

§ 447.520

§ 447.520 FFP: Conditions relating to physician-administered drugs.

(a) No FFP is available for physician-administered drugs for which a State has not required the submission of claims using codes that identify the drugs sufficiently for the State to bill a manufacturer for rebates.

(1) As of January 1, 2006, a State must require providers to submit claims for single source, physician-administered drugs using Healthcare Common Procedure Coding System codes or NDC numbers in order to secure rebates.

(2) As of January 1, 2008, a State must require providers to submit claims for the 20 multiple source physician-administered drugs identified by the Secretary as having the highest dollar value under the Medicaid Program using NDC numbers in order to secure rebates.

(b) As of January 1, 2007, a State must require providers to submit claims for physician-administered single source drugs and the 20 multiple source drugs identified by the Secretary using NDC numbers.

(c) A State that requires additional time to comply with the requirements of this section may apply to the Secretary for an extension.

**PART 455—PROGRAM INTEGRITY:
MEDICAID**

Sec.

- 455.1 Basis and scope.
- 455.2 Definitions.
- 455.3 Other applicable regulations.

Subpart A—Medicaid Agency Fraud Detection and Investigation Program

- 455.12 State plan requirement.
- 455.13 Methods for identification, investigation, and referral.
- 455.14 Preliminary investigation.
- 455.15 Full investigation.
- 455.16 Resolution of full investigation.
- 455.17 Reporting requirements.
- 455.18 Provider's statements on claims forms.
- 455.19 Provider's statement on check.
- 455.20 Recipient verification procedure.
- 455.21 Cooperation with State Medicaid fraud control units.
- 455.23 Withholding of payments in cases of fraud or willful misrepresentation.

42 CFR Ch. IV (10–1–07 Edition)

Subpart B—Disclosure of Information by Providers and Fiscal Agents

- 455.100 Purpose.
- 455.101 Definitions.
- 455.102 Determination of ownership or control percentages.
- 455.103 State plan requirement.
- 455.104 Disclosure by providers and fiscal agents: Information on ownership and control.
- 455.105 Disclosure by providers: Information related to business transactions.
- 455.106 Disclosure by providers: Information on persons convicted of crimes.

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.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—

- (1) Report fraud and abuse information to the Department; and
- (2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.

(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.

[51 FR 34787, Sept. 30, 1986]

§ 455.2 Definitions.

As used in this part unless the context indicates otherwise—

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 includes recipient practices that result in unnecessary cost to the Medicaid program.