Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200046 DECEMBER 8, 2000

To: All Indiana Health Coverage Program Providers

Subject: Surveillance and Utilization Review—Provider Overpayment and Appeal Procedures

Overview of Review and Appeal Procedures

This bulletin outlines *405 Indiana Administrative Code (IAC) 1-1-5*, *405 IAC 1-1.5-1*, and *405 IAC 1-1.5-2*. These rules govern the overpayment and appeal procedures of the Office of Medicaid Policy and Planning (OMPP) involving actions or determinations of reimbursement for all Indiana Health Coverage Program (IHCP) providers.

Determinations Resulting in Overpayment

Pursuant to *405 IAC 1-1-5(a)*, the OMPP may recover payment or instruct the fiscal contractor, Health Care Excel (HCE), to recover payment for services rendered or claimed to be rendered, if the OMPP or HCE, after investigation, finds one of the following:

- Services paid for cannot be documented by the provider as required by *405 IAC 1-5-1*.
- Amount paid for services has been or can be paid by other sources.
- Services were provided to a person other than the person in whose name the claim was made and paid.
- Service reimbursed was provided to a person who was not eligible for medical assistance at the time of the provision of the service.
- Paid claim arose out of any act or practice prohibited by law or by rules of the OMPP.
- Overpayment resulted from an inaccurate description of services or inaccurate use of procedure codes.
- Overpayment resulted from the provider's itemization of services rather than submission of one bill for a related group of services

provided to a member or global billing as set in the OMPP's medical policy.

- Overpayment resulted from duplicate billing.
- Overpayment resulted from claims for services or materials determined to have been not medically reasonable or necessary.
- Overpayment to the provider resulted from any other reason not specified in this subsection.

The OMPP or HCE may determine the amount of overpayment made to an IHCP provider by means of a random sample audit according to *405 IAC 1-1-5(b).* Also, HCE may use a focused or claim-by-claim audit or any other statistically valid sampling method. If the OMPP or HCE determines an overpayment has occurred, HCE will notify the provider by certified mail. In general, notification will occur within 120 days from the date of the onsite review however, additional time may be required due to unforeseen administrative delays.

The notice shall demand the provider reimburse the OMPP or HCE within 60 days of provider receipt of the notification as established in *405 IAC 1-1-5(d).* A **non-hospital provider** may elect to do one of the following:

- Repay the amount of the overpayment not later than 60 days after receipt of the notice from the OMPP or HCE, including interest from the date of overpayment.
- Request a hearing and repay the amount of the alleged overpayment not later than 60 days after receipt of the notice from the OMPP or HCE.
- Request a hearing no later than 60 days after receipt of the notice from the OMPP or HCE and not pay the alleged overpayment. If the Office of the Secretary determines (after the hearing and subsequent appeal) that the provider owes the money, the provider shall pay the amount of the overpayment, including interest from the date of the overpayment.

The **hospital provider** must adhere to virtually the same requirements as the non-hospital provider. However, a hospital provider must elect one of the same options within 180 days according to *405 IAC 1-1-5(f)*.

Additionally, the OMPP or HCE may enter into an **agreement** with a provider to repay any overpayment by having the overpayment and interest deducted from subsequent payments to the provider, **not to exceed a period of six months** according to *405 IAC 1-1-5(g).*

Provider Appeal Procedures

IHCP providers may appeal a determination by the OMPP or HCE that a provider has been paid more than it was entitled to receive under any federal or state statute or regulation. The appeal procedures are governed by Indiana Code (*IC) 4-21.5-3* and *405 IAC 1-1.5-1 - et. seq.*

Non-hospital providers must file an appeal request within 60 days from the date of receipt of the determination by the OMPP or HCE according to *405 IAC 1-1-5(d).* An appeal request must state facts demonstrating the following:

- Petitioner is the person to whom the order is specifically directed.
- Petitioner is aggrieved or adversely affected by the order.
- Petitioner is entitled to review under the law.

Failure by the provider to file the appeal request within the time limit will result in the waiver of any right to appeal the OMPP or HCE determination according to *405 IAC 1-1.5-2(c).*

In addition to the appeal request, the **non-hospital** provider will have 45 days from the date of receipt of the findings letter to file a statement of issues according to *405 IAC 1-1.5-2(d)*. The statement of issues will be considered timely if filed with the appeal, 60 days from the date of receipt of the determination. The statement of issues shall detail the following:

- The specific findings, actions, or determinations of the OMPP or HCE to which the provider is appealing;
- Why the provider believes that the determination was in error with respect to each finding, action, or determination;
- All statutes or rules supporting the provider's contentions of error with respect to each finding, action, or determination according to *405 IAC 1-1.5-2(e).*

A **hospital** that appeals one of these actions must adhere to virtually the same requirements for its statement of issues and appeal request. However, **a hospital should submit a statement of issues with the appeal request** and both must be filed within 180 days of receipt of the determination letter**.**

Informal Reconsideration by HCE

In addition to the formal administrative appeal procedures, the OMPP in conjunction with HCE, offers providers an opportunity to resolve

disagreements with overpayment determinations through a informal reconsideration process after the appeal is filed with the OMPP.

This informal reconsideration occurs between the provider and HCE. Once the provider has submitted its statement of issues and request for appeal, HCE will conduct a informal reconsideration of the original audit. A reviewer other than the one who performed the original or initial review will complete the informal reconsideration.

Further, for any appealed findings, the provider is strongly encouraged to submit copies of any and all requested medical records, charts, X-rays, notes, treatment plans, account information, billing records, appointment logs, statements, materials, and other documentation necessary to verify services were provided.

Upon receipt of the provider's documentation and information, HCE will conduct its informal reconsideration of the appeal documentation and provide a written Response to Statement of Issues. HCE will attempt to notify the provider 60 days from the date of receipt of all documentation with the findings from the informal reconsideration. The informal reconsideration provides an opportunity to resolve issues among the provider, OMPP, and HCE. The appeal process is ongoing during this informal reconsideration process; however, this does afford the provider an additional opportunity to resolve the overpayment determination or marrow the issues prior to continuing litigation with the OMPP before an ALJ.

Appeals and statement of issues documentation should be submitted to both of the following addresses:

Ms. Katherine Humphreys, Secretary
Indiana Family and Social Services Administration
In care of: Ms. Pat Nolting, Director
Program Operations—Acute Care
Office of Medicaid Policy and Planning
402 West Washington Street, W382
Indianapolis, IN 46204

Health Care Excel
Surveillance and Utilization Review
Attn.: Statement of Issues
P.O. Box 531700
Indianapolis, IN 46253-1700

Questions regarding this process should be directed to the Health Care Excel Surveillance and Utilization Review department at 800-457-4516 or 317-347-4527.