CHAPTER 800(A) – GENERAL ADMINISTRATION

CHANGE LOG

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INTRODUCTION

This chapter provides a general overview of the organization of the Bureau for Medical Services (BMS), including information on provider relation services, utilization review activities, and recovery of provider overpayments. In addition, this chapter sets forth the BMS' general administrative requirements for all providers enrolled in the West Virginia Medicaid Program concerning the services provided to eligible West Virginia Medicaid members.

The policies and procedures set forth herein and published as regulations governing the provision of all services in the Medicaid Program are administered by the West Virginia Department of Health and Human Resources under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

Additional information and requirements may also be found in the other chapters of the Provider Services Manuals:

- Chapter 100 General Information
- Chapter 300 Provider Participation Requirements
- Applicable Provider Manuals, Covered Services, Limitations and Exclusions, for specific health care areas of expertise

800.1 ADMINISTRATIVE RESPONSIBILITY

Responsibility for the administration of the Medicaid Program within the West Virginia Department of Health and Human Resources (DHHR) is placed within the BMS. The Commissioner of BMS has overall responsibility for the administration of the Medicaid Program (Title XIX).

There are 8 major Offices within BMS. The Offices are:

- Office of the Chief Financial Officer
- Office of Facility Based and Residential Care Services
- Office of Home and Community Based Services
- Office of Medicaid Management Information System (MMIS) Operations & IT Support
- Office of Pharmacy Services
- Office of Policy and Administrative Services
- Office of Professional Health Services
- Office of Quality & Program Integrity

Each of these Offices reports to the Commissioner of BMS.

In addition to its internal organization, BMS contracts with other entities for a number of administrative and operational functions including, but not limited to, Medicaid Management

Information System (MMIS), utilization management, fiscal intermediary, program management, and third party liability.

800.2 BUREAU FOR MEDICAL SERVICES' ORGANIZATIONAL STRUCTURE

- **The Office of Financial Services:** The Office of Financial Services is responsible for developing and tracking the Bureau's annual budget request and subsequent appropriations. This Office is responsible for preparing quarterly expenditure estimates and reports required by the Centers for Medicare and Medicaid Services (CMS), and the State Legislature. During the annual legislative session, this Office is also responsible for reviewing all bills affecting the Medicaid Program, preparing fiscal notes, and attending hearings as assigned. Additionally, this Office is responsible for the following:

    1. Budget & Reporting Division - The Division is responsible for managing the Bureau's Medical Services, Administrative, and Federal Reporting activities.
    2. Rate Setting Division - The Division sets payment rates for services provided by hospitals, physicians, and other health care providers participating in the West Virginia Medicaid program. Rates are set annually for more than 35,000 covered services. Additionally, the Unit is responsible for setting rates for the Bureau's supplemental payments.

3. Accounting Division - The Division is responsible for the Bureau's accounts payable, cash management, inventory/asset control, and purchasing control activities.
    4. Drug Rebate Division - The Division is responsible for managing the Bureau's Federal, and supplemental Drug rebate programs; and collecting millions of dollars annually from drug manufacturers.

- **Office of Facility Based and Residential Care Services**: The Office of Facility Based and Residential Care is responsible for the administration and oversight of various aspects of the policy unit that includes, but are not limited to, hospitals, both medical and mental health, Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs), organ transplants, renal dialysis, child residential treatment facilities, Psychiatric Residential Treatment Facilities (PRTF), Partial Hospitalization programs, Nursing Facilities and Intermediate Care and Mental Retardation Facilities (ICF/MR).

  This Office is responsible for the maintenance of the policy for the following provider manuals:

    1. Ambulatory Surgical Centers and Birthing Centers Services
    2. Hospital Services
    3. ICF/MR Services
    4. Nursing Facility Services
    5. Partial Hospitalization Services
    6. PRTF Services

7. RHC/FQHC Services

- **Office of Home and Community Based Services**: The Office of Home and Community Based Services (OH&CBS) is responsible for the development of home and community based human services systems that provide home health, hospice, mental health, waiver based services to West Virginia's families, children and vulnerable adults.

  This Office is responsible for the maintenance of the policy for the following provider manuals:

  1. Aged and Disabled Waiver Services
  2. Behavioral Health Clinic Services
  3. Behavioral Health Rehabilitation Services
  4. Children with Disabilities Community Services Program
  5. Home Health Services
  6. Hospice Services
  7. MR/DD Waiver Services
  8. Personal Care Services
  9. Targeted Case Management
  10. Psychological Services

- **Office of MMIS Operations & IT Support**: The Office is responsible for managing the Bureau's Medicaid Management Information System (MMIS) and Information Technology supports (ITS). The Office manages the State's fiscal agent contractor, and coordinates with the Bureau's Policy Units and various Department activities to ensure the State's Medicaid eligibility and coverage policies are correctly implemented within the MMIS. The Office is responsible for screening and processing ad hoc data requests. Also, the Office is responsible for planning and managing the Bureau's Information Technologies and State and Department network access, Third Party Liability (TPL), Eligibility, and MWIN (Buy-In).

- **Office of Pharmacy Services**: The Office of Pharmacy Services (OPS) is responsible for providing policy for drug coverage for Medicaid members in compliance with all Federal and State requirements and for providing a means for which pharmacy claims can be processed in order to provide this service. The OPS also provides a means for State Programs, Juvenile Justice System Program, Children with Special Health Care Needs, and the AIDS Drug Assistance Program to process their claims for pharmacy services.

- **Office of Policy and Administrative Services**: The Office of Policy Administrative Services is responsible for the administration and oversight of various aspects of the policy unit that include, but are not limited to Policy Coordination and Provider Enrollment, State Plan Administration, BMS vendor Contracts, BMS Administrative policies and oversight of other associated programs.

- **Office of Professional Health Services**: The Office of Professional Health Services is responsible for the following outpatient services provided by practitioners, certified providers and Medicaid Managed Care Organizations in accordance with current State, Federal, and Local regulations, medical practice standards, and mutual contracts, as applicable.

  This Office is responsible for the maintenance of the policy for the following provider manuals:

  1. Chiropractic Services
  2. Dental Services
  3. DME/Medical Supplies
  4. Laboratory Services
  5. Radiology Services
  6. Occupational/Physical Therapy Services
  7. Orthotics and Prosthetics Services
  8. Practitioner Services
  9. Podiatry Services
  10. Transportation Services
  11. Vision Services
  12. Speech and Audiology Services

- **Office of Quality & Program Integrity**: This Office has three functions:

  Surveillance and Utilization Review (SUR)

  SUR is responsible for conducting on-site and desk audits to monitor Medicaid program compliance for fee-for-service providers in compliance with State and Federal Medicaid policy and regulations.

  Quality Assessment

  This Division performs research and analysis to determine the quality of services provided to West Virginia's Medicaid recipients based on best clinical practices. Also, the Division analyzes the outcomes resulting from the Bureau's medical policies to determine the overall impact on the health of its members.

Program Integrity
This oversees all aspects of maintaining the integrity of the Medicaid Program.

800.3 PROVIDER ENROLLMENT/RELATIONS

An effective Medicaid Program is dependent upon the support and cooperation of the providers that render medical care and services. BMS is responsible for establishing and maintaining effective communication with providers participating in the Medicaid Program. Appropriate provider relations staff is available to respond to provider inquiries regarding (1) program policy, (2) reimbursement, (3) proper filing of claims, and (4) various other issues.

For a list of contacts and telephone numbers for specific provider relation activities, please refer to Chapter 100 General Information.

800.4 PROGRAM POLICIES

Program policies are specified in and disseminated to the provider community through program manuals. BMS will update manuals with new, revised, or clarified information, as applicable. The process may include manual updates to the web site, email notification, and/or direct mail. Please reference Chapter 100, topic "Manual Updates".

800.5 PROVIDER PARTICIPATION

Any provider may make application to enroll in the West Virginia Medicaid Program. For specific provider enrollment requirements, please refer to Chapter 300, Provider Participation Requirements and/or applicable provider manuals.

800.5.1 EXCLUSION FROM PARTICIPATION

The Commissioner of BMS, or his/her designee, may suspend or exclude a provider from participation in the Medicaid Program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations, or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the Medicaid Program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review.

800.5.2 EXCLUSION BY MEDICARE (TITLE XVIII)

A provider, who is excluded from participation in the Medicare Program (Title XVIII), is also excluded from participation in the Medicaid Program effective with the date of exclusion from Medicare.

800.5.3 EXCLUSION BY STATE MEDICAID AGENCY

A provider who is excluded from participation in the Medicaid Program (Title XIX) of another state may be excluded or denied participation in programs administered by BMS with the effective date the West Virginia BMS is notified of such exclusion.

800.5.4 DISCLOSURE REQUIREMENTS BY PROVIDERS

Providers must disclose to BMS the identity of any person who:

- Has ownership of 5 or more percent, or controlling interest in the provider practice or is an agent or managing employee of the provider;
- Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services;
- Has been included in the Office of the Inspector General's List of Excluded Individuals/Entities;
- Has been convicted of any crime related to health care delivery.

800.6 OFFICE OF QUALITY AND PROGRAM INTEGRITY

Federal Regulations as stated in 42 CFR 431.10 require the Single State Agency (in West Virginia this is BMS) to assure that services reimbursed by the Agency are medically necessary, appropriate, rendered in an approved setting by approved providers and that the services are supported by documentation in the record and recorded at the time of service.

The BMS addresses these requirements through activities performed throughout the BMS and in conjunction with our contractors, i.e., provider enrollment, claim system edits, prior authorization of services to assure they are medically necessary and appropriate and routine review of claims post payment to assure the processing of the claim follows BMS policy.

The Office of Quality and Program Integrity (OQPI) is the unit primarily responsible for post payment review of claims. One of the functions of this Office is to detect and examine unusual patterns of reimbursement to providers and unnecessary or inappropriate utilization of care and services rendered to Medicaid members. This function is commonly referred to as Surveillance and Utilization Review (SUR) activities. In addition, the OQPI researches complaints of fraud waste and abuse from all sources, and cooperates with CMS in the performance of various programmatic reviews such as Payment Error Rate Measurement (PERM), and program integrity reviews through the Medicaid Integrity Group as defined in the Deficit Reduction Act of 2005.

For additional information and contact telephone numbers on Utilization Review, please refer to Chapter 100, General Information, Chapter 300 Provider Participation Requirements, and applicable provider manuals for specific service authorization requirements.

800.6.1 SURVEILLANCE AND UTILIZATION REVIEW ACTIVITIES

The Office of Quality and Program Integrity (OQPI) is responsible for the evaluation of the medical necessity, appropriateness, adherence to current medical practice standards and conformance to nationally accepted billing practices. The reviews may involve the use of exception criteria, provider and member profiles, ad hoc reports obtained from the MMIS, and examination of provider records.

Provider reviews may be done by requesting documentation of services be submitted for review at the OQPI, or may be conducted at the provider's location. Medicaid members sign a release of information as part of the application process; therefore, no additional release of information is required for providers to make records available for review. Failure to comply with a request for records may result in a hold on all Medicaid payments until the records are received. Records may be selected using sampling techniques.

When onsite reviews are conducted, whenever possible, providers will make available a work area which provides some privacy and guarantees the confidentiality of the records during the review process. The cost of making necessary copies to validate appropriate utilization is included in provider reimbursement for Medicaid procedures.

When the BMS has identified unnecessary and inappropriate practices through monitoring activity or other reviews, it may pursue one or more of the following:

1. Recoupment of inappropriately paid monies
2. Requirement of a satisfactory written plan of correction
3. Limited participation in the plan that may include:
    - Prior authorization for all services;
    - Prepayment review of all applicable claims;
    - Suspension of payment until a plan of correction is filed and accepted;
    - Suspension of Medicaid admissions in the case of outpatient or inpatient facilities;
    - Ban on approving admissions for inpatient services;
4. Exclusion from participation in the West Virginia Medicaid Program through the following actions;
    - Suspension;
    - Disenrollment;
    - Denial, non-renewal, or termination of provider agreements.
5. Referral to Medicaid Fraud Control Unit (MFCU)
6. Withholding of payment involving fraud or willful misrepresentation.

Recoupment, if a provider is paid monies inappropriately, will be handled as defined in section 800.11.1 of this manual.

When a written plan of correction is required the provider must create and submit said plan to BMS within the time specified in the notice. Said plan should address all deficiencies noted in

the review report and give steps on how the actions will correct deficiencies and define time lines related to successful implementation of the corrective action plan.

In cases of limited enrollment, BMS will notify the provider in writing regarding the limitation placed on participation, the duration of the limitation, and the corrective action necessary to remove the restriction. In cases of exclusion from participation, BMS will notify the provider in writing in advance as to the reasons for exclusion and the effective date and duration.

After receipt of the notice that participation is being restricted or terminated, the provider may, within 30 days from the receipt, request a document/desk review.

800.7 PRIOR AUTHORIZATION OF SERVICES

- Please see applicable manuals for Prior Authorization requirements.

The provider must contact the medical review organization to obtain prior authorization for members who have exhausted their service limits. For contact and telephone number information for the contracted medical review organization, refer to Chapter 100 of the Provider Manual.

In order to receive payment from BMS, a provider shall comply with all prior authorization requirements. The BMS, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment. All other requirements must be met for payment.

Medical review organizations under contract to BMS are the final clinical authority. Also see Chapter 518 Pharmacy Services.

800.8 CLAIMS PROCESSING SCHEDULE

BMS processes provider payments once per week. Approved claims are posted to accounts payable after MMIS adjudication cycles. Approved claims are held in accounts payable until sufficient funds are available for payment. The provider payment cycle begins each Friday.

The Provider Relations department assists with questions regarding claims reimbursement, including face-to-face meetings where applicable. Further information regarding billing and reimbursement can be found in applicable provider manuals and Chapter 600.

800.9 ELECTRONIC CLAIMS SUBMISSION

Submitting claims via electronic media offers the advantage of speed and accuracy in processing. The provider may submit Medicaid claims through an electronic medium or choose from several firms that offer electronic submission services.

BMS Policy encourages electronic claim submission, as well as requires electronic funds transfer from its enrolled providers. If interested in submitting claims via electronic media, contact the Electronic Claim Specialists at the address below:

Bureau for Medical Services
C/o West Virginia MMIS Subcontractor
EMC Department
P.O. Box 2002
Charleston, West Virginia 25327-2002

800.10 CERTIFICATION ON CLAIM FORM

The medical services provider (professional practitioner or organization) is completely and solely responsible for the content of a claim. Federal regulations require that the following statement be printed on all Medicaid claim forms:

"This is to certify that the information on this invoice is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

The provider is responsible for all information provided on a claim form. This certification is also on the provider enrollment which can be accepted in place of the statement on the claim form.

800.11 TIMELY CLAIMS FILING

Federal regulations mandate that BMS must require providers to submit claims no later than 12 months from date of service. The West Virginia Medicaid Program will allow 24 months from the date of service for denied claims to be billed with corrections or paid claims to be replaced provided that the claims meet the requirements including requirements in 42CFR 447.45. Clean claims can be processed without obtaining additional information from the provider or a third party. Claims must have been timely filed. i.e., received by Medicaid within 12 months from date of service; must be on a prescribed form or through an approved electronic media transaction; must have valid provider and member ID number and a valid date of service. Services not billed prior to one year from the date of service cannot be added to a claim after a claim is one year old. Timely filing is the responsibility of the providers and is not subject to document/desk review hearings.

Previously submitted claims that are over 12 months from dates of service must be billed on the appropriate paper claim form to the Bureau's fiscal agent with appropriate documentation. (See Chapter 300, Section 340.2).

Exceptions to the 12 month time limit are:

- Corrected claims that were billed prior to the 12 month time limit and before 24 months from the date of service with copy of remittance advice (rejections, 824 and Return to Provider (RTP) letters are not accepted as proof of timely filing).

- Medicare primary claims billed within 12 months of the Medicare pay date with a copy or the Explanation of Medicare Benefits (EOMB). Medicaid can pay said claim within 6 months after notice of disposition of the Medicare claim.
- Claims for members with backdated Medical cards billed within 12 months of the issuance of the Medical card with a copy of the Medical card.

Providers submitting excessive duplicate claims may be subject to a monetary assessment.

For additional information and requirements, please refer to Chapter 300 Provider Participation Requirements.

800.12 RESTITUTION

BMS is responsible for recovery of State and Federal Medicaid funds improperly paid as a result of overpayments, false claims, and misrepresentation or concealment of facts related to a provider's qualifications, or costs as filed with BMS.

Procedures for auditing providers may include the use of sampling and extrapolation. If sampling reveals overpayment, the provider will be required to reimburse BMS for the entire amount of overpayment.

The Bureau's procedure for auditing providers may include the use of sampling and extrapolation. If sampling reveals patterns of inappropriate coding, failure to adhere to Bureau policies, consistent patterns of overcharging, or other fiscal abuse of the medical assistance program, the provider shall be required to reimburse the Bureau an extrapolated amount.

The Bureau may in its discretion decide to conduct desk audits with non-extrapolated findings based on, but not limited to the following factors: review of a new service; new provider groups utilizing a service; or a review to validate corrective action plan.

An example of an extrapolation technique for calculating such an overpayment may be as follows:

- An error rate is calculated based on the sample records reviewed.
- This error rate is then extrapolated for the total amount paid for that procedure code for the time period of review.

The provider will be notified in writing of the method of determining any overpayment and the amount to be recovered by BMS with appropriate documentation to support the findings.

800.12.1 RECOVERY OF OVERPAYMENTS

When a provider is notified of an overpayment by the BMS, the provider must enter into a written repayment arrangement within 30 days of such notification. The provider may select one of the following optional arrangements:

- Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or

- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to a 12 month period, through monthly payments or the placement of a lien against future payments.

If the provider selects the monthly restitution option, BMS will charge interest on the overpayment balance after 60 days following notification of the overpayment. The interest rate on overpayments will be the higher of the rate as set by the Secretary of the Treasury after taking into consideration private consumer rates of interest prevailing on the date of demand for payment or by the current value of funds rate. These rates are published quarterly in the Federal Register by the Secretary of the Treasury, subject to quarterly revisions. Each monthly payment must include at least 1/12 of the remaining balance of the overpayment, plus applicable interest (i.e., there can be no "back ending" under the recovery schedule).

In the event that the provider fails to submit a written repayment arrangement within thirty days, a lien may be imposed on all future Medicaid payments, effective thirty days after notification of the overpayment. Interest will accrue on any remaining balances commencing thirty days after the date of notification. The lien will remain in effect until the overpayment is recovered with interest.

If the provider does not comply in full with the repayment arrangement within 1 year of notification of the overpayment, the provider is subject to all of the sanctions set forth in §870 of the Medicaid regulations.

BMS reserves the right to waive or extend the recovery provisions set forth above in extraordinary circumstances in order to prevent undue hardship. Undue hardship requests must be accompanied by 5 years of financial statements for review by BMS, prior to the decision to waive or extend the recovery provision.

If the provider seeks a document/desk review of an overpayment decision, the repayment and interest provisions set forth above will begin 5 days after the date of the document/desk review decision or 60 days after the date of notification, whichever is later.

If the provider continues an appeal through an evidentiary hearing, any monetary findings in their favor will result in a refund to the provider's account after notification of the evidentiary hearing conclusion. If there is further appeal, a refund will be made at the conclusion of the appeal process.

800.12.2 DELINQUENCIES

Debts are considered overdue and payment to the provider may be withheld from future payments up to the amount of the debt plus interest when any of the following situations exist:

- The provider does not respond within 30 days following notification of the overpayment and repayment is not made;
- Arrangements for repayment or request for document/desk reviews or conferences are not made within the 30 day time period;

- The terms of the agreed upon installment payment plan are violated;
- The determination of overpayment is upheld in the appeal process and arrangements for repayment are not made within the 30 days following notification of the overpayment
- The appeal process exceeds 120 days due to delays requested by the provider;
- The provider, or if a corporation, any of its officers, has been found guilty in any court of competent jurisdiction of fraud or abuse of the Medicaid Program.

800.13 THIRD PARTY LIABILITY (TPL)

Federal regulations mandate that States identify any potentially liable third party resource available to meet a member's medical expenses. The "third party" may be an individual, institution, corporation, or public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, UMWA benefits, Veterans Administration benefits, CHAMPUS/TRICARE, Medicare, etc. There is no Medicaid reimbursement for any covered service for an eligible member that is eligible for payment by a Workers Compensation Plan.

It is important to note that 42 CFR 447.20(b) states that a provider may not refuse to furnish services covered under the Medicaid Plan to an eligible individual on account of a third party's potential liability for the service.

Prior to submitting a claim to Medicaid, the provider must secure information regarding possible third party coverage. Once identified, the provider must bill the third party. All requirements of the third party insurance plan must be met before Medicaid will reimburse including use of in-network providers. After receipt of payment, the provider may then bill the claim to Medicaid. For medical claims, the provider must report the TPL payment and any member liability amounts. The provider must report the third party payment and member liability amounts. If the third party denies payment for services, the provider must submit a claim on paper along with a copy of the Explanation of Benefits denying payment by the third party. The attached copy must contain the written denial reason. If a denial code is used, a description of the code must be attached.

If a provider learns of the potential for third party liability after Medicaid has paid, the provider must first refund Medicaid using the Void/Adjustment process described in Chapter 600. A claim is then submitted to the third party payer and if necessary, the provider re-bills Medicaid along with a copy of the third party's explanation of benefits.

If the member receives the insurance payment or notice of denial, it is the member's responsibility to forward the payment or denial to the provider. The member is considered a "private pay" until such time as the member provides the needed information to the provider.

Medicaid members are not responsible for any third party related co-insurance amounts, deductible amounts, or HMO related co-pays and deductibles, even if the claim payment is zero when the claim payment has been reduced as a result of the insurance payment or capitation agreement.

All TPL related claims that are not Medicare are subject to the timely filing requirements of 12 months from date of service. Claims that are Medicare and TPL related are subject to a filing deadline of 12 months from the date of the Medicare payment.

For additional TPL information and requirements, refer to Chapter 100 General Information, Chapter 300 Provider Participation Requirements, Chapter 400 Member Eligibility, and Chapter 600 Reimbursement Methodologies.

BMS, pursuant to federal and state law, recovers medical assistance payments from two sources. One is payment that is the responsibility of a member's insurance policy which pays primary to Medicaid. A provider is required to bill a member's insurance prior to billing Medicaid. The second source of third party recovery is subrogation. A member executes an assignment of benefits upon enrolling in Medicaid. If a member recovers payments from a liable third party, such as from an accident or lawsuit, Medicaid is entitled to payment of the medical assistance paid due to the accident, etc.

800.14 APPEALS

There are 2 types of appeal processes available. One addresses service denials and the other is administrative actions resulting in a negative action against a provider

800.14.1 SERVICE DENIALS

Requirements regarding who may initiate service denial appeals and the current time frames are as follows:

a. Prior Authorization Contractor Reconsideration of Medical Necessity Determination

Issues concerning medical necessity determinations may be appealed through the reconsideration process to the Utilization Management Contractor (UMC). At present, either the provider or member may initiate a request for reconsideration of any negative medical necessity determination issued by WVMI. The UMC must receive the written request and supporting documentation within 60 days of the notification of denial. Services that are initiated subsequent to the PA denial are not reimbursable unless a subsequent reconsideration or department appeal reverses the initial denial. Consequently, any provider who initiates services subsequent to the UMC denial does so at risk. A PA denial may result in either a provider appeal if a service has been provided and payment denied or a member appeal if a covered service has been denied or reduced.

b. DHHR Agency Fair Hearings Process

The Agency Fair Hearings Process provides an appeal mechanism through which applicants or members may appeal any adverse decision regarding eligibility or termination, denial, suspension, or reduction of covered services. For further information on the Fair Hearings Process, refer to Chapter 400.

800.14.2 DOCUMENT/DESK REVIEW

The provider document/desk review process involves 2 steps. The first step will be a document/desk review by BMS. If a provider disagrees with the resulting decision, a request can be made for an evidentiary hearing.

a. Request for Document/Desk Review

A provider, within 30 days after receipt of a notice of an adverse administrative action taken by the Bureau/Department which affects his/her participation in the Medicaid program or reimbursement for covered services provided to eligible Medicaid members, may request a document/desk review. The request for a document/desk review must be in writing, dated, signed and must set forth in detail the items in contention. Failure to request or late requests for prior authorizations (PA) for services are the responsibility of the providers and are not subject to document/desk review.

b. Additional Information

When information is requested from a provider, in the course of a review or audit by the Office of Quality and Program Integrity and/or the Office of Audit, Research and Analysis, or their agents or contractors, and the provider does not provide the information in a timely manner, BMS will consider that the information does not exist and proceed accordingly.

If the provider offers the information for review at a later time, BMS will charge for the staff time involved in the review. If the provider does not agree to reimburse BMS for staff time, any additional information will not be considered.

c. Decision from Document/Desk Review

The Commissioner of the Bureau or his/her designee will issue a decision from the document/desk review upholding, denying, or modifying the original decision.

800.15 EVIDENTIARY HEARING

An evidentiary hearing is a formal hearing procedure before the Commissioner of BMS or his/her designee. Only issues reviewed in reconsideration and set forth in written request for document/desk review will be considered.

800.15.1 REQUEST FOR EVIDENTIARY HEARING

The request for an evidentiary hearing must be in writing, dated, signed and received within 30 days of receipt of decision from the document/desk review. The request for an evidentiary hearing shall contain a statement as to the specific issues or findings of fact and/or conclusions of law in the preceding determination with which the provider disagrees and basis for its contention that the specific issues and/or findings and conclusions were incorrect. The request must include identification of the provider representatives who will be present at the hearing. The parties will be permitted only 2 continuances.

Any provider requesting a hearing resulting from an adverse decision of BMS shall bear the necessary and attendant costs of such hearing, including costs of transcription, court reporting, production and copying of documents and all similar costs. If a fact-finder or hearing examiner should be retained by BMS, the costs of said fact-finder or hearing examiner shall be borne by BMS.

800.15.2 RECORD OF HEARING

A complete record of proceedings at the hearing shall be made and transcribed in all cases.

800.15.3 NOTICE OF DECISION

BMS will issue a written decision based on findings of fact and conclusions of law, setting forth reasons for the decision as soon as practical after the hearing. The decision by the Commissioner of BMS or designee is final.

800.16 ACTIVITIES THAT CONSTITUTE FRAUDULENT PRACTICES OR ABUSE OF THE PROGRAM

The following is a non-inclusive sample list, of practices that constitute fraudulent practices or abuse of the West Virginia Medicaid Program:

- Billing for services, supplies, or equipment which were not rendered to or used for Medicaid members
- Billing for supplies or equipment that are clearly unsuitable for the member's needs or are so lacking in quality or sufficiency for the purpose as to be virtually useless
- Flagrant and persistent over-utilization of medical and paramedical services with little or no regard for results, the member’s ailments, condition, medical needs or the physician's orders
- Claiming of costs for non-covered or non-chargeable services, supplies, or equipment disguised as covered items
- Misrepresentations of dates and descriptions of services rendered, or the identity of the member or the individual who rendered the services
- Duplicate billing - this includes billing the West Virginia Medicaid Program twice for the same services
- Arrangements with employees, independent contractors, suppliers and others, designed primarily to overcharge the West Virginia Medicaid Program with various devices (commissions, fee splitting) used to siphon off or conceal illegal payments
- Charging the West Virginia Medicaid Program, by subterfuge, costs not incurred or which were attributable to non-program activities, other enterprises, or personal expenses

- Failure to comply with State and Federal laws or the regulations of the State or Federal agencies that govern the practice of a provider's respective profession, business, or trade
- Failure to comply with West Virginia Medicaid Program regulations, or submission of false certification of Medicaid billing forms or reports
- Failure to report or perform offsetting adjustments on Medicaid claims to reflect payment by other payers
- Billing for services paid for by another entity
- Billing for services that require the approval of the PAAS PCP without the approval of the PCP, including fraudulent use of the PAAS PCP approval number on a claim.
- Upcoding is when a provider increases the bill by exaggerating or falsely representing what medical conditions were present and/or what services were provided. An example of upcoding would be when a two minutes visit for diagnosis and treatment of an upper respiratory condition is upgraded from a low reimbursement rate code to a code that indicates a more serious ailment, for example, a more severe bronchitis or sinus infection which required a one hour visit because of a nebulizer treatment. Whether or not the additional services billed were provided or not, if they were not medically necessary, there is fraud.
- Other schemes or artifices that are in violation of State and Federal law.

For additional information and requirements, please refer to Chapter 100 General Information under Fraud and Abuse and Chapter 300 Provider Participation Requirements.

800.17 PROSECUTION AND PENALTY

Fraud is a serious crime. Suspected fraud will be referred to the proper government entities for investigation and prosecution. Criminal and civil penalties are severe for fraud in the Medicaid program. You should refer to the West Virginia Code and the United States Code for likely criminal and civil sanctions and penalties.

800.17.1 FEDERAL PENALTIES

Federal criminal and civil penalties are too numerous to list. Possible penalties include prison, fines and exclusion from federal and state programs. You should refer to the United States Code for likely sanctions and penalties.

800.18 PROTECTIVE SERVICES - MANDATORY REPORTING OF INCIDENCE OF ABUSE, NEGLECT OR EMERGENCY SITUATION

West Virginia State law provides for mandatory reporting of abuse or neglect of adults and children and assesses penalties for failure to do so.

The West Virginia Codes §9-6-9; §9-6-11; §9-6-14; §49-6A-3; §49-6A-8 provide in pertinent part that any medical, dental or mental health professional, social service worker, and person, official or institution etc. are mandated to report incidence of abuse, neglect, or emergency situation of an incapacitated adult or child.

Failure to report is a misdemeanor and is punishable by not more than one hundred dollars or imprisonment in county jail for not more than 10 days or both.

A person who has control of an incapacitated adult and willfully creates an emergency situation that leads to abuse and neglect and/or who knowingly permits another to abuse and/or neglect an incapacitated adult is guilty of a felony.

800.19 MAINTENANCE OF RECORDS

Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by BMS or the U.S. Department of Health and Human Services (DHHS).

The provider must make all records and documentation available upon request to BMS and/or DHHS. Such records and documentation must include but not be limited to:

- Financial Records
- Member Information
- Description of Medicaid Service Implementation
- Identification of Service Sites
- Dates of Service for Each Service Component by Member
- Client Records
- Personnel Records
- For additional requirements, refer to Chapter 300 Provider Participation Requirements and applicable provider manuals for the specific service requirements.