Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to the Oklahoma Health Care Authority (OHCA) Proposed Changes Blog.

OHCA COMMENT DUE DATE: February 17, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the January 3, 2017 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 9, 2017 and the OHCA Board of Directors on March 23, 2017.
Reference: APA WF 16-28A

SUMMARY:
Policy Revisions to Contracting Rules – The proposed provider contracting revisions revoke administrative sanction rules as the language is obsolete and does not accord with current agency practices. Proposed revisions also revoke other agency rules which have been substantively revised to clarify what the agency may consider when deciding whether to terminate a contract with a particular enrolled provider. Also, proposed revisions add a new rule which explains what factors OHCA may take into consideration when deciding whether to approve an application for a new or renewing provider enrollment contract. In addition, proposed revisions add a new rule which modifies and replaces the Emergency Rule which will expire on September 14, 2017. The new rule fulfills a Federal requirement for all state Medicaid agencies to institute fingerprint-based criminal background checks for certain "high categorical risk" providers who want to contract with the state. Proposed revisions also add a new rule which streamlines, clarifies and provides examples of the kinds of conduct that may serve as a basis for a for-cause termination of a provider contract.

LEGAL AUTHORITY
42 U.S.C. 1320a-7; 42 CFR 431.107; 42 CFR 455.400 – 455.470; 42 CFR 457.990; 42 CFR 424.518; The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Harvey Reynolds
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 16-28A

A. Brief description of the purpose of the rule:

Proposed revisions revoke OAC 317:30-3-19 because the language is obsolete and does not accord with current agency practices. Proposed revisions revoke OAC 317:30-3-19.1 because OHCA has substantively revised this section to clarify what the agency may consider when deciding whether to terminate a contract with a particular enrolled provider for cause. The new rule is OAC 317:30-3-19.5, Termination of provider agreements. Also, proposed revisions add a new rule, OAC 317:30-3-19.3, which explains what factors OHCA may take into consideration when deciding whether to approve an application for a new or renewing provider enrollment contract. These considerations include, but are not limited to, whether the provider has been terminated, suspended or excluded from participating in Medicaid in any other State or from Medicare, and whether the applicant has any pending charge or prior criminal conviction for any offense that could reasonably affect patient care. The rule also explains that applicants will be notified in writing of any denial and that a denial constitutes a final agency decision. Also, proposed revisions add a new rule, OAC 317:30-319.4, which modifies and replaces rule OAC 317:30-3-19.2 which will lapse on September 14, 2017. OAC 317:30-3-19.4 fulfills a Federal requirement for all State Medicaid agencies to institute fingerprint-based criminal background checks for certain "high categorical risk" providers who want to contract with the State. This rule is different from the aforementioned Emergency Rule in that it: replaces the phrase "high risk" with "high categorical risk" in order to mirror terminology in the applicable Federal regulation; includes prior abuse, neglect or exploitation of a vulnerable adult as a disqualifying crime; and limits disqualifications that are

based on prior criminal convictions for controlled substances to a ten-year period after conviction. Also, proposed revisions add a new rule, OAC 317:30-3-19.5, which streamlines and clarifies former rule OAC 317:30-3-19.1. It provides examples of the kinds of conduct that may serve as a basis for a for-cause termination, which includes, but is not limited to: noncompliance with enrollment and/or application requirements; provider exclusion, debarment, or suspension; convictions; the submission of false or misleading information to OHCA; results of an on-site review that implicate member care; misuse of the provider's billing number; abuse of billing privileges; failure to report and/or update pertinent information, such as changes in licensure, certification, and/or accreditation; failure to comply with documentation requirements and/or refusal to allow OHCA access to required documents; and adverse audit determinations. This rule strikes out an obsolete reference in former rule OAC 317:30-3-19.1 to application fees; because OHCA requires payment of the required fee prior to contracting with a given provider, contracts are not terminated on that basis.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Newly enrolling and re-enrolling providers are affected by the proposed rule if they meet one of the factors that would cause their provider contract application to not be approved. Also, newly enrolling and re-enrolling home health agencies and durable medical equipment providers, except those previously successfully screened by Medicare or by another state Medicaid agency, are affected by the proposed rule because they have been designated as high categorical risk for fraud, waste and abuse. Also affected by the proposed rule are currently enrolled providers who engage in conduct which the rule specifies as a basis for a for-cause termination. No information on any cost impacts were received from any entity.

C. A description of the classes of persons who will benefit from the proposed rule:

Members, providers and taxpayers will benefit from the proposed rule which is designed to: explain the factors OHCA

may consider when deciding whether to approve an application for a new or renewed provider enrollment contract; lower the risk for fraud, waste and abuse in the Medicaid program; and clarify the kinds of conduct which may serve as a basis for a for-cause termination of a provider agreement.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Agency staff has determined that the proposed rule is budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The agency does not anticipate that the proposed rule will have an adverse effect on small businesses.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less

intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should not have any effect on the public health, safety or environment. The proposed rule is not designed to reduce significant risks to the public health, safety or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health, safety or environment if the proposed rule is not implemented.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared date: December 6, 2016

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19. Administrative sanctions [REVOKED]

~~(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.~~

~~(1) **"Abuse"** means provider practices that are inconsistent~~

~~with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also recognizes recipient practices that result in unnecessary cost to the Medicaid program.~~

~~(2) **"Conviction" or "Convicted"** means a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.~~

~~(3) **"Exclusion"** means items or services which will not be reimbursed under Medicaid because they were furnished by a specific provider who has defrauded or abused the Medicaid program.~~

~~(4) **"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.~~

~~(5) **"Knowingly"** means that a person, with respect to information:~~

~~(A) has actual knowledge of the information;~~

~~(B) acts in deliberate ignorance of the truth or falsity of the information; or~~

~~(C) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.~~

~~(6) **"Medical Services Providers"** means:~~

~~(A) **"Practitioner"** means a physician or other individual licensed under State law to practice his or her profession or a physician who meets all requirement for employment by the Federal Government as a physician and is employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal facility.~~

~~(B) **"Supplier"** means an individual or entity, other than a provider or practitioner, who furnishes health care services under Medicaid or other medical services programs administered by the Oklahoma Health Care Authority.~~

~~(C) **"Provider"** means:~~

~~(i) A hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or a hospice that has in effect an agreement to participate in Medicaid, or any other medical services program administered by the Oklahoma Health Care Authority, or~~

~~(ii) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement.~~

(D) **"Laboratories"** means any laboratory or place equipped for experimental study in science or for testing or analysis which has an agreement with the Oklahoma Health Care Authority to receive Medicaid monies.

(E) **"Pharmacy"** means any pharmacy or place where medicines are compounded or dispensed or any pharmacist who has an agreement with OHCA to receive Medicaid monies for the dispensing of drugs.

(F) **"Any other provider"** means any provider who has an agreement with OHCA to deliver health services, medicines, or medical services for the receipt of Medicaid monies.

(7) **"OIG"** means Office of Inspector General of the Department of Health and Human Services.

(8) **"Sanctions"** means any administrative decision by OHCA to suspend or exclude a medical service provider(s) from the Medicaid program or any other medical services program administered by the Oklahoma Health Care Authority.

(9) **"Suspension"** means items or services furnished by a specified provider will not be reimbursed under the Medicaid program.

(10) **"Willfully"** means proceeding from a conscious motion of the will; voluntary, intending the result which comes to pass; intentional.

(b) **Basis for sanctions.**

(1) The Oklahoma Health Care Authority may sanction a medical provider who has an agreement with OHCA for the following reasons:

(A) Knowingly or willfully made or caused to be made any false statement or misrepresentation of material fact in claiming, or use in determining the right to, payment under Medicaid; or

(B) Furnished or ordered services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized standards for health care; or

(C) Submitted or caused to be submitted to the Medicaid program bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs. However, the agency must not impose an exclusion under this section if it finds the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities in which it is accepted medical practice to make an extra charge in such case.

(2) The agency may base its determination that services were excessive or of unacceptable quality on reports, including

sanction reports, from any of the following sources:

(A) The PRO for the area served by the provider or the PRO contracted by OHCA;

(B) State or local licensing or certification authorities;

(C) Peer review committees of fiscal agents or contractors;

(D) State or local professional societies;

(E) Surveillance and Utilization Review Section Reports done by OHCA; or

(F) Other sources deemed appropriate by the Medicaid agency or the OIG.

(3) OHCA must suspend from the Medicaid program any medical services provider who has been suspended from participation in Medicare or Medicaid due to a conviction of a program related crime. This suspension must be at a minimum the same period as the Medicare suspension.

(4) OHCA must also suspend any convicted medical services provider who is not eligible to participate in Medicare or Medicaid whenever the OIG directs such action. Such suspension must be, at a minimum, the same period as the suspension by the OIG.

(c) **Procedure for imposing sanctions.** The procedure for imposing a sanction under this section and the due process accorded in this section is provided at OAC 317:2-1-5.

317:30-3-19.1. Revocation of enrollment and billing privileges in the Medicaid Program. [REVOKED]

OHCA and providers have the right to terminate or suspend contracts with each other. Remedies are provided in this Section that may be used by the agency in addition to a formal contract action against the provider. When the use of these remedies results in a contract action, appropriate due process protections will be afforded to the provider for that contract action. Subsections (1) through (10) are additional remedies under which OHCA may revoke a currently enrolled provider or supplier's SoonerCare billing privileges and any corresponding provider agreement or supplier agreement.

(1) **Noncompliance.** The provider or supplier is determined not to be in compliance with the enrollment requirements described in OAC 317:30-3-2, or in the enrollment application applicable for its provider or supplier type. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under subsections (2), (3), (5), or (7) of this Section.

(A) OHCA may request additional documentation from the

~~provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.~~

~~(B) Requested additional documentation must be submitted within 60 calendar days of request.~~

~~(2) **Provider or supplier conduct**. The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:~~

~~(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR 1001.2; or~~

~~(B) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.~~

~~(3) **Felonies**. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that OHCA has determined to be detrimental to the best interests of the program and its beneficiaries. Denials based on felony convictions are for a period to be determined by the OHCA, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses. Offenses include but are not limited to:~~

~~(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;~~

~~(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;~~

~~(C) Any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct; and~~

~~(D) Any felonies that would result in mandatory exclusion under 42 U.S.C. § 1320a-7a of the Social Security Act.~~

~~(4) **False or misleading information**. The provider or supplier certified as "true" misleading or false information on the enrollment application to be enrolled or maintain enrollment in the SoonerCare program. Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.~~

~~(5) **On-site review**. OHCA determines, upon on-site review,~~

~~that the provider or supplier is no longer operational to furnish SoonerCare covered items or services, or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for, SoonerCare members.~~

~~(6) **Provider and supplier screening requirements.**~~

~~(A) A provider does not submit an application fee that meets the requirements set forth in 42 CFR 455.460.~~

~~(B) Either of the following occurs:~~

~~(i) OHCA is not able to deposit the full application amount.~~

~~(ii) The funds are not able to be credited to the State of Oklahoma.~~

~~(C) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or~~

~~(D) There is any other reason why OHCA is unable to deposit the application fee.~~

~~(7) **Misuse of billing number**. The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a (a)(32) or a change of ownership as outlined in 42 CFR 455.104(c) (within 35 days of a change in ownership).~~

~~(8) **Abuse of billing privileges**. The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.~~

~~(9) **Failure to report**. The provider or supplier did not comply with the reporting requirements specified in the SoonerCare provider agreement or regulations.~~

~~(10) **Failure to document or provide OHCA access to documentation.**~~

~~(A) The provider or supplier did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.~~

~~(B) A provider or supplier that meets the revocation criteria specified in (10)(A) of this subsection is subject to revocation for a period of not more than 1 year~~

~~for each act of noncompliance.~~

OAC 317:30-3-19.3. Denial of application for new or renewed provider enrollment contract

(a) The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Affiliates"** means persons having a relationship in which any of them directly or indirectly controls or has the ability to control one or more of the others.

(2) **"Applicant"** means providers and/or persons with a five percent or more direct or indirect ownership interest therein, as well as providers' officers, directors, and managing employees.

(3) **"Conviction"** or **"convicted"** means a person has been convicted of a criminal offense pursuant to 42 U.S.C. § 1320a-7(i), or, for civil offenses, has had a judgment of conviction entered against him or her by a Federal, State, or local court, regardless of whether an appeal from the judgment is pending.

(4) **"Person"** means any natural person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity.

(5) **"Provider"** means any person having or seeking to obtain a valid provider enrollment contract with the Oklahoma Health Care Authority (OHCA) for the purpose of providing services to eligible SoonerCare members and receiving reimbursement therefor.

(b) When deciding whether to approve an application for a new or renewed provider enrollment contract, OHCA may consider the following factors as they relate to the applicant and any of the applicant's affiliates, including, but not limited to:

(1) any false or misleading representation or omission of any material fact or information required or requested by OHCA as part of the application process;

(2) any failure to provide additional information to OHCA after receiving a written request for such additional information;

(3) any false or misleading representation or omission of any material fact in making application for any license, permit, certificate, or registration related to the applicant's profession or business in any State;

(4) any fine, termination, removal, suspension, revocation, denial, consented surrender, censure, sanction, involuntary invalidation of, or other disciplinary action taken against any license, permit, certificate, or registration related to the applicant’s profession or business in any State;

(5) any previous or current involuntary surrender, removal, termination, suspension, ineligibility, exclusion, or otherwise involuntary disqualification from participation in Medicaid in any State, or from participation in any other governmental or private medical insurance program, including, but not limited to, Medicare and Workers' Compensation;
(6) any Medicaid or Medicare overpayment of which the applicant has been notified, as determined exclusively by OHCA that was received, but has not made reimbursement, unless such reimbursement is the subject of an OHCA reimbursement agreement that is not in default,;
(7) any previous failure to correct deficiencies in the applicant's business or professional operations after having received notice of the deficiencies from the OHCA or any State or Federal licensing or auditing authority;
(8) any previous violation of any State or Federal statute or regulation that relates to the applicant's current or past participation in Medicaid, Medicare, or any other governmental or private medical insurance program;
(9) any pending charge or prior conviction of any civil or criminal offense relating to the furnishing of, or billing for, medical care, services, or supplies, or which is considered theft, fraud, or a crime involving moral turpitude;
(10) any pending charge or prior criminal conviction for any felony or misdemeanor offense that could reasonably affect patient care, including, but not limited to, those offenses listed in 317:30-3-19.4;
(11) any denial of a new or renewed provider enrollment contract within the past two (2) years that was based on the applicant's or an affiliate's prior conduct;
(12) any submission of an application that conceals the involvement in the enrolling provider's operation of a person who would otherwise be ineligible to participate in Medicaid or Medicare;
(13) any business entity that is required to register with a State office or agency in order to conduct its operations therein, including, but not limited to, the Oklahoma Secretary of State, any failure to obtain and/or maintain a registration status that is valid, active, and/or in good standing; and
(14) any other factor that impacts the quality or cost of medical care, services, or supplies that the applicant furnishes to SoonerCare members, or otherwise influences the fiscal soundness, effectiveness, or efficiency of the OHCA program.

(c) OHCA shall provide any applicant who is denied a new or renewed provider enrollment contract a written notice of the denial. Any denial shall become effective on the date it is sent to the applicant.
(d) Any OHCA decision to deny a provider's contract application in accordance with this Section shall be a final agency decision that is not administratively appealable.

317:30-3-19.4. Applicants subject to a fingerprint-based criminal background check

(a) Applicants designated as "'high' categorical risk" in accordance with Federal law, including, but not limited to, 42 C.F.R. § 424.518 and 42 C.F.R. Part 455, Subpart E, or if otherwise required by State and/or Federal law, shall be subject to a fingerprint-based criminal background check as a condition of new or renewed contract enrollment.
(b) Any applicant subject to a fingerprint-based criminal background check as provided in subsection (a) of this Section, shall be denied enrollment if he/she has a felonious criminal conviction and may be denied enrollment for a misdemeanor criminal conviction relating, but not limited, to:

(1) The provision of services under Medicare, Medicaid, or any other Federal or State health care program;
(2) Homicide, murder, or non-negligent manslaughter;
(3) Aggravated assault;
(4) Kidnapping;
(5) Robbery;
(6) Abuse, neglect, or exploitation of a child or vulnerable adult;
(7) Human trafficking;
(8) Negligence and/or abuse of a patient;
(9) Forcible rape and/or sexual assault;
(10) Terrorism;
(11) Embezzlement, fraud, theft, breach of fiduciary duty, or other financial misconduct; and/or
(12) Controlled substances, provided the conviction was entered within the preceding ten-year period.

(c) Any OHCA decision denying an application for contract enrollment based on the applicant's criminal history pursuant to OAC 317:30-3-19.3 shall be a final agency decision that is not administratively appealable. However, nothing in this section shall preclude an applicant whose criminal conviction has been overturned on final appeal, and for whom no other appeals are pending or may be brought, from reapplying for enrollment.

317:30-3-19.5. Termination of provider agreements

Pursuant to the terms of OHCA's Standard Provider Agreement, both OHCA and a provider may terminate the agreement without cause on sixty (60) days' notice, or for-cause on thirty (30) days' notice. In addition, OHCA can terminate the agreement immediately in order to protect the health and safety of members, or upon evidence of fraud (including, but not limited to, a credible allegation of fraud as defined by 42 C.F.R. § 455.2). Conduct that may serve as a basis for a for-cause termination of a provider includes, but is not limited to, any of the following:

(1) **Noncompliance.** The provider is determined not to be in compliance with the enrollment requirements described in OAC 317:30-3-2, OAC 317:30-3-19, or in the enrollment application applicable for its provider type. OHCA may, but is not required to, request additional documentation from the provider to determine compliance.

(2) **Provider exclusion, debarment, or suspension.** The provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel thereof is:

(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 C.F.R § 1001.2; or

(B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

(3) **Convictions.** Conviction of the provider or any of its affiliates for a Federal or State offense that OHCA has determined to be detrimental to the best interests of the program and its members. Such offenses may include, but are not limited to, those offenses enumerated in OAC 317:30-3-19.3 and OAC 317:30-3-19.4.

(4) **False or misleading information.** The provider submitted or caused to be submitted misleading or false information on its enrollment application to be enrolled or to maintain enrollment in the SoonerCare program. In addition to termination of a contract, offenders may be referred for prosecution, which could result in fines or imprisonment, or both, in accordance with current law and regulations.

(5) **On-site review.** OHCA determines, upon on-site review, that the provider is no longer operational, able to furnish SoonerCare covered items, or able to safely and adequately render services; or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for SoonerCare members.

(6) **Misuse of billing number.** The provider knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a(a)(32) or a change of ownership as outlined in 42 C.F.R. § 455.104(c) (within thirty-five (35) days of a change in ownership).

(7) **Abuse of billing privileges.** The provider submits a claim or claims for services that reasonably could not have been rendered, or that do not accurately reflect those services actually rendered, to a specific individual on the date of service. These instances include, but are not limited to: upcoding; unbundling of services; services that are purportedly provided to a member who has died prior to the date of service; services that are purportedly provided on a date on which the directing physician or member is not in the State or country or is otherwise physically incapable of providing or receiving the service; or the equipment necessary for testing was not present where the testing is said to have occurred, or was incapable of operating correctly at the supposed time of testing.

(8) **Failure to report.** The provider did not comply with the reporting requirements specified in the SoonerCare Provider Agreement or any applicable State and/or Federal statutes or regulations, including without limitation, changes in the provider's licenses, certifications, and/or accreditations provided at the time of enrollment. Providers shall report and update a change in mailing address within fourteen (14) days of such change.

(9) **Failure to document or provide OHCA access to documentation.**

(A) The provider did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) OHCA may suspend all SoonerCare payments to a provider who refuses or fails to produce for inspection those financial and other records as are required by 42 C.F.R. § 431.107 and the executed SoonerCare Provider Agreement, until such time as all requested records have been submitted to OHCA for review.

(10) **Adverse audit determinations.** The provider receives an adverse Program Integrity audit that demonstrates fraud, waste, abuse, and/or repeated failure or inability to comply with SoonerCare billing and provision of service requirements.