claim as long as the claim is within the timely filing limit. The request should clearly explain why the provider disagrees with the redetermination denial. The request for an administrative review must include:

- Completed Medical Utilization Administrative Review Form 402
- Corrected Paper Claim for ONLY the procedure codes that denied. The corrected claim must include the applicable modifier(s)
- Copy of previous request for redetermination correspondence sent to DXC
- Copies of all relevant remittances advices or DXC's redetermination denial notification
- Medical documentation (Operative Notes, Medical Justification, Medical Records, Supportive reports, etc.)

Documentation must be sent in on single sided paper, double sided copies are not allowed and will be returned without being processed.

Send the request for a Medical Utilization Administrative Review along with all supporting documentation to:

Administrative Review – Medical Utilization
Alabama Medicaid Agency
Attn: Fiscal Agent Policy and System Management
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

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

subsequent levels of appeal unless you show good cause for submitting the documentation late.

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

Step 3: Informal Conference (Optional)

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

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

Step 4: Fair Hearing

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

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

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

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

NOTE:

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

NCCI Denial Appeal Process

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

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

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

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The Medicaid NCCI Coding is available on the CMS NCCI website at: *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html*.

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

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

Step 1: Redetermination Request

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

When a claim is denied for NCCI, the provider may request a redetermination as long as the claim is within the timely filing limit. A *redetermination* is an examination of a claim and operative notes/medical justification by DXC personnel. The request for Redetermination must include:

- Completed NCCI Redetermination Review form http://www.medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.2_Billing_Forms.aspx
- Corrected, completed, red drop out, clean claim (applicable CMS form UB04 or 1500) for only the procedure codes that denied for NCCI. The corrected claim must include the applicable modifier(s)
- All relevant RAs and previous correspondence with DXC or the Agency
- Medical documentation (Operative Notes, Medical Justification, Medical Records, Supportive reports, etc.)

Documentation must be sent in on single sided paper, double sided copies are not allowed and will be returned without being processed.

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

DXC Technology
Request for NCCI Redetermination
PO Box 244032
Montgomery, AL 36124-4034

DXC will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. A letter will NOT be sent to the provider.

The ICN region for the redetermination request will begin with a "91". For example: 9111082123456

Step 2: NCCI Administrative Review

When the redetermination request results in a denial by DXC, the provider may request an *administrative review* of the claim as long as the claim is within the timely filing limit. The request should clearly explain why the provider disagrees with the redetermination denial. The request for an administrative review must include:

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review

  http://www.medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.2_Billing_Forms.aspx

- Corrected Paper Claim for ONLY the procedure codes that denied for NCCI. The corrected claim must include the applicable modifier(s)
- Copy of previous request for redetermination correspondence sent to DXC
- Copies of all relevant remittances advices or DXC's redetermination denial notification
- Medical documentation (Operative Notes, Medical Justification, Medical Records, Supportive reports, etc.)

Documentation must be sent in on single sided paper, double sided copies are not allowed and will be returned without being processed.

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

NCCI Administrative Review
Alabama Medicaid Agency
Fiscal Agent Policy and Systems Support
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

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

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

Step 3: Informal Conference (Optional)

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

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

Step 4: Fair Hearing

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

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

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

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

NOTE:

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

7.3 Medicare/Medicaid Fraud and Abuse Policy

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

Federal regulations require the State Plan for Medical Assistance to provide for the establishment and implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess payments. The Alabama Medicaid Agency has designated the Program Integrity Division

through its Provider Review, Recipient Review, and Investigations Units to perform this function. These units are responsible for detecting fraud and abuse within the Medicaid Program through reviewing paid claims history and conducting field reviews and investigations to determine provider/recipient abuse, deliberate misuse, and suspicion of fraud. In addition, these units are utilized to aid in program management and system improvement.

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

7.3.1 Providers Must Screen for Excluded Individuals

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156. In addition, the Alabama Medicaid Agency also excludes individuals and entities from participation in the Medicaid program under its own authority as specified in 42 CFR Part 1002.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i) (2) of the Act; and 42 CFR section 1001.1901(b)) Also, when the Medicaid Agency has excluded a provider, the Medicaid Agency is prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (42 CFR section 1002.211) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

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

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

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;
- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

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

- Screen all employees and contractors to determine whether any of them have been excluded by searching the exclusion list located on the Alabama Medicaid Agency's website. All providers must check the list prior to hiring staff to ensure potential staff has not been excluded

from participation in the program. All providers must check the list again monthly to ensure existing staff have not been excluded from participation in the program since the last search.

- Screen all employees and contractors by searching the HHS-OIG website by the names of any individual or entity to determine if any of them have been excluded from participation in the program. All providers must search the HHS-OIG website prior to hiring staff and again monthly to capture exclusions and reinstatements that have occurred since the last search.
- Screen all employees and contractors by searching the SAM (System for Award Management) website, formerly the EPLS (Excluded Parties List System), to determine if any of them are excluded from participation in the program. All providers must search the SAM website prior to hiring and again monthly.
- Providers must immediately report to Medicaid any exclusion information discovered.

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

Where Providers Can Look for Excluded Parties

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

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

The SAM website also contains information on individuals and entities that have been excluded from participating in federal and state healthcare programs. This website is located at https://www.sam.gov and is searchable by searching for individual or entity name, SSN or TIN, and also includes advanced search options including exclusion type, exclusion program, city, and state, etc.

7.4 Appeals

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

7.5 Refunds

Medicaid Refunds

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

Medicaid Adjustments

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

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

NOTE:

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

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

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

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

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