***Commonwealth of Massachusetts***
***Executive Office of Health and Human Services***
***Office of Medicaid***
*600 Washington Street*
*Boston, MA 02111*
*www.mass.gov/masshealth*

MassHealth
Transmittal Letter ALL-177
January 2010

**TO:** All Providers Participating in MassHealth

**FROM:** Terence G. Dougherty, Medicaid Director

**RE:** All Provider Manuals (Overpayments Determined by Another Agency)

This letter transmits amendments to the MassHealth administrative and billing regulations about overpayments. The amended regulations provide that where an overpayment amount is based on a determination by a federal or state agency (other than MassHealth), a provider may contest only the factual assertion that the federal or state agency made such a determination and not the amount or basis for such determination.

These regulations are effective February 15, 2010.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

All Provider Manuals

Pages ii and 2-21 through 2-24

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

All Provider Manuals

Page ii — transmitted by Transmittal Letter ALL-175

Pages 2-21 through 2-24 — transmitted by Transmittal Letter ALL-154

2. Administrative Regulations

450.200: Conflict Between Regulations and Contracts .................................................... 2-1
450.201: Choice of Provider .................................................... 2-1
450.202: Nondiscrimination .................................................... 2-1
450.203: Payment in Full .................................................... 2-2
450.204: Medical Necessity .................................................... 2-2
450.205: Recordkeeping and Disclosure .................................................... 2-3
450.206: Determination of Compliance with Medical Standards .................................................... 2-5
450.207: Utilization Management Program for Acute Inpatient Hospitals .................................................... 2-5
450.208: Utilization Management: Admission Screening for Acute Inpatient Hospitals .................................................... 2-6
450.209: Utilization Management: Prepayment Review for Acute Inpatient Hospitals .................................................... 2-7
450.210: Pay for Performance Payments: MassHealth Agency Review .................................................... 2-9
(130 CMR 450.211 Reserved)
450.212: Provider Eligibility: Eligibility Criteria .................................................... 2-11
450.213: Provider Eligibility: Termination of Participation for Ineligibility .................................................... 2-12
450.214: Provider Eligibility: Suspension of Participation Pursuant to U.S. Department of Health and Human Services Order .................................................... 2-12
450.215: Provider Eligibility: Notification of Potential Changes in Eligibility .................................................... 2-12
450.216: Provider Eligibility: Limitations on Participation .................................................... 2-13
450.217: Provider Eligibility: Ineligibility of Suspended Providers .................................................... 2-13
(130 CMR 450.218 through 450.220 Reserved)
450.221: Provider Contract: Definitions .................................................... 2-14
450.222: Provider Contract: Application for Contract .................................................... 2-16
450.223: Provider Contract: Execution of Contract .................................................... 2-16
450.224: Provider Contract: Exclusion and Ineligibility of Convicted Parties .................................................... 2-18
(130 CMR 450.225 Reserved)
450.226: Provider Contract: Issuance of Provider Numbers .................................................... 2-19
450.227: Provider Contract: Termination or Disapproval .................................................... 2-19
(130 CMR 450.228 through 450.230 Reserved)
450.231: General Conditions of Payment .................................................... 2-20
450.232: Rates of Payment to In-State Providers .................................................... 2-21
450.233: Rates of Payment to Out-of-State Providers .................................................... 2-21
(130 CMR 450.234 Reserved)
450.235: Overpayments .................................................... 2-21
450.236: Overpayments: Calculation by Sampling .................................................... 2-22
450.237: Overpayments: Determination .................................................... 2-22
450.238: Sanctions: General .................................................... 2-23
450.239: Sanctions: Calculation of Administrative Fine .................................................... 2-24
450.240: Sanctions: Determination .................................................... 2-25
450.241: Hearings: Claim for an Adjudicatory Hearing .................................................... 2-26

450.232: Rates of Payment to In-State Providers

Payment to all providers is made in accordance with the payment methodology applicable to the provider, subject to federal payment limitations. Without limiting the generality of the foregoing, payment to a Massachusetts in-state noninstitutional provider for any medical services payable under MassHealth is made in accordance with the applicable payment methodology established by DHCFP, or the MassHealth agency, subject to any applicable federal payment limit (see 42 CFR 447.304).

450.233: Rates of Payment to Out-of-State Providers

(A) Payment to an out-of-state institutional provider for any medical service payable under MassHealth is made by the MassHealth agency at the lesser of

(1) the rate of payment established for the medical service under the other state's Medicaid program;

(2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or

(3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider must submit to the MassHealth agency a copy of the applicable rate schedule under its state's Medicaid program.

(C) Payment to an out-of-state noninstitutional provider for any medical service payable under MassHealth is made in accordance with the applicable fee schedule established by DHCFP or the MassHealth agency, subject to any applicable federal payment limit (see 42 CFR 447.304).

(130 CMR 450.234 Reserved)

450.235: Overpayments

Overpayments include, but are not limited to, payments to a provider

(A) for services that were not actually provided or that were provided to a person who was not a member on the date of service;

(B) for services that were not payable under MassHealth on the date of service, including services that were payable only when provided by a different provider type and services that were not medically necessary (as defined in 130 CMR 450.204);

(C) in excess of the maximum amount properly payable for the service provided, to the extent of such excess;

(D) for services for which payment has been or should be received from health insurers, worker's compensation insurers, other third-party payers, or members;

(E) for services for which a provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state laws and regulations and contracts;

(F) for services provided when, as of the date of service, the provider was not a participating provider, or was in any breach or default of the provider contract;

(G) for services billed that result in a duplicate payment; or

(H) in an amount that a federal or state agency (other than the MassHealth agency) has determined to be an overpayment.

450.236: Overpayments: Calculation by Sampling

In any action or administrative proceeding to determine or recover overpayments, the MassHealth agency may ascertain the amount of overpayments by reviewing a representative sample drawn from the total number of claims paid to a provider during a given period and extrapolating the results of the review over the entire period. The MassHealth agency employs statistically valid techniques in establishing the size and distribution of the sample to ensure that it is a valid and representative sample.

450.237: Overpayments: Determination

The existence and amount of overpayment may be determined in an action to recover the overpayment in any court having jurisdiction. The MassHealth agency may also determine the existence and amount of overpayments. The procedures described in 130 CMR 450.236 and 450.237 do not apply to overpayments resulting from rate adjustments, which are governed by methods described in 130 CMR 450.259.

(A) Overpayment Notice. When the MassHealth agency believes that an overpayment has been made, it notifies the provider in writing of the facts upon which the MassHealth agency bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. When the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), the MassHealth agency will so inform the provider. The MassHealth agency may notify the provider by letter, draft audit report, computer printout, or other format.

(B) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the MassHealth agency and such reply must be received by the MassHealth agency within 30 calendar days of the date on the overpayment notice. The reply must specifically identify and address all allegations in the overpayment notice with which the provider disagrees. With the reply, the provider may submit additional data and argument to support its claim for payment and must include any documentary evidence it wants the MassHealth agency to consider. Where the MassHealth agency states in the overpayment notice that the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), a provider may contest only the factual assertion that the federal or state agency made such a determination. The provider may not contest in any proceeding before or against the MassHealth agency the amount or basis for such determination.

(C) Overpayment Determination. The MassHealth agency considers and reviews only information submitted with a timely reply. If, after reviewing the provider's reply, the MassHealth agency determines that the provider has been overpaid, the MassHealth agency will so notify the provider in writing of its final determination, which will state the amount of overpayment that the MassHealth agency will recover from the provider.

(D) Adjudicatory Hearing. If the provider submits a timely reply, the provider may claim an adjudicatory hearing to appeal the MassHealth agency's final determination, in accordance with 130 CMR 450.241 and 450.243.

(E) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing if it fails to submit a timely reply. The MassHealth agency will take appropriate action to recover the overpayment.

450.238: Sanctions: General

(A) Introduction. All providers are subject to the rules, regulations, standards, and laws governing MassHealth. The regulations at 130 CMR 450.238 through 450.240 set forth the MassHealth agency's procedures for imposing sanctions for violations of those rules, regulations, standards, and laws. Such sanctions may include, but are not limited to, administrative fines and suspension or termination from participation in MassHealth. The MassHealth agency determines the amount of any fine and may take into account the particular circumstances of the violation. The MassHealth agency may assess an administrative fine whether or not overpayments have been identified based on the same set of facts.

(B) Instances of Violation. Instances of violation include, but are not limited to

(1) billing a member for services that are payable under MassHealth, except copayments as provided in 130 CMR 450.130;

(2) submitting claims under an individual provider's MassHealth provider number for services for which the provider is entitled to payment from an employer or under a contract or other agreement;

(3) billing the MassHealth agency for services provided by someone other than the provider, unless expressly permitted by the applicable regulations;

(4) billing the MassHealth agency before delivery of service, unless permitted by the applicable regulations;

(5) failing to comply with recordkeeping and disclosure requirements;

(6) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more comprehensive service for which a single rate of payment is established;

(7) failing to return credit balance funds to the MassHealth agency within 60 days of their receipt;

(8) failing to obtain or provide a physician's order, prescription, or referral when required by the applicable regulations;

(9) failing to comply with MassHealth enrollment, licensure, or certification requirements; and

(10) misapplication or misappropriation of personal needs allowance funds.

450.239: Sanctions: Calculation of Administrative Fine

(A) The MassHealth agency may assess an administrative fine not to exceed the greater of

(1) $100 for each instance of violation of the rules, regulations, standards, or laws governing MassHealth;

(2) $100 for each day of violation of the rules, regulations, standards, or laws governing MassHealth; or

(3) three times the payable amount of each claim, in accordance with 130 CMR 450.239.

(B) In determining the amount of any administrative fine, the MassHealth agency considers the following factors.

(1) Nature and Circumstances of the Claim. The MassHealth agency considers the circumstances to be mitigating if the violations were of the same type and occurred within a short period of time; there were only a few such instances; there was no history of similar types of violations; and the total monetary value of these instances was less than $1,000. Conversely, the MassHealth agency considers the circumstances to be aggravating if the violations were of a single type or several types and occurred over a lengthy period of time; there were many such instances; there was a history of similar types of violations; and the total monetary value of these instances was $1,000 or more.

(2) Prior Offenses. The MassHealth agency may consider the circumstances to be aggravating if the provider previously had been held liable for criminal, civil, or administrative sanctions relating to MassHealth.

(3) Financial Condition and Member-Access Considerations. The MassHealth agency considers the circumstances to be mitigating if the imposition of a full penalty will jeopardize the ability of the provider to continue as a health-care provider and if the provider's inability to continue as a health-care provider would result in a demonstrable access problem for members in the provider's geographic region. The provider has the burden of demonstrating such access problem.

(4) Other Factors. The MassHealth agency will consider other mitigating or aggravating circumstances. If there are substantial mitigating circumstances, the MassHealth agency will decrease the administrative fine to be assessed. Conversely, if there are substantial aggravating circumstances, the MassHealth agency will increase the administrative fine to be assessed.