DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES
Statutory Authority: 31 Delaware Code, Chapter 5, Section 512 (31 Del.C. Ch.5, §512)

FINAL

ORDER

Provider Contractual/Programmatic Responsibilities

Nature of the Proceedings

Delaware Health and Social Services ("Department") / Division of Social Services initiated proceedings to amend the Delaware Medicaid/Medical Assistance Program Provider Manual to add language to Section 1.6 of the General Policy to promote provider accuracy in processing claims. The Department's proceedings to amend its regulations were initiated pursuant to 29 *Delaware Code* Section 10114 and its authority as prescribed by 31 *Delaware Code* Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 *Delaware Code* Section 10115 in the December 2004 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 31, 2004 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary of Proposed Change

Medical services are reimbursed by the Delaware Medicaid/Medical Assistance Program (DMAP) under Title XIX of the Social Security Act, as amended. Direct health care services are provided by a variety of provider groups. This amendment clarifies general provider participation requirements and provider responsibilities for claims submitted to the DMAP.

All DMAP providers are responsible for their own claims preparation and submission. The effects of this amendment are: 1) more efficient service delivery through more detailed billing requirements; and, 2) increase level of provider accountability for services rendered.

Summary of Comments Received with Agency Response

The Delaware Developmental Disabilities Council (DDDC) and the State Council for Persons with Disabilities (SCPD) offered the following summarized observations:

First, since Medicaid reimbursement rates are low, many providers already have a disincentive to participate in the program. For this reason, DSS may wish to be cautious in imposing additional administrative requirements on providers. Although the actual regulations do not specifically address more detailed billing, imposing onerous billing standards on providers may simply result in more administrative work and less inclination to participate in the Medicaid program.

Agency Response: The proposed clarification is an extension of the Medicaid Provider Certification on Form CMS-1500 Claim Form. The billing standard simply states that DMAP providers are responsible for the accuracy of all claims submitted by the provider to assure processing and timely claims payment.

Second, many of the provisions favor consumers (e.g. acceptance of Medicaid as payment in full; informing client of services that will not be covered by Medicaid). These are important safeguards and DDDC and SCPD endorse inclusion of the regulation.

Agency Response: Thank you for your endorsement.

Third, we have a minor concern with the requirement of "assuring that all necessary authorizations from the managed care organizations are obtained prior to the delivery of the service" (§1.6.1 5th bullet). Emergency services may not require prior authorization. See 42 C.F.R. §438.114. Moreover, there is a history of MCO failure to provide timely reauthorizations or terminating services without proper notice. For example, if an MCO advises a provider that it will no longer authorize an on-going service (e.g. speech therapy; home health service) and it is clear that no Medicaid qualifying notice has been given to the Medicaid beneficiary, the provider should be permitted to continue services and expect reimbursement. At a minimum, the word "initiation" could be substituted for "delivery" to focus the directive on ensuring the existence of an initial authorization as juxtaposed to continuing services based on non-

extended authorization.

Agency Response: §1.6.1 is not the subject of the proposed regulation. The section was inserted for ease of reading in the context of the proposed change.

Fourth, in the 10th bullet under §1.6.1, some words are missing.

Agency Response: Due to a publication error, the proposed regulation shows eleven bullets and there should only be ten bullets. The final order regulation shows the following correct text for the 10th bullet: "Notifying EDS in writing of any changes related to their Medicaid participation including but not limited to, changes in address or changes in group affiliation."

Findings Of Fact

The Department finds that the proposed changes as set forth in the December 2004 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the DMAP Provider Manual relating to provider contractual/programmatic responsibilities is adopted and shall be final effective February 10, 2005.

Vincent P. Meconi, Secretary, DHSS, 1/13/2005

DSS FINAL ORDER REGULATION #05-04

1.6 Provider Contractual/Programmatic Responsibilities

1.6.1 A provider who signs a contract with the DMAP is responsible to meet certain conditions in order to remain an eligible provider and receive payment for services rendered. The provider must abide by the DMAP's policies and procedures, for example, including but not limited to:

- Directing clients to the most appropriate, medically necessary, and cost-efficient care possible.
- Acceptance of final DMAP payment disposition as payment in full for Medicaid covered services; [therefore, providers cannot charge the client for any services reimbursable by the DMAP (refer to Billing DMAP Clients section in this General Policy for exceptions)].
- Billing all other insurance resources or legally liable third parties prior to billing DMAP (unless under special arrangement as a managed care provider in which third party liability is accounted for in the capitated rate).
- Keeping records necessary to verify the services provided and permitting federal/state representatives access to the records.
- Determining that the client has valid Medical Assistance eligibility before rendering service and, if the client is enrolled in managed care, assuring that all necessary authorizations from the managed care organization are obtained prior to the delivery of services.
- Informing the client of any service that will not be covered by the DMAP prior to the delivery of the service.
- Making restitution for any overpayment promptly.
- Notifying the DMAP of any suspensions or exclusions from any program.
- Sending copies of professional license or certifications to EDS, the fiscal agent, whenever renewed or altered.
- Notifying EDS in writing of any changes related to their Medicaid participation including but not limited to, changes in address or changes in group affiliation.

1.6.2 Providers are responsible for the accuracy, truthfullness, and completeness of all claims submitted to DMAP. The provider is further responsible for all costs associated with the preparation for the submission of claims, whether prepared or submitted by the provider or by an outside agency or service. State employees are prohibited from submitting claims on behalf of non-government providers.

Providers acknowledge that by submitting a claim to DMAP they certify the services were rendered prior to the submission of the claim.