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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #04-142(F)

DIGEST

Amends 405 IAC 1-1.5-1 to specify that disputes related to claims submitted to Medicaid managed care organizations by Medicaid providers who do not have a contract with the managed care organization are governed by 405 IAC 1-1.6. Adds 405 IAC 1-1.6 to set out the dispute resolution process for disputes related to claims submitted to Medicaid managed care organizations by Medicaid providers who do not have a contract with the managed care organization. Effective 30 days after filing with the secretary of state.

405 IAC 1-1.5-1
405 IAC 1-1.6

SECTION 1. 405 IAC 1-1.5-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1.5-1 Scope
Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 1. (a) This rule governs the procedures for appeals to the office of Medicaid policy and planning (office) involving actions or determinations of reimbursement for all Medicaid providers.

(b) This rule governs the procedures for appeals to the office from the following actions or determinations:
(1) Setting rates of reimbursement.
(2) Any action based upon a final audit.
(3) Determination of change of provider status for purposes of setting a rate of reimbursement.
(4) Determination by the office that an overpayment to a provider has been made due to a year-end cost settlement.
(5) Any other determination by the office that a provider has been paid more than it was entitled to receive under any federal or state statute or regulation.
(6) The office's refusal to enter into a provider agreement.
(7) The office's suspension, termination, or refusal to renew an existing provider agreement.

(c) Notwithstanding subsections (a) and (b), this rule does not govern determinations by the office or its contractor with respect to the authorization or approval of Medicaid services requested by a provider on behalf of a recipient.

(d) Disputes relating to claims submitted to a managed care organization (MCO) by providers who are not under contract to the MCO, and who provide services to recipients in the risk-based managed care program are governed by 405 IAC 1-1.6.
(Office of the Secretary of Family and Social Services; 405 IAC 1-1.5-1; filed Oct 31, 1994, 3:30 p.m.: 18 IR 862; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Nov 10, 2004, 3:15 p.m.: 28 IR 815; errata filed Nov 15, 2004, 10:20 a.m.: 28 IR 970)

SECTION 2. 405 IAC 1-1.6 IS ADDED TO READ AS FOLLOWS:

Rule 1.6. Managed Care Provider Reimbursement Dispute Resolution

405 IAC 1-1.6-1 Scope
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 1. (a) This rule applies to disputes relating to claims submitted to risk-based managed care organizations (MCOs) contracted with the office of Medicaid policy and planning (office) by providers who are not contracted with the MCO, and who provide services to a Medicaid recipient enrolled in a risk-based managed care plan.

(b) This rule governs the procedures for a provider's objection to a determination by the MCO involving the provider's claim, including a provider's objection to:

(1) any determination by the MCO regarding payment for a claim submitted by the provider, including the amount of such payment; or

(2) the MCO's determination that a claim submitted by the provider lacks sufficient supporting information, records, or other materials.

(c) The procedures in this rule may, at the election of a provider, be utilized to determine the payment due for a claim in the event the MCO fails, within thirty (30) days after the provider submits the claim, to notify the provider of its determination:

(1) regarding payment for the provider's claim; or

(2) that the provider's claim lacked sufficient supporting information, records, or other materials.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-1; filed Nov 10, 2004, 3:15 p.m.: 28 IR 816)

405 IAC 1-1.6-2 Informal objection

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-15

Sec. 2. (a) The provider may make verbal inquiries at any time to resolve a claim matter. Before the provider may submit a formal claim appeal under section 3 of this rule, the provider shall attempt to informally resolve the matter as described in this section.

(b) The informal dispute process shall be commenced by a provider submitting a written objection to the MCO, within the following time limits:

(1) If the provider disagrees with the MCO's determination regarding the provider's claim, the informal process must be commenced within sixty (60) days after the provider's receipt of written notification of the MCO's determination.

(2) If the MCO fails to make a determination within thirty (30) days of the date the claim was submitted, the informal process must be commenced within ninety (90) days of the date the claim was submitted to the MCO.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-2; filed Nov 10, 2004, 3:15 p.m.: 28 IR 816; errata filed Nov 15, 2004, 10:20 a.m.: 28 IR 970)

405 IAC 1-1.6-3 Formal appeal to managed care organization

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-15

Sec. 3. (a) In the event the matter is not resolved to the provider's satisfaction within thirty (30) days after the provider commenced the informal process set out in section 2 of this rule, the provider shall have sixty (60) days after the end of the thirty (30) day period to submit a formal appeal notice to the MCO.

(b) The provider's claim appeal notice must be in writing and specify the basis of the provider's dispute with the MCO.

(c) The formal claim appeal procedure is commenced by the MCO's receipt of the provider's written claim appeal notice. The appeal review is conducted by a panel of one (1) or more individuals selected by the MCO. The panel shall:

(1) be knowledgeable about the policy, legal, and clinical issues involved in the matter subject to the appeal;

(2) not include an individual who has been involved in any previous consideration of the matter; and

(3) consider all information and material submitted to it by the provider that bears directly upon an issue involved in the matter.

(d) The MCO shall allow the provider an opportunity to appear in person before the panel or to communicate with the panel through appropriate other means if the provider is unable to appear in person.

(e) The provider may be represented by an attorney or other representative during the formal claim appeal procedure.

(f) The MCO's medical director, or other licensed physician designated by the medical director, shall serve as a consultant to the panel in the event the matter involves a question of medical necessity or medical appropriateness.

(g) The panel shall make a written determination of the matter that is the subject of the provider's appeal. The panel's written determination of the matter shall:
(1) be the MCO's final position in regard to the matter;
(2) include, as applicable, a detailed explanation of the factual, legal, policy, and clinical basis of the panel's determination; and
(3) include notice to the provider of the provider's right to submit to binding arbitration, or other binding resolution procedure to which the MCO and provider mutually agree, the matter that was the subject of the formal claim resolution procedure.

(h) The panel's written determination shall be issued to the provider within forty-five (45) days after the commencement of the formal claim appeal process. In the event the panel fails to issue the panel's written determination within forty-five (45) days after the commencement of the formal claim appeal process, the failure on the part of the panel shall have the effect of an approval by the panel of the provider's claim. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-3; filed Nov 10, 2004, 3:15 p.m.: 28 IR 816)*

405 IAC 1-1.6-4 Arbitration
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 34-57-2

Sec. 4. (a) If the provider is dissatisfied with the decision of the MCO panel, the provider may submit the matter to binding arbitration. The binding arbitration process must be conducted in accordance with the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the state of Indiana at IC 34-57-2, unless:
(1) the provider and MCO mutually agree to some other binding resolution procedure; or
(2) the MCO or providers are subject to statutorily imposed arbitration procedures for the resolution of these claims. In that case, the statutorily imposed arbitration procedures shall be followed.

(b) The arbitration process may include, in a single arbitration proceeding, matters from multiple formal claim resolution procedures involving the MCO and the provider.

(c) The fees and expenses of arbitration or other binding resolution procedure shall be borne by the nonprevailing party. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-4; filed Nov 10, 2004, 3:15 p.m.: 28 IR 817)*

405 IAC 1-1.6-5 Supporting documentation for claims; final determination
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 5. (a) A claim that is finally determined through the claim resolution procedure not to lack sufficient supporting documentation shall be processed by the MCO within thirty (30) days after such final determination.

(b) If it is finally determined that a claim lacks sufficient supporting documentation, the provider shall have thirty (30) days after receipt of written notice of the final determination to submit the requisite supporting documentation. The claim shall be processed by the MCO within thirty (30) days after the provider submits to the MCO the required supporting documentation. *(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-5; filed Nov 10, 2004, 3:15 p.m.: 28 IR 817)*

405 IAC 1-1.6-6 Record keeping and reporting requirements
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 6. The MCO shall maintain a log of all written informal provider objections to determinations and formal provider

appeals involving claims. The logged information shall include the:

(1) provider's name;

(2) date of objection;

(3) nature of the objection; and

(4) disposition.

The MCO shall submit quarterly reports to the office regarding the number and type of provider objections and appeals.

(Office of the Secretary of Family and Social Services; 405 IAC 1-1.6-6; filed Nov 10, 2004, 3:15 p.m.: 28 IR 817)

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