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2.1 General Information

Payment for covered goods, care, and services shall only be made to providers approved by the Department of Human Services, Med-QUEST Division (MQD) to participate in the Medicaid Program. An authorized provider is:

- a) an individual,
- b) an institution, or
- c) an organization

that meets all of the following requirements for participation.

2.2 Requirements for Participation

a) Licensed or Certified

An individual provider must be licensed to practice within the scope of his/her profession in accordance with State law. Permits, temporary licenses or any form of license or permit that requires supervision of the licensee do not serve to qualify a provider as an eligible provider of services under the Hawaii Medicaid Program.

The State Department of Health must certify a medical or health-related institution or facility under the applicable public health regulations of the State and standards established by the Federal government.

Providers of any other health care services must comply with standards and all licensure, certification and other requirements as applicable.

b) Non-Discrimination Provision

A participating provider must comply with the non-discrimination provisions found in Form 1139 (Provider Information Form). A sample of the Provider Information Form and instructions to complete this form are in Appendix 2.

c) Acceptance of Medicaid as Payment in Full

Providers must accept as payment in full, the amount paid by the Medicaid Program for any covered service provided to an eligible recipient. Providers may not seek any additional payment, in case or kind, from recipients, for the difference between the Medicaid payment and a provider's charge except for third party payments and/or identified cost shares. If reimbursement by a third party exceeds the Medicaid maximum, the provider is entitled to

the amount paid by the third party but must accept it as payment in full. Further, if payment is received from a third party for services for which full Medicaid payment has already been received, the provider must reimburse the Medicaid Program accordingly.

d) Fee Limitation

Fees charged for services to eligible recipients may not exceed the provider's usual and customary charge to the general public. Public Law 95-142 makes the willful overcharging of the Medicaid Program a felony punishable by a fine of \$25,000 and imprisonment of up to 5 years.

2.3 Application for Participation

Any provider (practitioner, institution, or organization) wishing to participate in the fee-for-service (FFS) Medicaid Program must complete and submit a DHS Application Form (Appendix 2 - Form 1139 Provider Information Form) to participate as a Medicaid provider.

Applicants who fully meet the requirements for participation will be notified in writing regarding approval of the application and assignment of a provider identification number. The provider identification number is to be used on the claim forms submitted to the fiscal agent for payment for services rendered to an eligible Medicaid recipient.

Applicants not meeting all the requirements for participation shall also be notified in writing regarding the reason(s) for denial. Providers will, at that time, be notified of their right to a hearing if they disagree with the Department's decision.

2.3.1 Written Agreement

Providers participating or applying to participate in Hawaii's Medicaid FFS Program must have a current and valid written agreement on file with MQD. The completed and signed Provider Information Form (Form 1139) will constitute the full written agreement.

Failure to maintain an agreement may result in the suspension, termination, or withholding payment of claims until a current and valid written agreement is signed and on file with MQD. Providers desiring information on the status of an application should contact MQD/HCMB. Refer to Appendix 1 for the phone number and address.

2.3.2 Agent Authorization Forms

All persons authorized to sign claim forms on behalf of a provider, including themselves, must be identified on an Agent Authorization Form that is part of the application packet issued by DHS/MQD. All persons are to sign their names on the form exactly as they intend to sign claim forms. Claims will be returned to providers if the person signing them is not authorized. All providers must notify DHS/MQD of any change in the persons authorized to sign claims on the provider's behalf.

A new Agent Authorization Form can be obtained by writing to DHS/MQD/HCMB. Refer to Appendix 1 for the address.

2.3.3 Change in Provider Data/Authorized Agents

Providers are to immediately notify MQD, in writing, of changes affecting their identification data (i.e., group to solo practice, change of location, closure of a location, etc.). In the event of a change in ownership, providers must continue to maintain all recipient records unless an alternate method has been provided in writing and approved by the State.

2.4 Classification of Providers

Within the FFS Program, there are three overall provider classifications that allow a provider to receive Medicaid reimbursement:

- a) Fee-for-service provider
- b) QMB-Only provider
- c) Locum tenens provider

Under the Fee-for-service provider classification, providers may elect certain designations that qualify them to perform certain services. Unless a special designation is specifically requested on the application, and the appropriate information is completed, each provider will be registered as a general Fee-for-service provider without a special designation.

The QMB-Only provider classification is for providers that provide Medicare covered services that are not covered by Medicaid, to individuals that are eligible for both Medicare and Medicaid. Some provider specialties may only be QMB-Only providers.

A provider may receive reimbursement for Medicaid covered services performed on Medicaid eligible individuals through a locum tenens arrangement. This arrangement is when a provider performs services on behalf of a Medicaid Fee-for-service provider for a limited period of time.

2.4.1 Fee-For-Service Providers

Fee-for-service providers are eligible to be reimbursed for Medicaid covered services provided to Medicaid eligible individuals. There are three basic designations under the Fee-for-service provider classification: General, EPSDT Program Provider, and Federally Qualified Health Centers or Rural Health Centers.

To qualify as a general fee-for-service provider, the applicant provider must meet the requirements to be licensed or certified (if required) as a provider in the State of Hawaii.

Any other specialty designation of a provider under the FFS program (i.e. cardiologist, dermatologist) requires that the provider be Board Eligible or Board Certified in that specialty. Proof of Board Eligibility or Board Certification must be included with the Provider Application (Form 1139 Provider Information Form).

To be designated as an EPSDT Program Provider, Federally Qualified Health Center or Rural Health Center, the provider must meet other criteria, agree to perform certain services and assume additional responsibilities.

2.4.1.2 EPSDT Program Providers

a) Program Description

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) refers to a mandatory program under Title XIX of the Social Security Act that is administered through Medicaid and provides for early screening and diagnostic studies to identify physical or mental conditions in recipients and provide health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered through screening visits. The EPSDT Program is described in more detail in Chapter 5 of this Manual.

b) Provider Participation

- All EPSDT health screening assessments must be performed by or under the supervision and responsibility of a licensed physician who is an approved Medicaid provider and an EPSDT provider. Participation may be limited to providers who serve as the primary provider to the child and agree to provide all required screening and scheduled visits.
- Providers typically include specialties such as pediatricians, family practitioners, and general practitioners but may include other specialties provided the physician agrees to provide all required EPSDT screening and services and serve as the child's medical home.
- Because of detailed federal requirements covering all aspects of the EPSDT program, all physicians, groups, and clinics desiring to participate as EPSDT providers must enter into an agreement with DHS/MQD specifically as an EPSDT provider. EPSDT providers agree to provide EPSDT program services according to EPSDT program guidelines, policies, procedures, and regulations.
- Reimbursement for EPSDT health screening assessments is made only to those providers with a signed EPSDT Provider Agreement in place with the Med-QUEST Division. Providers desiring to participate as an EPSDT provider should complete the EPSDT Agreement (Form 1139 Provider Information Form) found in Appendix 2 and return it to DHS/MQD/HCMB. Refer to Appendix 1 for mailing information.

c) Provider Responsibility

The EPSDT provider is responsible to control, direct and coordinate the health care needs of the Medicaid recipient to ensure that appropriate and adequate care is provided on a timely basis.

d) An EPSDT provider must:

- Seek out their patients who are Medicaid eligible and may not be receiving EPSDT services and inform them of the availability of the EPSDT Program.
- Agree to provide health screening assessment services according to the EPSDT specified screening requirements and periodicity schedule. This includes all necessary immunizations and procedures.
- Provide information as appropriate, to enable recipients or their families to make medically informed decisions about their health care practices and to foster patient compliance with the prescribed treatment program.
- Promptly initiate diagnostic services and/or treatment or provide referral for follow-up for those problems identified during the screening process. Diagnosis or treatment services must start within six (6) months from the request for screening services by the recipient or family.
- Maintain a consolidated health record for each recipient which includes:
 - 1) Information received from other providers, such as results of laboratory tests and consultations.
 - 2) Dates of contact regarding appointments (also rescheduling when necessary) for EPSDT screening, recommended diagnostic or treatment services and follow-up referrals.
- Utilize reminder techniques to increase the probability of kept appointments by the recipient in order to meet the requirement that all newly enrolled children receive a health screening within six months of enrollment. Reminder techniques may consist of face-to-face, telephone and postcard contact, as appropriate. Use of reminders should be documented and kept in the patient's file.

2.4.2 *Federally Qualified Health Centers/Rural Health Centers*

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are providers that have applied for and received this designation from the Department of Health and Human

Services, Centers for Medicare and Medicaid Services of the federal government. FQHCs and RHCs will be reimbursed for covered items and services which are:

- a) Within the legal authority of an FHQC/RHC to deliver;
- b) Actually provided by the FQHC/RHC, either directly or under arrangements;
- c) Covered benefits under the Medicaid program;
- d) Provided to a recipient eligible for Medicaid benefits;
- e) Delivered exclusively by health care professionals (a physician, a physician's assistant, a nurse practitioner, a nurse midwife, a clinical social worker or a clinical psychologist) and other persons acting within the lawful scope of their license or certificate to provide services.

Determination of covered items and services are also subject to requirements included in the FQHC/RHC provider agreement and requirements generally imposed on payment for benefits under the Medicaid program. Refer to Chapter 21 for detailed information on FQHCs and RHCs.

2.4.3 QMB-Only Provider

A QMB-Only provider provides a Medicare covered service that Medicaid does not cover. Examples of QMB-Only providers are chiropractors, certified registered nurse anesthetists and clinical social workers. To become a QMB-Only provider contact the Provider Relations Section of the Med-QUEST Division in the Department of Human Services to obtain the appropriate application forms.

If the application is approved, a provider number will be sent from the Med-QUEST Division. Claims for Medicare services not covered by Medicaid submitted from providers not enrolled as QMB-Only providers will be denied. Medicaid only pays the recipients' Medicare deductibles and coinsurance for these services.

2.4.4 Locum Tenens

"Locum tenens" refers to one provider temporarily providing services in the place of another provider whom is licensed to provide the same type of service within the State of Hawaii. Under this situation, the locum tenens provider uses the absent provider's Medicaid provider number to submit claims for services provided to Medicaid recipients.

The period of a locum tenens should not exceed sixty (60) consecutive days. If a provider will be absent for longer than 60 days, the provider of service should submit claims utilizing his/her own Medicaid provider number.

a) Required Notification

It is the responsibility of the provider who will be absent to notify the Health Coverage Management Branch (HCMB) within the Med-QUEST Division (MQD) in writing at least seven days prior to the effective date of locum tenens and to assure that the provider is properly licensed to provide the services. The written notification shall include the following information:

- The name and address of the provider who will be absent;
- The name and address of the provider who will be providing services and submitting claims in the absence of the provider;
- The period of time the provider will be absent. The period of absence shall not exceed 60 consecutive days;
- The provider's statement that the covering provider is properly licensed within the State of Hawaii and qualified to provide the services;
- The provider who will be absent agrees to accept joint responsibility for the services provided to recipients and claims for services submitted in the provider's absence;
- The provider who will be absent certifies that services and claims for services will comply with all State and Federal Medicaid requirements.

The Locum Tenens statements shall be sent to the following, DHS/MQD/HCMB (mailing information in Appendix 1).

b) Services That Have Been Prior Approved

When services that are to be provided have been prior approved on a form DHS 1144, the provider who will be absent must notify MQD or its designated representative of the change and the claim must state that locum tenens coverage is being provided, with the name of the absent provider.

c) Mental Health Services

Mental health services under a locum tenens arrangement must be provided by certified a Medicaid provider. The person who provides locum tenens coverage must obtain approval on Form 1018 to provide outpatient psychotherapy services to Medicaid recipients. Refer to Appendix 4 for a sample of this form. Approval must be obtained before the recipient is seen. Claims should be filed in accordance with this section.

2.5 Medicaid Provider Numbers

Providers are assigned a single six-digit Medicaid provider number with a two-digit service location code by DHS. A different two-digit service location code will be assigned for each physical location where services are provided. In addition to the Medicaid provider number, the service location number must be submitted on the claim form as part of the provider number.

2.6 Professional Services

Professional services submitted for payment under the State's Medicaid Program must be personally rendered by the provider submitting the claim. The provider certifies that:

- a) Services are performed in accordance with Federal and State Medicaid laws, rules and policies and that any false claim, statements, documents or concealment of a material fact(s) may be prosecuted under applicable Federal or State laws.
- b) Service(s) claimed was medically indicated and necessary for the health of the recipient. The provider is responsible for determining the necessity of service, subject to review by the State's Medical Consultant.
- c) Medical necessity refers to those procedures and services, as determined by the department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided to draw conclusions if it is peer-reviewed, is well controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside a research setting.
- d) Service(s) claimed is accurate and provider agrees to keep all records, as defined in Section 2.8.1(b), to disclose fully the extent of services.
- e) If services were provided by the provider's support staff that support staff must be salaried employee(s) of the provider. Provider certifies support staff are medically and legally (meets Medicaid requirements) qualified to provide the service(s) under the provider's direct supervision (though not necessarily in the same room) and they must be of a type commonly furnished in the provider/ physician's office. Any service provided by the provider's support staff must be claimed at the minimum level of service with the appropriate indicator identifying that services were performed by support staff. Covered services requiring the knowledge and training of a professional with an advanced degree in the healing arts (examination, evaluation and treatment of illness or injury) may not be billed/claimed to the Medicaid Program unless specifically rendered by the provider submitting the claim.

Physician Assistant services for examination, evaluation and treatment without direct provider/physician observation or contact with the patient are not reimbursable by Medicaid.

- f) A Medicaid Provider must provide all covered psychotherapy services. All covered psychotherapeutic services must be provided by a qualified licensed psychiatrist or psychologist. Services delegated to paraprofessional personnel are not billable to the Medicaid Program.
- g) Telephone services, including consultation, medical advice, and course of treatment (including long distance calls), are not recognized as a valid medical service(s) and may not be claimed as a Medicaid service.

2.6.1 Restrictions

Except for those provider conditions listed under locum tenens, psychotherapy services and those services delegated to a provider's support staff, all services claimed by a provider must be provided by that provider. Provider services to be reimbursable under this State's Program:

- a) Must be performed within the scope or certification of the provider's license as defined by State law;
- b) Must be performed in the provider's office, a hospital, a clinic or in an emergency situation in the patient's home and appropriately indicated on the provider's claim for service;
- c) Must be a covered service under this State's Medicaid Program;
- d) Must be provided to a recipient who is eligible for Medicaid at the time the service(s) are provided;
- e) Must be documented in the patient's medical record at the time care and/or services are rendered; and
- f) Must be determined medically necessary for the condition for which care is required.
- g) No payment will be made for procedures, services, materials or other charges:
 - Of generally unproven benefit;
 - Of an experimental nature;
 - Excluded by Federal or State regulation/policy;
 - Considered not medically necessary by the State Medicaid Program;

- When the same or similar results may be obtained by other less costly method;
- When frequently followed by severe complications which in themselves are life-threatening or require prolonged medical care or secondary operations;
- When prior authorization was required but not obtained;
- When not normally charged to private patients;
- When rendered to an inmate of a public institution, except for hospital stays where an inmate may be temporarily confined and has been determined eligible, or a patient in an institution for tuberculosis or mental disorders;
- When psychiatric or psychological services are rendered at a patient's home, care home or boarding home; and
- Any service(s) the Medicaid Program Administrator deems not reimbursable under this State's Program.

2.7 Confidential Communications and Disclosure Requirements

Legal Conditions

The provider and the State and/or Fiscal Agent are bound by the Privacy Act of 1974 which prevents the release of information that could result in substantial harm, embarrassment, inconvenience or unfairness to any individual on whom information is maintained. Confidential information on Medicaid recipients or applicants includes:

- Names, addresses, and amounts/types of assistance provided;
- Information related to the social or economic condition or circumstance;
- Agency evaluation of recorded or unrecorded information;
- Medical, psychological, or psychiatric data including diagnosis and past history of disease or disability.

There is no privilege under this condition in any administrative or judicial proceeding where the provider's competency, practitioner license, provider status, or practice is an issue. This includes fair hearings, criminal cases involving fraud, or civil cases involving overpayment by the Medicaid Program. The identifying data of a recipient whose records are admitted into evidence

at an administrative hearing will be kept confidential. The proceedings may be closed to the public to protect a recipient's confidentiality.

DHS may require providers to seek written authorization to provide services. This request for authorization must include recipient as well as medical information.

In this context, the diagnosis, findings, and treatment plan are not considered confidential. Confidential communication consists of statements made between a physician or psychologist and a patient during a therapy session.

The extent to which the State and/or Fiscal Agent may release information is limited under the confidentiality restrictions set by the Federal government.

a) **Provider Confidentiality**

Provider's release of payment information to attorneys, no-fault insurance companies, or other parties must be coordinated with DHS/MQD even if a recipient's statement authorizing the release of such information is provided.

Providers are required to notify DHS/MQD of such release of information to ensure that all possible third party liability (TPL) resources are properly reported to the State. Such notification, including copies of the signed release statement, the requesting letter and the transmittal letter, is to be mailed within 48-hours to the DHS/MQD/Finance Office, TPL Section. Refer to Appendix 1 for the mailing address.

b) **Release of Information to MQD**

The provider's confidentiality requirement should not be misconstrued to prevent the provider from keeping accurate records and from furnishing such information upon request by the State agency or its representative in administration of the Medicaid Program.

2.8 Provider Monitoring

As part of the Medicaid program, the Med-QUEST Division of the Department of Human Services monitors providers in the FFS program. Some of the areas monitored are:

- a) Quality Management
- b) Utilization Management
- c) Fraud and Abuse

2.8.1 Quality and Utilization Management

2.8.1.1 Description

- a) The Med-QUEST Division is required by the Federal Centers for Medicare and Medicaid Services (CMS) to assure that quality, cost-effective services are provided to Medicaid recipients. In order to assist the Division in meeting these goals, a Peer Review Organization/External Quality Review Organization has been contracted. Their activities may include focused and outcome studies, satisfaction surveys, post payment utilization and quality review.
- b) Utilization review reviews the level, type and costs of services for appropriateness. This is performed through either prior authorization or post-payment review.

2.8.1.2 Quality

- a) Recipients in the Medicaid Program are entitled to quality care. The delivery of cost effective quality health care should not be compromised. Quality care is defined as care that is accessible and efficient, provided in the appropriate setting and provided according to professionally accepted standards.
- b) Quality care includes but is not limited to:
 - Provision of services in a timely manner with reasonable waiting times for office visits and scheduling of appointments.
 - Provision of services in a manner, which is sensitive to the cultural differences of the recipients.
 - Opportunities for patients to participate in decisions regarding their care.
 - Emphasis on health promotion and prevention as well as early diagnosis, treatment and health maintenance.
 - Appropriate use of services in the provision of care by providers.
 - Appropriate use of technology in the provision of care by providers.
 - Appropriate documentation, in accordance with defined standards, of the assessment and treatment of patients.

2.8.1.3 *Medical Records Management*

- a) Providers, including terminated and suspended providers, who have provided services under the State Medicaid Program shall maintain and keep all records necessary to fully disclose the extent of services or supplies rendered to recipients.
- b) Records are to be retained for seven (7) years or in accordance with Federal retention laws, whichever is greater.
- c) Medical records must document at a minimum the following:
 - Billing and account ledgers;
 - Records of documented patient appointments documenting the complaint or medical necessity of the appointment;
 - Patient history forms, medical history records, prior diagnosis and orders prescribed, patient's progress and treatment plans;
 - Records of requests for laboratory and radiological tests and results of tests or examinations or consultations ordered;
 - Records of prescriptions, medication assistive devices or appliances prescribed, ordered or furnished;
 - All records which are necessary to justify the amount of the claim(s) for payment which are determine by cost reimbursement or a similar basis, including billing documents showing the provider's cost of services or supplies provided to the patient.
- d) Institutional Providers:
 - In addition to the above records, institutional providers must also maintain records and receipts and disbursements of patient's trust funds by the provider, including but not limited to ledger accounts, reflecting credits, debits and balances for each recipient.
 - Cost report files of an institutional provider must contain reimbursable cost, cost finding schedules and other financial and statistical data to support reimbursable cost, and payroll records of all institutional personnel, owners and corporate officers.

Release of Information

- a) The Hawaii Revised Statutes Section 346.40 gives the authority to administer the State Medicaid Program to the State of Hawaii, Department of Human Services. Accordingly the

Department of Human Services is the State's Medicaid Oversight Agency mandated for the purpose to review all services provided directly or indirectly to insure that services meet State or Federal requirements.

- b) Under State law providers must keep all records to fully disclose the extent of the services claimed. Copies of any and all records requested will be furnished at no cost to the State.
- c) Under Federal Regulations 42 Code of Federal Regulations 456.3 and Hawaii Revised Statutes §346.40 providers of service under the State Medicaid Program shall not refuse to release any records or documents requested by authorized representatives as described below.

2.8.1.4 Examination of Records

Access to provider records by a duly authorized DHS representative or agent such as the Peer Review Organization/External Quality Review Organization (PRO/EQRO), CMS, the fiscal agent or a representative of the fiscal agent, the investigative and recovery service, and any representative of the Medicaid Fraud Control Unit of the Attorney General's office is to be permitted upon request. In the event a provider is terminated from participation, all records remain subject to the conditions of this section. This section is detailed as follows.

Access to provider records:

Under Code of Federal Regulations 42 C.F.R 456.3 and Hawaii Revised Statutes §346.40 the State of Hawaii, Department of Human Services is mandated to review each provider of health care, service or supplies under the State Medicaid program. To protect the State against fraud or abuse each provider shall:

- Make available all such records necessary to disclose the type and extent of health care services or supplies provided to Medicaid recipients including but not limited to patient notes, prescriptions, diagnostic testing, consultation reports requested or provided and any medical document used for the treatment and care of the patient if paid for by Medicaid or not;
- Make available all records and invoices of services or supplies received or distributed;
- Make available all records of employee time sheets, payroll checks and records;
- Make available all contracts with other providers used to provide any service or part thereof claimed by the provider;
- Make copies of any documents requested at no cost to the State or its representative.

2.8.1.5 *Records obtained*

- a) No provider, including terminated or suspended providers, shall refuse or fail to make available at the provider's place of business or appropriate location during normal business hours, or, if the appropriate representative agrees, at the mutual convenience of the parties, immediate access to all records under this mandate to:
- The State's Department of Human Services representatives, its intermediary/fiscal agent or a named representative; and
 - The State's Department of Attorney General.
- b) Records obtained by the State Agency or any agency listed above shall be maintained in safekeeping and may be used for auditing, scientific examination and writing analysis, photocopying or any testing that will not alter, damage or destroy the record. Records not undergoing examination or testing and not intended to be used as evidence in a judicial or administrative hearing by the State will be immediately returned to the provider.
- c) Whenever a provider without reasonable justification fails to keep adequate supporting records as required by this section or rules or fails to make these records available to those authorized above, the provider:
- Can be suspended or terminated from participation in the Medicaid program and/or can be arrested for violation of HRS §346-40 a misdemeanor and subject to the penalties under HRS 446-43.5.

2.8.2 *Fraud and Abuse*

2.8.2.1 *Description*

Under Federal Regulations 42 C.F.R and Hawaii Revised Statutes §346-40 through 346-43.5, Social Services, the Hawaii State Medicaid agency is mandated to notify providers of the Social Security Act which provide for Federal penalties for fraudulent acts and false reporting. Accordingly, Section 1128B of the Social Security Act as amended states in part:

Section 1128B as amended, whoever:

- a) Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal Health Care Program, State Medicaid plan; or
- b) Knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights of such benefit or payment; or

- c) Having knowledge of the occurrence of any event affecting:
- His/Her initial or continued right to such benefit or payment; or
 - The initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent to fraudulently secure such benefit or payment either in a greater amount or quantity than is due or when such benefit or payment is authorized; or
 - Having made an application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, shall: in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made; or
 - For a fee, knowingly consults or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan, under this section upon conviction is guilty of a Class C felony of imprisonment of up to five years or subject thereof fined not more than \$25,000 penalties or both.
- d) In the case of such a statement, representation, concealment, failure, or conversion by any other person, upon conviction is guilty of a misdemeanor and upon conviction thereof may be imprisoned for not more than one year or fined not more than \$10,000 penalties or both.
- e) In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not to exceed one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.
- f) Whoever solicits or receives any remuneration (including any kickback, bribe, rebate or incentive) directly or indirectly, overtly or covertly, in cash or in kind:
- In return for referring an individual to a person for the furnishing or arranging of any item or service for which payment may be made in whole or in part under this title, or

- In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this title shall upon conviction be guilty of a Class C felony of imprisonment of up to five years or fined not more than \$25,000 civil penalties or both.
- g) Whoever offers or pays any remuneration (including any kickbacks, bribe, rebate or incentive) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person:
- To refer an individual to a person for the furnishing or arranging, leasing, or ordering any goods, facility, service for which payment may be made in whole or in part under this title, or
 - To purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this title, shall upon conviction be guilty of a Class C felony of imprisonment of not more than five years or fined not more than \$25,000 or both.
- h) This shall not apply to:
- A discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and
 - Any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.
- i) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon rectification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be imprisoned for not more than five years or subject to civil penalties, or both.
- j) Whoever knowingly and willfully:
- Charges, for any services provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the provider's general patient population first and if there being no such rate then that rate established by the State, or

- Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient):
 - 1) As a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
 - 2) As a requirement for the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be imprisoned for not more than five years, subject to civil penalties or both.

2.9 Reasons and Notification of Adverse Action

A provider will be informed by certified mail of any possible action that may be taken against the provider. The actions requiring notification under this section shall consist of the following:

a) Overpayments:

- Due to claims processing error; or
- Due to procedure coding error; or
- Due to misinterpretation of service or procedure; or
- For payments made for a non-covered service or supplies; or
- For any payments made on claims the State Medicaid Medical Director deems not reimbursable; or
- For payments of services deemed not medically necessary.

The provider will be notified of the reason of the overpayment, the provider's rights to appeal any decision and any applicable laws, rules or policies governing this situation.

- ### b) A review of provider's services may reveal an error in a provider's protocol for services provided or for the submission of claims for services.

2.10 Suspension or Termination of a Provider

The Director of the Department of Human Services or their designee may suspend or terminate a provider's participation in the Medicaid program based on any one or a combination of the following:

- a) Provider's failure to maintain or comply with the signed agreement identifying the terms and conditions under which the provider may participate in the State's Medicaid Program. Including but not limited to:
- Falsification of application;
 - Failure to disclose all person(s) who have ownership or controlling interest in the provider; and
 - Any agent, managing employee, or employee of the provider who has been convicted of a criminal offense relating to that person's involvement in the Medicaid and/or Medicare Program.
- b) Conviction of Medical Assistance Fraud, Social Security Act Section 1128 (Medicare), and/or Hawaii Medical Assistance Program. Provider shall be terminated from Medicaid for a minimum of five years.
- c) Provider has been suspended or terminated from the Medicare Program. The suspension or termination shall be at least under the same condition(s). The Director may impose more stringent action than that of the Medicare Program.
- d) A provider whose license, certificate, authorization or permit to practice is not current or has been suspended, revoked, or restricted by a state or federal government, court, or agency.
- e) A provider who without reasonable justification fails to keep adequate supporting records or fails to make these records available to those authorized under this Chapter, as required, shall be suspended. The provider, during the period of noncompliance, shall not receive payments for services during the period of suspension.
- f) Criminal complaint, indictment by a grand jury or information about or conviction of a provider by state or federal court of an offense involving the provider's participation in the Medicaid Program.
- g) Determination by a peer review organization that a provider failed to provide adequate quality services to Medicaid recipients is judged against accepted medical community standards in Hawaii.
- h) Intentional failure to repay overpayments made by the Medicaid Program to the provider.
- i) Any effort by the provider to interfere with, hinder, or stop an investigation by any State or Federal agency authorized to investigate fraud or abuse in the Program.

A provider who has been terminated from the Medicaid Program for a violation may not petition the Director for reinstatement to the Program for a period of five years.

All actions of suspension or termination of a provider may be initiated or continued even though a provider voluntarily withdraws from the Medicaid Program.

2.10.1 Investigation of Violation

- a) Preliminary Investigation – MQD initiates preliminary investigations of all fraud and abuse complaints received from all sources to determine whether there is sufficient merit to warrant a full investigation.

If the findings reveal sufficient evidence to support the complaint or allegation, DHS/MQD will refer the case to the Medicaid Investigations Unit in the State Department of Attorney General.

- b) Full Investigation – The Medicaid Investigations Unit fully investigates all cases of suspected fraud referred by DHS/MQD to determine whether the facts presented reveal any criminal violations of the law relating to the Medicaid Program and whether there is sufficient evidence that can be developed to support a criminal fraud conviction or a civil legal action against the provider.
- c) Resolution of Investigation – An investigation continues until appropriate criminal or civil legal action is initiated, the case is closed due to insufficient supporting evidence, or the matter is resolved between DHS/MQD and the provider in any one or combination of the following actions:
- A warning letter to the provider giving notice that continuation of any improper activity will result in administrative action or civil or criminal suit by the State.
 - The suspension of the provider from participating under the Medicaid Program
 - Termination of the provider from participating as a provider in the Medicaid Program
 - A demand letter to the provider requiring repayment of overpayments made to the provider by the Medicaid Program, and a warning that payment on pending claims may be withheld in part or in whole to be applied to overpayments previously made.

In the event that the Medicaid Investigations Division (MID) or MQD is unable to determine whether a provider's actions constitute improper medical practice, an opinion of the Hawaii Medical Association peer review committee will be requested by the Unit.

2.10.2 Provider Notification

The provider will be informed by certified mail of the possible action that may be taken against him/her. The notification shall include the following information:

- a) The reason(s) for suspension or termination from the program including any applicable laws or rules violated.
- b) Period or duration of the suspension or termination will be in effect.
- c) The provider's rights to an administrative review and to be represented at the provider's own expense by a legal counsel and/or by any other person(s) of his/her choice.
- d) The effective date of the suspension or termination.

When a decision is made to suspend or terminate a provider from participation, the provider shall be informed by certified mail that such action will take effect 30 calendar days following the date of the letter. When suspension or termination is based on restriction, suspension or revocation of a provider's license, certification, authorization or permit to practice, Medicaid suspension will take effect the date of the licensure or permit suspension or revocation.

A provider suspected of abusive practices that are inconsistent with sound business or medical practices and resulting in unnecessary cost or overpayments to the Medicaid Program will be investigated by the Department of Human Services. The substantiation of any abusive practice will be determined by the Department of Human Services. Any and all overpayments will be recouped and appropriate sanctions imposed.

2.11 Provider's Right to Fair Hearing

The Director of the Department of Human Services shall appoint a hearings officer following receipt of a written request for an administrative hearing within the 30 days in which a provider may respond to the alleged violations. The written request must be accompanied by pertinent documents and written evidence relevant to the case.

Providers wishing to appeal decisions by DHS/MQD must submit written requests to the Medicaid Administration (address information in Appendix 1)

2.11.1 Limitation to Fair Hearing

A provider's right to fair hearing will be denied if:

- a) The provider failed to request a Fair Hearing in writing within the specified time limit.
- b) Suspension or termination is a final administrative decision based on a State or Federal agency withdrawing the license, certification, authorization, or permit of the provider to

practice or furnish services under the specialty for which the provider is authorized under the Medicaid Program.

- c) Suspension or termination is based upon a State or Federal court conviction of the provider of an offense involving fraud or abuse against the Medicaid Program.