TITLE 467 MEDICALLY HANDICAPPED CHILDREN'S PROGRAM

CHAPTER 5 MEDICAL PROVIDERS AND PAYMENTS FOR THE MEDICALLY HANDICAPPED CHILDREN'S PROGRAM AND GENETICALLY HANDICAPPED PERSONS PROGRAM

001. MEDICAL PROVIDERS. Medical providers provide services and treatment to recipients with special health care needs and receive payment for prior authorized services.

001.01 PROVIDER ENROLLMENT. Prior to services being authorized for payment, providers must sign a Department form which requires the following:

(A) The Provider must follow the Program regulations and other applicable laws;
(B) The Provider must maintain current licensing and certifications required by state law;
(C) The Provider must be screened for abuse and neglect on the child and adult central registry and must have criminal background checks completed; and
(D) The Provider must maintain records on services provided for a minimum of six years after the date of service.

002. MEDICAL PAYMENTS. Medical payments are made to medical providers for authorized services after the Department reviews the billings for compliance with requirements.

002.01 BILLING REQUIREMENTS. The Department only considers payment for claims when the following billing requirements are met:

002.01(A) THIRD PARTY. All third party sources must be exhausted before payment may be considered.

002.01(B) REQUIRED DETAIL ON CLAIMS. The detail required on claims is dependent upon the type of medical claim being submitted. All medical claims submitted to the Department for payment must be completed in its entirety by the provider. Additional supporting documentation may be requested in order to process the claim. Failure to submit additional documentation timely will result in the claim being denied payment.

002.01(C) ACCEPT PAYMENT IN FULL. Medical providers must accept the Department's payment as payment in full. Any balance remaining on a claim after payment has been made cannot be billed to the recipient. If the Department does not make payment due to third party sources paying more than the Department's rate, the remaining balance must not be billed to the recipient. Recipients must not be billed for claims denied by the Department for untimely filing.

002.01(D) TIMELY FILING. Medical providers must bill within six months from the date of service for payment to be considered by the Department. Claims received beyond six months from the date of service will be denied.

002.01(E) REFUNDS. Medical providers have 45 days to refund any overages or erroneous payments or to show that the refunds have already been made or that the refund requests were made in error.

003. PAYMENT RATES FOR MEDICAL SERVICES. The Department follows the rates below for medical services provided while allowing the Department the discretion to negotiate rates when excessive costs are billed.

003.01 PHARMACY RATES. Pharmacy rates are as billed.

003.02 DURABLE MEDICAL EQUIPMENT. Durable medical equipment rates follow the Medicaid fee schedules.

003.03 PHYSICIAN RATES. Physician rates follow the Medicaid fee schedules.

003.04 HOSPITAL RATES. Hospital rates follow the Medicaid fee schedules.

003.05 DENTAL RATES. Dental rates follow the Medicaid fee schedules.

003.06 UNKNOWN RATES. Certain medical services do not have available Medicaid pricing. Rates that are unknown are determined by the Department on a negotiated basis until pricing becomes available.