



MISSISSIPPI DIVISION OF  
**MEDICAID**

## Administrative Code

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Title 23: Medicaid  
Part 305  
Program Integrity

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## **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. 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.
- C. 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.
- D. 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.
- E. Overpayment is defined as an incorrect payment that results in the provider receiving a higher reimbursement than is appropriate for the service provided.
- F. Beneficiary error is defined as the client's incomplete, incorrect or misleading information because the client misunderstood, was unable to comprehend the relationship of the facts about the situation to eligibility requirements or there was other inadvertent failure on the client's part to supply the pertinent or complete facts affecting Medicaid or Children's Health Insurance Program (CHIP) eligibility.
- G. 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 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 1.2: Fraud, Waste, and Abuse*

- A. The Division of Medicaid investigates suspected cases of fraud, waste, and abuse using methods that:
  - 1. Do not infringe on the legal rights of persons involved, and
  - 2. Afford due process of law to individuals under investigations.
- B. The Division of Medicaid must make a formal, written fraud referral to the Medicaid Fraud Control Unit (MFCU) for each credible allegation of fraud or an allegation that leads to the initiation of a payment suspension, in whole or in part. If the Division of Medicaid determines that good cause exists to remove a payment suspension, in whole or in part, or to discontinue a payment suspension previously imposed, the Division of Medicaid is not relieved of its obligation to make a referral to MFCU.
- C. The Division of Medicaid must suspend all payments to a provider when the Division of Medicaid determines there is a credible allegation of fraud for which an investigation is pending unless the Division of Medicaid determines that good cause exists not to suspend or partially suspend such payments or not to continue a payment suspension previously imposed including, but not limited to:
  - 1. Law enforcement:
    - a) Specifically requesting payments not be suspended, or
    - b) Declining to cooperate in certifying that a matter continues to be under investigation.
  - 2. The Division of Medicaid determining:
    - a) Other available remedies exist that could be implemented by the Division of Medicaid to more effectively or quickly protect Medicaid funds,
    - b) A payment suspension is not in the best interest of the Medicaid program, or
    - c) A payment suspension would have an adverse effect on beneficiary access to necessary items or services because either of the following is true:

- 1) An individual or entity is the sole community physician or the sole source of essential specialized services in a community, or
  - 2) The individual or entity serves a large number of beneficiaries within a Health Resources and Services Administration (HRSA) designated medically underserved area.
- d) A payment suspension should be removed based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension.
- D. The Division of Medicaid will notify providers of suspension of payments within five (5) days of the suspension unless requested in writing by a law enforcement agency to temporarily withhold such notice.
- E. The Division of Medicaid may grant an administrative hearing, if requested by the provider, as described in Miss. Admin. Code Part 300, to determine whether or not good cause exists to remove a payment suspension or suspend payment only in part.
- F. Suspension of payments will continue until:
1. The Division of Medicaid or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider, or
  2. Legal proceedings related to the provider's alleged fraud are completed.
- G. The Division of Medicaid will:
1. Make a referral to the appropriate law enforcement agency if there is reason to believe that a beneficiary has defrauded the Medicaid program.
  2. Conduct a full investigation if there is reason to believe that a beneficiary has abused the Medicaid program or if an applicant made a false statement or failed to disclose a material fact in his/her Medicaid application.

Source: 42 C.F.R. Part 455; Miss. Code Ann. §§ 43-13-121, 43-13-129.

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

*Rule 1.3: Overpayments*

- A. Providers must notify the Division of Medicaid's Office of Program Integrity in writing within thirty (30) calendar days of the discovery of any overpayments.
1. Any self-disclosure of overpayments submitted to the Division of Medicaid must include the following information:

- a) Name and address of the affected provider,
- b) A provider which is entity owned, controlled, or otherwise part of a system or network must include:
  - 1) A description or diagram of any pertinent business/legal relationships,
  - 2) The names and addresses of any related and/or affected entities, corporate divisions, departments, or branches, and
  - 3) The name and address of the disclosing entity's designated representative,
- c) Medicaid provider number(s) associated with claims,
- d) Tax identification number(s),
- e) Payee identification number(s),
- f) Affected claims submitted in Excel or Access which must include the following information:
  - 1) Beneficiary name,
  - 2) Claim transmittal control number (TCN),
  - 3) Procedure code,
  - 4) Dates of service,
  - 5) Billed amount,
  - 6) Paid amount,
  - 7) Paid date, and
  - 8) Refund amount,
- g) A report that includes a full description of the information being disclosed, the person who identified the overpayment and the manner in which the individual discovered it,
- h) A detailed account of the provider's investigation of the overpayment,
- i) A statement disclosing whether the provider is under investigation by any government agency or contractor,
- j) A statement detailing the provider's explanation of the cause of the overpayment,

- k) A certification that the information submitted to the Division of Medicaid is based upon a good faith effort to disclose a billing inaccuracy and is true and correct, and
  - l) The methodology used in determining the amount of the overpayment.
2. The provider must submit additional information to the Office of Program Integrity as requested in order to verify the information submitted including the financial impact.
  3. Any issues discovered during the verification process which are outside the scope of the self-disclosure may be treated as new matters subject to further investigation.
  4. Refunds to the Division of Medicaid for overpayments must be conducted through the claims payment adjustment process or in the form of a refund check within thirty (30) calendar days of the overpayment discovery.
  5. Self-disclosure does not release the provider from any other cause of action, civil or criminal, by another state agency or department of the United States under applicable law and regulations regarding these payments.
- B. The Division of Medicaid, or designee, will send a demand letter via certified mail return receipt requesting the refund of overpayments discovered through audit or investigation:
1. On or before thirty (30) calendar days of the receipt of the demand letter, sent via certified mail, or thirty (30) calendar days from the date of the letter if the provider does not sign the certified mail notice, the provider must:
    - a) Request an administrative hearing [Refer to Miss. Admin. Code Part 300], or
    - b) Refund the overpayment by:
      - 1) A lump sum payment,
      - 2) Offsetting against current payments through the claims payment adjustment process until overpayment is recovered,
      - 3) A repayment agreement executed between the provider and the Division of Medicaid, or
      - 4) Any other method of recovery available to and deemed appropriate by the Division of Medicaid.
  2. Providers that fail to refund overpayments as described in Miss. Admin. Code Part 305, Rule 1.3.B.1.b) within the thirty (30) calendar day timeframe, may:
    - a) Be placed under investigation for waste and/or abuse of the Medicaid program, and

- b) Be subject to charges for any allowable interest under state law which will begin accruing thirty-one (31) calendar days after receipt of the demand letter sent via certified mail, or thirty (30) calendar days from the date of the letter if the provider does not sign the certified mail notice.
- C. The Division of Medicaid will accept reimbursement for overpayments without penalty in the event that:
- 1. Overpayments are disclosed voluntarily and in good faith, and
  - 2. The acts that led to the overpayments were not the result of fraudulent or abusive conduct.
- D. The Division of Medicaid will refund any payment recovered in error.  
Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

*Rule 1.4: Corrective Action Plan (CAP)*

- A. The Division of Medicaid may require a provider to submit a Corrective Action Plan (CAP) to correct deficiencies found during an investigation.
- 1. A CAP must be specific and must, at a minimum, include:
    - a) Provisions aimed toward correction of the deficiencies,
    - b) Reasonable completion dates,
    - c) A full description of the methods used to permanently correct the deficiencies that necessitated the CAP, and
    - d) A description of methods used for ensuring full compliance with the CAP.
  - 2. The CAP will be subject to approval by the Division of Medicaid to ensure compliance.
- B. The determination of a violation of the CAP, including failure to implement as directed, will subject the provider to further adverse actions.

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

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.



*Rule 1.5: Improper Payments Due to Inaccurate Eligibility Information*

- A. The Division of Medicaid will identify the cause of any improper payments due to an error in the beneficiary's eligibility information including, but not limited to, incorrect income or deductions, and take corrective action.
- B. All underpayments are corrected upon discovery:
  - 1. Underpayments resulting from agency error may be corrected retroactively.
  - 2. Underpayments resulting from beneficiary errors are corrected, but they are not corrected retroactively.
- C. The Division of Medicaid will attempt to recover the amount of any overpayment from the beneficiary directly or from the beneficiary's state tax refund when the beneficiary provides incorrect eligibility data resulting in an overpayment.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule, language moved from Miss. Admin. Code Part 100, Chapter 6 eff. 11/01/2016.

*Rule 1.6: Medicaid Eligibility Quality Control*

- A. A beneficiary must cooperate with Medicaid Eligibility Quality Control (MEQC) reviews.
- B. If a beneficiary fails to cooperate with MEQC reviews and an investigator is unable to obtain information needed to complete a review, the case will be referred back to the regional office for a redetermination.
  - 1. As part of the redetermination process, the information needed by the MEQC will be requested.
  - 2. If the information is not provided to the regional office, coverage will be terminated because the Division of Medicaid will be unable to determine eligibility.

Source: 42 C.F.R. § 431.810, *et seq.*

History: New Rule, language moved from Miss. Admin. Code Part 100, Chapter 7 eff. 11/01/2016.

**Part 305 Chapter 2: Beneficiary Health Management**

*Rule 2.1: Authority and Purpose*

- A. The Division of Medicaid defines Beneficiary Health Management (BHM) as the program

implemented by the Division of Medicaid to:

1. Closely monitor program usage and to identify beneficiaries who may be potentially over utilizing or misusing their Medicaid services and benefits.
  2. Restrict beneficiaries whose utilization of medical and/or pharmacy services is documented at a frequency or amount that is not medically necessary.
  3. Prevent beneficiaries from obtaining non-medically necessary quantities of prescribed drugs through multiple visits to physicians and pharmacies.
- B. The Division of Medicaid will lock-in beneficiaries for twelve (12) consecutive months whose utilization of medical and/or pharmacy services is documented as being excessive, as determined in accordance with utilization guidelines established by the Division of Medicaid, to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization.
- C. The Division of Medicaid requires a beneficiary to designate a physician and/or a pharmacy of choice when the beneficiary's medical record indicates utilization is excessive or inappropriate with reference to medical need, and in accordance with the BHM program, to:
1. Promote quality health care,
  2. Promote coordination of care and ensure appropriate access for beneficiaries at high risk of overdose,
  3. Provide continuity of medical care,
  4. Prevent harmful practices such as duplication of medical services, drug interaction, and possible drug abuse,
  5. Prevent misuse or excessive utilization of beneficiary's Medicaid benefits,
  6. Provide education and monitoring to deter misuse and/or excess utilization, and
  7. Assure beneficiaries are receiving only health care services which are medically necessary as defined in Miss. Admin. Code Part 200, Rule 5.1.

Source: 42 C.F.R. § 431.54; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

*Rule 2.2: Program Oversight*

A. The Division of Medicaid's Office of Program Integrity:

1. Manages the Beneficiary Health Management (BHM) program,
  2. Screens beneficiaries against criteria designed to identify drug seeking behavior and inappropriate use of prescription drugs, and
  3. Reviews claims and pharmacy point-of-sale data to identify patterns of inappropriate, excessive or duplicative use of pharmacy services.
- B. The Division of Medicaid will require the Mississippi Coordinated Access Network (MSCAN) contractor to lock-in beneficiaries who have had prior lock-ins with the Medicaid fee-for-service program or other Medicaid-participating Coordinated Care Organizations (CCOs).

Source: 42 C.F.R. § 431.54; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

*Rule 2.3: Provider Participation*

The Beneficiary Health Management (BHM) program may include physician only, pharmacy only, or physician and pharmacy providers.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

*Rule 2.4: Beneficiary Notification*

- A. The Division of Medicaid will notify the beneficiary in writing prior to the imposing of the restrictions of:
1. Its intent to enroll them in the Beneficiary Health Management (BHM) program, and
  2. Their opportunity for a hearing as outlined in Miss. Admin. Code Part 300.
- B. The Division of Medicaid will ensure that the beneficiary has reasonable access to Medicaid services of adequate quality taking into account geographic location and reasonable travel time.
- C. The BHM program restrictions do not apply to emergency services provided to the beneficiary.

Source: 42 C.F.R. § 431.54; Miss. Code Ann §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

*Rule 2.5: Provider Selection*

- A. The beneficiary has ten (10) days to choose his/her Beneficiary Health Management (BHM) designated physician and/or pharmacy provider(s) from the date of receipt of the notification letter.
- B. The Division of Medicaid will designate a BHM physician and/or pharmacy provider for the beneficiary if the beneficiary does not specify a provider within the ten (10) day time-frame.
- C. Beneficiaries are required to specify one (1) physician and/or one (1) pharmacy and up to three (3) physician specialists, if requested, for his/her medical and/or pharmacy services while in the Beneficiary Health Management (BHM) program.
- D. The beneficiary may request a change in his/her BHM physician and/or pharmacy provider if any of the following occur:
  - 1. Change in physical address of the beneficiary or a provider,
  - 2. Death, retirement, or closing of the specified physician, pharmacy and/or specialist,
  - 3. Change in primary diagnosis which requires a different specialist, or
  - 4. The BHM physician and/or pharmacy provider disenrolls or loses eligibility to participate in the Mississippi Medicaid Program.
- E. The BHM physician or specialist may refer the beneficiary to another provider for consultation by submitting the BHM Referral Form to the Division of Medicaid, Office of Program Integrity, or designee.
  - 1. Prior approval from the Division of Medicaid or designee is required before the beneficiary can be seen by the referring physician.
  - 2. Emergency situations are excluded from this requirement.
  - 3. The referral may cover one (1) or multiple visits as long as those visits are part of the consulting physician's plan of care and are medically necessary.
  - 4. A referral is limited to one (1) year from the date of approval.
- F. The Division of Medicaid will lock-in beneficiaries to only one (1) pharmacy when one (1) of the following criteria is met:
  - 1. The beneficiary has one (1) or more of the following:
    - a) Received services from four (4) or more prescribers and/or four (4) or more pharmacies relative to controlled substances in the past six (6) months, including

- emergency department visits,
- b) A history of substance use disorder within the past twelve (12) months,
  - c) A diagnosis of drug abuse or narcotic poisoning within the past twelve (12) months,  
or
  - d) Utilizes cash payments to purchase controlled substances.
2. When any written prescription is stolen, forged or altered,
3. When the Division of Medicaid has received a proven report of fraud, waste and/or abuse from one (1) or more of the following:
- a) Prescriber,
  - b) Pharmacy,
  - c) Any medical provider, and/or
  - d) Law enforcement entity.

Source: 42 C.F.R. § 431.54; Miss. Code Ann §§ 43-13-117, 43-13-121.

History: New Rule eff. 02/01/2019.

*Rule 2.6: Beneficiary Health Management (BHM) Services*

The Division of Medicaid locks-in a beneficiary in the Beneficiary Health Management (BHM) program for a period of twelve (12) months with ongoing reviews to monitor patterns of care.

- A. Beneficiaries in the BHM program are allowed two (2) counseling sessions in addition to State Plan service limits per month during the twelve (12) month lock-in.
- B. Beneficiaries locked-in the BHM program will continue to have access to the following services with applicable State Plan service limits:
  - 1. Emergency department,
  - 2. Inpatient hospital,
  - 3. Outpatient hospital,
  - 4. Dental,
  - 5. Vision,

6. Mental Health,
7. Home Health and Durable Medical Equipment (DME), medical appliances and medical supplies,
8. Hospice, and
9. Medicaid Waivers.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

*Rule 2.7: Exclusions*

The Division of Medicaid may exclude a beneficiary from the Beneficiary Health Management (BHM) program if the beneficiary:

- A. Has one (1) of the following diagnoses including, but not limited to:
  1. Cancer,
  2. Sickle cell anemia, or
  3. Burns.
- B. Is enrolled in hospice care.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

*Rule 2.8: Reimbursement*

- A. The Division of Medicaid reimburses for:
  1. Office visits only with the Beneficiary Health Management (BHM) designated physician,
  2. Drugs prescribed only by the BHM designated physician, by the consultant physician, or by an emergency department physician, and
  3. Drugs dispensed only by the BHM designated pharmacy provider.
- B. The Division of Medicaid requires post utilization review by the Division of Medicaid or designee for reimbursement to physician and/or pharmacy provider(s) other than the BHM

designated physician and/or pharmacy provider(s) when :

1. Emergency care is required and the BHM designated physician and/or pharmacy provider is not available, or
  2. The BHM designated physician and/or pharmacy provider requires consultation with another physician and/or pharmacy provider.
- C. BHM designated physician and/or pharmacy providers are required to bill the specified procedure codes if counseling sessions are provided.
1. The counseling procedure codes can be billed in conjunction with any other service the BHM designated physician provides to the beneficiary.
  2. Documentation must support billing of the specified procedure codes by the BHM designated physician and/or pharmacy.
- D. The Division of Medicaid reimburses for inpatient hospitalization for treatment of alcohol and/or drug abuse when the diagnosis is a substance use disorder diagnosis in accordance with the most current Diagnostic and Statistical Manual (DSM) of Mental Disorders and the inpatient hospital stay is prior authorized by the Division of Medicaid or designee.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.