PART III. MEDICAL ASSISTANCE MANUAL

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Authority

The provisions of this Part III issued under sections 403 and 443.1—443.4 of the Human Services Code (62 P.S. §§ 403 and 443.1—443.4), unless otherwise noted.

Source

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Cross References

This part cited in 6 Pa. Code § 22.2 (relating to definitions); 28 Pa. Code § 709.94 (relating to project management services); 28 Pa. Code § 711.94 (relating to project management services); and 55 Pa. Code § 451.4 (relating to procedures).

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Cross References

This chapter cited in 55 Pa. Code § 52.3 (relating to definitions); 55 Pa. Code § 52.14 (relating to ongoing responsibilities of providers); 55 Pa. Code § 52.22 (relating to provider monitoring); 55 Pa. Code § 52.24 (relating to quality management); 55 Pa. Code § 52.42 (relating to payment policies); 55 Pa. Code § 52.65 (relating to appeals); 55 Pa. Code § 283.31 (relating to funeral director violations); 55 Pa. Code § 1102.1 (relating to policy); 55 Pa. Code § 1102.41 (relating to provider participation and enrollment); 55 Pa. Code § 1102.71 (relating to scope of claims review procedures); 55 Pa. Code § 1102.81 (relating to prohibited acts of a shared health facility and providers practicing in the shared health facility); 55 Pa. Code § 1121.1 (relating to policy); 55 Pa. Code § 1121.11 (relating to types of services covered); 55 Pa. Code § 1121.12 (relating to outpatient services); 55 Pa. Code § 1121.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1121.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1121.51 (relating to general payment policy); 55 Pa. Code § 1121.71 (relating to scope of claims review procedures); 55 Pa. Code § 1121.81 (relating to provider misutilization); 55 Pa. Code § 1123.1 (relating to policy); 55 Pa. Code § 1123.11 (relating to types of services covered); 55 Pa. Code § 1123.12 (relating to outpatient services); 55 Pa. Code § 1123.21 (relating to scope of benefits for the categorically needy); 55 Pa. Code § 1123.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1123.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1123.51 (relating to general payment policy); 55 Pa. Code § 1123.71 (relating to scope of claim review procedures); 55 Pa. Code § 1123.81 (relating to provider

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scope of benefits for the categorically needy); 55 Pa. Code § 1221.22 (relating to scope of benefits for the medically needy); 55 Pa. Code § 1221.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1221.41 (relating to participation requirements); 55 Pa. Code § 1221.46 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1221.51 (relating to general payment policy); 55 Pa. Code § 1221.71 (relating to scope of claims review procedures); 55 Pa. Code § 1221.81 (relating to provider misutilization); 55 Pa. Code § 1223.1 (relating to policy); 55 Pa. Code § 1223.12 (relating to outpatient services); 55 Pa. Code § 1223.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1223.41 (relating to participation requirements); 55 Pa. Code § 1223.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1223.51 (relating to general payment policy); 55 Pa. 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Code § 6210.21 (relating to categorically needy and medically needy recipients); 55 Pa. Code § 6210.75 (relating to noncompensable services); 55 Pa. Code § 6210.82 (relating to annual adjustment); 55 Pa. Code § 6210.93 (relating to auditing requirements related to cost reports); 55 Pa. Code § 6210.101 (relating to scope of claims review procedures); 55 Pa. Code § 6210.109 (relating to provider misutilization); and 55 Pa. Code § 6211.2 (relating to applicability).

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PRELIMINARY PROVISIONS

§ 1101.11. General provisions.

(a) *Scope.* This chapter sets forth the MA regulations and policies which apply to providers. Regulations specific to each type of provider are located in the separate chapters relating to each provider type.

(b) *Legal authority.* The MA Program is authorized under Article IV of the Human Services Code (62 P.S. §§ 401—488) and is administered in conformity with Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396q) and regulations issued under it.

Cross References

This section cited in 55 Pa. Code § 1130.51 (relating to provider enrollment requirements).

DEFINITIONS

§ 1101.21. Definitions.

The following words and terms, when used in this part, have the following meanings, unless the context clearly indicates otherwise:

Adult—An MA recipient 21 years of age or older.

CRNP—Certified registered nurse practitioner.

Categorically needy—Aged, blind or disabled individuals or families and children who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for TANF, SSI or an optional State supplement.

Complete medical history—A chronological medical record which includes, but is not limited to, major complaints, present medical history, past medical history, family history and social history.

County Assistance Offices or *CAOs*—The local offices of the Department that administer the MA Program on the local level. They determine recipient eligibility and perform other necessary MA functions such as prior authorization and client referral to a source of medical services.

Covered service—A benefit to which a MA recipient is entitled under the MA Program of the Commonwealth.

Department—The Department of Human Services of the Commonwealth or a subagency thereof.

Emergency situation—A condition in which immediate medical care is necessary to prevent the death or serious impairment of health of the individual.

Enroll—The act of becoming eligible to participate in the MA Program by completing the provider enrollment form, entering into or renewing as required a written provider agreement and meeting other participation requirements specified in this chapter and the appropriate separate chapters relating to each provider type.

EPSDT—Early and Periodic Screening, Diagnosis and Treatment Program.

FQHC—Federally qualified health center.

Factor—An individual or an organization, such as a service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or a deduction of a portion of the accounts receivable.

GA—General Assistance—MA funded solely by State funds as authorized under Article IV of the Human Services Code (62 P.S. §§ 401—488).

General public—Payors other than Medicaid. The term includes other health insurance plans.

HHS—The United States Department of Health and Human Services or its successor agency, which is given responsibility for implementation of Title XIX of the Social Security Act.

MA—Medical Assistance.

Medicaid—Medical Assistance provided under a State Plan approved by HHS under Title XIX of the Social Security Act.

Medical facility—A licensed or approved hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, public clinic, shared health facility, rural health clinic, psychiatric clinic, pharmacy, laboratory, drug and alcohol clinic, partial hospitalization facility or family planning clinic.

Medically necessary—A service, item, procedure or level of care that is:

(i) Compensable under the MA Program.

(ii) Necessary to the proper treatment or management of an illness, injury or disability.

(iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.

Medically needy—A term used to refer to aged, blind or disabled individuals or families and children who are otherwise eligible for Medicaid and whose income and resources are above the limits prescribed for the categorically needy but are within limits set under the Medicaid State Plan.

Noncompensable item—A service or supply a provider furnishes for which there is no provision for payment under this part.

Parent/caretaker—The person responsible for the care and control of an unemancipated minor child. This includes mother or father, grandmother or grandfather, stepmother or stepfather or another relative related by blood or marriage.

Postpartum period—The period beginning on the last day of the pregnancy and extending through the end of the month in which the 60-day period following termination of the pregnancy ends.

Practitioner—A medical doctor, doctor of osteopathy, dentist, optometrist, podiatrist, chiropractor or other medical professional licensed by the Commonwealth or by another state who is authorized to participate in the MA Program as a provider.

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Prepayment review—Determination of the medical necessity of a service or item before payment is made to the provider. Prepayment review is performed after the service or item is provided and involves an examination of an invoice and related material, when appropriate. Prepayment review is not prior authorization.

Prior authorization—A procedure specifically required or authorized by this title wherein the delivery of an MA item or service is either conditioned upon or delayed by a prior determination by the Department or its agents or employees that an eligible MA recipient is eligible for a particular item or service or that there is medical necessity for a particular item or service or that a particular item or service is suitable to a particular recipient.

Professional Standards Review Organization or *PSRO*—An organization which HHS has charged with the responsibility for operating professional review systems to determine whether hospital services are medically necessary, provided appropriately, carried out on a timely basis and meet professional standards.

Program—The MA program of the Commonwealth.

Provider—An individual or medical facility which signs an agreement with the Department to participate in the MA program, including, but not limited to: licensed practitioners, pharmacies, hospitals, nursing homes, clinics, home health agencies and medical purveyors.

Public clinic—A health clinic operated by a Federal, State or local governmental agency.

Purveyor—A person other than a practitioner who, directly or indirectly, engages in the business of supplying to patients medical supplies, equipment or services for which reimbursement under the MA program is received, including, but not limited to: clinical laboratory services or supplies, X-ray laboratory services or supplies, inhalation therapy services or equipment, ambulance services, sick room supplies, physical therapy services or equipment, and orthopedic or surgical appliances or supplies.

Recipient—A person or family that is eligible for MA benefits.

School child—A child attending a kindergarten, elementary, grade or high school, either public or private.

Shared health facility—An entity other than a licensed or approved hospital facility, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rural health clinic, public clinic or Health Maintenance Organization in which:

(i) Medical services, either alone or together with support services, are provided at a single location.

(ii) Services are provided by three or more practitioners, two or more of whom are practicing within different professions.

(iii) Practitioners share any of the following: common waiting areas, examining rooms, equipment, supporting staff or records.

(iv) At least one practitioner receives payment on a fee for service basis.

(v) A provider receiving more than $30,000 in payment from the MA Program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the MA Program.

State Blind Pension recipient—An individual 21 years of age or older who by virtue of meeting the requirements of Article V of the Human Services Code (62 P.S. §§ 501—515) is eligible for pension payments and payments made on his behalf for medical or other health care, with the exception of inpatient hospital care and post-hospital care in the home provided by a hospital. Payment for medical and health care is made solely from Commonwealth funds since these individuals do not meet the criteria for Federal funding of their medical care under Medicaid.

Authority

The provisions of this § 1101.21 amended under sections 201(2), 403(b), 443.1, 443.3, 443.4, 443.6, 448 and 454 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 443.1, 443.3, 443.4, 443.6, 448 and 454).

Source

The provisions of this § 1101.21 amended through April 27, 1984, effective April 28, 1984, 14 Pa.B. 1454; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended August 5, 2005, effective August 10, 2005, 35 Pa.B. 4309; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811. Immediately preceding text appears at serial pages (266131) to (266132) and (286983) to (286984).

Cross References

This section cited in 55 Pa. Code § 140.721 (relating to conditions of eligibility); 55 Pa. Code § 1101.31 (relating to scope); 55 Pa. Code § 1101.63 (relating to payment in full); 55 Pa. Code § 1187.11 (relating to scope of benefits for the categorically needy); 55 Pa. Code § 1187.12 (relating to scope of benefits for the medically needy); and 55 Pa. Code § 1187.152 (relating to additional reimbursement of nursing facility services related to exceptional DME).

§ 1101.21a. Clarification regarding the definition of "medically necessary"—statement of policy.

A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:

(1) Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

(2) Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

(3) Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.

Source

The provisions of this § 1101.21a adopted April 20, 2007, effective April 21, 2007, 37 Pa.B. 1880.

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BENEFITS

§ 1101.31. Scope.

(a) *Scope*. The scope of benefits for which MA recipients are eligible differs according to recipients' categories of assistance, as described in this section.

(1) Recipients under 21 years of age are eligible for all medically necessary services.

(2) The benefit limits specified in subsections (b), (c), and (e) apply only to adults, with the exception of pregnant women, including throughout the postpartum period.

(3) Recipients shall exhaust other available medical resources prior to receiving MA benefits.

(b) *Categorically needy*. The categorically needy are eligible for all of the following benefits:

(1) Inpatient hospital services other than services in an institution for mental disease, as specified in Chapter 1163 (relating to inpatient hospital services), including one medical rehabilitation hospital admission per fiscal year.

(2) Up to a combined maximum of 18 clinic, office and home visits per fiscal year by physicians, podiatrists, optometrists, CRNPs, chiropractors, outpatient hospital clinics, independent medical clinics, rural health clinics, and FQHCs.

(3) Outpatient hospital services as follows:

(i) Short procedure unit services as specified in Chapter 1126 (relating to ambulatory surgical center services and hospital short procedure unit services).

(ii) Psychiatric partial hospitalization services as specified in Chapter 1153 (relating to outpatient psychiatric services) up to one hundred and eighty three-hour sessions, 540 total hours, per recipient per fiscal year.

(iii) Outpatient hospital clinic services as specified in Chapter 1221 (relating to clinic and emergency room services) and in paragraph (2).

(iv) Rural health clinic services and FQHC services as specified in Chapter 1129 (relating to rural health clinic services) and in paragraph (2).

(4) Laboratory and X-ray services as specified in Chapter 1243 (relating to outpatient laboratory services) and Chapter 1230 (relating to portable X-ray services).

(5) Nursing facility care as specified in Chapter 1181 (relating to nursing facility care) and Chapter 1187 (relating to nursing facility services).

(6) Intermediate care.

(7) Inpatient psychiatric care as specified in Chapter 1151 (relating to inpatient psychiatric services), up to 30 days per fiscal year.

(8) Physicians' services as specified in Chapter 1141 (relating to physicians' services) and in paragraph (2).

(9) Optometrists' services as specified in Chapter 1147 (relating to optometrists' services) and in paragraph (2).

(10) Home health care as specified in Chapter 1249 (relating to home health agency services).

(11) Clinic services as follows:

(i) Independent medical clinic services as specified in Chapter 1221 and in paragraph (2).

(ii) Ambulatory surgical center services as specified in Chapter 1126.

(iii) Psychiatric clinic services as specified in Chapter 1153, including up to 5 hours or 10 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

(iv) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223 (relating to outpatient drug and alcohol clinic services).

(12) Ambulance services as specified in Chapter 1245 (relating to ambulance transportation).

(13) Dental services as specified in Chapter 1149 (relating to dentists' services).

(14) Medical equipment, supplies, prostheses, orthoses and appliances as specified in Chapter 1123 (relating to medical supplies).

(15) EPSDT services, for recipients under 21 years of age as specified in Chapter 1241 (relating to early and periodic screening, diagnosis, and treatment program).

(16) Family planning services and supplies as specified in Chapter 1245.

(17) Drugs as specified in Chapter 1121 (relating to pharmaceutical services).

(18) Chiropractic services as specified in Chapter 1145 (relating to chiropractors' services) limited to the visits specified in paragraph (2).

(19) Podiatrists' services as specified in Chapter 1143 (relating to podiatrists' services) and in paragraph (2).

(20) CRNP services as specified in Chapter 1144 (relating to certified registered nurse practitioner services) and in paragraph (2).

(c) *Medically needy*. The medically needy are eligible for the benefits in subsection (b) with the exception of the following:

(1) Medical equipment, supplies, prostheses, orthoses and appliances.

(2) Drugs.

(d) *State Blind Pension*. State Blind Pension recipients are eligible for the following benefits:

(1) Outpatient hospital services as follows:

(i) Psychiatric partial hospitalization services as specified in Chapter 1153 up to 240 three-hour sessions, 720 total hours, per recipient in a 365 consecutive day period.

(ii) Rural health clinic services and FQHC services, as specified in Chapter 1129.

(2) Physicians' services as specified in Chapter 1141.

(3) Optometrists' services as specified in Chapter 1147.

(4) Home health care as specified in Chapter 1249.

(5) Clinic services as follows:

(i) Psychiatric clinic services as specified in Chapter 1153, including up to 7 hours or 14 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

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(ii) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223.

(6) Ambulance services as specified in Chapter 1245.

(7) Dental services as specified in Chapter 1149.

(8) Family planning services and supplies as specified in Chapter 1245.

(9) Drugs as specified in Chapter 1121.

(10) Chiropractors' services as specified in Chapter 1145.

(e) *GA recipients*. GA recipients are eligible for benefits as follows:

(1) GA chronically needy and nonmoney payment recipients are eligible for all of the following benefits:

(i) Up to a combined maximum of 18 clinic, office, and home visits per fiscal year by physicians, podiatrists, optometrists, CRNPs, chiropractors, outpatient hospital clinics, independent medical clinics, rural health clinics and FQHCs.

(ii) Home health care as specified in Chapter 1249, up to a maximum of 30 visits per fiscal year.

(iii) Legend and nonlegend drugs as specified in Chapter 1121 not to exceed a maximum of six prescriptions and refills per month.

(iv) Inpatient hospital services other than services in an institution for mental disease as specified in Chapter 1163, as follows:

(A) One acute care inpatient hospital admission per fiscal year.

(B) One medical rehabilitation hospital admission per fiscal year.

(C) Up to 30 days of drug and alcohol inpatient hospital care per fiscal year.

(v) Outpatient hospital services as follows:

(A) Short procedure unit services as specified in Chapter 1126.

(B) Psychiatric partial hospitalization services as specified in Chapter 1153, up to 180 three-hour sessions, 540 total hours, per recipient per fiscal year.

(C) Outpatient hospital clinic services as specified in Chapter 1221 and in subparagraph (i).

(D) Rural health clinic services and FQHC services as specified in Chapter 1129 and in subparagraph (i).

(vi) Ambulance services as specified in Chapter 1245, for medically necessary emergency transportation and transportation to a nonhospital drug and alcohol detoxification and rehabilitation facility from a hospital when a recipient presents to the hospital for inpatient drug and alcohol treatment and the hospital has determined that the required services are not medically necessary in an inpatient facility.

(vii) Emergency room care as specified in Chapter 1221, limited to emergency situations as defined in §§ 1101.21 and 1150.2 (relating to definitions; and definitions).

(viii) Laboratory and X-ray services as specified in Chapter 1243 and Chapter 1230.

(ix) Nursing facility care as specified in Chapter 1181 and Chapter 1187.

(x) Intermediate care.

(xi) Inpatient psychiatric care as specified in Chapter 1151, up to 30 days per fiscal year.

(xii) Clinic services as follows:

(A) Independent medical clinic services as specified in Chapter 1221 and in subparagraph (i).

(B) Ambulatory surgical center services as specified in Chapter 1126.

(C) Psychiatric clinic services as specified in Chapter 1153, including a total of 5 hours or 10 one-half hour sessions of psychotherapy per recipient in a 30 consecutive day period.

(D) Drug and alcohol clinic services, including methadone maintenance, as specified in Chapter 1223.

(xiii) Physicians' services as specified in Chapter 1141 and in subparagraph (i).

(xiv) Dental services as specified in Chapter 1149.

(xv) Podiatrists' services as specified in Chapter 1143 and in subparagraph (i).

(xvi) Chiropractic services as specified in Chapter 1145 limited to the visits specified in subparagraph (i)

(xvii) CRNP services as specified in Chapter 1144 and in subparagraph (i).

(xviii) Medical equipment, supplies, prostheses, orthoses and appliances as specified in Chapter 1123.

(xix) Family planning services and supplies as specified in Chapter 1225.

(2) GA medically needy only recipients are eligible for the benefits described in paragraph (1) of subsection (e), with the following exceptions:

(i) Medical equipment, supplies, prostheses, orthoses and appliances.

(ii) Drugs.

(3) The Department will inform recipients subject to the limits established in this subsection and medical service providers of these limits and the recipient's current usage of limited services. When the Department determines that a recipient's usage of services is likely to exceed the limits established by this subsection, it will review the case to determine whether the recipient should be referred to the Disability Advocacy Program.

(f) *Exceptions*.

(1) The Department is authorized to grant exceptions to the limits specified in subsections (b) and (e) when it determines that one of the following criteria applies:

(i) The recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the serious deterioration of the health of the recipient.

(ii) Granting the exception is a cost-effective alternative for the MA Program.

(iii) Granting the exception is necessary in order to comply with Federal law.

(2) The process for requesting an exception is as follows:

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(i) A recipient or a provider on behalf of a recipient may request an exception.

(ii) A request for an exception may be made to the Department in writing, by telephone, or by facsimile.

(iii) A request for an exception may be made prospectively, before the service has been delivered, or retrospectively, after the service has been delivered.

(iv) The Department will respond to a request for an exception no later than:

(A) For prospective exception requests, within 21 days after the Department receives the request.

(B) For prospective exception requests when the provider indicates an urgent need for quick response, within 48 hours after the Department receives the request.

(C) For retrospective exception requests, within 30 days after the Department receives the request.

(v) A retrospective request for an exception must be submitted no later than 60 days from the date the Department rejects the claim because the service is over the benefit limit. Retrospective exception requests made after 60 days from the claim rejection date will be denied.

(vi) Both the recipient and the provider will receive written notice of the approval or denial of the exception request. For prospective exception requests, if the provider or recipient is not notified of the decision within 21 days of the date the request is received, the exception will be automatically granted.

(vii) Departmental denials of requests for exception are subject to the right of appeal by the recipient in accordance with Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

(viii) A provider may not hold a recipient liable for payment for services rendered in excess of the limits established in subsections (b) and (e) unless both of the following conditions are met:

(A) The provider has requested an exception to the limit and the Department has denied the request.

(B) The provider informed the recipient before the service was rendered that the recipient is liable for the payment as specified in § 1101.63(a) (relating to payment in full) if the exception is not granted.

Authority

The provisions of this § 1101.31 amended under sections 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 443.1, 443.6, 448 and 454).

Source

The provisions of this § 1101.31 amended December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995; amended November 24, 1995, effective November 25, 1995, and apply retroactively to November 1, 1995, 25 Pa. B. 5240; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811. Immediately preceding text appears at serial pages (286984), (204503) to (204504) and (266133) to (266135).

Notes of Decisions

Services

The provisions of 55 Pa. Code § 1101.31 contemplate the availability of non-medically necessary as well as medically necessary services for eligible participants. *Leader Nursing Centers, Inc. v. Department of Public Welfare*, 475 A.2d 859 (Pa. Cmlth. 1984).

Cross References

This section cited in 55 Pa. Code § 1121.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1123.21 (relating to scope of benefits for the categorically needy); 55 Pa. Code § 1123.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1126.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1127.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1128.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1129.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1130.23 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1141.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1142.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1143.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1144.24 (relating to scope of benefits for GA recipients); 55 Pa. Code § 1145.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1147.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1151.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1151.43 (relating to limitation on payment); 55 Pa. Code § 1163.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1163.424 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1181.25 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1221.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1223.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1225.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1230.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1243.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1245.24 (relating to scope of benefits for General Assistance recipients); 55 Pa. Code § 1249.24 (relating to scope of benefits for General Assistance recipients); and 55 Pa. Code § 1251.24 (relating to scope of benefits for General Assistance recipients).

§ 1101.31a. {Reserved}.

Source

The provisions of this § 1101.31a adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 6006; reserved February 10, 1995, effective February 11, 1995, 25 Pa.B. 538. Immediately preceding text appears at serial pages (177038) to (177042).

§ 1101.32. Coverage variations.

(a) *Expanded coverage.* Expanded coverage benefits include the following:

(1) *EPSDT.* Recipients under age 21 are entitled to benefit coverage for preventive health screening and vision, dental, and hearing problems. The basis for this coverage is the EPSDT. The Department will pay for scheduled periodic health screening services for categorically needy and medically needy individuals. Clients may receive these benefits at approved screening centers. If requested, the CAO will assist clients in making an appointment. Recipients under age 21 are also entitled to necessary vision care by a doctor of optometry or a physician skilled in the diseases of the eye, hearing and dental exams and treatment covered in the State Plan by virtue of being screened under EPSDT. A child need not be screened first if an existing vision problem can be diagnosed and treated by an appropriate specialist. Medically needy children

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referred from EPSDT are not eligible for pharmaceuticals, medical supplies, equipment or prostheses and orthoses.

(2) *School medical program.* A medically needy school child is eligible for benefits available to categorically needy recipients if the benefits are required to treat a health problem noted in his school medical record. The school nurse or doctor refers the child to the provider by completing a School Medical Referral Form. Payment for services provided under this program shall be subject to this chapter and the applicable provider regulations.

(b) *Coverage for out-of-State services.* The Department pays for compensable services furnished out-of-State to eligible Commonwealth recipients if:

(1) The recipient requires emergency medical care while temporarily away from his home.

(2) The recipient would be risking his health if he waited for the service until he returned home.

(3) The trip back to this Commonwealth would endanger his health.

(4) It is general practice for recipients in an area of the Commonwealth to use medical resources in a neighboring state.

(5) The Department decides, based on the attending practitioner's advice, that the recipient has better access to the type of care he needs in another state.

Source

The provisions of this § 1101.32 amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (114356) and (117307) to (117308).

Notes of Decisions

Program Exception

The Department of Public Welfare acted within its discretion in denying a claimant's request for a Medical Assistance regulation program exception to compensate her for the expense of a special commercially processed food, where the claimant did not present any medical evidence to show that the food was medically necessary for her physical maintenance; the Department did not refuse the claimant, ''the minimum necessary medical services required for the successful treatment of the particular medical condition presented,'' as required under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396a—1396i). *Shappell v. Department of Public Welfare*, 445 A.2d 1334 (Pa. Cmwlth. 1982).

The Department of Public Welfare's denial of a Program Exception for over-the-counter items, where alternative items were available under the Department's fee schedule, was not an abuse of discretion and did not offend the statutory purpose of providing minimum necessary medical services. *Wengrzyn v. Cohen*, 498 A.2d 61 (Pa. Cmwlth. 1985).

Cross References

This section cited in 55 Pa. Code § 1121.22 (relating to scope of benefits for the medically needy); 55 Pa. Code § 1123.22 (relating to scope of benefits for the medically needy); 55 Pa. Code § 1123.56 (relating to vision aids); 55 Pa. Code § 1123.57 (relating to hearing aids); 55 Pa. Code § 1147.21 (relating to scope of benefits for the categorically needy); and 55 Pa. Code § 1147.22 (relating to scope of benefits for the medically needy).

§ 1101.33. Recipient eligibility.

(a) *Verification of eligibility.* The County Assistance Office determines whether or not an applicant is eligible for MA services. If the applicant is determined to be eligible, the Department issues Medical Services Eligibility (MSE) cards that are effective from the first of the month through the last day of the

month. Providers are responsible for checking the effective dates on the MSE card and for making sure that services are furnished to a person named on the card. The Department may not pay providers for services the provider rendered to persons ineligible on the date of service unless there is specific provision for the payment in the provider regulations. If the provider notes any discrepancies, he should call the recipient's County Assistance Office to verify eligibility.

(b) *Services restricted to a single provider.* Providers are responsible for checking the recipient's MSE card and other forms of notification sent to the provider by the Department, to verify that the recipient has not been restricted to obtaining the service from a single provider. The Department may not pay for a restricted service rendered by a provider other than the one to which a recipient has been restricted unless it was furnished in response to an emergency situation. Reference should be made to § 1101.91(b) (relating to recipient misutilization and abuse).

(c) *Other resources.* The MSE card lists any other medical coverage a recipient has of which the Department may be aware. However, the provider has the responsibility of attempting to identify and utilize all of the recipient's medical resources before billing the Department as described in § 1101.64 (relating to third-party medical resources (TPR)).

Source

The provisions of this § 1101.33 amended April 27, 1984, effective April 28, 1984, 14 Pa.B. 1454. Immediately preceding text appears at serial pages (86692) and (86693).

Notes of Decisions

It is the provider's responsibility to fill out a newborn infant's identification number. *Nayak v. Department of Public Welfare*, 529 A.2d 557 (Pa. Cmwlth. 1987).

PARTICIPATION

§ 1101.41. Provider participation and registration of shared health facilities.

(a) Any physician, dentist, optometrist, podiatrist, chiropractor, pharmacy, laboratory, nursing facility, hospital, clinic, home health agency, ambulance service, health establishment, State Mental Retardation Center or medical supplier in this Commonwealth or another state may apply to participate in the MA Program.

(b) Shared health facilities shall register and sign a shared health facility agreement with the Department and meet the requirements set forth in Chapter 1102 (relating to shared health facilities).

(c) Each provider who renders services in a registered shared health facility shall enroll in the program and meet § 1102.41 (relating to provider participation and enrollment).

Source

The provisions of this § 1101.41 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial page (75054).

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Cross References

This section cited in 55 Pa. Code § 1121.41 (relating to participation requirements); 55 Pa. Code § 1123.41 (relating to participation requirements); 55 Pa. Code § 1127.41 (relating to participation requirements); 55 Pa. Code § 1128.41 (relating to participation requirements); 55 Pa. Code § 1141.41 (relating to participation requirements); 55 Pa. Code § 1142.41 (relating to participation requirements); 55 Pa. Code § 1143.41 (relating to participation requirements); 55 Pa. Code § 1144.41 (relating to participation requirements); 55 Pa. Code § 1149.41 (relating to participation requirements); and 55 Pa. Code § 1251.41 (relating to participation requirements).

§ 1101.42. Prerequisites for participation.

(a) *In-state providers.* In order to be eligible to participate in the MA Program, Commonwealth-based providers shall be currently licensed and registered or certified or both by the appropriate State agency, complete the enrollment form, sign the provider agreement specified by the Department, and meet additional requirements described in this chapter and the separate chapters relating to each provider type. The Department may at its discretion refuse to enter into a provider agreement. Each individual practitioner or medical facility shall have a separate provider agreement with the Department.

(b) *Out-of-State providers.* Out-of-State providers shall be licensed, and registered or certified or both, by the appropriate agencies in their respective states. A provider shall also be currently participating in the Medicaid program of his state if it has one. Providers in states adjacent to this Commonwealth who regularly furnish services to Pennsylvania MA recipients shall be required to enter into a written provider agreement. A service an out-of-State provider renders to a Pennsylvania MA recipient shall be subject to the regulations of the MA Program of the Commonwealth.

(c) *Providers or applicants ineligible for program participation.* Providers whose provider agreements have been terminated by the Department or who have been excluded from the Medicare program or any other state's Medicaid program are not eligible to participate in this Commonwealth's MA Program during the period of their termination. Providers who are ineligible under this subsection are subject to the restrictions in § 1101.77(c) (relating to enforcement actions by the Department).

Source

The provisions of this § 1101.42 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial pages (75054) and (75055).

Notes of Decisions

Waiver

Where the Department had created confusion regarding whether or not the Department of Health approval was required for certain Medical Assistance Program health-care providers' facilities, and where the Department had *sua sponte* waived the approval requirement for a short period of time the Department abused its discretion in refusing to extend the waiver to encompass the full period of time necessary for the providers to obtain Department of Health approval. *Eye and Ear Hospital v. Department of Public Welfare*, 514 A.2d 976 (Pa. Cmwlth. 1986).

Cross References

This section cited in 55 Pa. Code § 1101.42a (relating to policy clarification regarding physician licensure—statement of policy); 55 Pa. Code § 1121.41 (relating to participation requirements); 55 Pa. Code § 1123.41 (relating to participation requirements); 55 Pa. Code § 1127.41 (relating to par-

ticipation requirements); 55 Pa. Code § 1128.41 (relating to participation requirements); 55 Pa. Code § 1130.51 (relating to provider enrollment requirements); 55 Pa. Code § 1141.41 (relating to participation requirements); 55 Pa. Code § 1142.41 (relating to participation requirements); 55 Pa. Code § 1143.41 (relating to participation requirements); 55 Pa. Code § 1144.41 (relating to participation requirements); 55 Pa. Code § 1149.41 (relating to participation requirements); 55 Pa. Code § 1187.21a (relating to nursing facility exception requests—statement of policy); 55 Pa. Code § 1225.44 (relating to participation requirements for out-of-State family planning clinics); and 55 Pa. Code § 1251.41 (relating to participation requirements).

§ 1101.42a. Policy clarification regarding physician licensure—statement of policy.

(a) To participate in the MA Program, a physician shall have and maintain a current license.

(1) Services rendered, ordered, arranged for or prescribed for MA recipients by a physician whose license to practice medicine has expired are not eligible for payment under the MA Program.

(2) Refer to § 1101.42 (relating to prerequisites for participation) and 49 Pa. Code Chapters 16, 17 and 25 (relating to State Board of Medicine—general provisions; State Board of Medicine—medical doctors; and State Board of Osteopathic Medicine) for additional requirements.

(3) The Department intends to periodically monitor the expiration of medical licenses to ensure compliance with MA regulations.

(b) The Department will initiate action to recover monies from a physician for one or both of the following:

(1) Medical services billed directly by the physician during the period in which his license is expired.

(2) Services ordered, arranged for or prescribed by the physician whose license has expired, including the services of other providers such as laboratories, radiologists, pharmacies, inpatient and outpatient hospitals and nursing homes that bill the Department for the ordered, arranged or prescribed services.

(c) A physician may not bill the recipient or another provider/person for services for which the Department has requested restitution.

(d) If the physician decides to eventually renew his license, the amount collected for services rendered, ordered, arranged for or prescribed during the unlicensed period will not be returned, and restitution requested shall be paid before reinstatement into the MA Program is considered.

Source

The provisions of this § 1101.42a adopted September 1, 1989, effective immediately, retroactively applicable to July 1, 1988, 19 Pa.B. 3762.

Cross References

This section cited in 55 Pa. Code § 1121.41 (relating to participation requirements); 55 Pa. Code § 1123.41 (relating to participation requirements); 55 Pa. Code § 1127.41 (relating to participation requirements); 55 Pa. Code § 1128.41 (relating to participation requirements); 55 Pa. Code § 1141.41 (relating to participation requirements); 55 Pa. Code § 1142.41 (relating to participation requirements); 55 Pa. Code § 1143.41 (relating to participation requirements); 55 Pa. Code § 1144.41 (relating to participation requirements); 55 Pa. Code § 1149.41 (relating to participation requirements); and 55 Pa. Code § 1251.41 (relating to participation requirements).

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§ 1101.42b. Certificate of Need requirement for participation—statement of policy.

(a) Effective December 19, 1996, the Department will not enter into a provider agreement with an ICF/MR, nursing facility, an inpatient psychiatric hospital or a rehabilitation hospital unless the Department of Health issued a Certificate of Need authorizing construction of the facility or hospital in accordance with 28 Pa. Code Chapter 401 (relating to Certificate of Need program) or a letter of nonreviewability indicating that the facility or hospital was not subject to review under 28 Pa. Code Chapter 401 dated on or before December 18, 1996.

(b) The Department will consider exceptions to subsection (a) on a case-by-case basis. Exceptions requested by nursing facilities will be reviewed under § 1187.21a (relating to nursing facility exception requests—statement of policy).

Source

The provisions of this § 1101.42b adopted December 13, 1996, effective December 19, 1996, 26 Pa.B. 5996; amended January 9, 1998, effective January 12, 1998, 28 Pa.B. 138. Immediately preceding text appears at serial page (223578).

§ 1101.43. Enrollment and ownership reporting requirements.

(a) *Request for approval.* Written requests to participate in the MA Program should be sent to the Department's Office of MA, Bureau of Hospital and Outpatient Programs. The Bureau of Hospital and Outpatient Programs will forward an enrollment form and provider agreement to the applicant to be completed and returned to the Department.

(b) *Ownership reporting requirements.*

(1) *Medical facilities.* A medical facility shall disclose to the Department, upon execution of a provider agreement or renewal thereof, the name and social security number of a person who has a direct or indirect ownership or control interest of 5% or more in the facility. Disclosure shall include the identity of a person who has been convicted of a criminal offense under section 1407 of the Human Services Code (62 P.S. § 1407) and the specific nature of the offense. A change in ownership or control interest of 5% or more shall be reported to the Department within 30 days of the date the change occurs. Failure to submit a complete and accurate report constitutes a deceptive practice under section 1407(a)(1) of the Human Services Code (62 P.S. § 1407(a)(1)) and justifies a termination of the provider agreement by the Department.

(2) *Additional reporting requirements for nursing facilities.* In addition to the reporting requirements specified in paragraph (1), nursing facilities shall meet the requirements of this paragraph.

(i) If a provider enters into an agreement of sale that will result in a change of ownership of its nursing facility, the provider shall notify the Department of the sale no less than 30 days prior to the effective date of the sale.

(ii) The provider shall include in the notice of the agreement of sale the effective date of the sale and a copy of the sales agreement. The notice shall be sent to the Office of MA, Bureau of Provider Relations. The notice requirement shall be deemed met on the date it is received by the Department, not the date of mailing.

(iii) If a provider fails to notify the Department as specified in subparagraphs (i) and (ii), the provider forfeits all reimbursement for nursing care services for each day that the notice is overdue.

(3) *The effect of change in ownership of a nursing facility.* When there is a change in ownership of a nursing facility, the Department will enter into a provider agreement with the buyer or transfer the current provider agreement to the buyer subject to the terms and conditions under which it was originally issued, if:

(i) Applicable State and Federal statutes and regulations are met.

(ii) The buyer has applied to the Division of Provider Enrollment, Bureau of Provider Relations, Office of MA, Department of Human Services, and has been determined to be eligible to participate in the MA Program.

(iii) The seller has repaid to the Department monies owed by the seller to the Department as determined by the Comptroller, Department of Human Services.

(4) *Additional reporting requirements for a shared health facility.* In addition to the reporting requirements specified in paragraph (1), a shared health facility shall meet the requirements of section 1403 of the Human Services Code (62 P.S. § 1403) and Chapter 1102 (relating to shared health facilities).

(5) *Providers.* Providers shall meet the reporting requirements specified in § 1101.71(b) (relating to utilization control).

(c) *Notification by the Department.* The Department will notify applicants in writing either that they have been approved or disapproved to participate in the program. A provider who has been approved is eligible to be reimbursed only for those services furnished on or after the effective date on the provider agreement and only for services the provider is eligible to render subject to limitations in this chapter and the applicable provider regulations. An applicant may appeal under 2 Pa.C.S. §§ 501—508 and 701—704 (relating to Administrative Agency Law), if the Department denies enrollment in the program.

Source

The provisions of this § 1101.43 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial pages (75055) and (75056).

Cross References

This section cited in 55 Pa. Code § 1121.41 (relating to participation requirements); 55 Pa. Code § 1123.41 (relating to participation requirements); 55 Pa. Code § 1127.41 (relating to participation requirements); 55 Pa. Code § 1128.41 (relating to participation requirements); 55 Pa. Code § 1130.51 (relating to provider enrollment requirements); 55 Pa. Code § 1130.52 (relating to ongoing responsi-

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bilities of hospice providers); 55 Pa. Code § 1141.41 (relating to participation requirements); 55 Pa. Code § 1142.41 (relating to participation requirements); 55 Pa. Code § 1143.41 (relating to participation requirements); 55 Pa. Code § 1144.41 (relating to participation requirements); 55 Pa. Code § 1149.41 (relating to participation requirements); 55 Pa. Code § 1187.22 (relating to ongoing responsibilities of nursing facilities); and 55 Pa. Code § 1251.41 (relating to participation requirements).

RESPONSIBILITIES

§ 1101.51. Ongoing responsibilities of providers.

(a) *Recipient freedom of choice of providers.* A recipient may obtain services from any institution, agency, pharmacy, person or organization that is approved by the Department to provide them. Therefore, the provider shall not make any direct or indirect referral arrangements between practitioners and other providers of medical services or supplies but may recommend the services of another provider or practitioner; automatic referrals between providers are, however, prohibited.

(b) *Nondiscrimination.* Federal regulations require that programs receiving Federal assistance through HHS comply fully with Title VI of the Civil Rights Act of 1964 (42 U.S.C.A. §§ 2000d—2000d-4), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. § 794), and the Pennsylvania Human Relations Act (43 P.S. §§ 951—963). Providers are prohibited from denying services or otherwise discriminating against an MA recipient on the grounds of race, color, national origin or handicap.

(c) *Interrelationship of providers.* Providers are prohibited from making the following arrangements with other providers:

(1) The referral of MA recipients directly or indirectly to other practitioners or providers for financial consideration or the solicitation of MA recipients from other providers.

(2) The offering of, or paying, or the acceptance of remuneration to or from other providers for the referral of MA recipients for services or supplies under the MA Program.

(3) {Reserved}.

(4) The solicitation or receipt or offer of a kickback, payment, gift, bribe or rebate for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering a good, facility, service or item for which payment is made under MA. This does not preclude discounts or other reductions in charges by a provider to a practitioner for services, that is, laboratory and x-ray, so long as the price is properly disclosed and appropriately reflected in the costs claimed or charges made by a practitioner.

(5) A participating practitioner or professional corporation may not refer a MA recipient to an independent laboratory, pharmacy, radiology or other ancillary medical service in which the practitioner or professional corporation has an ownership interest.

(d) *Standards of practice.* In addition to licensing standards, every practitioner providing medical care to MA recipients is required to adhere to the basic standards of practice listed in this subsection. Payment will not be made when the Department's review of a practitioner's medical records reveals instances where these standards have not been met.

(1) A proper record shall be maintained for each patient. This record shall contain, at a minimum, all of the following:

(i) A complete medical history of the patient.

(ii) The patient's complaints accompanied by the findings of a physical examination.

(iii) The information set forth in subsection (e)(1).

(2) A diagnosis, provisional or final, shall be reasonably based on the history and physical examination.

(3) Treatment, including prescribed drugs, shall be appropriate to the diagnosis.

(4) Diagnostic procedures and laboratory tests ordered shall be appropriate to confirm or establish the diagnosis.

(5) Consultations ordered shall be relevant to findings in the history, physical examination or laboratory studies.

(6) The principles of medical ethics shall be adhered to.

(e) *Record keeping requirements and onsite access.* Providers shall retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA recipients and that meet the criteria established in this section and additional requirements established in the provider regulations. Providers shall make those records readily available for review and copying by State and Federal officials or their authorized agents. Readily available means that the records shall be made available at the provider's place of business or, upon written request, shall be forwarded, without charge, to the Department. Providers who are subject to an annual audit shall submit their cost reports within 90 days following the close of their fiscal years. If the Department terminates its written agreement with a provider, the records relating to services rendered up to the effective date of the termination remain subject to the requirements in this section.

(1) *General standards for medical records.* A provider, with the exception of pharmacies, laboratories, ambulance services and suppliers of medical goods and equipment shall keep patient records that meet all of the following standards:

(i) The record shall be legible throughout.

(ii) The record shall identify the patient on each page.

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(iii) Entries shall be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record shall be signed and dated.

(iv) The record shall contain a preliminary working diagnosis as well as a final diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

(v) Treatments as well as the treatment plan shall be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages shall be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to this effect.

(vi) The record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment.

(vii) The record shall contain summaries of hospitalizations and reports of operative procedures and excised tissues.

(viii) The record shall contain the results, including interpretations of diagnostic tests and reports of consultations.

(ix) The disposition of the case shall be entered in the record.

(x) The record shall contain documentation of the medical necessity of a rendered, ordered or prescribed service.

(2) *Fiscal records.* Providers shall retain fiscal records relating to services they have rendered to MA recipients regardless of whether the records have been produced manually or by computer. This may include, but is not necessarily limited to, purchase invoices, prescriptions, the pricing system used for services rendered to patients who are not on MA, either the originals or copies of Departmental invoices and records of payments made by other third party payors.

(3) *Additional record keeping requirements for providers in a shared health facility.* In addition to the record keeping and access requirements specified in this subsection, practitioners and purveyors in a shared health facility shall meet § 1102.61 (relating to inspection by the Department).

(4) *Penalties for noncompliance.* The Department may terminate its written agreement with a provider for noncompliance with the record keeping requirements of this chapter or for noncompliance with other record keeping requirements imposed by applicable Federal and State statutes and regulations.

Authority

The provisions of this § 1101.51 amended under section 403.1(a)(6) of the Human Services Code (62 P.S. § 403.1(a)(6)).

Source

The provisions of this § 1101.51 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653; amended January 13, 2023, effective January 14, 2023, 53 Pa.B. 376. Immediately preceding text appears at serial pages (201237) to (201238) and (399385) to (399387).

Notes of Decisions

Penalties

Although termination of the written provider agreement is the only sanction expressly provided for in subsection (e)(4), the Department has the right to impose a lesser included penalty of suspension of that agreement. *Del Borrello v. Department of Public Welfare*, 508 A.2d 368 (Pa. Cmwlth. 1986).

Recordkeeping Requirements

The fact that this section requires physicians to maintain records for 4 years does not preclude the Department of Public Welfare from using available records which are more than 4 years old in the course of a civil proceeding leading to the termination of a physician's participation in the MA Program. *Clark v. Department of Public Welfare*, 540 A.2d 996 (Pa. Cmwlth. 1988); appeal denied 569 A.2d 1370 (Pa. 1989).

Since subsection (e)(1) adequately sets forth minimum standards for medical provider records and since a health provider is charged with knowledge of applicable Department regulations, regardless of whether a copy has been supplied by the Department, order of restitution for keeping inadequate records did not violate due process or fundamental principle of fairness. *Del Borrello v. Department of Public Welfare*, 508 A.2d 368 (Pa. Cmwlth. 1986).

Cross References

This section cited in 55 Pa. Code § 52.15 (relating to provider records); 55 Pa. Code § 1101.51a (relating to clarification of the term ''within a provider's office''—statement of policy); 55 Pa. Code § 1101.71 (relating to utilization control); 55 Pa. Code § 1121.41 (relating to participation requirements); 55 Pa. Code § 1123.41 (relating to participation requirements); 55 Pa. Code § 1126.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1127.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1127.51 (relating to general payment policy); 55 Pa. Code § 1128.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1128.51 (relating to general payment policy); 55 Pa. Code § 1130.52 (relating to ongoing responsibilities of hospice providers); 55 Pa. Code § 1149.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1150.56b (relating to payment policy for observation services—statement of policy); 55 Pa. Code § 1153.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1155.22 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1181.542 (relating to who is required to be screened); 55 Pa. Code § 1230.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1243.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1247.42 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1251.42 (relating to ongoing responsibilities of providers); and 55 Pa. Code § 5100.90a (relating to State mental hospital admission of involuntarily committed individuals—statement of policy).

§ 1101.51a. {Reserved}.

Source

The provisions of this § 1101.51a adopted May 27, 2016, effective May 28, 2016, 46 Pa.B. 2683; deleted July 14, 2023, effective July 15, 2023, 53 Pa.B. 3704. Immediately preceding text appears at serial page (399387).

FEES AND PAYMENTS

§ 1101.61. Reimbursement policies.

The Department will only pay for medically necessary compensable services and items in accordance with this part and Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.

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Source

The provisions of this § 1101.61 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (75057).

Cross References

This section cited in 55 Pa. Code § 1181.542 (relating to who is required to be screened).

§ 1101.62. Maximum fees.

The Department's maximum fees or rates are the lowest of the upper limits set by Medicare or Medicaid, or the fees or rates listed in the separate provider chapters and fee schedules or the provider's usual and customary charge to the general public. For the purpose of establishing the usual and customary charge to the general public, the provider shall permit the Department access to payment records of non-MA patients without disclosing the identity of the patients.

Source

The provisions of this § 1101.62 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial page (75057).

Cross References

This section cited in 55 Pa. Code § 1143.51 (relating to general payment policy); and 55 Pa. Code § 1143.58 (relating to noncompensable services and items).

§ 1101.63. Payment in full.

(a) *Supplementary payment for a compensable service.* A provider shall accept as payment in full, the amounts paid by the Department plus a copayment required to be paid by a recipient under subsection (b). A provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment. A provider may bill a MA recipient for a noncompensable service or item if the recipient is told before the service is rendered that the program does not cover it.

(b) *Copayments for MA services.*

(1) Recipients receiving services under the Program are responsible to pay the provider the applicable copayment amounts set forth in this subsection.

(2) The following services are excluded from the copayment requirement for all categories of recipients:

(i) Services furnished to individuals under 18 years of age.

(ii) Services and items furnished to pregnant women, which include services during the postpartum period.

(iii) Services furnished to an individual who is a patient in a long term care facility, an intermediate care facility for the mentally retarded or other related conditions, as defined in 42 CFR 435.1009 (relating to definitions relating to institutional status) or other medical institution if the individual is required as a condition of receiving services in the institution, to spend all but a minimal amount of his income for medical care costs.

(iv) Services provided to individuals residing in personal care homes and domiciliary care homes.

(v) Services provided to individuals eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program.

(vi) Services provided to individuals eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance.

(vii) Services provided in an emergency situation as defined in § 1101.21 (relating to definitions).

(viii) Laboratory services.

(ix) The professional component of diagnostic radiology, nuclear medicine, radiation therapy and medical diagnostic services, when the professional component is billed separately from the technical component.

(x) Family planning services and supplies.

(xi) Home health agency services.

(xii) Services provided to individuals receiving hospice care.

(xiii) Psychiatric partial hospitalization program services.

(xiv) Services furnished by a funeral director.

(xv) Renal dialysis services.

(xvi) Blood and blood products.

(xvii) Oxygen.

(xviii) Ostomy supplies.

(xix) Rental of durable medical equipment.

(xx) Targeted case management services.

(xxi) Tobacco cessation counseling services.

(xxii) Outpatient services when the MA fee is under $2.

(xxiii) Medical examinations when requested by the Department.

(xxiv) Screenings provided under the EPSDT Program.

(xxv) More than one of a series of a specific allergy test provided in a 24-hour period.

(xxvi) Diabetic supplies.

(xxvii) Drugs, including immunizations, that are dispensed by a licensed prescriber as defined in § 1121.2 (relating to definitions).

(xxviii) Specific drugs identified by the Department in the following categories:

(A) Antihypertensive agents.

(B) Antidiabetic agents.

(C) Anticonvulsants.

(D) Cardiovascular preparations.

(E) Antipsychotic agents, except those that are also schedule C-IV antianxiety agents.

(F) Antineoplastic agents.

(G) Antiglaucoma drugs.

(H) Antiparkinson drugs.

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(I) Drugs with only an approved indication for the treatment of acquired immunodeficiency syndrome (AIDS).

(J) Opioid overdose agents.

(K) Immunizations.

(3) {Reserved}.

(4) Except for the exclusions specified in paragraphs (2) and (3), each MA service furnished by a provider to an eligible recipient is subject to copayment requirements.

(5) The amount of the copayment, which is to be paid to providers by categories of recipients, except GA recipients, and which is deducted from the Commonwealth's MA fee to providers for each service, is as follows:

(i) For pharmacy services, drugs and over-the-counter medications:

(A) For recipients other than State Blind Pension recipients, $1 per prescription and $1 per refill for generic drugs.

(B) For recipients other than State Blind Pension recipients, $3 per prescription and $3 per refill for brand name drugs.

(C) For State Blind Pension recipients, $1 per prescription and $1 per refill for brand name drugs and generic drugs.

(ii) For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $3 per covered day of inpatient care, to an amount not to exceed $21 per admission.

(iii) For nonemergency services provided in a hospital emergency room, the copayment on the hospital support component is double the amount shown in subparagraph (vi), if an approved waiver exists from the United States Department of Health and Human Services. If an approved waiver does not exist, the copayment will follow the schedule shown in subparagraph (vi).

(iv) When the total component or only the technical component of the following services are billed, the copayment is $1:

(A) Diagnostic radiology.

(B) Nuclear medicine.

(C) Radiation therapy.

(D) Medical diagnostic services.

(v) For outpatient psychotherapy services, the copayment is 50¢ per unit of service.

(vi) For all other services, the amount of the copayment is based on the MA fee for the service, using the following schedule:

(A) If the MA fee is $2 through $10, the copayment is 65¢.

(B) If the MA fee is $10.01 through $25, the copayment is $1.30.

(C) If the MA fee is $25.01 through $50, the copayment is $2.55.

(D) If the MA fee is $50.01 or more, the copayment is $3.80.

(E) The Department may, by publication of a notice in the *Pennsylvania Bulletin*, adjust these copayment amounts based on the percentage increase in the medical care component of the Consumer Price Index for

All Urban Consumers for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(6) The amount of the copayment, which is to be paid to providers by GA recipients age 21 to 65, and which is deducted from the Commonwealth's MA fee to providers for each service, is as follows:

(i) For prescription drugs:

(A) $1 per prescription and $1 per refill for generic drugs.

(B) $3 per prescription and $3 per refill for brand name drugs.

(ii) For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $6 per covered day of inpatient care, not to exceed $42 per admission.

(iii) When the total component or only the technical component of the following services are billed, the copayment is $2:

(A) Diagnostic radiology.

(B) Nuclear medicine.

(C) Radiation therapy.

(D) Medical diagnostic services.

(iv) For all other services, the amount of the copayment is based on the MA fee for the service, using the following schedule:

(A) If the MA fee is $2 through $10, the copayment is $1.30.

(B) If the MA fee is $10.01 through $25, the copayment is $2.60.

(C) If the MA fee is $25.01 through $50, the copayment is $5.10.

(D) If the MA fee is $50.01 or more, the copayment is $7.60.

(E) The Department may, by publication of a notice in the *Pennsylvania Bulletin*, adjust these copayment amounts based on the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(7) A provider participating in the program may not deny covered care or services to an eligible MA recipient because of the recipient's inability to pay the copayment amount. This paragraph does not change the fact that the recipient is liable for the copayment, and it does not prevent the provider from attempting to collect the copayment amount. If a recipient believes that a provider has charged the recipient incorrectly, the recipient shall continue to pay copayments charged by that provider until the Department determines whether the copayment charges are correct.

(8) A provider may not waive the copayment requirement or compensate the recipient for the copayment amount.

(9) If a recipient is covered by a third-party resource and the provider is eligible for an additional payment from MA, the copayment required of the recipient may not exceed the amount of the MA payment for the item or service.

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(c) *MA deductible.*

(1) A $150 deductible per fiscal year shall be applied to adult GA recipients for the following MA compensable services:

(i) Ambulatory surgical center services.

(ii) Inpatient hospital services.

(iii) Outpatient hospital services.

(2) Laboratory and X-ray services are excluded from the deductible requirement.

Authority

The provisions of this § 1101.63 amended under sections 201(2), 403(b), 403.1, 443.1, 443.3, 443.6, 448 and 454 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 403.1, 443.1, 443.3, 443.6, 448 and 454).

Source

The provisions of this § 1101.63 amended August 10, 1984, effective September 1, 1984, 14 Pa.B. 2926; amended January 22, 1988, effective January 23, 1988, 18 Pa.B. 336; amended April 12, 1991, effective May 1, 1991, 21 Pa.B. 1557; amended December 11, 1993, effective January 1, 1993, 22 Pa.B. 5995; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811; amended April 13, 2012, effective May 15, 2012, 42 Pa.B. 2010; amended January 2, 2026, effective January 3, 2026, 56 Pa.B. 16. Immediately preceding text appears at serial pages (414770), (380957) to (380958) and (399389) to (399390).

(*Editor's Note*: The amendment made to this section at 21 Pa.B. 1557 (April 13, 1991) was promulgated under section 6(b) of the Regulatory Review Act (71 P.S. § 745.6(b)).)

Notes of Decisions

The Board of Claims may decide whether the Department's action in refusing to reimburse for depreciation and interest expenses constituted a breach of the provided agreement. The Department's jurisdiction over provider appeal is not mandatory and exclusive. *Department of Public Welfare v. Divine Providence Hospital*, 516 A.2d 82 (Pa. Cmwlth. 1986); appeal dismissed 544 A.2d 1323 (Pa. 1988).

Cross References

This section cited in 55 Pa. Code § 1101.31 (relating to scope); 55 Pa. Code § 1101.63a (relating to full reimbursement for covered services rendered—statement of policy); 55 Pa. Code § 1121.55 (relating to method of payment); 55 Pa. Code § 1127.51 (relating to general payment policy); and 55 Pa. Code § 1128.51 (relating to general payment policy).

§ 1101.63a. Full reimbursement for covered services rendered—statement of policy.

(a) Section 1406(a) of the Human Services Code (62 P.S. § 1406(a)) and MA regulations in § 1101.63(a) (relating to payment in full) mandate that all payments made to providers under the MA Program plus any copayment required to be paid by a recipient shall constitute full reimbursement to the provider for covered services rendered.

(b) A provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment.

(c) A provider may bill an MA recipient for a noncompensable service or item if the recipient is told before the service is rendered that the program does not cover it.

Source

The provisions of this § 1101.63a adopted October 29, 1999, effective October 30, 1999, 29 Pa.B. 5622.

Cross References

This section cited in 55 Pa. Code § 1187.158 (relating to appeals).

§ 1101.64. Third-party medical resources (TPR).

(a) *General.* Other private or governmental health insurance benefits shall be utilized before billing the MA Program. Providers shall make reasonable efforts to secure from the recipient sufficient information regarding the primary coverages necessary to bill the insurers or programs. The medical resources which are primary third parties to MA include Medicare; CHAMPUS (Civilian Health and Medical Programs of the Uniformed Services); Blue Cross, Blue Shield or other commercial insurance; VA benefits; Workman's Compensation; and the like. The information needed to bill third parties includes the insurer's name and address, policy or group I.D. number, and the patient's or the patient's employer's address. When the total amount of payment by the third-party resource is less than the Department's fee or rate for the same service, the provider may bill the Department for the difference by submitting an invoice with a copy of the third party's statement of payments attached. If a third-party resource refuses payment to the provider based on coverage exclusions or other reasons, the provider may bill the Department by submitting an invoice with a copy of the third party's refusal advisory attached.

(b) *Persons covered by Medicare and MA.* If a MA recipient also has Medicare coverage, the Department may be billed for charges that Medicare applied to the deductible or coinsurance, or both. Payment will be made in accordance with established MA rates and fees.

Cross References

This section cited in 55 Pa. Code § 1101.33 (relating to recipient eligibility); 55 Pa. Code § 1140.54 (relating to noncompensable services and items); 55 Pa. Code § 1142.55 (relating to noncompensable services); 55 Pa. Code § 1144.53 (relating to noncompensable services); 55 Pa. Code § 1155.31 (relating to general payment policy); 55 Pa. Code § 1187.155 (relating to exceptional DME grants—payment conditions and limitations); and 55 Pa. Code § 6100.482 (relating to payment).

§ 1101.65. Method of payment.

The Department makes direct payments to enrolled providers for medically necessary compensable services and items furnished to eligible recipients. The MA Program does not reimburse recipients for their expenditures. To be reimbursed for an item or service, the provider shall be eligible to provide it on the date it is provided, and the recipient shall be eligible to receive it on the date it is furnished unless there is specific provision for such payment in the provider

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regulations. Providers are prohibited from factoring, assigning, reassigning or executing a power of attorney for the rights to any claims or payments for services rendered under the program except as provided in paragraphs (1) and (3).

(1) *Reassignment of payment.* The Department will not make payment to a collection agency or a service bureau to which a provider has assigned his accounts receivable; however, payment may be made if the provider has reassigned his claim to a government agency or the reassignment is by a court order.

(2) *Payment through business agents.* The Department will not make payment to a provider through a billing service or accounting firm that receives payment in the name of the provider.

(3) *Payment through employers.* Payment may be made to practitioners' professional corporations or partnerships if the professional corporation or partnership is composed of like practitioners. Payment is made directly to practitioners if they are members of professional corporations or partnerships composed of unlike practitioners. The Department will not make payment to a shared health facility for services rendered by a practitioner practicing at the shared health facility.

Source

The provisions of this § 1101.65 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial pages (75058) and (75059).

§ 1101.66. Payment for rendered, prescribed or ordered services.

(a) The Department pays for compensable services or items rendered, prescribed or ordered by a practitioner or provider if the service or item is:

(1) Within the practitioner's scope of practice.

(2) Medically necessary.

(3) Not in an amount that exceeds the recipient's needs.

(4) Not ordered or prescribed solely for the recipient's convenience.

(5) Ordered with the recipient's knowledge.

(b) Prescriptions and orders shall be written, except telephoned prescriptions addressed in subsection (c). The written prescriptions and orders shall contain the practitioner's:

(1) Printed name.

(2) Signature.

(3) Professional license number.

(c) A practitioner may telephone a drug prescription to a pharmacist in accordance with the Pharmacy Act (63 P.S. §§ 390-1—390-13). The pharmacist shall:

(1) Record the complete prescription on a standard prescription form.

(2) Keep the recorded prescription on file.

(d) The practitioner's signature on the prescription is waived only for a telephoned drug prescription.

(e) Payment is not made for services or items rendered, prescribed or ordered by providers who have been terminated from the Medical Assistance program.

Source

The provisions of this § 1101.66 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial page (75059).

Cross References

This section cited in 55 Pa. Code § 1101.66a (relating to clarification of the terms ''written'' and ''signature''—statement of policy).

Notes of Decisions

A hospital was entitled to reimbursement from the Department for procedures which were provided and medically necessary, as documented in the medical record, even though a physician's written orders were not contained in the medical record. *Children's Hospital of Philadelphia v. Department of Public Welfare*, 621 A.2d 1230 (Pa. Cmwlth. 1993); appeal denied 634 A.2d 225 (Pa. 1993).

This section supports DPW's decision to deny reimbursement to hospital which admitted patient overnight for treatment which could have safely been rendered in Special Procedure Unit. *Episcopal Hospital v. Department of Public Welfare*, 528 A.2d 676 (Pa. Cmwlth. 1987).

§ 1101.66a. Clarification of the terms ''written'' and ''signature''—statement of policy.

(a) The term ''written'' in § 1101.66(b) (relating to payment for rendered, prescribed or ordered services) includes orders and prescriptions that are handwritten or transmitted by electronic means.

(b) Written orders and prescriptions transmitted by electronic means must be electronically encrypted or transmitted by other technological means designed to protect and prevent access, alteration, manipulation or use by any unauthorized person.

(c) The term ''signature'' in § 1101.66(b)(2) includes a handwritten or electronic signature that is made in accordance with the Electronic Transaction Act (73 P.S. §§ 2260.101—2260.5101).

Source

The provisions of this § 1101.66a adopted July 16, 2010, effective July 17, 2010, 40 Pa.B. 3963.

§ 1101.67. Prior authorization.

(a) This section does not apply to noncompensable items or services. Medical services and items that require prior authorization are designated in Chapter 1150 (relating to MA Program payment policies) and the MA Program Fee Schedule and may also be addressed in the specific provider chapters. Providers shall follow the instructions in the provider handbook for processing prior authorization requests. Services and items that require prior authorization shall be prescribed or ordered by a licensed practitioner.

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(b) If a recipient is not notified of a decision on a request for a covered service or item within 21 days of the date the written request is received by the Department, the authorization is automatically approved.

(1) For services prior authorized at the State level, the 21 day time period will be satisfied if the Department mails to the recipient, the recipient's practitioner or provider, a notice of approval or denial of prior authorization request on or before the 18th day after receipt of the request at the address specified in the handbook. If the notice is not mailed within 18 days from the date of receipt at the address specified in the handbook, the request is automatically authorized.

(2) The Department will, if necessary, ask the practitioner for additional information to assist the Department's medical consultants to reach a decision. If the practitioner fails to provide the additional information in sufficient time for the Department to consider it before the time for the Department's acting on the request expires, prior authorization will be denied.

(c) Prior authorization is not required in a medical emergency situation. For the purposes of prior authorization, emergency situations are those which meet the Federal Medicaid definition of medical emergency as it may be amended in the future. The definition is codified at 42 CFR 440.170(e)(1) (relating to any other medical care or remedial care recognized under State law and specified by the Secretary) and is a situation when immediate medical services are necessary to prevent death or serious impairment of the health of the individual.

Authority

The provisions of this § 1101.67 issued under sections 403(a) and (b) and 443.6 of the Human Services Code (62 P.S. §§ 403(a) and (b) and 443.6).

Source

The provisions of this § 1101.67 amended November 30, 1984, effective December 1, 1984, 14 Pa.B. 4370, and by approval of the court of a joint motion for modification of a consent agreement dated February 11, 1985 in *Turner v. Beal, et al.*, C.A. No. 74-1680 (E.D. Pa. 1975); amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (124108) to (124110).

Cross References

This section cited in 55 Pa. Code § 1121.52 (relating to payment conditions for various services); 55 Pa. Code § 1123.55 (relating to oxygen and related equipment); 55 Pa. Code § 1123.58 (relating to prostheses and orthoses); 55 Pa. Code § 1123.60 (relating to limitations on payment); 55 Pa. Code § 1141.53 (relating to payment conditions for outpatient services); 55 Pa. Code § 1143.53 (relating to payment conditions for outpatient services); 55 Pa. Code § 1149.52 (relating to payment conditions for various dental services); and 55 Pa. Code § 1150.63 (relating to waivers).

Notes of Decisions

Applicability

Petitioner claimed the Department was required to comply with her request for equipment since the Department failed to notify her of its decision within the prescribed 21-day time period. However, since the request was for a noncovered item, the 21-day response requirement is not applicable. *Zatuchni v. Department of Public Welfare*, 784 A.2d 242 (Pa. Cmwlth. 2001).

Optometrists' invoices for services rendered to qualified participants in the Medical Assistance Program submitted to the Department after 180 days of the service shall be rejected unless exceptions apply. *Department of Public Welfare v. Soffer*, 544 A.2d 1109 (Pa. Cmwlth. 1988).

§ 1101.68. Invoicing for services.

(a) *Invoices.* When billing for MA services or items, a provider shall use the invoices specified by the Department or its agents, according to billing and other instructions contained in the provider handbooks.

(b) *Time frame.* MA providers shall submit invoices correctly and in accordance with established time frames. For purposes of this section, time frames referred to are indicated in calendar days.

(1) A provider shall submit original or initial invoices to be received by the Department within a maximum of 180 days after the date the services were rendered or compensable items provided. Nursing facility providers and ICF/MR providers shall submit original or initial claims to be received by the Department within 180 days of the last day of a billing period. A billing period for nursing facility providers and ICF/MR providers covers the services provided to an eligible recipient during a calendar month and starts on the first day service is provided in that calendar month and ends on the last day service is provided in that calendar month.

(2) Departmental receipt of a claim is evidenced by appearance of the claim on a remittance advice (RA). The claim reference number (CRN) identifies when the claim was received by the Department. The first digit of the CRN indicates the year. The next three digits refer to the Julian Calendar date.

(3) Resubmission of a rejected original claim or a claim adjustment shall be received by the Department within 365 days of the date of service, except for nursing facility providers and ICF/MR providers. Resubmission of a rejected original claim or claim adjustment by a nursing facility provider or an ICF/MR provider shall be received by the Department within 365 days of the last day of each billing period.

(4) A claim which has been submitted to the Department not appearing within 45 days following that submission, should be resubmitted by the provider. Similarly, a claim which appears as a pend on a remittance advice and does not subsequently appear as an approved or rejected claim before the expiration of an additional45 days should be resubmitted immediately by the provider.

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(c) *Invoice exception criteria.* Invoices submitted after the 180-day period will be rejected unless they meet the criteria established in paragraph (1) or (2).

(1) Eligibility determination was requested within 60 days of the date of service and the Department has received an invoice exception request from the provider within 60 days of receipt of the eligibility determination.

(2) Payment from a third party was requested within 60 days of the date of service and the Department has received an invoice exception request from the provider within 60 days of receipt of the statement from the third party.

(d) *Other invoice exception requirements.* In addition to the requirements in subsection (c), the following requirements apply:

(1) A provider shall submit invoice exception requests in writing to the Office of Medical Assistance Programs.

(2) A request for an invoice exception shall include supporting documentation, including documentation to and from the CAO or third party. A correctly completed invoice shall accompany the request.

(3) The Department may request additional documentation to justify approval of an exception. If the requested documentation is not received within 30 days from the date of the Department's request, a decision will be made based on available information.

(4) Invoice exceptions will be granted on a one time basis. Exception claims rejected through the claims processing system due to provider error will not be granted additional exceptions. Claims may be resubmitted directly to the claims processing system in accordance withsubsection (b). The claim shall indicate the CRN of the exception claim on the invoice.

(5) No exceptions to the normal invoice processing deadlines will be granted other than under this section. In addition, if a provider's claim to the Department incurs a delay due to a third party or an eligibility determination, and the 180-day time frame has not elapsed, the provider shall still submit the claim through the normal claims processing system. A request for an exception to the 180-day time frame is not required whenever the provider can submit the claim within that 180-day period.

(6) No exceptions will be granted for claims which were submitted for normal processing within normal deadlines and rejected by the Department due to provider error.

Authority

This section amended under Articles I—XI and XIV of the Human Services Code (62 P.S. §§ 101—1411).

Source

The provisions of this § 1101.68 amended December 14, 1990, effective January 1, 1991, 20 Pa.B. 6164; amended December 27, 2002, effective January 1, 2003, 32 Pa.B. 6364. Immediately preceding text appears at serial pages (290141) to (290143).

Notes of Decisions

Conformity with Federal Law

The time constraints in § 1101.68 for providers to submit claims are wholly in conformity with Federal law. *Presbyterian Medical Center of Oakmont v. Department of Public Welfare*, 792 A.2d 23 (Pa. Cmwlth. 2002).

Agency Interpretation

Because the Federal government has approved the Commonwealth's Medical Assistance State Plan, the court is obligated to grant great deference to that plan, as well as to the Department's interpretation of its own regulations. *Presbyterian Medical Center of Oakmont v. Department of Public Welfare*, 792 A.2d 23 (Pa. Cmwlth. 2002).

Denial Not a Forfeiture

The denial of a claim for failure to comply with the properly enacted time constraints is not a forfeiture. The denial of the claim was not an arbitrary act, but was based upon duly enacted regulations that are reasonable and provide ample time for submission of a claim. There is no basis in logic or law—constitutional or otherwise—to conclude that the denial is a forfeiture. *Presbyterian Medical Center of Oakmont v. Department of Public Welfare*, 792 A.2d 23 (Pa. Cmwlth. 2002); appeal denied 839 A.2d 354 (Pa. 2003).

De Novo Hearing

The failure of the administrative hearing officer to provide a full evidentiary, de novo hearing from a denial of an application for a Medical Assistance Provider Agreement constitutes reversible error. *Millcreek Manor v. Department of Public Welfare*, 796 A.2d 1020 (Pa. Cmwlth. 2002).

Invoice Exception

The 60-day time periods set forth at 55 Pa. Code § 1101.68(c)(1) are considered satisfied if, for services provided during an entire month, the last day of service in that month falls within the 60-day period. *Ashton Hall, Inc. v. Department of Public Welfare*, 743 A.2d 529 (Pa. Cmwlth. 1999).

Because the request for an eligibility determination was made on June 12, which was more than 60 days after the last day of March, the nursing facility's exception request was not timely submitted and the Department properly denied it. *Ashton Hall, Inc. v. Department of Public Welfare*, 743 A.2d 529 (Pa. Cmwlth. 1999).

Because strict compliance with the requirements of duly promulgated regulations is mandatory, the doctrine of substantial performance was inapplicable and could not excuse the nursing facility's failure to submit an exception request within the 60-day period specified in the regulation. *Ashton Hall, Inc. v. Department of Public Welfare*, 743 A.2d 529 (Pa. Cmwlth. 1999).

Since failure of Medical Assistance provider to submit invoices for payment within the 6-month period as required by subsection (a) was due to extreme negligence of an employe rather than the result of a technical or inadvertent omission, the equitable doctrine of substantial performance could not be invoked to require payment. *State College Manor Ltd. v. Department of Public Welfare*, 498 A.2d 996 (Pa. Cmwlth. 1985).

The strict 6 month deadline for submission of invoices by Medical Assistance providers is not arbitrary or unreasonable since it was intended and does benefit providers by assuring prompt payment. *State College Manor Ltd. v. Department of Public Welfare*, 498 A.2d 996 (Pa. Cmwlth. 1985).

Question of the proper interpretation of the 180-day rule under this provision was not reached by the court, where the fact-finder, the director of the Office of Hearing and Appeals of the Department, made a finding of fact concerning the submission of invoices so vague as to be insufficient to resolve

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the complex questions in the case. *Allied Services for Handicapped, Inc. v. Department of Public Welfare*, 528 A.2d 702 (Pa. Cmwlth. 1987).

The exceptions found in this section are intended to prevent payment denial because of circumstances beyond the provider's control. *Nayak v. Department of Public Welfare*, 529 A.2d 557 (Pa. Cmwlth. 1987).

Regulations are not Contract Terms

Section 1101.68 is not a contract term. Therefore, strict compliance is mandatory and substantial compliance is insufficient. *Presbyterian Medical Center of Oakmont v. Department of Public Welfare*, 792 A.2d 23 (Pa. Cmwlth. 2002); appeal denied 839 A.3d 354 (Pa. 2003).

Validity; Effect

A regulation such as § 1101.68 (relating to invoicing for services), which was duly promulgated under legislative authority, has the force and effect of law if it is within the granted power, is issued pursuant to proper procedure and is reasonable. If so, it enjoys the presumption of validity and bears a heavy burden to overcome that presumption. *Presbyterian Medical Center of Oakmont v. Department of Public Welfare*, 792 A.2d 23 (Pa. Cmwlth. 2002); appeal denied 839 A.2d 354 (Pa. 2003).

Cross References

This section cited in 55 Pa. Code § 41.92 (relating to expedited disposition procedure for certain appeals); 55 Pa. Code § 52.14 (relating to ongoing responsibilities of providers); 55 Pa. Code § 52.41 (relating to provider billing); 55 Pa. Code § 1187.155 (relating to exceptional DME grants—payment conditions and limitations); and 55 Pa. Code § 6100.483 (relating to provider billing).

§ 1101.69. Overpayment—underpayment.

(a) Except as provided in subsection (b), if a provider discovers that the Department has underpaid the provider under this part, or that a recipient has other coverage for a service for which the Department has made a payment, the provider shall be paid the amount of the underpayment or shall reimburse the Department the amount of the overpayment according to the instructions in the provider handbook.

(b) For payments to providers that are subject to cost settlement, if either an analysis of the provider's audit report by the Office of the Comptroller discloses that an overpayment has been made to the provider or the provider advises the Department in writing that an overpayment has occurred for a cost reporting period ending on or after October 1, 1985, the following recoupment procedure applies:

(1) The Office of the Comptroller will issue a cost settlement letter to the provider notifying the provider of the amount of the overpayment. The cost settlement letter will request that the provider contact the Office of the Comptroller within 15 days of the date of the letter to establish a repayment schedule. The date of the cost settlement letter will count as day 1 in determining the 15-day response period to the cost settlement letter and the repayment period for the overpayment. The provider's timely written response to the cost settlement letter will be determined by the postmark on the provider's letter or, if hand delivered, the Department's date stamp.

(2) If the provider does not submit an acceptable repayment plan to the Department or fails to respond to the cost settlement letter within the specified time period, the Department will offset the overpayment amount against the provider's MA payments until the overpayment is satisfied.

(3) An acceptable repayment schedule includes either direct payment to the Department by check from the provider or a request by the provider to have the overpayment offset against the provider's Medical Assistance payments until the overpayment is satisfied. To be acceptable, a direct repayment or offset plan shall ensure that the total overpayment amount is repaid to the Department by the date on which the Department is required to credit the Federal government with the Federal share of the overpayment, not including an administrative processing period that may be granted to the Department under Federal procedures for completing the Medicaid expenditure report. Direct repayment to the Department by check from the provider may be made only in one lump sum payment. If the provider chooses the offset method, the provider may choose to offset the overpayment in one lump sum or in a maximum of four equal installments over the repayment period.

(4) If a provider chooses to make direct repayment by check to the Department, but fails to repay by the specified due date, the Department will offset the overpayment against the provider's MA payments. If the provider chooses to repay by check but fails to do so as agreed, the Department reserves the right to refuse to allow the provider to elect a direct repayment plan, other than immediate direct repayment in response to the cost settlement letter, if an overpayment is discovered for subsequent cost reporting periods.

(5) Paragraphs (1)—(4) do not apply if the provider is bankrupt or out-of-business and the debt is uncollectable under section 1903(d)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396(b)(2)(D)).

(6) An appeal by the provider of the action by the Department to offset the overpayment against the provider's MA payments when the provider fails either to respond timely to the cost settlement letter or to pay the overpayment amount directly when due will not stay the Department's action.

(7) Under § 1101.84(b)(5) (relating to provider right of appeal), an appeal by the provider of the audit disallowance does not suspend the provider's obligation to repay the amount of the overpayment to the Department. If the provider prevails in whole or in part in an appeal and is thereby owed money by the Department, the Department will refund to the provider monies due as a result of the provider's appeal.

Authority

The provisions of this § 1101.69 amended under sections 201 and 443.1 of the Human Services Code (62 P.S. §§ 201 and 443.1).

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Source

The provisions of this § 1101.69 amended February 5, 1988, effective February 6, 1988, 18 Pa.B. 556. Immediately preceding text appears at serial page (124111).

Cross References

This section cited in 55 Pa. Code § 1151.47 (relating to annual cost reporting); 55 Pa. Code § 1163.452 (relating to payment methods and rates); and 55 Pa. Code § 1181.69 (relating to annual adjustment).

§ 1101.69a. Establishment of a uniform period for the recoupment of overpayments from providers (COBRA).

(a) For overpayments relating to cost reporting periods ending prior to October 1, 1985, which were not appealed prior to February 6, 1988, the Department will use its current policy specified in §§ 1101.84(b)(4) and (5) and 1181.101(f) (relating to provider right of appeal; and facility's right to a hearing).

(b) For overpayments relating to cost reporting periods ending on or after October 1, 1985, the Department will use the following recoupment procedure:

(1) If an analysis of the provider's audit report and the Department's payment records, by the Office of the Comptroller, discloses that an overpayment has been made, or if the provider notifies the Department in writing that an overpayment has occurred, the Office of the Comptroller will issue a letter to the provider notifying the provider of the amount of the overpayment. The letter will request that the provider contact the Office of the Comptroller within 15 days of the date of the letter to establish a repayment schedule. The provider's invoices (MA 309C) will continue to be processed by the Department. The date of the cost settlement letter will serve as day one in determining relevant time frames.

(2) If the provider does not submit an acceptable repayment plan to the Department or fails to respond to the cost settlement letter within the specified time period, the Department will offset the overpayment amount against the provider's pending MA payments until the overpayment is satisfied.

(3) An acceptable repayment schedule includes either direct payment to the Department by check from the provider or a request by the provider to have the overpayment offset against the provider's pending claims until the overpayment is satisfied. To be acceptable, a direct repayment plan or an intermittent offset plan must ensure the total overpayment amount will be repaid to the Department no later than the date the Department must credit the Federal government with the Federal share of the overpayment. Under current Federal procedure, the overpayment would be due at the end of the calendar quarter during which the 60th day from the date of the cost settlement letter falls.

(4) The Department reserves the right to refuse to allow a direct repayment plan if a provider chose this method, but failed to remit payment as agreed for

a previous overpayment. When the provider fails to remit payment, the Department will offset the overpayment against the provider's MA payments until the overpayment is satisfied.

(5) The procedures in this subsection do not apply if the provider is bankrupt or out-of-business under section 1903(d)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396b(d)(2)(D)).

(6) An appeal by the provider of the Department's action to offset the overpayment against the provider's MA payments when the provider fails either to respond timely to the cost settlement letter or to pay the overpayment directly when due will not stay the Department's action.

(7) An appeal by the provider of the audit disallowance does not suspend the provider's obligation to repay the amount of the overpayment to the Department. If the provider prevails in whole or in part in the appeal and is thereby owned money by the Department, the Department will refund money due the provider as a result of the provider's appeal.

(c) For overpayments relating to cost reporting periods prior to October 1, 1985, which were appealed prior to February 6, 1988, the Department will apply § 1181.101(f) as effective prior to February 6, 1988, permitting stays of repayment pending the decision of the Office of Hearings and Appeals on the appeal of the underlying audit or overpayment, or both.

Source

The provisions of this § 1101.69a adopted October 20, 1989, effective February 6, 1989, 19 Pa.B. 4543.

§ 1101.70. {Reserved}.

Source

The provisions of this § 1101.70 reserved August 5, 2005, effective August 10, 2005, 35 Pa.B. 4309. Immediately preceding text appears at serial page (262038).

Notes of Decisions

Notice Requirements

Federal law no longer requires a 60-day period between proposal notice and the effective date of the rate change. *Rite Aid of Pennsylvania, Inc. v. Houston*, 171 F.3d 842 (3d Cir. 1999).

The Department of Public Welfare's procedure in issuing public notice satisfied the Federal public notice requirements at 42 CFR 447.205, even though the notice was not issued 60 days before the pharmacy reimbursement rates went into effect. There has not been a Federally required 60-day comment period for this type of proposed rate change since 1981. See 46 FR 58677 (December 3, 1981). *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 998 F. Supp. 522 (E. D. Pa. 1997), rev'd on other grounds, 171 F.3d 842 (3rd Cir. 1999).

§ 1101.71. Utilization control.

(a) The Department, in accordance with section 1902(a)(30) of the Social Security Act (42 U.S.C.A. § 1396(a)(30)), has established procedures for review-

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ing the utilization of, and payment for, Medical Assistance services. Providers are required, upon request, to furnish the Department or its designated agents, the Office of the Attorney General or the Secretary of Health and Human Services, with medical and fiscal records as specified in § 1101.51(e) (relating to ongoing responsibilities of providers). Providers shall cooperate with audits and reviews made by the Department for the purpose of determining the validity of claims and the reasonableness and necessity of service provided or for any other purpose.

(b) Providers shall submit to the Department or the Secretary of Health and Human Services or to the Office of the Attorney General of this Commonwealth within 35 days of request, information related to business transactions which shall include complete information about:

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Source

The provisions of this § 1101.71 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial page (47804).

Cross References

This section cited in 55 Pa. Code § 1101.43 (relating to enrollment and ownership reporting requirements); 55 Pa. Code § 1127.71 (relating to scope of claims review procedures); 55 Pa. Code § 1128.71 (relating to scope of claims review procedures); 55 Pa. Code § 1181.542 (relating to who is required to be screened); 55 Pa. Code Chapter 1181 Appendix O (relating to OBRA sanctions); and 55 Pa. Code § 5221.43 (relating to quality assurance and utilization review).

§ 1101.72. Invoice adjustment.

The Bureau of Utilization Review on a prepayment review may either reject invoices or adjust invoices downward to eliminate noncompensable items or items that are not medically necessary. Also, future invoices may be adjusted downward to correct previous overpayments discovered through postpayment invoice review.

Cross References

This section cited in 55 Pa. Code § 5221.43 (relating to quality assurance and utilization review).

§ 1101.73. Provider misutilization and abuse.

If the Department's routine utilization review procedures indicate that a provider has been billing for services that are inconsistent with MA regulations, unnecessary, inappropriate to patients' health needs or contrary to customary standards of practice, the provider will be notified in writing that payment on all

of his invoices will be delayed or suspended for a period not to exceed 120 days pending a review of his billing and service patterns. Some providers may have their invoices reviewed prior to payment. In addition, the provider's medical or fiscal records, or both, may be reviewed and he may be asked to appear before one of the Department's peer review committees to explain his billing practices. Written notice of the Department's action to delay payment will also be sent to the PSRO, where applicable.

Cross References

This section cited in 55 Pa. Code Chapter 1181 Appendix O (relating to OBRA sanctions); and 55 Pa. Code § 5221.43 (relating to quality assurance and utilization review).

§ 1101.74. Provider fraud.

If, after investigation, the Department determines that a provider has submitted or has caused to be submitted claims for payments which the provider is not otherwise entitled to receive, the Department will, in addition to the administrative action described in §§ 1101.82—1101.84 (relating to administrative procedures), refer the case record to the Medicaid Fraud Control Unit of the Department of Justice for further investigation and possible referral for prosecution under Federal, State and local laws. Providers who are convicted by a Federal court of willfully defrauding the Medicaid program are subject to a $25,000 fine or up to five years imprisonment or both.

Cross References

This section cited in 55 Pa. Code § 51.27 (relating to misuse and abuse of funds and damage of participants property); 55 Pa. Code § 5221.43 (relating to quality assurance and utilization review); and 55 Pa. Code § 6100.744 (relating to additional conditions and sanctions).

§ 1101.75. Provider prohibited acts.

(a) An enrolled provider may not, either directly or indirectly, do any of the following acts:

(1) Knowingly or intentionally present for allowance or payment a false or fraudulent claim or cost report for furnishing services or merchandise under MA, knowingly present for allowance or payment a claim or cost report for medically unnecessary services or merchandise under MA, or knowingly submit false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled for furnishing services or merchandise under MA.

(2) Knowingly submit false information to obtain authorization to furnish services or items under MA.

(3) Solicit, receive, offer or pay a remuneration, including a kickback, bribe or rebate, directly or indirectly, in cash or in kind, from or to a person in connection with furnishing of services or items or referral of a recipient for services and items.

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(4) Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.

(5) Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.

(6) Submit a claim for services or items which includes costs or charges which are not related to the cost of the services or items.

(7) Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner and are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary.

(8) Submit a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.

(9) Submit a claim for a service or item at a fee that is greater than the provider's charge to the general public.

(10) Except in emergency situations, dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient.

(11) Except in emergency situations, dispense, render or provide a service or item to a patient claiming to be a recipient without first making a reasonable effort to verify by a current Medical Services Eligibility card that the patient is an eligible recipient with no other medical resources.

(12) Enter into an agreement, combination or conspiracy to obtain or aid another in obtaining payment from the Department for which the provider or other person is not entitled, that is, eligible.

(13) Make a false statement in the application for enrollment or reenrollment in the program.

(14) Commit a prohibited act specified in § 1102.81(a) (relating to prohibited acts of a shared health facility and providers practicing in the shared health facility).

(b) A provider or person who commits a prohibited act specified in subsection (a), except paragraph (11), is subject to the penalties specified in §§ 1101.76, 1101.77 and 1101.83 (relating to criminal penalties; enforcement actions by the Department; and restitution and repayment).

Authority

The provisions of this § 1101.75 issued under sections 403(a) and (b), 441.1 and 1410 of the Human Services Code (62 P.S. §§ 403(a) and (b), 441.1 and 1410).

Source

The provisions of this § 1101.75 adopted November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653.

Cross References

This section cited in 55 Pa. Code § 41.153 (relating to burden of proof and production); 55 Pa. Code § 1101.76 (relating to criminal penalties); 55 Pa. Code § 1101.83 (relating to restitution and repayment); 55 Pa. Code § 1101.84 (relating to provider right of appeal); and 55 Pa. Code § 5221.43 (relating to quality assurance and utilization review).

§ 1101.75a. Business arrangements between nursing facilities and pharmacy providers—statement of policy.

(a) *General.* The following listings, which are not all-inclusive, set forth examples of items and practices that would be considered accepted or improper under the Program.

(b) *Accepted practices.* Ancillary enhancements that are solely confined to the practice of pharmacy as defined in section 2(11) of the Pharmacy Act (63 P.S. § 390-2(11)) and remain in the control and ownership of the pharmacy would be considered an accepted practice under section 1407(a)(2) of the Human Services Code (62 P.S. § 1407(a)(2)) and § 1101.75(a)(3) (relating to provider prohibited acts).

(c) *Examples of accepted practices.* Examples of accepted practices include:

(1) Medication carts whether the pharmacy uses unit dose or standard prescription containers.

(2) Treatment and medication forms that are already part of the pharmacy's software and may be supplied to the nursing facility. The nursing facility shall pay for the cost of paper.

(d) *Examples of improper practices.* Examples of improper practices include:

(1) Cash or equipment in which ownership or control is changed.

(2) Funding for parties. This includes money, food or decorations.

(3) Vacation trips and professional seminars.

(4) Free or below market value items.

(i) Pharmacy consultations which include reviewing charts, conducting education sessions and observing nurses administering medication. The market value of a pharmacy consultant's fee shall be at least the average hourly wage of a pharmacist in that particular geographic area.

(ii) Drugs—legend or over-the-counter (OTCs).

(iii) Intravenous drugs, tubing or related items.

(iv) Drugs for emergency carts.

(v) Facsimile machines. This is not to preclude the use of facsimile machines. The State Board of Pharmacy will continue to regulate the proper use of facsimile machines. The prohibition includes a pharmacy placing by

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loan, gift or rental a facsimile machine in a nursing facility for the purpose of transmitting MA prescriptions.

(vi) Treatment or external medication carts. This does not include medication carts used exclusively to store drugs whether dispensed in a container or unit dose.

(vii) Computers and software.

(viii) Medical or pharmacy books and journals.

(ix) Prescriptions for nursing facility staff.

(x) Administrative functions which include billing, payroll and nursing facility report preparation. This does not include reports regarding drug usage.

(xi) Staff to perform nursing facility functions outside the practice of pharmacy.

(e) For the purpose of subsection (d)(4)(ii)—(iv) the Department will accept a volume discount as market value if it remains equal to or above the actual acquisition cost of the product.

Source

The provisions of this § 1101.75a adopted October 1, 1993, effective October 2, 1993, 23 Pa.B. 4653.

§ 1101.76. Criminal penalties.

A person who is convicted of committing an offense listed in § 1101.75(a)(1)—(10) and (12)—(14) (relating to provider prohibited acts) will be subject to the following penalties:

(1) For the first conviction, the person is guilty of a felony of the third degree and is subject to a maximum penalty of a $15,000 fine and 7 years imprisonment for each violation.

(2) When a person has been previously convicted in a State or Federal court of conduct that would constitute a violation of § 1101.75(a)(1)—(10) and (12)—(14), a subsequent allegation, indictment or information under § 1101.75(a) shall be classified as a felony of the second degree with a maximum penalty of $25,000 and 10 years imprisonment.

(3) In addition to the penalties specified in subsections (a) and (b) and as ordered by the court, the convicted person shall repay the amount of excess benefits or payments received under the program, plus interest on the amount at the maximum legal rate. Interest will be calculated from the date payment was made by the Department to the date full repayment is made to the Commonwealth.

(4) As ordered by the Court, a convicted person shall pay to the Commonwealth an amount not to exceed threefold the amount of excess benefits or payments.

(5) The convicted person is ineligible to participate in the program for 5 years from the date of the conviction.

Authority

The provisions of this § 1101.76 issued sections 403(a) and (b), 441.1 and 1410 under the act of June 13, 1967 (P.L. 31, No. 21) (62 P.S. §§ 403(a) and (b), 441.1 and 1410).

Source

The provisions of this § 1101.76 adopted November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653.

Cross References

This section cited in 55 Pa. Code § 1101.75 (relating to provider prohibited acts).

§ 1101.77. Enforcement actions by the Department.

(a) *Departmental determination of violation.* The Department may terminate a provider's enrollment and direct and indirect participation in the MA Program and seek restitution as specified in § 1101.83 (relating to restitution and repayment) if it determines that a provider, an employe of the provider or an agent of the provider has:

(1) Failed to comply with this chapter or the appropriate separate chapters relating to each provider type.

(2) Committed a prohibited act as specified in this chapter or the appropriate separate chapter relating to each provider type or under Article XIV of the Human Services Code (62 P.S. §§ 1401—1411).

(3) Failed to comply with the conditions of participation listed in Articles IV or XIV of the Human Services Code (62 P.S. §§ 401—493 and 1401—1411).

(4) Not complied with the terms of the provider agreement.

(5) Been suspended or terminated from Medicare.

(6) Been convicted of a Medicare or Medicaid related criminal offense as certified by a Federal, State or local court.

(7) Been convicted of a criminal offense under State or Federal laws relating to the practice of the provider's profession as certified by a court.

(8) Been subject to a disciplinary action taken or entered against the provider in the records of the State licensing or certifying agency.

(9) Had a controlled drug license withdrawn or failed to report to the Department changes in the Provider's Drug Enforcement Agency Number.

(10) Rendered or ordered services or items which the Department's medical professionals have determined to be harmful to the recipient, of inferior quality or medically unnecessary.

(11) Ordered services for recipients or billed the Department for rendering services to recipients at an unregistered shared health facility after the shared

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health facility and provider are notified by the Department that the shared health facility is not registered.

(12) Refused to permit duly authorized State or Federal officials or their agents to examine the provider's medical, fiscal or other records as necessary to verify services or claims for payment under the program.

(b) *Departmental termination of the provider's enrollment and participation.*

(1) The Department may terminate the enrollment and direct and indirect participation of, and suspend payments to, any provider upon 30 days advance notice for the convenience or best interest of the Department.

(2) If the Department terminates the enrollment and participation of a provider for reasons specified in subsections (a)(3), (5), (6), (7) or (8), the effective date of the termination will be the date of the action specified in the appropriate paragraph of subsection (a).

(3) Termination for criminal conviction or disciplinary action shall be as follows:

(i) The Department will terminate a provider's enrollment and participation for 5 years if the provider is convicted of a criminal act listed in Article XIV of the Human Services Code (62 P.S. §§ 1401—1411), a Medicare/Medicaid related crime or a criminal offense under State or Federal law relating to the practice of the provider's profession. If the Department has an additional basis for termination which is unrelated to, and in addition to, the criminal conviction, it may terminate the provider for a period in excess of 5 years.

(ii) If the additional basis for the termination is a disciplinary action taken against the provider or entered in the records of the State licensing or certifying agency, the period of termination will be the duration of the disciplinary action plus 5 years for the criminal conviction.

(iii) If the Department has a basis for termination which is related to the criminal conviction (with the exception of exclusions from Medicare) the minimum period of the termination will be the longer of 5 years or the period related to the other action.

(c) *Effects of termination of providers.*

(1) The Department does not pay for services or items rendered, prescribed or ordered on and after the effective date of a provider's termination from the Medical Assistance Program.

(i) A provider is not paid for services or items rendered on and after the effective date of his termination from the program.

(ii) A participating provider is not paid for services, including inpatient hospital care and nursing home care, or items prescribed or ordered by a provider who has been terminated from the program.

(iii) A participating provider is paid for services or items prescribed or ordered by a provider who voluntarily withdraws from the program.

(2) A provider whose enrollment in the program has been terminated may not, during the period of termination:

(i) Own, render, order or arrange for a service for a recipient.

(ii) Receive direct or indirect payments from the Department in the form of salary, equity, dividends, shared fees, contracts, kickbacks or rebates from or through a participating provider or related entity.

(3) If a provider appeals the Department's action of terminating the enrollment and participation of or suspending payments to the provider:

(i) The Department will pay the provider for compensable service rendered on and after the effective date specified in the notice if the appeal of the provider is upheld.

(ii) The Department will not pay the provider for services rendered on or after the effective date specified in the notice if the appeal of the provider is denied.

(d) *Provider notification.*

(1) The Department will issue a Notice of Termination to a provider whose enrollment and participation is being terminated with cause or as a result of a criminal conviction. The notice will state the basis for the action, the effective date, whether the Department will consider re-enrollment and, if so, the date when re-enrollment will be considered.

(2) If the Department is terminating the enrollment and participation of all providers or all providers of a specific type under a statute of the General Assembly of the Commonwealth or of the Congress of the United States, notification will be by publication in the *Pennsylvania Bulletin.*

(3) A provider's participation is automatically terminated as of the effective date of the provider's termination or suspension from Medicare. A notice confirming the termination will be sent to the provider.

(e) *Dissemination of information.*

(1) When the Department takes an action against a provider, including termination and initiation of a civil suit, it will also notify and give the reason for the termination to all of the following:

(i) The Medicaid Fraud Control Unit, Office of the Attorney General.

(ii) The Health Care Financing Administration.

(iii) Other State and local agencies involved in providing health care.

(iv) The applicable professional licensing board.

(2) After final adjudication, a copy of the Notice of Termination and the reasons for termination may be made available to Medicaid agencies of other states, the appropriate professional associations and the news media. Detailed case material and findings will be made available to the agencies specified in paragraph (1).

(3) The Department will issue a medicheck list containing the names of all providers who have been terminated from the Program.

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(f) *Violations by nonparticipating former providers.*

(1) The Department may take an enforcement action against a nonparticipating former provider that it may impose upon a participating provider for an act committed while a provider.

(2) If the Department takes action, it will issue a Notice of Exclusion to the nonparticipating former provider stating the basis for the action, the effective date, whether the Department will consider re-enrollment, and, if so, the date when the request for re-enrollment will be considered.

Authority

The provisions of this § 1101.77 issued under sections 403(a) and (b) and 1410 of the Human Services Code (62 P.S. §§ 403(a) and (b) and 1410).

Source

The provisions of this § 1101.77 adopted November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653.

Notes of Decisions

Reimbursement Appropriate

The Department of Public Welfare was equitably estopped from denying the nursing care facility full Medical Assistance (MA) reimbursement for the patient care the facility provided to MA patients during its period of decertification. In response to its numerous inquiries, the facility was misled by several assurances from the Department of Health (DOH) that the facility would not have to relocate the MA patients for the period at issue. In fact, DOH instructed the facility to take no action to relocate the patients, gave the facility consecutive provisional licenses to provide long-term health care services and to admit new MA patients throughout another year. Further, the Secretary of the DPW assured the president of the facility that payment would be received for the services provided. *Cameron Manor, Inc. v. Department of Public Welfare*, 681 A.2d 836 (Pa. Cmwlth. 1996).

Termination

Termination of a provider's enrollment in MA Program because of conviction takes effect date of conviction; thus restitution can be claimed from that date. *Jack v. Department of Public Welfare*, 568 A.2d 1339 (Pa. Cmwlth. 1990).

Where the Department of Public Welfare had authority under subsection (a)(1) to terminate a provider agreement permanently for providing pharmacy services outside the scope of customary standards, and there had been no fraud or bad faith alleged, imposition of a 2 year suspension was not an abuse of discretion. *Girard Prescription Center v. Department of Public Welfare*, 496 A.2d 83 (Pa. Cmwlth. 1985); appeal granted 503 A.2d 930 (Pa. 1986).

Cross References

This section cited in 55 Pa. Code § 1101.42 (relating to prerequisites for participation); 55 Pa. Code § 1101.75 (relating to provider prohibited acts); 55 Pa. Code § 1101.77a (relating to termination for convenience and best interests of the Department—statement of policy); 55 Pa. Code § 1101.84 (relating to provider right of appeal); 55 Pa. Code § 1121.81 (relating to provider misutilization); 55 Pa. Code Chapter 1181 Appendix O (relating to OBRA sanctions); 55 Pa. Code § 1187.21a (relating to nursing facility exception requests—statement of policy); and 55 Pa. Code § 6100.744 (relating to additional conditions and sanctions).

§ 1101.77a. Termination for convenience and best interests of the Department—statement of policy.

(a) Effective December 19, 1996, under § 1101.77(b)(1) (relating to enforcement actions by the Department), the Department will terminate the enrollment and direct and indirect participation of, and suspend payments to, an ICF/MR, inpatient psychiatric hospital or rehabilitation hospital provider that expands its existing licensed bed capacity by more than ten beds or 10%, whichever is less, over a 2-year period, unless the provider obtained a Certificate of Need or letter of nonreviewability from the Department of Health dated on or prior to December 18, 1996, approving the expansion. Effective August 11, 1997, under § 1101.77(b), the Department will terminate the enrollment and direct and indirect participation of, and suspend payments to, a nursing facility provider that expands its existing licensed bed capacity. A nursing facility provider that, prior to August 11, 1997, relied on the interim policy effective December 19, 1996, and substantially implemented a project to expand its facility by ten beds or 10%, whichever is less, within a 2-year period, will not be terminated from enrollment under this policy.

(b) The Department will consider exceptions to subsection (a) on a case-by-case basis. Exceptions requested by nursing facilities will be reviewed under § 1187.21a (relating to nursing facility exception requests—statement of policy).

Source

The provisions of this § 1101.77a adopted December 13, 1996, effective December 14, 1996, 26 Pa.B. 5996; amended August 8, 1997, effective August 11, 1997, 27 Pa.B. 4005; amended January 9, 1998, effective January 12, 1998, 28 Pa.B. 138. Immediately preceding text appears at serial page (233035).

ADMINISTRATIVE PROCEDURES

§ 1101.81. {Reserved}.

Source

The provisions of this § 1101.81 reserved November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653.

Notes of Decisions

Following an administrative proceeding, Medicare provider's plea of *nolo contendere* was a conviction under this statute but the provider should have been given an opportunity to present evidence at the disciplinary hearing where the plea was being used to establish a violation of Department regulations. *Eisenberg v. Department of Public Welfare*, 516 A.2d 333 (Pa. 1986).

§ 1101.82. Re-enrollment.

(a) *Request for re-enrollment.* To request re-enrollment, the provider shall send a written request to the Department's Office of Medical Assistance, Bureau of Provider Relations. For the request to be considered, it should include state-

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ments from peer review bodies, probation officers where appropriate, or professional associates, giving factual evidence of why they believe the violations leading to the termination will not be repeated. A statement from the provider setting forth the reasons why he should be re-enrolled should also be included.

(b) *Criteria for provider re-enrollment.* In considering the provider's request for re-enrollment, the Department will take into account such factors as the severity of the offense, whether there has been any licensure action against the provider, whether the provider has been convicted in a State, Federal or local court of Medicaid offenses and whether there are any claims or penalties outstanding against the provider. If the Department's notice of termination or exclusion specifies a date after which the Department will consider re-enrolling the provider, the Department will, under no circumstances, consider re-enrolling the provider before the specified date. Departmental rejection of a request for re-enrollment prior to the specified date is not subject to appeal.

(c) *Notification of action on re-enrollment request.* The provider will be notified in writing of the Department's decision on a request within 60 days of the date of receipt of the application. Under no circumstances will re-enrollment be granted retroactive to the date of application.

Source

The provisions of this § 1101.82 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial pages (47807) and (62900).

Cross References

This section cited in 55 Pa. Code § 1101.74 (relating to provider fraud); 55 Pa. Code § 1127.81 (relating to provider misutilization); and 55 Pa. Code Chapter 1181 Appendix O (relating to OBRA sanctions).

§ 1101.83. Restitution and repayment.

(a) If the Department determines that a provider has billed and been paid for a service or item for which payment should not have been made, it will review the provider's paid and unpaid invoices and compute the amount of the overpayment or improper payment. The Department will use statistical sampling methods and, where appropriate, purchase invoices and other records for the purpose of calculating the amount of restitution due for a service, item, product or drug substitution.

(b) The Department may seek reimbursement from the ordering or prescribing provider for payments to another provider, if the Department determines that the ordering or prescribing provider has done either of the following:

(1) Prescribed excessive diagnostic services; or

(2) Ordered diagnostic services or treatment or both, without documenting the medical necessity for the service or treatment in the medical record of the MA recipient.

(c) The amount of restitution demanded by the Department will be the amount of the overpayment received by the ordering or prescribing provider or the amount of payments to other providers for excessive or unnecessary services prescribed or ordered. If the ordering or prescribing provider is convicted of an offense under Article XIV of the Human Services Code (62 P.S. §§ 1401—1411), the restitution penalties of that article applies.

(d) The provider shall pay the amount of restitution owed to the Department either directly or by offset of valid invoices that have not yet been paid. The method of repayment is determined by the Department. All Departmental demands for restitution will be approved by the Deputy Secretary for Medical Assistance before the provider is notified.

(e) If the Department determines that a provider has committed any prohibited act or has failed to satisfy any requirement under § 1101.75(a) (relating to provider prohibited acts), it may institute a civil action against the provider in addition to terminating the provider's enrollment. If the Department institutes a civil action against the provider, the Department may seek to recover twice the amount of excess benefits or payments plus legal interest from the date the violations occurred.

(f) The provider is prohibited from billing an eligible recipient for any amount for which the provider is required to make restitution to the Department.

Source

The provisions of this § 1101.83 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial page (62900).

Notes of Decisions

Pharmacist convicted of crime related to practice committed prior to effective date of statute charged with knowledge of regulations dealing with termination and participation in program. *Jack v. Department of Public Welfare*, 568 A.2d 1339 (Pa. Cmwlth. 1990).

Where the statistical sample selected appeared to be representative and where the petitioner was afforded a rebuttal opportunity, the statistical methods utilized by Department under subsection (a) represented a proper method for determining the proper amount of restitution. *Del Borrello v. Department of Public Welfare*, 508 A.2d 368 (Pa. Cmwlth. 1986).

The Department did not abuse its discretion in deciding that § 1101.81(a) (rescinded 1983, similar regulations currently at § 1101.83) permitted the Department to compel provider to make restitution where his documentation is so poor that the necessity of the billed services cannot be determined. *Del Borrello v. Department of Public Welfare*, 508 A.2d 368 (Pa. Cmwlth. 1986).

Cross References

This section cited in 55 Pa. Code § 1101.74 (relating to provider fraud); 55 Pa. Code § 1101.75 (relating to provider prohibited acts); 55 Pa. Code § 1101.77 (relating to enforcement actions by the Department); 55 Pa. Code § 1127.81 (relating to provider misutilization); 55 Pa. Code § 1181.542 (relating to who is required to be screened); and 55 Pa. Code Chapter 1181 Appendix O (relating to OBRA sanctions).

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§ 1101.84. Provider right of appeal.

(a) *Right to appeal from termination of a provider's enrollment and participation.* If a provider's enrollment and participation are terminated by the Department, the provider may appeal the Department's decision, subject to the following conditions:

(1) If a provider's enrollment and participation are terminated by the Department under the provider's termination or suspension from Medicare or conviction of a criminal act under § 1101.75 (relating to provider prohibited acts), the provider may appeal the Department's action only on the issue of identity.

(2) If the Department has terminated a provider's enrollment and participation for an additional cause unrelated to the conviction or disciplinary action as specified in § 1101.77(b)(3) (relating to enforcement actions by the Department), the provider may only appeal the period of the termination attributable to that additional cause.

(3) A written Notice of Appeal shall be filed within 30 days of the date of the notice of termination. The Notice of Appeal will be considered filed on the date it is received by the Director, Office of Hearings and Appeals.

(4) The Notice of Appeal shall include a copy of the letter of termination, state the actions being appealed and explain in detail the reasons for the appeal.

(b) *Right to appeal interim per diem rates, audit disallowances or payment settlements.*

(1) A hospital, nursing home or other provider reimbursed by the Department on the basis of an interim per diem rate that is retrospectively adjusted on the basis of the provider's cost experience during the period for which the interim rate is effective can appeal its interim per diem rate, the results of its annual audit or its annual payment settlement as follows:

(i) The Notice of Appeal of an interim rate shall be filed within 30 days of the date of the letter from the Bureau of Reimbursement Methods, Office of Medical Assistance, advising the provider of its interim per diem rate.

(ii) The Notice of Appeal from an audit disallowance shall be filed within 30 days of the date of the letter from the Bureau of Reimbursement Methods, Office of Medical Assistance, or the Bureau of State-Aided Audits, Office of the Auditor General, transmitting the provider's audit report. If a facility fails to appeal from the auditor's findings at audit, the facility may not contest the finding in another proceeding.

(iii) The Notice of Appeal of the final payment settlement shall be appealed within 30 days of the date of the letter from the Comptroller of the Department, advising the provider of the final settlement of accounts.

(2) The Notice of Appeal shall include a copy of the letter establishing the interim per diem rate, the letter forwarding the audit report or the letter setting

forth the payment settlement, as applicable, to the provider. The Notice of Appeal also shall set forth in detail the reasons for the appeal.

(3) The Notice of Appeal will be considered filed on the date it is received by the Director, Office of Hearings and Appeals.

(4) This paragraph applies to overpayments relating to cost reporting periods ending prior to October 1, 1985. If an analysis of a provider's audit report by the Office of the Comptroller discloses that an overpayment has been made to the provider, the Comptroller of the Department shall advise the provider of the amount of the overpayment. The provider shall repay the amount of the overpayment within 6 months of the date the Comptroller notifies the provider of the overpayment. The repayment period will commence on the date set forth in the notice from the Comptroller of the overpayment. If repayment is not made within 6 months, the Department will recoup the amount of the overpayment from future payments to the provider.

(5) An appeal of an audit disallowance does not suspend the provider's obligation to repay the amount of the overpayment to the Department.

(c) *Right to appeal other action of the Department.* Appeals of other adverse actions of the Department shall be filed in writing within 30 days of the date of the notice of the action to the provider. The Notice of Appeal will be considered filed on the date it is received by the Director, Office of Hearings and Appeals. The Notice of Appeal shall include a copy of the notice of adverse action sent to the provider by the Department and shall set forth in detail the reasons for the appeal.

(d) *Nonappealable actions.* The provider does not have the right to appeal the following:

(1) Disallowances for services or items provided to noneligible individuals.

(2) Invoice adjustments to correct clerical errors or to reduce the amount billed to the maximum fee allowed by the Department.

(3) Disallowances for untimely submission of invoices, except where it is alleged the Department has directly caused the delay.

(4) Disallowances for services or items rendered during a period of nonenrollment or termination, except on the issue of identity.

(5) Rejection of an application to re-enroll a terminated or excluded provider prior to the date the Department specified that it would consider re-enrollment.

Authority

The provisions of this § 1101.84 issued under sections 403(a) and (b), 441.1 and 1410 of the Human Services Code (62 P.S. §§ 403(a) and (b), 441.1 and 1410); amended under sections 201 and 443.1 of the Human Services Code (62 P.S. §§ 201 and 443.1).

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Source

The provisions of this § 1101.84 adopted November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653; amended February 5, 1988, effective February 6, 1988, 18 Pa.B. 556. Immediately preceding text appears at serial pages (117328) to (117331).

Notes of Decisions

No basis existed to allow Medical Assistance program provider to pursue separate appeals regarding disputed audit findings of Department of Public Welfare's final cost settlement report regarding reimbursement claims; dismissal of appeal transferred from Board of Claims to Bureau of Hearings and Appeals was warranted since provider had other appeal before Bureau which provided adequate remedy to seek relief and the transferred appeal challenged same cost adjustments. *Lancaster v. Department of Public Welfare*, 916 A.2d 707, 712 (Pa. Cmwlth. 2006).

A petitioner's failure to correct or respond not once, but twice, to a request regarding the lack of specificity of issues stated on the Notice of Appeal was unreasonable and justified dismissal of the appeal. *Greensburg Nursing and Convalescent Center v. Department of Public Welfare*, 633 A.2d 249 (Pa. Cmwlth. 1993).

In the absence of a timely appeal, a request to reopen a cost report was discretionary. *Quincy United Methodist Home v. Department of Public Welfare*, 530 A.2d 1026 (Pa. Cmwlth. 1987).

There is an ambiguity between the 30-day time requirement of this section and the limitation that all resubmissions be received within 365 days of the date of service under § 1101.68. *Nayak v. Department of Public Welfare*, 529 A.2d 557 (Pa. Cmwlth. 1987).

Nursing care facilities have the right to appeal any adjustments made by the Department of Public Welfare based on audits performed after the facility filed its annual "cost report". *Harston Hall Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 513 A.2d 1097 (Pa. Cmwlth. 1986).

This section provides the administrative remedy for providers whose bills have been rejected for payment by the Department, and failure of the Department to afford this avenue of relief may result in an equitable estoppel preventing the Department from claiming these bills were not timely submitted. *Brog Pharmacy v. Department of Public Welfare*, 487 A.2d 49 (Pa. Cmwlth. 1985).

Cross References

This section cited in 55 Pa. Code § 41.3 (relating to definitions); 55 Pa. Code § 1101.69 (relating to overpayment—underpayment); 55 Pa. Code § 1101.69a (relating to establishment of a uniform period for the recoupment of overpayments from providers (COBRA)); 55 Pa. Code § 1101.74 (relating to provider fraud); 55 Pa. Code § 1127.81 (relating to provider misutilization); 55 Pa. Code § 1150.59 (relating to PSR program); 55 Pa. Code § 1181.68 (relating to upper limits of payment); 55 Pa. Code § 1181.73 (relating to final reporting); 55 Pa. Code § 1181.101 (relating to facility's right to a hearing); 55 Pa. Code § 1187.113b (relating to capital cost reimbursement waivers—statement of policy); 55 Pa. Code § 1187.141 (relating to nursing facility's right to appeal and to a hearing); 55 Pa. Code § 1189.141 (relating to county nursing facility's right to appeal and to a hearing); 55 Pa. Code § 6210.122 (relating to additional appeal requirements); and 55 Pa. Code § 6210.125 (relating to right to reopen audit).

VIOLATIONS

§ 1101.91. Recipient misutilization and abuse.

(a) *Identification of recipient misutilization and abuse.* It is a function of the CAO to identify recipient misutilization; abuse or possible fraud in relation to the

MA Program. Therefore, providers should notify the CAO if they have reason to believe that a recipient is misutilizing or abusing MA services or may be defrauding the MA Program. In addition, the Department has established procedures for reviewing recipient utilization of MA services. The review procedures identify recipients or families that are receiving excessive or unnecessary treatment, diagnostic services, drugs, medical supplies, or other services by visiting numerous practitioners. If the results of the Department's review warrant it, the recipient will be placed on the restricted recipient program, which means that he will be restricted to obtaining certain services from a single provider of his choice.

(b) *Restricted recipient program.* A recipient who has been placed on the restricted recipient program will be notified in writing at least 10 days prior to the effective date of the restriction. The notice will include the name of a proposed provider which will become the one the recipient shall use if he does not notify the Department, in writing, prior to the effective date of the restriction, that he wishes to choose a different provider. If, during a period of restriction, a recipient wishes to change a designated provider, a 30-day written notice shall be given in writing to the Office of Medical Assistance.

Cross References

This section cited in 55 Pa. Code § 1101.33 (relating to recipient eligibility); 55 Pa. Code § 1121.54 (relating to noncompensable services and items); and 55 Pa. Code § 1141.53 (relating to payment conditions for outpatient services).

§ 1101.92. Recipient prohibited acts, criminal penalties and civil penalties.

(a) It shall be unlawful for a person to commit any of the following acts:

(1) Knowingly or intentionally make or cause to be made a false statement or representation of a material fact in an application for a benefit or payment.

(2) Having knowledge of the occurrence of an event affecting his initial or continued right to a benefit or payment or the initial or continued right to a benefit or payment of another individual in whose behalf he has applied for or is receiving the benefit or payment, conceal or fail to disclose the event with an intent fraudulently to secure the benefit or payment either in a greater amount or quantity than is due or when no the benefit or payment is authorized.

(3) Having made application to receive a benefit or payment for the use and benefit of himself or another and having received it, knowingly or intentionally convert the benefit or a part of it to a use other than for the use and benefit of himself or the other person.

(4) Knowingly or intentionally visit more than three practitioners or providers, who specialize in the same field, in the course of 1 month for the purpose of obtaining excessive services or benefits beyond what is reasonably needed (as determined by medical professionals engaged by the Department) for the treatment of a diagnosed condition of the recipient.

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(5) Borrow or use a MA identification card for which he is not entitled or otherwise gain or attempt to gain medical services covered under the MA Program if he has not been determined eligible for the Program.

(b) Criminal penalties shall consist of the following:

(1) A person who commits a violation of subsection (a)(1), (2) or (3) is guilty of a felony of the third degree for each violation thereof with a maximum penalty $15,000 and 7 years imprisonment.

(2) A person who commits a violation of subsection (a)(4) or (5) is guilty of a misdemeanor of the first degree for each violation thereof with a maximum penalty of $10,000 and 5 years imprisonment.

(c) Noncriminal penalties shall consist of the following:

(1) A person who is convicted of a violation of subsection (a)(1), (2), (3), (4) or (5) shall, upon notification by the Department, forfeit all rights to MA benefits for any period of incarceration.

(2) If the Department determines that a recipient misuses or overutilizes MA benefits, the Department is authorized to restrict a recipient to a provider of his choice for each medical specialty or type of provider covered under the MA Program.

(3) If the Department determines that a general assistance eligible person who is also a MA recipient has violated subsection (a)(3), (4) or (5), the Department will have the authority to terminate the recipient's rights to MA benefits for a period up to 1 year.

(4) If the Department determines that a recipient has violated subsection (a)(3), (4) or (5), the Department will have the authority to institute a civil suit against the recipient in the court of common pleas for the amount of the benefits obtained by the recipient in violation of the paragraphs plus legal interest from the date the violations occurred.

(5) If it is found that a recipient or a member of his family or household, who would have been ineligible for MA, possessed unreported real or personal property in excess of the amount permitted by law, the amount collectible shall be limited to an amount equal to the market value of such excess property or the amount of MA granted during the period the excess property was held, whichever is less. Reimbursement of the overpayment shall be sought from the recipient, the person acting on the recipient's behalf or survivors benefiting from receiving the property. Proof of date of acquisition of the property shall be provided by the recipient or person acting on his behalf. Where a person receives MA for which he would have been ineligible due to possession of the unreported property, and proof of date of acquisition of the property is not provided, it shall be deemed that the personal property was held by the recipient the entire time he was on Medical Assistance, and reimbursement shall be for MA paid for the recipient or the value of the excess property, whichever is less. Reimbursement shall be sought from the recipient, the person acting on the recipient's behalf, the person receiving or holding the property, the recipient's

estate or survivors benefiting from receiving the property. The Department is authorized to institute a civil suit in the court of common pleas to enforce the rights established by this section.

Source

The provisions of this § 1101.92 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial page (62901).

§ 1101.93. Restitution by recipient.

In addition to civil action or criminal prosecution and upon written notification by the Office of Medical Assistance or the Office of Claims Settlement, a recipient shall reimburse the Department for services, supplies and drugs that were improperly obtained, transferred to other persons, resold or exchanged for other merchandise or products.

§ 1101.94. Recipient right of appeal.

Departmental actions against a recipient for misutilization and abuse, which include assignment to the restricted recipient program, are subject to the right of appeal in accordance with Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

Source

The provisions of this § 1101.94 amended April 27, 1984, effective April 28, 1984, 14 Pa.B 1454. Immediately preceding text appears at serial page (86720).

§ 1101.95. Conflicts between general and specific provisions.

To the extent, if any, that this chapter conflicts with the specific regulations for various services or items contained in this part, this chapter will control unless the specific regulations are one of the following, in which case the specific regulations control:

(1) Chapter 1245 (relating to ambulance transportation).
(2) Chapter 1145 (relating to chiropractors' services).
(3) Chapter 1221 (relating to clinic and emergency room services).
(4) Chapter 1223 (relating to outpatient drug and alcohol clinic services).
(5) Chapter 1241 (relating to early and periodic screening diagnosis and treatment program).
(6) Chapter 1225 (relating to family planning clinic services).
(7) Chapter 1251 (relating to funeral directors' services).
(8) Chapter 1229 (relating to health maintenance organization services).
(9) Chapter 1249 (relating to home health agency services).
(10) Chapter 1123 (relating to medical supplies).
(11) Chapter 1147 (relating to optometrists' services).
(12) Chapter 1243 (relating to outpatient laboratory services).
(13) Chapter 1153 (relating to outpatient psychiatric services).

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(14) Chapter 1121 (relating to pharmaceutical services).
(15) Chapter 1141 (relating to physicians' services).
(16) Chapter 1143 (relating to podiatrists' services).
(17) Chapter 1129 (relating to rural health clinic services).
(18) Chapter 1102 (relating to shared health facilities).
(19) Chapter 1230 (relating to portable x-ray services).
(20) Chapter 1142 (relatinig to midwives' services).
(21) Chapter 1181 (relating to nursing facility care).

Source

The provisions of this § 1101.95 amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3653. Immediately preceding text appears at serial page (69575).

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