Title 23: Division of Medicaid

Part 305: Program Integrity

Part 305 Chapter 1: Program Integrity

Rule 1.1: Definitions

A. Abuse is defined as beneficiary practices that result in unnecessary cost to the Medicaid program and/or provider practices that are inconsistent with sound fiscal, business, or medical practices that result in:

1. An unnecessary cost to the Mississippi Medicaid Program,

2. Reimbursement for services that are not medically necessary, or

3. Reimbursement for services that fail to meet professionally recognized standards for health care.

B. Administrative Hearing is defined as a trial-like proceeding before the Division of Medicaid at which evidence and testimony may be offered.

C. Beneficiary error is defined as the beneficiary's incomplete, incorrect or misleading information because the beneficiary misunderstood, was unable to comprehend the relationship of the facts about the situation to eligibility requirements or there was other inadvertent failure on the beneficiary's part to supply the pertinent or complete facts affecting Medicaid or Children's Health Insurance Program (CHIP) eligibility.

D. Corrective Action Plan (CAP) is defined as a documented plan that includes a well-defined identification of the problem, a specific time frame for the remedy to be implemented, specific actions taken to remedy the defined problem, plan on how to prevent the problem from recurring and the consequences if the problem is not resolved. At a minimum, the CAP must include:

a) The specific obligations violated,

b) The specific actions taken that address correction of the behavior that led to the violation(s),

c) The duration of the CAP which must be greater than ninety (90) calendar days, and

d) The means by which compliance with the CAP will be monitored and assessed.

E. Credible allegation of fraud is defined as an allegation from any source that has indicia of reliability in which the Division of Medicaid has verified through facts and evidence including, but not limited to, alleged fraud from:

1. Fraud hotline complaints,

2. Claims data mining, and/or

3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

F. Demand Letter is defined as a notification that a provider is required to refund improper payments.

G. Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, or an act that constitutes fraud as defined by federal or state law.

H. Incorrect payment is defined as an error in reimbursement which results in an overpayment or underpayment which may be due to a billing error, systems error and/or human error.

I. Overpayment is defined as an incorrect payment that results in the provider receiving a higher reimbursement than is appropriate for the service provided.

J. Peer Review (PR) is defined as a retrospective review of medical records by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) to assess if:

a) Services and items were reasonable and medically necessary;

b) The quality of services met professionally recognized standards of health care;

c) The beneficiary received the appropriate health care in a safe, appropriate and cost-effective setting based on the beneficiary's diagnosis and severity of the symptoms;

d) Services were provided economically and only when and to the extent they were medically necessary; and

e) The utilization billing and coding practices and/or overall utilization patterns of a provider for beneficiaries being reviewed are appropriate.

K. Peer Review Consultant (PRC) is defined as the medical reviewer in a comparable specialty as the provider or a certified professional coder (CPC) when appropriate.

L. Peer Review Panel (PRP) is defined as at least three (3) providers, at least one (1) of whom practices in the same class group as the subject provider; Selection of the PRP members shall ensure that their objectivity and judgment will not be affected by personal bias for or against the subject provider or by direct economic competition or cooperation with the subject provider.

M. Reconsideration Review is defined as an impartial review of the case by a Peer Review Consultant not involved in the initial Peer Consultant Review determination, at the request of the Division of Medicaid, a provider, or as part of a UM/QIO follow-up.

N. Waste is defined as the overutilization, underutilization, or misuse of resources.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: Revised eff. 03/01/2023; Revised and moved language to Rules 1.2-1.4, and 1.6 eff. 11/01/2016; Revised Miss. Admin. Code Part 305, Rule 1.1.D. eff. 10/01/2014; Miss. Admin. Code Part 305, Rule 1.1.B.3. and D.1. revised effective 08/15/2013 to comply with the Medical Assistance Participation Agreement Section C.

Rule 1.4: Provider Peer Review Protocol

A. Mississippi Medicaid providers must ensure that the services or items provided to beneficiaries are:

1. Provided economically, to the extent medically necessary,

2. Of a quality that meets professionally recognized standards of health care,

3. Supported by the appropriate documentation of medical necessity and quality,

4. Provided when no other effective and more conservative or substantially less costly treatment, service and/or setting are available,

5. Not solely for the convenience of the beneficiary, the beneficiary's family, or the provider, and/or

6. Not primarily custodial care, unless custodial care is a covered service.

B. Providers with a possible violation of one (1) or more of the obligations listed in Rule 1.4.A. are generally referred to the fee-for-service (FFS) Utilization Management/Quality Improvement Organization (UM/QIO) to perform a Peer Review (PR).

1. A Peer Review Consultant (PRC) is selected by the Medical Director of the UM/QIO, or designee, when a referral is received from the Division of Medicaid, which has already made an initial audit/investigation.

a) The selection process of the PRC ensures that they practice in a comparable specialty as the provider being reviewed and that the PRC's objectivity and judgment will not be affected by personal bias for or against the subject provider, or by direct economic competition or cooperation with the provider.

b) The Division of Medicaid will provide records relevant to the possible violation to

the PRC.

c) If the PRC determines that there is no further action needed, then the case is closed. If the PRC identifies violations or confirms violations, then the PRC refers the case for a Peer Review Panel (PRP).

3. After reviewing the case, the PRP may close a case if they determine that there was no violation.

   a) If they determine or confirm one or more violations exist, then the PRP will notify The Division of Medicaid with additional proposed actions. Actions by the UM/QIO PRP may include:

      1) If the PRP determines that there has been no violation of obligations, it will notify the Division of Medicaid, in writing, of that finding and recommend that the case be closed with no further action taken. Along with the written notification of the PRP recommendations, the PRP will also transmit the records it relied on to make the recommendation, as well as the transcript of the minutes of the PRP meeting.

      2) The Division of Medicaid shall make a final decision, within ten (10) business days of its receipt of the recommendation, and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid.

   b) If the PRP finds a potential violation of one or more of the requirements listed in Miss. Admin. Code Title 23, Part 305, Rule 1,4 A., the UM/QIO shall notify the Division of Medicaid in writing of the preliminary recommended findings within ten (10) business days of the PRP decision. The letter must contain all related requirements in Part 305, including, but not limited to, giving notice of potential violation(s), the specifics of the potential violation(s), and the PRP's recommended date to have the provider attend a Peer Review Panel conference, which will be set no later than thirty (30) calendar days after the notice to the Division of Medicaid.

      1) The Division of Medicaid shall make a final decision, within ten (10) business days of its receipt of the recommendation, and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid. If the Division of Medicaid accepts the PRP recommendation, at the same time it notifies the UM/QIO, Director of Program Integrity, or his designee, will transmit a letter by certified mail, restricted delivery, return receipt requested to the provider with all of the relevant information listed above.

      2) The provider shall be instructed in the letter to provide the PRP with any

additional information in support of the provider's position within a specified time. The provider also must submit a written statement to the Division of Medicaid within ten (10) business days of receipt of the findings notification indicating whether the provider agrees or disagrees with the findings. At the UM/QIO's discretion, the provider may choose alternate dates to convene the PRP conference meeting. If the provider agrees with the findings, the Division of Medicaid may send a Corrective Action Plan (CAP) letter to the provider.

c) If the PRP determines that the provider has violated one or more of the requirements listed in Miss. Admin Code Title 23 Part 305 Rule 1.4 A., it will formulate recommendations that will include a corrective action plan (CAP), provider education requirements, and/or recoupment. The UM/QIO PRP shall submit all findings and recommendations in writing to the Division of Medicaid within ten (10) business days of the PRP decision. The letter must contain all related requirements in Part 305, including, but not limited to the violation(s), the specifics of the violation(s), and the PRP's recommended actions and recommended date to have the provider attend a Peer Review Panel conference, which will be set no later than thirty (30) calendar days after the notice to the Division of Medicaid.

    1) The Division of Medicaid shall make a final decision, within ten (10) business days of its receipt of the recommendations, and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid, and as defined in Part 305. If the Division of Medicaid accepts the PRP recommendation, at the same time it notifies the UM/QIO, the Division of Medicaid will transmit a letter by certified mail, restricted delivery, return receipt requested to the provider with all of the relevant information listed above.

    2) The provider shall be instructed in the letter to provide the PRP with any additional information in support of the provider's position within ten (10) business days prior to the conference to allow time for its proper study. At the UM/QIO's discretion, the provider may choose alternate dates to convene the conference meeting. Regardless of a provider's acceptance of findings, for any confirmed violations of Part 305, which resulted in or identified any improper payments, the Division of Medicaid will send a certified demand letter to that provider. If the provider agrees with the findings, the Division of Medicaid may send a CAP letter to the provider.

C. The Division of Medicaid will send all provider correspondence regarding findings, decisions, or other documents from a PRC or PRP by certified mail, restricted delivery, return receipt requested.

D. The provider must sign and return the CAP within ten (10) business days after receipt of the Demand Letter and CAP. If the provider fails to submit the signed CAP to the Division of Medicaid within (10) business days, a sanction may be imposed on the provider. The

UM/QIO Medical Director, or designee, and the Peer Review Consultant will monitor the signed CAP.

E. Within thirty (30) calendar days of the receipt of a completed CAP, the PRC will determine if the provider complied with the CAP, and whether or not the CAP was effective. If the CAP was effective and the provider has met all requirements, the Division of Medicaid will notify the provider that the review is closed. If the CAP was not effective and the provider is deemed to be continuing to violate requirements, the provider will be subject to a sanction.

1. If the provider disagrees with the findings of the PRC, the provider may request a Reconsideration Review using the following steps:

   a) The provider may submit a request for a Reconsideration Review to the Division of Medicaid within ten (10) business days of receipt of the final findings notification.

   b) The Reconsideration Review request must include the reason for the request, pertinent medical documentation, or other information to justify the need for reconsideration.

   c) The UM/QIO will select a different PRC, who practices in a comparable specialty, to obtain a second opinion.

   d) The Reconsideration Review will include the findings of the initial PRC.

   e) The Division of Medicaid is notified in writing by the UM/QIO Contract Administrator of the findings, action recommended, the records relied upon to make the recommendation, and the Peer Review Consultant's notes.

   f) The Division of Medicaid will notify the provider of the results of the Reconsideration Review which will be one (1) of the following:

      1) No violation of requirements and the review is closed, or

      2) Violation of requirements affirmed and a Demand Letter and CAP are sent to the provider.

2. If the provider disagrees with the findings of the Reconsideration Review, the provider may request an Administrative Hearing. [Refer to Miss. Admin. Code Part 300]

3. If the provider does not request an Administrative Hearing, the Division of Medicaid will proceed with the appropriate administrative action outlined in the Demand Letter.

F. The process for sanctions include the following steps and information:

1. The Executive Director of the Division of Medicaid, upon review of the record,

proceedings, and recommendation of the Division of Medicaid Administrative Hearing Officer and/or Peer Review Consultant, will render a final written decision whether or not to impose sanctions, which may include disqualification, suspension, or termination from the Medicaid program for a limited period or permanently.

2. A violation of requirements such that the life and welfare of the provider's beneficiaries are in jeopardy, the provider is subject to immediate suspension.

3. The Executive Director of the Division of Medicaid will notify the provider of the intent to impose a sanction by sending a notice containing the following:

    a) The authority and responsibility afforded the Division of Medicaid under Miss. Code Ann. Section 43-13-121;

    b) The requirement(s) violated;

    c) The situation, circumstance, or activity that resulted in the violation;

    d) A summary of the information used in arriving at the determination to initiate sanction; and

    e) Notice that the Division of Medicaid will impose the sanction(s) within thirty (30) calendar days of the date of provider's receipt of the notice unless the provider requests an Administrative Hearing within thirty (30) calendar days of the receipt of the notice.

4. The Executive Director may assess all or any part of the cost of implementing the sanction protocol to the provider.

5. The Executive Director's decision is a final administrative decision.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: Revised and moved from Miss. Admin. Code, Part 300, eff. 03/01/2023; New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.