THE SOCIAL WELFARE ACT (EXCERPT)
Act 280 of 1939

400.111b Requirements as condition of participation by provider.

Sec. 111b. (1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27).

(2) A provider shall comply with all licensing and registration laws of this state applicable to the provider's practice or business. For a facility that is periodically inspected by a licensing authority, maintenance of licensure constitutes compliance.

(3) A provider shall be certified, if the provider is of the type for which certification is required by title XVIII or XIX.

(4) A provider shall enter into an agreement of enrollment specified by the director.

(5) A provider who renders a reimbursable service described in section 109 to a medically indigent individual shall provide the individual with service of the same scope and quality as would be provided to the general public.

(6) A provider shall maintain records necessary to document fully the extent and cost of services, supplies, or equipment provided to a medically indigent individual and to substantiate each claim and, in accordance with professionally accepted standards, the medical necessity, appropriateness, and quality of service rendered for which a claim is made.

(7) Upon request and at a reasonable time and place, a provider shall make available any record required to be maintained by subsection (6) for examination and photocopying by authorized agents of the director, the department of attorney general, or federal authorities whose duties and functions are related to state programs of medical assistance under title XIX. If a provider releases records in response to a request by the director made under section 111a(13) or in compliance with this subsection, that provider is not civilly liable in damages to a patient or to another provider to whom, respectively, the records relate solely, on account of the response or compliance.

(8) A provider shall retain each record required to be maintained by subsection (6) for a period of 7 years after the date of service. A provider who no longer personally retains the records due to death, retirement, change in ownership, or other reason, shall ensure that a suitable person retains the records and provides access to the records as required in subsection (7).

(9) A provider shall require, as a condition of a contract with a person, sole proprietorship, clinic, group, partnership, corporation, association, or other entity, for the purpose of generating billings in the name of the provider or on behalf of the provider to the department, that the person, partnership, corporation, or other entity, its representative, successor, or assignee, retain for not less than 7 years, copies of all documents used in the generation of billings, including the certifications required by subsection (17), and, if applicable, computer billing tapes if returned by the department.

(10) A provider shall submit all claims for services rendered under the program on a form or in a format and with the supporting documentation specified and required by the director under section 111a(7)(c) and by the commissioner of insurance under section 111i. Submission of a claim or claims for services rendered under the program does not establish in the provider a right to receive payment from the program.

(11) A provider shall submit initial claims for services rendered within 12 months after the date of service, or within a shorter period that the director may establish or that the commissioner of insurance may establish under section 111i. The director shall not delegate the authority to establish a time period for submission of claims under this subsection. Except as otherwise provided in section 111i, the director, with the consultation required by section 111a, may prescribe the conditions under which a provider may qualify for a waiver of the time period established under this subsection with respect to a particular submission of a claim. Neither this state nor the medically indigent individual is liable for payment of claims submitted after the period established under this subsection.

(12) A provider shall not charge the state more for a service rendered to a medically indigent individual than the provider's customary charge to the general public or another third party payer for the same or similar service.

(13) A provider shall submit information on estimated costs and charges on a form or in a format and at times that the director may specify and require according to section 111a(16).

(14) Except for copayment authorized by the department and in conformance with applicable state and federal law, a provider shall accept payment from the state as payment in full by the medically indigent individual for services received. A provider shall not seek payment from the medically indigent individual, the family, or representative of the individual for either of the following:

(a) Authorized services provided and reimbursed under the program.

(b) Services determined to be medically unnecessary in accordance with professionally accepted standards.

(15) A provider may seek payment from a medically indigent individual for services not covered nor reimbursed by the program if the individual elected to receive the services with the knowledge that the services would not be covered nor reimbursed under the program.

(16) A provider promptly shall notify the director of a payment received by the provider to which the provider is not entitled or that exceeds the amount to which the provider is entitled. If the provider makes or should have made notification under this subsection or receives notification of overpayment under section 111a(17), the provider shall repay, return, restore, or reimburse, either directly or through adjustment of payments, the overpayment in the manner required by the director. Failure to repay, return, restore, or reimburse the overpayment or a consistent pattern of failure to notify the director shall constitute a conversion of the money by the provider.

(17) As a condition of payment for services rendered to a medically indigent individual, a provider shall certify that a claim for payment is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information. A provider is responsible for the ongoing supervision of an agent, officer, or employee who prepares or submits the provider's claims. A provider's certification required under this subsection shall be prima facie evidence that the provider knows that the claim or claims are true, accurate, prepared with his or her knowledge and consent, do not contain misleading or deceptive information, and are filed in compliance with the policies, procedures, and instructions, and on the forms established or developed under this act. Certification shall be made in the following manner:

(a) For an invoice or other prescribed form submitted directly to the department by the provider in claim for payment for the provision of services, by an indelible mark made by hand, mechanical or electronic device, stamp, or other means by the provider, or an agent, officer, or employee of the provider.

(b) For an invoice or other form submitted in claim for payment for the provision of services submitted indirectly by the provider to the department through a person, sole proprietorship, clinic, group, partnership, corporation, association, or other entity that generates and files claims on a provider's behalf, by the indelible written name of the provider on a certification form developed by the director for submission to the department with each group of invoices or forms in claim for payment. The certification form shall indicate the name of the person, if other than the provider, who signed the provider's name.

(c) For a warrant issued in payment of a claim submitted by a provider, by the handwritten indelible signature of the payee, if the payee is a natural person; by the handwritten indelible signature of an officer, if the payee is a corporation; or by handwritten indelible signature of a partner, if the payee is a partnership.

(18) A provider shall comply with all requirements established under section 111a(1), (2), and (3).

(19) A provider shall file with the department, on disclosure forms provided by the director, a complete and truthful statement of all of the following:

(a) The identity of each individual having, directly or indirectly, an ownership or beneficial interest in a partnership, corporation, organization, or other legal entity, except a company registered according to the securities exchange act of 1934, 15 USC 78a to 78nn, through which the provider engages in practice or does business related to claims or charges against the program. This subdivision does not apply to a health facility or agency that is required to comply with and has complied with the disclosure requirements of section 20142(3) of the public health code, 1978 PA 368, MCL 333.20142. With respect to a company registered under the securities exchange act of 1934, 15 USC 78a to 78nn, a provider shall disclose the identity of each individual having, directly or indirectly, separately or in combination, a 5% or greater ownership or beneficial interest.

(b) The identity of each partnership, corporation, organization, legal entity, or other affiliate whose practice or business is related to a claim or charge against the program in which the provider has, directly or indirectly, an ownership or beneficial interest, trust agreement, or a general or perfected security interest. This subdivision does not apply to a health facility or agency that is required to comply with and has complied with the disclosure requirements of section 20142(4) of the public health code, 1978 PA 368, MCL 333.20142.

(c) If applicable to the provider, a copy of a disclosure form identifying ownership and controlling interests submitted to the United States department of health and human services in fulfillment of a condition of participation in programs established according to title V, XVIII, XIX, and XX. To the extent that information disclosed on this form duplicates information required to be filed under subdivision (a) or (b), filing a copy of the form shall satisfy the requirements under those subdivisions.

(20) If requested by the director, a provider shall supply complete and truthful information as to his or her professional qualifications and training, and his or her licensure in each jurisdiction in which the provider is licensed or authorized to practice.

(21) In the interest of review and control of utilization of services, a provider shall identify each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number

on each claim or adjustment of a claim submitted to the department.

(22) It is the obligation of a provider to assure that services, supplies, or equipment provided to, ordered, or prescribed on behalf of a medically indigent individual by that provider will meet professionally accepted standards for the medical necessity, appropriateness, and quality of health care.

(23) If any service, supply, or equipment provided directly by a provider, or any service, supply, or equipment prescribed or ordered by a provider and delivered by someone other than that provider, is determined not to be medically necessary, not appropriate, or not otherwise in accordance with medical assistance program coverages, the provider who directly provided, ordered, or prescribed the service, supply, or equipment is responsible for direct and complete repayment of any program payment made to the provider or to any other person for that service, supply, or equipment. Services, supplies, or equipment provided by a consulting provider based upon his or her independent evaluation or assessment of the recipient's needs is the responsibility of the consulting provider. This subsection does not apply to repayment by a provider who has ordered a nursing home or hospital admission of the service billed by and reimbursed to a nursing home or hospital. This section also does not apply to a nursing home or hospital unless the nursing home or hospital acted on its own initiative in providing the service, supply, or equipment as opposed to following the order or prescription of another.

(24) A provider shall satisfy or make acceptable arrangement to satisfy all previous adjudicated program liabilities including those adjudicated according to section 111c or established by agreement between the department and the provider, and restitution ordered by a court. As used in this subsection, provider includes, but is not limited to, the provider, the provider's corporation, partnership, business associates, employees, clinic, laboratory, provider group, or successors and assignees. For a nursing home or hospital, "business associates", as used in this subsection, means those persons whose identity is required to be disclosed under section 20142(3) of the public health code, 1978 PA 368, MCL 333.20142.

(25) A provider who is a physician, dentist, or other individual practitioner shall file with the department a complete and factual disclosure of the identity of each employer or contractor to whom the provider is required to submit, in whole or in part, payment for services provided to a medically indigent individual as a condition of the provider's agreement of employment or other agreement. A provider who has properly disclosed the required information by filing a form or forms has 30 business days in which to report changes in the list of identified individuals and entities. The disclosure required by this subsection may serve as the provider's authorization for the department to make direct payments to the employer.

(26) As a condition of receiving payment for services rendered to a medically indigent individual, a provider may enter, as an employee, into agreements of employment of the type described in subsection (25) only with an employer who has entered into an agreement as described in subsection (27).

(27) An employer described in subsection (25) shall enter into an agreement on a form prescribed by the department, in which, as a condition of directly receiving payment for services provided by its employee provider to a medically indigent individual, the employer agrees to all of the following:

(a) To require as a condition of employment that the employee provider submit, in whole or in part, payments received for services provided to medically indigent individuals.

(b) To advise the department within 30 days after any changes in the employment relationship.

(c) To comply with the conditions of participation established by this subsection and subsections (6) to (19) and (21).

(d) To agree to be jointly and severally responsible with the employee provider for any overpayments resulting from the department's direct payment under this section.

(e) To agree that disputed claims relative to overpayments shall be adjudicated in administrative proceedings convened under section 111c.

(28) If a provider who is a nursing home intends to withdraw from participation in the title XIX program, the provider shall notify the department in writing. The provider shall continue to participate in the title XIX program for each patient who was admitted to the nursing home before the date notice is given under this subsection and who is or may become eligible to receive medical assistance under this act.

(29) A provider shall protect, maintain, retain, and dispose of patient medical records and other individually identifying information in accordance with subsection (6), any other applicable state or federal law, and the most recent provider agreement.

(30) At a minimum, if a provider is authorized to dispose of patient records or other patient identifying information, including records required by subsection (6), the provider shall ensure that medical records that identify a patient and other individually identifying information are sufficiently deleted, shredded, incinerated, or disposed of in a fashion that will protect the confidentiality of the patient's health care information and personal information. The department may take action to enforce this subsection. If the department cannot enforce compliance with this subsection, the department may enter into a contract or make other arrangements

to ensure that patient records and other individually identifying information are disposed of in a fashion that will protect the confidentiality of the patient's health care information and personal information and assess costs associated with that disposal against the provider. The provider's responsibilities with regard to maintenance, retention, and disposal of patient medical records and other individually identifying information continue after the provider ceases to participate in the medical assistance program for the time period specified under this section.

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