Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-202
September 2013

TO: All Providers Participating in MassHealth

FROM: Kristin L. Thorn, Acting Medicaid Director

RE: All Provider Manuals (Revised Regulations about Recordkeeping and Disclosure, and Overpayments)

This letter transmits revised regulations to the administrative and billing regulations for recordkeeping and disclosure, and overpayments.

Recordkeeping and Disclosure

MassHealth has amended its regulations at 130 CMR 450.205 to clarify that providers are required to provide, upon request by the State Auditor and U.S. Department of Health and Human Services, records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for members, as well as other information about payments claimed by the provider. In addition, providers must disclose such records and information to other state and federal agencies to which disclosure is required by law.

These amendments are effective September 13, 2013.

Overpayments

MassHealth has amended its regulations at 130 CMR 450.235 to reflect changes in federal law. See 42 U.S.C. 1320a-7k(d), added by Section 6402(a) of the Affordable Care Act. The amendments require a provider to report in writing and return any overpayments to MassHealth within 60 days of the provider identifying such overpayment or, for payments subject to reconciliation based on a cost report, by the date any corresponding cost report is due, whichever is later. The provider must include in such written report the reason for the overpayment and use such form and follow such process that may be prescribed by MassHealth. MassHealth has also amended its regulations at 130 CMR 450.260 to reflect the amendment to 130 CMR 450.235.

These amendments are effective September 13, 2013.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

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 2-3 and 2-4, 2-23, 2-24, 2-31, and 2-32

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 2-3 and 2-4 — transmitted by Transmittal Letter ALL-154

Pages 2-23, 2-24, 2-31, and 2-32 — transmitted by Transmittal Letter ALL-201

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

450.205: Recordkeeping and Disclosure

(A) The MassHealth agency will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. All providers must keep such records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for, members and must provide to the MassHealth agency and the Attorney General's Medicaid Fraud Division, the State Auditor and the United States Department of Health and Human Services on request such information and any other information about payments claimed by the provider for providing services or otherwise described in 130 CMR 450.205 (see e.g., 42 U.S.C. 1396a(a)(27) and the regulations thereunder). All providers must also disclose such records and information to any other state and federal agency to which disclosure is required by law.

(B) All providers must maintain complete patient account records. Patient account records must include complete documentation of charges, indicate the date and amount of all debit and credit transactions, and support the appropriateness of the amounts billed and paid. Institutional providers must, in addition, provide on request all records maintained by or within the institution about services provided to members by other providers. Pharmacy providers must, in addition, keep photocopies of the temporary MassHealth cards referenced when filling prescriptions, if applicable, and must produce a copy of the card on request.

(C) A provider must maintain and disclose any and all financial, statistical, and other information as may be required by the MassHealth agency, the Center for Health Information and Analysis, or any other agency described in 130 CMR 450.205(A). The required information must include, but is not limited to, ownership and licensure information, cost reports, charge books, audited financial statements, financial records, federal and state tax returns, invoices, general ledgers, trial balances, remittance advices, and explanations of benefits from health insurers and managed care organizations. Such records and documents must be provided within the time period specified by the requesting agency.

(D) All records, including but not limited to those containing signatures of medical professionals authorizing services, such as prescriptions, must, at a minimum, be legible and comply with generally accepted standards for recordkeeping within the applicable provider type as they may be found in laws, rules, and regulations of the relevant board of registration, professional treatises, and guidelines and other information published, adopted, or promulgated by state or national professional organizations and societies. All accounting records must be maintained in accordance with generally accepted accounting principles. In those instances where MassHealth regulations identify specific recordkeeping requirements for particular types of providers, such regulations constitute an additional standard against which the adequacy of records will be measured for the purposes of 130 CMR 450.205. In no instance will the completion of the appropriate MassHealth claim, the maintenance of a copy of such claim, or the simple notation of service codes constitute sufficient documentation for the purpose of 130 CMR 450.205.

(E) Except as provided under 130 CMR 450.205 (F), the records and information required to be maintained or disclosed under 130 CMR 450.000 include only those that relate in any manner to services provided to or prescribed for members, provided, however, that disclosure may not be refused on the ground that such records are commingled with records related to persons who are not members. Such records and information must be made available to the MassHealth agency and any other agency described in 130 CMR 450.205(A) for examination or copying during reasonable office hours at the provider's place of business or record depository. Alternatively, the requesting agency may require that the provider submit copies of such records and information.

(F) (1) Providers subject to the federal requirements for employee education about false claims laws under 42 U.S.C. §1396a(a)(68) must:

(a) provide written certification, on or before June 30 of each year, or such other date as specified by the MassHealth agency, signed under the pains and penalties of perjury, of compliance with the federal requirements;

(b) make available to the MassHealth agency, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. 1396a(a)(68), any employee handbook, and other information as the MassHealth agency may deem necessary to determine compliance; and

(c) initiate corrective actions necessary to comply with such federal requirements.

(2) The MassHealth agency may recover as overpayments any payments made to a provider that the MassHealth agency determines failed to comply with the requirements of 130 CMR 450.205(F)(1) or 42 U.S.C. §1396a(a)(68), and impose sanctions against a provider in accordance with the provisions of 130 CMR 450.000.

(G) Notwithstanding any regulatory or contractual provisions that may provide for a shorter retention period, all records described in 130 CMR 450.204 and 450.205 must be kept for at least six years after the date of medical services for which claims are made or the date services were prescribed, or for such length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever period is longer. Providers must retain records to substantiate costs listed on a cost report for at least six years following the date of filing of the cost report or for such length of time as may be required by DCHFP regulations, whichever period is longer. In no event may any provider destroy any records while any review, audit, or administrative or judicial action involving such records is pending.

(H) In cases where audits or other reviews reveal provider noncompliance with 130 CMR 450.204 and 450.205, the MassHealth agency may seek to pursue recovery of overpayments and to impose sanctions in accordance with the provisions of 130 CMR 450.000.

(I) (1) The provider, as holder of personal data under M.G.L. c 66A, must comply with all regulatory and statutory requirements applicable to such a holder, including those set forth in M.G.L. c. 66A, and must inform each of its employees having access to such personal data of such requirements and ensure compliance by each employee with such requirements.

(2) The provider must take reasonable steps to ensure the physical security of personal data under its control including, but not limited to:

(a) fire protection;

(b) protection against smoke and water damage;

(c) alarm systems;

(d) locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data;

(e) passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; and

(f) limited access to input and output documents.

450.235: Overpayments

(A) Overpayments include, but are not limited to, payments to a provider

(1) for services that were not actually provided or that were provided to a person who was not a member on the date of service;
(2) 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);
(3) in excess of the maximum amount properly payable for the service provided, to the extent of such excess;
(4) for services for which payment has been or should be received from health insurers, worker's compensation insurers, other third-party payers, or members;
(5) 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;
(6) 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;
(7) for services billed that result in a duplicate payment; or
(8) in an amount that a federal or state agency (other than the MassHealth agency) has determined to be an overpayment.

(B) A provider must report in writing and return any overpayments to the MassHealth agency within 60 days of the provider identifying such overpayment or, for payments subject to reconciliation based on a cost report, by the date any corresponding cost report is due, whichever is later. A provider must include in such written report the reason for the overpayment and use such form and follow such process that may be prescribed by the MassHealth agency.

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.

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;

450.259: Overpayments Attributable to Rate Adjustments

(A) Whenever an overpayment occurs due to a rate adjustment that is certified by DHCFP or otherwise established by the MassHealth agency in accordance with applicable law, the MassHealth agency notifies the provider in writing by issuing a remittance advice identifying the impact of the rate adjustment on all previously paid claims and stating the amount of the overpayment.

(B) A provider must pay to the MassHealth agency the full amount of any overpayment attributable to a rate adjustment within 30 calendar days after the date of issuance of a remittance advice under 130 CMR 450.259(A), unless the provider enters into a payment arrangement with the MassHealth agency under 130 CMR 450.260(H).

(C) If a provider disputes the MassHealth agency's computation of an overpayment attributable to a rate adjustment, the provider must submit proposed corrections, including a detailed explanation, in writing to the MassHealth agency within 30 calendar days after the date of issuance of the remittance advice under 130 CMR 450.259(A). The fact that any rate adjustment certified by DHCFP is under appeal is not considered a factor in determining the amount of liability. The fact that a provider has submitted proposed corrections to the MassHealth agency does not delay or suspend the provider's payment obligations set forth under 130 CMR 450.259(B).

(D) If proposed corrections are timely submitted in accordance with 130 CMR 450.259(C), the MassHealth agency reviews the proposed corrections and notifies the provider of its decision within 30 calendar days of receipt of the provider's corrections. If the MassHealth agency determines that corrections are required, the MassHealth agency makes any appropriate payment adjustments reflecting the corrections.

(E) A provider must pay the MassHealth agency the full amount of the overpayment stated in a remittance advice under 130 CMR 450.259(A), regardless of any pending appeal, action, or other proceeding contesting the overpayment, including but not limited to, any appeal, action, or other proceeding contesting any rate on which the overpayment is computed. If required by a final disposition of any such appeal, action, or proceeding, the MassHealth agency issues a revised remittance advice and makes any appropriate payment adjustments to effect the final disposition.

450.260: Monies Owed by Providers

(A) Provider Liability. A provider is liable for the prompt payment to the MassHealth agency of the full amount of any overpayments, or other monies owed under 130 CMR 450.000 et seq., including but not limited to 130 CMR 450.235(B), or under any other applicable law or regulation. A provider that is a group practice is liable for any overpayments owed and subject to sanctions imposed as a result of any violation of any statute or regulation committed by the individual practitioner that provided the service.

(B) Ownership Liability. Any owner of an institutional provider is liable for the monetary liability of the institutional provider under 130 CMR 450.260(A) to the extent of the owner's ownership interest. For purposes of 130 CMR 450.260, an "owner" is a person or entity having an ownership interest in an institutional provider, as such interest is defined in 130 CMR 450.221(A)(9)(a), (b), (c), or (f). An "institutional provider" is any provider that provides nursing facility services, or acute, chronic, or rehabilitation hospital services.

(C) Common Ownership Liability. Any two or more providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or

otherwise, are jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260(A).

(D) Successor Liability. Any successor owner of a provider is liable for the obligation of any prior owner to pay the full amount of any monies owed by the prior owner under 130 CMR 450.260(A). For purposes of 130 CMR 450.260, a "successor owner" is any successor owner, operator, or holder of any right to operate all or a part of the prior owner's health-care business, which includes, but is not limited to, the business management, personnel, physical location, assets, or general business operations. A successor owner of a nursing facility, or acute, chronic, psychiatric, or rehabilitation hospital includes any successor owner or holder of a license to operate all or some of the beds of a nursing facility, or acute, chronic, psychiatric, or rehabilitation hospital.

(E) Group Practice Liability. The individual practitioner who provided the service and the group practice will be jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260.

(F) Recoupment. If a provider fails to pay the full amount of any monies owed under 130 CMR 450.260(A), the Division may recoup up to 100 percent of any and all payments to the provider, without further notice or demand, until such time as the full amount of any monies owed under 130 CMR 450.260(A) is paid in full.

(G) Set-Off. The Division may apply a set-off against payments to a provider in the following circumstances.

(1) Providers Under Common Ownership. Whenever any monies are owed by a provider under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to any providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or otherwise, without further notice or demand, until such time as the full amount of the monies owed under 130 CMR 450.260(A) is repaid in full.
(2) Successors. Upon the sale or transfer of all or part of a provider, the Division may set off up to 100 percent of any and all payments to any successor owner, without further notice or demand, until such time as the full amount of any monies owed by any prior owner under 130 CMR 450.260(A) is repaid in full.
(3) Group Practices. Whenever monies are owed by a group practice under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to the individual practitioner who provided the service, without further notice or demand, until such time as the full amount of any monies owed by the group practice under 130 CMR 450.260(A) is repaid in full. Whenever monies are owed by an individual practitioner who is a member of a group practice under 130 CMR 450.260(A), the Division may set off up to 100 percent of any and all payments to the group practice, without further notice or demand, until such time as the full amount of any monies owed by the individual practitioner under 130 CMR 450.260(A) is repaid in full.

(H) Payment Arrangements. At its discretion, the Division may enter into a written arrangement with a provider, its owner, any provider under common ownership, or any successor owner to establish a schedule to pay to the Division the full amount of any monies owed, on such terms as are acceptable to the Division. The arrangement may provide for such guarantees or collateral as may be acceptable to the Division to secure the payment schedule.

(I) Court Action. The Division may recover the full amount of any monies owed to the