health clinic services and other ambulatory services on the basis of the cost reimbursement principles in part 413 of this chapter. For purposes of this section, a provider clinic is an integral part of a hospital, skilled nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with other departments of the facility.

(b) For clinics other than provider clinics that do not offer any ambulatory services other than rural health clinic services, the agency must pay for rural health clinic services at the reasonable cost rate per visit determined by a Medicare carrier under §§405.2426 through 405.2429 of this chapter.

(c) For clinics other than provider clinics that do offer ambulatory services other than rural health clinic services, the agency must pay for the other ambulatory services by one of the following methods:

1. The agency may pay for other ambulatory services at a single rate per visit that is based on the cost of all services furnished by the clinic. The rate must be determined by a Medicare carrier under §§405.2426 through 405.2429 of this chapter.

2. The agency may pay for other ambulatory services at a rate set for each visit by the agency. The rate must not exceed the upper limits in this subpart. The agency must pay for rural health clinic services at the Medicare reimbursement rate per visit, as specified in §405.2426 of this chapter.

3. The agency may pay for dental services at a rate per visit that is based on the cost of dental services furnished by the clinic. The rate must be determined by a Medicare carrier under §§405.2426 through 405.2429 of this chapter.

4. The agency must pay for ambulatory services other than dental services under paragraph (c) (1) or (2) of this section.

(d) For purposes of paragraph (c) (1) and (3) of this section, “visit” means a face-to-face encounter between a clinic patient and any health professional whose services are reimbursed under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.


PART 455—PROGRAM INTEGRITY: MEDICAID

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Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Source: 43 FR 45262, Sept. 29, 1978, unless otherwise noted.

§ 455.1 Basis and scope.
This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.
§ 455.12 State plan requirement.

A State plan must meet the requirements of §§455.13 through 455.23.

§ 455.13 Methods for identification, investigation, and referral.

The Medicaid agency must have—
(a) Methods and criteria for identifying suspected fraud cases;
(b) Methods for investigating these cases that—
(1) Do not infringe on the legal rights of persons involved; and
(2) Afford due process of law; and
(c) Procedures, developed in cooperation with State legal authorities, for

Conviction or Convicted means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

Suspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

§ 455.3 Other applicable regulations.

Part 1002 of this title sets forth the following:
(a) State plan requirements for excluding providers for fraud and abuse, and suspending practitioners convicted of program-related crimes.
(b) The limitations on FFP for services furnished by excluded providers or suspended practitioners.
(c) The requirements and procedures for reinstatement after exclusion or suspension.
(d) Requirements for the establishment and operation of State Medicaid fraud control units and the rates of FFP for their fraud control activities.

Subpart A—Medicaid Agency Fraud Detection and Investigation Program
§ 455.14 Preliminary investigation.

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

§ 455.15 Full investigation.

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:

(a) If a provider is suspected of fraud or abuse, the agency must—

(1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under § 1002.309 of this title; or

(2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.

(b) If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.

(c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

§ 455.16 Resolution of full investigation.

A full investigation must continue until—

(a) Appropriate legal action is initiated;

(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or

(c) The matter is resolved between the agency and the provider or recipient. This resolution may include but is not limited to—

(1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action;

(2) Suspending or terminating the provider from participation in the Medicaid program;

(3) Seeking recovery of payments made to the provider; or

(4) Imposing other sanctions provided under the State plan.

§ 455.17 Reporting requirements.

The agency must report the following fraud or abuse information to the appropriate Department officials at intervals prescribed in instructions.

(a) The number of complaints of fraud and abuse made to the agency that warrant preliminary investigation.

(b) For each case of suspected provider fraud and abuse that warrants a full investigation—

(1) The provider’s name and number;

(2) The source of the complaint;

(3) The type of provider;

(4) The nature of the complaint;

(5) The approximate range of dollars involved; and

(6) The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.

§ 455.18 Provider’s statements on claims forms.

(a) Except as provided in § 455.19, the agency must provide that all provider claims forms be imprinted in boldface type with the following statements, or with alternate wording that is approved by the Regional HCFA Administrator:
§ 455.23 Withholding of payments in cases of fraud or willful misrepresentation.

(a) Basis for withholding. The State Medicaid agency may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program. The State Medicaid agency may withhold payments without first notifying the provider of its intention to withhold such payments. A provider may request, and must be granted, administrative review where State law so requires.

(b) Notice of withholding. The State agency must send notice of its withholding of program payments within 5 days of taking such action. The notice must:

(1) State that payments are being withheld in accordance with this provision;

(2) State that the withholding is for a temporary period, as stated in paragraph (c) of this section, and cite the circumstances under which withholding will be terminated;

(i) Access to, and free copies of, any records or information kept by the agency or its contractors;

(ii) Computerized data stored by the agency or its contractors. These data must be supplied without charge and in the form requested by the unit; and

(iii) Access to any information kept by providers to which the agency is authorized access by section 1902(a)(27) of the Act and § 431.107 of this subchapter. In using this information, the unit must protect the privacy rights of recipients; and

(3) On referral from the unit, initiate any available administrative or judicial action to recover improper payments to a provider.

§ 455.19 Provider's statement on check.

As an alternative to the statements required in § 455.18, the agency may print the following wording above the claimant’s signature on the reverse of checks or warrants payable to each provider: “I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.”

§ 455.20 Recipient verification procedure.

(a) The agency must have a method for verifying with recipients whether services billed by providers were received.

(b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by § 433.116(e) and (f).

§ 455.21 Cooperation with State Medicaid fraud control units.

In a State with a Medicaid fraud control unit established and certified under subpart C of this part—

(a) The agency must—

(1) Refer all cases of suspected provider fraud to the unit;

(2) If the unit determines that it may be useful in carrying out the unit’s responsibilities, promptly comply with a request from the unit for—

(3) On referral from the unit, initiate any available administrative or judicial action to recover improper payments to a provider.

(b) The agency need not comply with specific requirements under this subpart that are the same as the responsibilities placed on the unit under subpart D of this part.
§ 455.100 Purpose.

This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth State plan requirements regarding—

(a) Disclosure by providers and fiscal agents of ownership and control information; and

(b) Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

The subpart also specifies conditions under which the Administrator will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

§ 455.101 Definitions.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider’s total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

§ 455.102 Determination of ownership or control percentages.

(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A’s interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B’s interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider’s assets, B’s interest in the provider’s assets equates to 4 percent and need not be reported.

§ 455.103 State plan requirement.

A State plan must provide that the requirements of §§ 455.104 through 455.106 are met.

§ 455.104 Disclosure by providers and fiscal agents: Information on ownership and control.

(a) Information that must be disclosed. The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;

(2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must—
§ 455.105 Disclosure by providers: Information related to business transactions.  

(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and 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.

(c) Denial of Federal financial participation (FFP). (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under §420.225 of this chapter (Medicare requirements for disclosure).

(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of
any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider’s application for participation in the program.

(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person’s involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

PART 456—UTILIZATION CONTROL

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