

**CHAPTER 22. PHARMACEUTICAL ASSISTANCE CONTRACT
FOR THE ELDERLY**

GENERAL PROVISIONS

- Sec.
- 22.1. Scope and authority.
- 22.2. Definitions.

GENERAL PAYMENT PRINCIPLES

- 22.11. General payment principles.

CLAIMANT ELIGIBILITY

- 22.21. General claimant eligibility policy.
- 22.22. Residence provisions.
- 22.23. Age provisions.
- 22.24. Income provisions.
- 22.25. Other third-party benefits.
- 22.26. PACE eligibility.

APPLICATION PROCESS

- 22.31. General provisions.
- 22.32. Initiating the application process.
- 22.33. Responsibilities of the applicant in the application process.
- 22.34. Authorized agent.
- 22.35. Certification.
- 22.36. Authorization.
- 22.37. Right of appeal.

ELIGIBILITY REDETERMINATION PROCESS

- 22.41. General provisions.
- 22.42. Responsibilities of the claimant in the eligibility redetermination process.
- 22.43. Authorized agent.
- 22.44. Certification.
- 22.45. Authorization.
- 22.46. Right of appeal.

CONTINUING CLAIMANT RESPONSIBILITIES

- 22.51. Responsibilities regarding eligibility.
- 22.52. Use of the PACE identification card.

PROVIDER PARTICIPATION

- 22.61. Conditions of provider eligibility.
- 22.62. Conditions of provider participation.
- 22.63. Other provisions for providing services by mail.

MISUTILIZATION AND ABUSE OF PROGRAM BENEFITS

- 22.71. False or fraudulent claims by applicants and claimants.
- 22.72. Prohibited acts and criminal penalties.
- 22.73. Administrative actions and penalties.
- 22.74. Claimant right of appeal.

PROVIDER MISUTILIZATION AND ABUSE

- 22.81. Utilization control.
- 22.82. False or fraudulent claims by providers.
- 22.83. Prohibited acts and criminal penalties.
- 22.84. Administrative actions and penalties.
- 22.85. Re-enrollment of providers whose agreements have been terminated.
- 22.86. Provider right of appeal.

CLAIMANT HEARINGS AND APPEALS

- 22.91. Applicant or claimant appeals.
- 22.92. Notification of adverse action and right to appeal.
- 22.93. Filing of appeals.
- 22.94. Informal handling of appeals.
- 22.95. Formal appeals and hearings.

PROVIDER HEARINGS AND APPEALS

- 22.101. Provider appeals.
- 22.102. Notification of adverse action and right to appeal.
- 22.103. Filing of appeals.
- 22.104. The handling of appeals.

OTHER ADMINISTRATIVE PROVISIONS

- 22.111. Forms, handbooks and other materials.

Authority

The provisions of this Chapter 22 issued under the Pharmaceutical Assistance Contract for the Elderly Act (62 P. S. §§ 2901—2908), unless otherwise noted.

Source

The provisions of this Chapter 22 adopted June 15, 1984, effective June 16, 1984, 14 Pa. B. 2109, unless otherwise noted.

GENERAL PROVISIONS**§ 22.1. Scope and authority.**

(a) This chapter sets forth regulations governing the administration, provision and receipt of prescription drug benefits available to older Pennsylvanians under the Pharmaceutical Assistance Contract for the Elderly (PACE) Program.

(b) This chapter applies to the Department, providers who wish to participate in the PACE Program, applicants for program benefits and claimants.

(c) This chapter is issued under the Pharmaceutical Assistance Contract for the Elderly Act (62 P. S. §§ 2901—2908).

(d) The Department will develop PACE Program policies and regulations, and reserves the right to delegate administrative responsibilities as may be necessary to implement the PACE Program.

Source

The provisions of this § 22.1 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

§ 22.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act—The Pharmaceutical Assistance Contract for the Elderly Act (62 P. S. §§ 2901—2908).

Acute condition—A short-term medical condition or ailment for which the normal and typically recommended drug therapy does not exceed 15 days.

Applicant—A person who applies to participate in the PACE Program, either personally or through an authorized agent.

Application—The form completed and submitted to the Department by an applicant which is used by the Department to determine that applicant's eligibility to participate in the PACE Program. Also, the form completed and submitted to the Department by a claimant which is used by the Department to redetermine that claimant's eligibility to participate in the PACE Program.

Average wholesale cost—The cost of a dispensed drug based upon the price published in a national drug pricing system in current use by the Department as the average wholesale price of a prescription drug in the most common package size. The terms "average wholesale cost" and "average wholesale price" are synonymous.

Claim—In the case of a claimant, presentation to an enrolled provider of a valid PACE identification card in order to receive prescription drugs. In the

case of an enrolled provider, a request to the Department for payment for providing prescription drugs under the PACE Program.

Claimant—A resident of this Commonwealth who meets the conditions specified in §§ 22.21—22.26 (relating to claimant eligibility) and whose application for enrollment in the PACE Program has been approved by the Department.

Contractor—The person, partnership or corporate entity which has an approved contract with the Department to administer the pharmaceutical assistance program as established under the act and this chapter.

Copayment—The dollar amount which is required under the program to be paid to enrolled providers by claimants for each prescription.

DESI (Drug Efficacy Study Implementation) drug—Drug products introduced into the market as new drugs from 1938-1962 which were submitted for review by the National Academy of Sciences—National Research Council Drug Efficacy Study Group and are still considered by the Food and Drug Administration as less than effective in meeting their manufacturers' claims. The term includes identical, related or similar products as covered under 21 CFR 310.6 (relating to applicability of "new drug" or safety or effectiveness findings in drug efficacy study implementation notices and notices of opportunity for hearing to identical, related, and similar drug products). The term includes the same drug products considered not reimbursable by the Medical Assistance Program under 42 CFR 441.25 (relating to prohibition on FFP for certain prescribed drugs).

Department—The Department of Aging of the Commonwealth, its authorized agent or the contractor.

Dispensing—Under the PACE Program, the preparation of a prescription drug by a PACE provider, the delivery of the prepared prescription drug to a PACE claimant and the collection from the PACE claimant of the required copayment.

Dispensing fee—The dollar amount paid to the participating pharmacy by the program for filling prescriptions approved under the PACE Program.

Dispensing physician—A medical doctor or osteopathic doctor currently licensed by the Commonwealth who dispenses prescription drugs.

Enrolled provider—A pharmacy or dispensing physician that meets the conditions of eligibility and participation in §§ 22.61 and 22.62 (relating to conditions of provider eligibility; and conditions of provider participation).

Experimental drug—A drug currently being administered under an investigational new drug application as required by the United States Food and Drug Administration (FDA) under 21 CFR Part 312 (relating to new drugs for investigational use) to determine its safety and effectiveness.

Generically equivalent drugs—Prescription drug products, including those sold under brand names, having the same generic name, dosage form and

labeled potency, listed in the Formulary of Generically Equivalent Drug Products at 28 Pa. Code § 25.58 (relating to generically equivalent drug products).

Generic differential—A percentage of the average wholesale cost of a brand name prescription drug as provided under § 22.11(g) (relating to general payment principles). The percentage is the same for all applicable transactions. This percentage is established by the Department as specified under § 22.11(g)(3).

Income—All income from whatever source derived, as specified in § 22.24 (relating to income provisions).

Mail—First class mail under the regulations of the United States Postal Service or common carrier, able to assure delivery within 5 calendar days.

Medical Assistance Program—The Federal Medicaid program as administered under 55 Pa. Code Part III (relating to Medical Assistance Manual).

Medicare—The Federal program which provides medical care under Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395xx).

Medication history—A pharmacy medication record established and maintained on each PACE claimant served by the pharmacy. This record shall include, as a minimum, the following claimant information as obtained from the claimant or equivalent information as approved by the Department:

- (i) Name.
- (ii) PACE identification card number.
- (iii) Medication allergies and other allergies.
- (iv) Current medication utilization.
- (v) Indication of all medical disorders known to the claimant.
- (vi) Separate entries for each prescription medication dispensed by the provider.

Most common package size—A prescription drug package size identified in one of the following descriptions as the size most commonly purchased by enrolled providers:

- (i) The package size listed in the February 1984 “Yellow Book” distributed by the United States Health Care Financing Administration (HCFA) for drugs contained on that list.
- (ii) Changes or additions to the package sizes listed in the February 1984 “Yellow Book” established by the Department with the approval of the Pharmaceutical Assistance Review Board and published in the *Pennsylvania Bulletin*.

National drug pricing system—A published data information system which includes listings of average wholesale prices and direct prices of prescription drugs such as “The Drug Topics Red Book,” Medi-Span, Inc. or “Prescription Pricing Guide.”

PACE—The Pennsylvania Pharmaceutical Assistance Contract for the Elderly Program.

Pharmaceutical Assistance Review Board—The Board established by the act in order to help ensure the continuing efficiency and effectiveness of the PACE Program.

Pharmacy—A pharmacy currently licensed by the Commonwealth.

Prescriber—A physician or other health practitioner licensed by the Commonwealth to prescribe drugs or a physician authorized by the Department under § 22.11(f)(9).

Prescription drugs or drugs—Drugs requiring a prescription in this Commonwealth, and insulin, insulin syringes and insulin needles. The term does not include experimental drugs, DESI drugs and drugs not approved by the Department of Health for use in this Commonwealth.

Principal place of business—A location in this Commonwealth where an enrolled provider can and will conduct all business directly related to the dispensing of prescription drugs under the PACE Program.

Resident—A person who has lived within this Commonwealth for a period of at least 90 consecutive days and who meets the conditions as set forth in § 22.22 (relating to residence provisions).

Secretary—The Secretary of the Department.

Unit—The measured quantity of a prescription drug to be used such as a single tablet or capsule. The term only includes drugs dispensed in tablet or capsule form.

Universal Claim Form—The standard form, copyrighted by the National Council of Prescription Drug Programs, and in current usage by pharmacies to document for third-party payors prescription services provided by claimants eligible for prescription benefits under a plan administered by a third-party payor. Current usage connotes the most current official version of this form in use at this time and at any given time in the future.

Usual charge—An enrolled provider's charge to the cash-paying public for a prescription drug, in a specific strength and quantity within a specific calendar month. Discounts or coupons offered to the cash-paying public shall be considered to be offered to the Commonwealth as well. Discounts applicable to claimants or coupons presented by claimants shall be accepted by the provider and credited to the PACE Program payment and not the copayment or, if applicable, the generic differential.

Source

The provisions of this § 22.2 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; corrected July 6, 1984, effective June 16, 1984, 14 Pa.B. 2331; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; corrected April 12, 1985, effective March 30, 1985, 15 Pa.B. 1353; amended December 13, 1985, effective December 14, 1985, 15 Pa.B. 4427; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (91333) to (91334) and (103119) to (103120).

Cross References

This section cited in 6 Pa. Code § 22.11 (relating to general payment principles); 6 Pa. Code § 22.24 (relating to income provisions); 6 Pa. Code § 22.33 (relating to responsibilities of the applicant in the application process); and 6 Pa. Code § 22.42 (relating to responsibilities of the claimant in the eligibility redetermination process).

GENERAL PAYMENT PRINCIPLES**§ 22.11. General payment principles.**

(a) *Provider billing.* A provider is required to bill the Department at the usual charge for the drug dispensed.

(b) *Payment elements.* A payment to an enrolled provider under the PACE Program shall consist of the following:

(1) The copayment required of claimants on each prescription billed under the PACE Program.

(2) The payment of the generic differential required of claimants under subsection (g).

(3) The approved PACE Program payment.

(c) *Program payment calculations.* When the Department calculates the approved PACE Program payment, the following requirements apply:

(1) A pharmacy will be paid the lower of the following two amounts:

(i) The average wholesale cost of the prescription drug dispensed, plus the dispensing fee, minus the copayment and, if required under subsection (g), minus the generic differential.

(ii) The pharmacy's usual charge for the dispensed drug, minus the copayment and, if required under subsection (g), minus the generic differential.

(2) In addition to the approved program payment under paragraph (1), a pharmacy may qualify for a supplemental dispensing fee as provided under subsection (e)(2).

(3) A dispensing physician will be paid the lower of the following two amounts:

(i) The average wholesale cost of the prescription drug dispensed, minus the copayment and, if required under subsection (g), minus the generic differential.

(ii) The dispensing physician's usual charge minus the copayment and, if required under subsection (g), minus the generic differential.

(d) *Copayments.*

(1) A claimant of PACE Program benefits is required to pay to the provider the established copayment for each prescription filled under the PACE Program.

(2) The copayment amount for each prescription is \$6. The copayment amount will increase or decrease on an annual basis by the average percent

change, as determined by the Department, of ingredient costs for prescription drugs dispensed under the program plus a differential to raise the copayment to the next highest 25¢ increment. The Department will publish a notice in the *Pennsylvania Bulletin* of changes in the copayment amount.

(3) The Department may increase or decrease the amount of the copayment based upon the financial experience and projections of PACE and after consultation with the Pharmaceutical Assistance Review Board. The Department will not approve adjustments to the copayment more frequently than semiannually.

(e) *Dispensing fee.*

(1) The minimum dispensing fee under the PACE Program will be the dollar amount of the dispensing fee in use under the Medical Assistance Program as specified in 55 Pa. Code § 1121.55(a) (relating to method of payment). A dispensing fee of \$2.75 was adopted by the Department as the dispensing fee under the PACE Program effective July 1, 1985. Only pharmacies enrolled in the PACE Program are eligible to receive dispensing fees. A dispensing fee will not be paid to dispensing physicians enrolled in the PACE Program.

(2) When a pharmacy enrolled in the PACE Program can document that, as a result of one of its pharmacist's consultation with a prescriber, a claimant's prescription for a higher priced brand name drug, with no substitutions permitted, was changed to permit substitutions and a lower priced generically equivalent drug was dispensed, the Department will pay that pharmacy a supplemental dispensing fee of \$1. This fee shall apply only to an original prescription and not to subsequent refills for the same drug. Documentation of the prescription change shall consist of a notation on the back of the original prescription which includes the initials of the pharmacist who consulted with the prescriber, and the date of the consultation.

(f) *Special conditions for payment.*

(1) A provider shall collect the full copayment required on each prescription filled before the provider submits an allowable claim to the Department for payment. A claim which relates to services for which the full copayment has not been collected will not be considered an allowable claim.

(2) Payments will be made for prescription drugs dispensed by mail when prescription drugs have been ordered and dispensed under this chapter.

(3) A provider who dispenses prescription drugs to PACE claimants by both mail and walk-in procedures will be assigned one number for mail transactions and a second number for walk-in transactions. To be considered a valid claim, a claim submitted to the Department for payment shall be identified as a claim for service by mail or for walk-in service by use of the appropriate provider number. The use of the incorrect provider number shall invalidate a claim and result in a disallowance of the related costs.

(4) A provider of PACE benefits may not charge PACE claimants additional fees above the required copayment and, if applicable, charges due for generic differential costs.

(5) Payment will not be made for prescription drugs dispensed in response to a prescription issued by a prescriber who has been precluded or excluded from the Medicare Program or the Medical Assistance Program for cause or who has committed offenses related to the standards of practice of the medical professions as regulated by the Department of State. This preclusion or exclusion for cause includes voluntary or involuntary termination for cause or voluntary or involuntary suspension for cause. The prescriptions of a prescriber whose name appears on a list issued by the Department of Public Welfare which indicates that the prescriber's participation in Medicare or Medical Assistance has been precluded or excluded will not be paid for by the PACE Program. The Department will notify providers of prescribers which it learns have been precluded or excluded from the Medical Program or Medical Assistance Program within 30 days of the date when the Department learned of these actions. The Department will reimburse providers for prescriptions written by precluded or excluded prescribers when the prescriptions were filled before the Department's notification of providers. Prescriptions written by precluded or excluded prescribers which are filled after the Department's notification are not reimbursable under the PACE Program.

(6) A payment for prescription drugs dispensed under the PACE Program is limited to a prescription filled in a quantity which:

- (i) Is consistent with the medical needs of the claimant.
- (ii) Does not exceed a 30-day supply or 100 units, whichever is less. The 100 unit limitation applies only to drugs dispensed in tablet or capsule form. Liquids, ointments, powders and other drug forms are subject only to the 30-day supply restriction.
- (iii) Does not exceed a 15-day supply and may not be renewed beyond that 15-day period in the case of a prescription for an acute condition.
- (iv) Is the maximum supply covered under the act in other cases; that is, a 30-day supply or 100 units, whichever is less, except in cases where the prescriber is utilizing a test dosage to determine the appropriateness of a specific drug for use in maintenance therapy for a chronic condition.

(7) Except for drugs prescribed for acute conditions, payment shall be made for prescriptions refilled up to and including five refills or to provide a 6-month supply, whichever occurs first, from the date of the original filling of the prescription.

(8) Payments will not be made to a claimant or to a party other than an enrolled provider.

(9) PACE Program benefits are not available to cover the costs of filling prescriptions written by prescribers who are not licensed by the Commonwealth unless the pharmacist complies with the following:

- (i) At the time of dispensing, the pharmacist shall determine that a physician not licensed by the Commonwealth to practice medicine has a

valid license to practice in the District of Columbia or one of the following states: Delaware, Maryland, New Jersey, New York, Ohio, Virginia or West Virginia.

(ii) Under procedures set forth by the Department, the pharmacist shall submit to the Department the name, address, telephone number and appropriate out-of-State physician license number.

(10) Failure by the provider to comply with paragraph (9)(i) and (ii) constitutes grounds for denial of reimbursement under the PACE Program and termination of the provider agreement.

(11) The Department will not pay providers for prescription drugs dispensed when the claimant is outside this Commonwealth.

(12) The Department will not pay providers for dispensing DESI drugs unless the prescription indicates that the prescribed DESI drug is medically necessary.

(13) The Department will not pay a provider for claims for which documentation, as required under § 22.62(c)—(e) (relating to conditions of provider participation), cannot be presented by the provider.

(g) *Generic differential.*

(1) When a claimant’s prescription permits the substitution of generically equivalent drugs and the claimant requests and purchases a more expensive brand name drug, the claimant is required to pay the provider the generic differential, as defined under § 22.2 (relating to definitions), in addition to the required copayment.

(2) When a claimant’s prescription permits the substitution of a generically equivalent drug, and the provider dispenses a more expensive brand name drug not requested by the claimant, the provider will be charged for the generic differential.

(3) When applicable under paragraphs (1) and (2), the generic differential is 50% of the average wholesale cost, as defined under § 22.2, of the brand name drug dispensed. The Department may increase or decrease the amount of the generic differential based upon the financial experience projections of PACE. Changes will be effective when announced in the *Pennsylvania Bulletin*.

Example: Usual and customary charge of drug demanded by cardholder	\$20
Average wholesale cost (AWC/AWP) of drug	\$18
Generic differential (50% OF AWC/AWP)	\$9

Copayment	\$6
Amount collected by provider	\$15
Amount billed to PACE	\$5
(Usual and custom- ary charge minus amount collected)	

(h) *Payment procedures of the Department.*

(1) The national drug pricing system currently in use by the Department is “The Drug Topics Red Book.” The Department may change that system after consultation with the Pharmaceutical Assistance Review Board to be effective upon announcement in the *Pennsylvania Bulletin*.

(2) The Department’s payments to enrolled providers will be remitted within 21 calendar days of the Department’s receipt of a complete and approvable claim.

(3) Claims containing errors or omissions which are the fault of the enrolled provider will be rejected by the Department and returned to the enrolled provider within 21 days of the date of receipt.

(4) Enrolled providers are entitled to interest for payments not remitted by the Department within the 21-day period on complete and approvable claims at a rate to be determined by the Department of Revenue, under section 1507 of The Fiscal Code (72 P. S. § 1507) and approved by the Pharmaceutical Assistance Review Board. Interest payments by the Department will be limited to that time period beginning with the 22nd day and ending with the issuance of payment.

(5) The Department reserves the right to refuse payment of claims submitted more than 90 days after the date the provider dispensed the prescription drugs covered by the claim.

(6) The PACE Program is the payor of last resort. Claimants are required under §§ 22.33(1)(ii)(D) and 22.51(1) (relating to responsibilities of the applicant in the application process; and responsibilities regarding eligibility) to inform the Department of coverage they may have under other prescription drug benefit programs. The PACE Program will accept responsibility only for costs not covered by the claimant’s other prescription drug benefit program.

Example—If a claimant purchases a prescription drug costing \$15 and has other coverage which provides \$7 toward the cost of the prescription, then \$6 would be payable by the claimant in the form of a copayment, \$7 by the other resource and \$2 by PACE.

(i) *Other benefits.* The Department will be responsible for the coordination and collection of other benefits due in cases where enrolled providers were unable to determine the availability of the other benefits or to secure payment for costs due under the other benefit programs. When PACE ben-

efits have inadvertently been paid to cover costs payable under other prescription benefit programs, the Department will take the necessary steps to recover those costs plus interest.

Source

The provisions of this § 22.11 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; corrected July 6, 1984, effective June 16, 1984, 14 Pa.B. 2331; amended December 13, 1985, effective December 14, 1985, 15 Pa.B. 4427; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143; amended June 14, 1991, effective July 1, 1991, 21 Pa.B. 2722. Immediately preceding text appears at serial pages (153445) to (153451).

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions); 6 Pa. Code § 22.62 (relating to conditions of provider participation); and 6 Pa. Code § 22.84 (relating to administrative actions and penalties).

CLAIMANT ELIGIBILITY

§ 22.21. General claimant eligibility policy.

To be eligible to participate in PACE, an applicant shall be a resident of this Commonwealth, be 65 years of age or older, have annual income less than the maximum annual income and not be qualified for payment for prescription drug benefits under a public assistance program or qualified for full coverage of prescription drugs under another plan of insurance or assistance. These eligibility conditions are detailed in §§ 22.22—22.26.

Source

The provisions of this § 22.21 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial page (103124).

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions).

§ 22.22. Residence provisions.

(a) *Residence criteria.* Except as set forth in subsection (d), a resident is a person who has lived within this Commonwealth, under color of law, for a period of at least 90 consecutive days immediately preceding the date the applicant's application to participate in PACE is received by the Department. The applicant shall have or intend to have a fixed place of abode in this Commonwealth, with the present intent of maintaining a permanent home in this Commonwealth for the indefinite future. The burden of establishing proof of residence within this Commonwealth is on the applicant. Included in this section are persons residing in long-term care institutions located within this Commonwealth.

(b) *Documentation of residence.* The following are categories of documents which may be submitted as proof of residence in this Commonwealth. Documents submitted shall show the applicant's name and address. If the application submitted has the applicant's current name and address preprinted upon it, no other piece of documentation of residence is required to be submitted. Otherwise, one document from one of the following categories shall be photocopied and be provided as reasonable proof of residence:

- (1) Motor vehicle records, such as a valid driver's license.
- (2) Housing records, such as mortgage records, rent receipts or certification of residency in a nursing home.
- (3) Public utility records and receipts, such as electric bills.
- (4) Local tax records.
- (5) A completed and signed, Federal, State or local income tax return with the applicant's name and address preprinted on it.
- (6) Records of contacts with public or private social agencies.
- (7) Employment records, including records of unemployment compensation.
- (8) Additional documents or records determined acceptable by the Department and indicated in the instructions which accompany the PACE application form.

(c) *Other documentation.* If an individual does not have one or more documents listed in subsection (b), the individual may submit other documentation showing the applicant's name and address for consideration by the Department. Documentation evidencing financial transactions, such as bank statements or credit card statements, are preferable. If it can be determined that no documentation of residency is available to the applicant, PACE may accept a notarized statement from a family member or other responsible person. The statement shall include the relationship to the applicant of the person making the statement, the address and length of residence of the applicant, and shall be dated within the current or preceding year. The statement shall include the address and telephone number of the person making the statement. These statements shall be approved by the Department before they will be accepted.

(d) *Exception to the 90-day residency provision.* An applicant who has not lived within this Commonwealth for 90 consecutive days will be considered a resident under the PACE Program if the applicant can establish intent to maintain a permanent home in this Commonwealth for the indefinite future by submitting a photocopy of a document from one of the following categories:

- (1) Motor vehicle records, such as a valid driver's license.
- (2) Public utility records and receipts, such as electric bills.
- (3) Local tax records.
- (4) A completed and signed Federal, State or local income tax return with the applicant's name and address preprinted on it.

(e) *Continued residence.* Residence in this Commonwealth of a claimant absent from this Commonwealth shall be based upon whether or not the claimant intends to return to this Commonwealth or remain indefinitely in another jurisdiction. If a claimant leaves this Commonwealth with the intent to establish a place of abode elsewhere, the claimant becomes ineligible to participate in PACE effective as of the date of exit from this Commonwealth.

Source

The provisions of this § 22.22 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (103124) to (103125).

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions); 6 Pa. Code § 22.21 (relating to general claimant eligibility policy); 6 Pa. Code § 22.33 (relating to responsibilities of the applicant in the application process); and 6 Pa. Code § 22.42 (relating to responsibilities of the claimant in the eligibility redetermination process).

§ 22.23. Age provisions.

(a) *Age limit.* An applicant shall be 65 years of age or older to participate in the PACE Program.

(b) *Early application.* An applicant may, in order to assist in the timely determination of eligibility, submit a completed application to participate in PACE up to 30 calendar days prior to the actual date that the applicant will become 65 years of age.

(c) *Documentation of age.* The following are examples of documents, one of which shall be photocopied and provided as reasonable proof of age:

- (1) Birth certificate or delayed birth certificate.
- (2) Church baptismal record showing date of birth.
- (3) Hospital birth record established during the first few years of life and certified by the custodian of the record.
- (4) Additional documents or records determined acceptable by the Department and indicated on the instructions which accompany the PACE application form.

(d) *Other documentation of age.* If none of the documents listed in subsection (c) establishing age or date of birth is available, the applicant shall furnish for consideration photocopies of at least two other types of documents showing age or date of birth. Examples of these documents include a Bible or other family record, employment record, voting or registration record and immunization record.

Source

The provisions of this § 22.23 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (103125) and (96825).

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions); 6 Pa. Code § 22.21 (relating to general claimant eligibility policy); and 6 Pa. Code § 22.33 (relating to responsibilities of the applicant in the application process).

§ 22.24. Income provisions.

(a) *Income limits.* Applicants shall have an annual income of \$11,999.99 or less in the case of a single individual, or \$14,999.99 or less combined income in the case of married couples, with the following exceptions:

(1) Married applicants will be subject to the income provisions for single individuals if each spouse maintains a separate residence and neither spouse has access to, or receives support from, the other's income during the year for which income is declared as provided for in subsections (d) and (f).

(2) Married applicants will be subject to the income provisions for single individuals if either spouse is a resident of a long-term care facility during the year for which income is declared as provided for in subsections (d) and (f).

(3) Recently widowed or divorced applicants, will be subject to the income provisions for married couples if they had access to, or received support from, the former spouse's income during the year for which income is declared as provided for in subsections (d) and (f).

(b) *Income inclusions.* Income includes income from whatever source derived, including but not limited to the following:

- (1) Salaries.
- (2) Wages.
- (3) Bonuses.
- (4) Commissions.
- (5) Income from self-employment or partnership income.
- (6) Alimony.
- (7) Support money.
- (8) Cash public assistance and relief.
- (9) The gross amount of pensions or annuities including Railroad Retirement benefits.
- (10) The gross amount of cash benefits received under the Federal Social Security Act, except Medicare benefits.
- (11) Benefits received under State unemployment insurance laws.
- (12) Veteran's disability payments.
- (13) Interest, including interest received from the Federal government, State government or an instrumentality or political subdivision thereof.
- (14) Realized capital gains except as provided in subsection (c).

(15) Rental income.

(16) Workmen's compensation benefits and the gross amount of loss of time insurance benefits, except those benefits granted under section 306(c) of the Workmen's Compensation Act (77 P. S. § 513).

(17) Life insurance benefits and proceeds, except as provided in subsection (c).

(18) Gifts or bequests of cash or property, other than transfers by gift between members of a household, in excess of a total value of \$300.

(19) Any amount of money or the fair market value of a prize, such as an automobile or a trip won in a lottery, a contest or by a form of gambling.

(20) Royalties.

(21) Dividends.

(c) *Income exclusions.* Income does not include the following:

(1) Surplus food or other noncash relief, including food stamps, supplied by a government agency.

(2) Property tax rebate payments, rent rebate payments, and inflation dividends received under the Senior Citizens Rebate and Assistance Act (72 P. S. §§ 4751-1—4751-12).

(3) Medicare benefits.

(4) The first \$5,000 of the total of death benefit payments received upon the death of each person from whom the benefits may be due.

(5) The difference between the purchase price of a person's residence and its selling price, to the extent that the person uses the proceeds from the sale of the residence to purchase a different residence within 2 years of the sale of the former residence.

(6) The amount of damages received, whether by civil suit or settlement agreement, on account of personal injuries. Damages received means an amount received through prosecution of a legal suit, action or other claim based on tort or tort type rights, or through a settlement agreement entered into in lieu of litigation, except to the extent that the amount duplicates reimbursements previously received. Damages include black lung benefits and benefits granted under section 306(c) of the Workmen's Compensation Act (77 P. S. § 513).

(7) Payments provided to eligible low income households under the Commonwealth's Low Income Home Energy Assistance Program.

(8) With reference to client payments received by home providers of the domiciliary care program administered by the Department under the act of June 20, 1978 (P. L. 477, No. 70) (71 P. S. §§ 581-1—581-12), that portion of the payments which, for any specific income year, does not exceed the actual expenses of providing domiciliary care services.

(d) *Declaration of income.* An applicant shall declare the total annual income for the calendar year immediately preceding the year in which the applicant applies to participate in PACE.

Example—An applicant applies to participate in the PACE Program on August 16, 1990. The applicant shall declare his total annual income for the previous year, which is calendar year 1989. Accordingly, the applicant shall declare all of the income which he received from January 1, 1989 up to and including December 31, 1989.

(1) The applicant shall indicate, in spaces provided on the PACE Application Form, the source and amount of each type of annual income.

(2) The applicant shall declare all income, as defined in this section, identifying each source separately.

(3) A married applicant, unless covered under subsection (a), shall declare all applicable income of the spouse, identifying each source separately. If only one spouse is applying for PACE benefits, that spouse shall declare all applicable income of both spouses.

(4) The failure to provide truthful information with respect to this section will subject the applicant to the criminal penalties provided in § 22.72 (relating to prohibited acts and criminal penalties).

(e) *Documentation of income.* An applicant or a claimant may be required to document the annual receipt of income, derived from all sources, when requested to do so by the Department. Whenever this is the case, the following are examples of documents, photocopies of which shall be provided as reasonable proof of income:

(1) Federal, State or local income tax returns.

(2) Pension checks, annuity checks or checks from other sources of income. When the checks are issued monthly, or on some other less-than-annual basis, a photocopy of the check for a single month, or other applicable period, will suffice. United States Treasury checks may not be photocopied.

(3) Statements from a financial institution where direct deposit is made for the applicant or claimant or statements from a government agency, such as the Social Security Administration or the Railroad Retirement Board.

(4) Another type of document which is likely to verify the type and amount of income.

(f) *Period used to determine income.* For purposes of PACE eligibility, the income, as defined in § 22.2 (relating to definitions) and this section, used to determine eligibility will be that income received by an applicant during the calendar year immediately preceding the year in which the applicant applies to participate in PACE.

Source

The provisions of this § 22.24 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, except subsection (a) which shall take effect April 1, 1985, 15 Pa.B. 1163; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (96825) to (96828).

Notes of Decisions*Declaration of Income*

The Department of Aging did not err in denying the claimant benefits based upon the receipt of past due Social Security benefits in 1999 when, in fact, those benefits were attributable to years prior to 1997, since this regulation illustrates that all income acquired between January and December of a given year is to be considered as income. *Scanlon v. Department of Public Welfare*, 739 A.2d 635 (Pa. Cmwlth. 1999).

Participation in PACE Based on Preceding Year's Income

Department of Aging Pharmaceutical Assistance Contract for the Elderly (PACE) regulation that eligibility is based on income received by applicant during calendar year immediately preceding year in which applicant applies to participate is not an unreasonable interpretation of the statute. *Peek v. Department of Aging*, 873 A.2d 43, 47 (Pa. Cmwlth. 2005).

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions); 6 Pa. Code § 22.21 (relating to general claimant eligibility policy); 6 Pa. Code § 22.33 (relating to responsibilities of the applicant in the application process); and 6 Pa. Code § 22.42 (relating to responsibilities of the claimant in the eligibility redetermination process).

§ 22.25. Other third-party benefits.

(a) Applicants who are qualified for coverage of payments for prescription drugs under a public assistance program are ineligible for PACE as long as they are so qualified.

(b) Applicants who are qualified for full coverage of payments for prescription drugs under another plan of assistance or insurance are ineligible for PACE as long as they are so qualified.

(c) Applicants or claimants who are qualified for partial payments for prescription drugs under another insurance plan are eligible for PACE, but may receive reduced assistance from PACE.

Source

The provisions of this § 22.25 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; corrected July 6, 1984, effective June 16, 1984, 14 Pa.B. 2331; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (96828) to (96829).

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions); 6 Pa. Code § 22.21 (relating to general claimant eligibility policy); 6 Pa. Code § 22.33 (relating to responsibilities of the applicant in the application process); 6 Pa. Code § 22.42 (relating to responsibilities of the claimant in the eligibility redetermination process); and 6 Pa. Code § 22.51 (relating to responsibilities regarding eligibility).

§ 22.26. PACE eligibility.

(a) Eligibility for PACE is established during a calendar year when a valid PACE application is approved, and remains in effect until the expiration date stated on the PACE identification card, unless there is cause for earlier termination.

(b) The PACE eligibility effective date and expiration date shall appear on the face of the PACE identification card issued by the Department to claimants.

Source

The provisions of this § 22.26 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions); and 6 Pa. Code § 22.21 (relating to general claimant eligibility policy).

APPLICATION PROCESS**§ 22.31. General provisions.**

The application process includes all activity relating to a request for eligibility determination. It begins with the receipt by the Department of an eligibility application and continues until there is an official disposition of the request by the Department.

Source

The provisions of this § 22.31 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

§ 22.32. Initiating the application process.

An applicant requests a determination of eligibility to participate in the PACE Program by completing a PACE application form and submitting it to the Department.

Source

The provisions of this § 22.32 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

§ 22.33. Responsibilities of the applicant in the application process.

The applicant has the responsibility to conform to the following:

- (1) Complete the PACE application form legibly and accurately.
 - (i) Answer questions fully.
 - (ii) Present necessary evidentiary documents under the following requirements:
 - (A) Regarding residence, one of the documents listed in § 22.22(b) (relating to residence provisions) or other documentation of residence acceptable to the Department, except when the application has the applicant's name and current address preprinted on it.
 - (B) Regarding age, one of the documents listed in § 22.23(c) (relating to age provisions), or two of the other types of documentation of age listed in § 22.23(d).
 - (C) Regarding income, documents required to substantiate each source of income, as defined in § 22.2 (relating to definitions) and as set forth in § 22.24(e) (relating to income provisions), whenever required to do so by the Department.
 - (D) Regarding qualification for other benefits, information identifying participation in any of the other programs referred to in § 22.25 (relating to other third-party benefits).
 - (iii) Read the certification and authorization statement.
 - (iv) Sign or mark the application form.
 - (v) Obtain signatures required by the Department on the instructions which accompany the application form.

- (2) Submit the completed PACE application form to the Department.
- (3) Assist the Department in securing evidence which corroborates the applicant's statements when necessary.
- (4) Consent to a review by the Department of information submitted on the application form, with reasonable prior notice to the applicant, if selected for review. PACE eligibility may be denied if the applicant refuses to cooperate with the request.

Source

The provisions of this § 22.33 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; corrected July 6, 1984, effective June 16, 1984, 14 Pa.B. 2331; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (96829) to (96830).

Cross References

This section cited in 6 Pa. Code § 22.11 (relating to general payment principles).

§ 22.34. Authorized agent.

(a) *Adjudicated incompetency.* When the applicant is adjudicated incompetent, the Department will accept the court-appointed guardian as an authorized agent for the purpose of initiating an application on behalf of the applicant.

(b) *Incapacity.* If the applicant is incapable of filing an application on his own behalf, the Department will accept one of the following persons designated by the applicant, listed in the order of priority, as an authorized agent for the purpose of initiating the application if a power of attorney or agent's affidavit of authority accompanies the application:

- (1) A close relative by blood or marriage, such as a parent, spouse, son, daughter, brother or sister.
- (2) A representative payee designated by the Social Security Administration.
- (3) A representative of a public/private social service agency, of which the applicant is a client, who has been designated by the agency to so act.

Source

The provisions of this § 22.34 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (96830) to (96831).

Cross References

This section cited in 6 Pa. Code § 22.43 (relating to authorized agent).

§ 22.35. Certification.

The applicant shall certify that the answers to the questions and items on the application form are true and accurate to the best of the applicant's knowledge. Before the application can be processed, the certificate shall be dated and signed

by the applicant and any other party whose signature is required by the Department in the instructions which accompany the application form.

Source

The provisions of this § 22.35 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163. Immediately preceding text appears at serial page (89803).

§ 22.36. Authorization.

By signing/marketing the certification and authorization statement on the application form, the applicant authorizes:

- (1) The Department to verify any information on the form by contacting the Social Security Administration, the Internal Revenue Service, the Department of Revenue, employers or others, as the need arises.
- (2) The Department to visit, with reasonable prior notice to the applicant, for the purpose of determining the validity of claims made under the PACE Program.

Source

The provisions of this § 22.36 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

§ 22.37. Right of appeal.

Departmental actions against an applicant which relate to the application process are subject to the right of appeal under §§ 22.91—22.95 (relating to claimant hearings and appeals).

Source

The provisions of this § 22.37 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

ELIGIBILITY REDETERMINATION PROCESS

§ 22.41. General provisions.

A claimant requests a redetermination of eligibility to participate in the PACE Program each year by completing a PACE application form and submitting it to the Department. Eligibility will continue without interruption each year if the claimant completes and submits the application form on or before the date specified by the Department. If the application form is not submitted at that time, eligibility will begin after the date when a completed application form is received and approved by the Department.

Source

The provisions of this § 22.41 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

§ 22.42. Responsibilities of the claimant in the eligibility redetermination process.

The claimant has the responsibility to conform to the following:

- (1) Complete the PACE application form legibly and accurately.
 - (i) Answer questions fully.
 - (ii) Present necessary evidentiary documents under the following requirements:
 - (A) Regarding residence, a photocopy of one of the documents listed in § 22.22(b) (relating to residence provisions) or other documentation acceptable to the Department, except when the application has the claimant's current name and address preprinted on it. A claimant applying for redetermination of eligibility is not required to submit documentation of residence if the claimant's name and current address is preprinted on the application form.
 - (B) Regarding income, documents required to substantiate each source of income, as defined in § 22.2 (relating to definitions) and as set forth in § 22.24(e) (relating to income provisions), whenever required to do so by the Department.
 - (C) Regarding qualification for other benefits, information identifying participation in the other programs referred to in § 22.25 (relating to other third-party benefits).
 - (iii) Read the certification and authorization statement.
 - (iv) Sign or mark the application form.
 - (v) Obtain signatures required by the Department on the instructions which accompany the application form.
- (2) Submit the completed application form to the Department.
- (3) Assist the Department in securing evidence which corroborates the claimant's statements when necessary.
- (4) Consent to a review by the Department of information submitted on the application form, with reasonable prior notice to the claimant, if selected for review. PACE eligibility may be terminated if the claimant refuses to cooperate with the request.

Source

The provisions of this § 22.42 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; amended December 15, 1990, effective December 16, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (96832) and (103127).

§ 22.43. Authorized agent.

In those instances when the claimant is either adjudicated incompetent or is incapable of filing an application form on the claimant's own behalf, the Department will accept as authorized agents the persons designated in § 22.34(a) and

(b) (relating to authorized agent) for the purpose of submitting the application form on behalf of the claimant.

Source

The provisions of this § 22.43 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

§ 22.44. Certification.

The claimant shall certify that all the answers to the questions and items on the application form are true and accurate to the best of the claimant's knowledge. Before the application form can be processed, the certification shall be dated and signed by the claimant and by any other party whose signature is required by the Department in the instructions which accompany the application form.

Source

The provisions of this § 22.44 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163. Immediately preceding text appears at serial page (89805).

§ 22.45. Authorization.

By signing or marking the certification and authorization statement on the application form, the claimant authorizes:

- (1) The Department to verify information on the form by contacting the Social Security Administration, the Internal Revenue Service, the Department of Revenue, employers or others, as the need arises.
- (2) The Department to visit, with reasonable prior notice to the claimant, for the purpose of determining the validity of claims made under the PACE Program.

Source

The provisions of this § 22.45 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

§ 22.46. Right of appeal.

Departmental actions against a claimant which relate to the eligibility redetermination process are subject to the right of appeal under §§ 22.91—22.95 (relating to claimant hearings and appeals).

Source

The provisions of this § 22.46 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

CONTINUING CLAIMANT RESPONSIBILITIES

§ 22.51. Responsibilities regarding eligibility.

The claimant has the responsibility to:

22-23

- (1) Notify the Department whenever the claimant becomes eligible for another plan of assistance or insurance, as set forth in § 22.25 (relating to other third-party benefits).
- (2) Return the PACE identification card to the Department whenever becoming ineligible due to one of the following:
 - (i) Establishing residence outside of this Commonwealth.
 - (ii) Becoming eligible for full coverage of payment for prescription drugs under another plan of assistance or insurance under § 22.25(a) and (b).
- (3) Repay the Commonwealth, upon request, for the cost of benefits inappropriately paid on the claimant's behalf, if the payment was caused by an act or omission on the part of the claimant.

Source

The provisions of this § 22.51 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial page (103128).

Cross References

This section cited in 6 Pa. Code § 22.11 (relating to general payment principles).

§ 22.52. Use of the PACE identification card.

- (a) The PACE identification card shall be retained in the possession of claimant or the claimant's authorized representative and not be given to providers except for inspection and immediate return. The claimant remains responsible for its appropriate use to claim benefits. In no case may a claimant send the PACE identification card through the mail to a provider.
- (b) A claimant may claim PACE benefits only if the claimant, or the claimant's designated representative, presents the enrolled provider with a validated PACE identification card except when the claimant orders prescription services by mail.
- (c) An incapacitated claimant who is, because of the incapacity, unable to personally claim PACE benefits may designate another person to do so. Persons so designated shall, whenever they claim PACE benefits on behalf of an incapacitated claimant, present the enrolled provider with the claimant's validated PACE identification card except when they request prescription services by mail; inform the enrolled provider of their designation; and sign their own name and indicate their relationship to the incapacitated claimant on the PACE claim form. To claim PACE Program benefits through prescription services by mail, designated representatives of an incapacitated claimant shall have legal authority to represent the claimant as evidenced by power of attorney or other legal document and shall sign all forms requiring the claimant's signature.

(d) Eligibility for PACE benefits terminates upon the death of a claimant. A deceased claimant's PACE identification card should be promptly returned to the Department by the claimant's relative, representative or by another responsible person.

Source

The provisions of this § 22.52 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 13, 1985, effective December 14, 1985, 15 Pa.B. 4427. Immediately preceding text appears at serial page (96834).

Cross References

This section cited in 6 Pa. Code § 22.62 (relating to conditions of provider participation).

PROVIDER PARTICIPATION

§ 22.61. Conditions of provider eligibility.

(a) Only pharmacies and dispensing physicians that are currently licensed by the Commonwealth and which have their principal place of business in this Commonwealth are eligible to participate as providers in the PACE Program.

(b) Only services of enrolled providers which are performed and delivered within this Commonwealth are eligible for coverage under the PACE Program.

(c) Pharmacies or dispensing physicians whose PACE provider agreements have been terminated for cause, or who have been precluded or excluded for cause from participation in the Medicare Program or the Commonwealth's Medical Assistance Program are not eligible to participate as providers in the PACE Program unless they meet the requirements for re-enrollment in § 22.85 (relating to re-enrollment of providers whose agreements have been terminated).

Source

The provisions of this § 22.61 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; corrected April 12, 1985, effective March 30, 1985, 15 Pa.B. 1353; amended December 13, 1985, effective December 14, 1985, 15 Pa.B. 4427; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial page (103129).

Notes of Decisions

Failure to Keep Pharmacy License Current

The failure of a PACE provider to have a current license constitutes a material breach of the provider agreement and the recoupment of all claims made by an unlicensed provider is not excessive and constitutes liquidated damages, not a "penalty." *Calabro v. Department of Aging*, 689 A.2d 347 (Pa. Cmwlth. 1997); appeal denied 698 A.2d 596 (Pa. 1997).

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions); and 6 Pa. Code § 22.62 (relating to conditions of provider participation).

§ 22.62. Conditions of provider participation.(a) *Enrollment.*

(1) Only providers who have been enrolled in the PACE Program are qualified to receive payments made under the program.

(2) A provider seeking enrollment as a PACE provider may seek to be enrolled as a provider of walk-in prescription services, as a provider of prescription services by mail or as a provider of both kinds of services. The Department will assign separate and distinct provider numbers to be used in identifying claims submitted for reimbursement as claims for walk-in services or mail-order services and delivery as required under § 22.11(f)(3) (relating to general payment principles).

(3) In order to become enrolled in the PACE Program as a provider of walk-in prescription services, a provider shall:

(i) Meet the conditions of eligibility set forth in § 22.61 (relating to conditions of provider eligibility), both at the time of initial application for enrollment and on an ongoing basis.

(ii) Satisfactorily complete and submit to the Department the appropriate enrollment forms.

(iii) Submit a signed provider agreement with the enrollment forms which sets forth the provisions and assurances required of all participating providers and makes specific reference to the instructions in the standard provider manual relating to the dispensing of walk-in prescription services.

(4) In order to become enrolled as a provider of PACE prescription services by mail, a provider shall:

(i) Meet the conditions of eligibility set forth in § 22.61, both at the time of initial application for enrollment and on an ongoing basis.

(ii) Satisfactorily complete and submit to the Department the appropriate enrollment forms which shall include information which establishes the provider's methods and procedures for carrying out the requirements of subsection (e)(3) and § 22.63 (relating to other provisions for providing services by mail).

(iii) Submit with the enrollment forms a signed provider agreement which sets forth the standard provisions and assurance required of participating providers and makes specific reference to § 22.63 and instructions in the standard provider manual relating to the dispensing of prescription services by mail.

(5) Providers who meet all of the following conditions will not be considered to be providers of PACE benefits by mail:

(i) Those who do not have or do not take steps to develop a systematic mail order operation.

(ii) Those who limit their use of mail delivery of PACE Program benefits to claimants with whom they have already established a face-to-face customer relationship and comply with § 22.63(c)(1).

(iii) Those who do not dispense to PACE Program claimants more than ten PACE claims by mail in a given month.

(6) A provider's enrollment in the PACE Program shall be effective on the date when the signatures of the Department's authorized representatives have been affixed to the provider agreement. Except as provided for in subsection (b), no services rendered prior to that date shall be eligible for reimbursement.

(7) A provider's enrollment shall cease to be effective on the date when the Department suspends or terminates the provider agreement under § 22.84 (relating to administrative actions and penalties). Payments or reimbursements will not be made for prescription drugs dispensed on dates when a provider's enrollment is not effective.

(b) *Change of ownership.* For the purposes of this subsection, a change of ownership includes a sale, a change in corporate structure or controlling interest in the pharmacy business, the addition of a partner or other corporate reorganization. When a change of ownership is to take place in a pharmacy which has, until that time, been an enrolled provider of the PACE Program, the following applies to avoid unnecessary interruption in the participation of the pharmacy and the PACE claimants who use the pharmacy:

(1) As early as possible before the change of ownership occurs, the prospective provider shall file a PACE enrollment application and agreement with the Department.

(2) Immediately upon receipt of its pharmacy permit number, issued by the State Board of Pharmacy, the prospective provider shall notify the Department of the permit number.

(3) Upon notification of the new owner's pharmacy permit number, the Department will execute the provider agreement and enroll the new owner's pharmacy in the PACE Program.

(4) The effective date of the new owner's provider agreement shall be the date of issuance of the permit number by the State Board of Pharmacy, unless the Department is reviewing the change of ownership. If the Department is reviewing the change of ownership, the Department will determine the effective date of the new owner's provider agreement. The Department will notify the new owner that a review of the change in ownership is occurring and that the Department will not pay the provider for prescriptions filled prior to the date of a valid and fully executed provider agreement. During the period of review, the provider may service claimants with the understanding that reimbursement under the PACE Program may subsequently be disallowed if the Department determines that the provider will not be enrolled or that disenrollment of the provider is warranted.

(c) *Maintenance of prescriptions.* As required under § 22.11(f)(12), the Department will not pay for claims for which the following documentation cannot be presented, and the lack of this documentation may constitute grounds for terminating a provider agreement:

(1) An enrolled provider shall retain original hardcopy prescriptions for 4 years at the principal place of business. An original hardcopy prescription is one of the following:

(i) The original order as it was reduced to writing by the prescriber by hand, typewriter, computer or other mechanical or electronic means.

(ii) The oral order, such as one issued over the telephone, as it was originally reduced to writing by the pharmacist by hand, typewriter, computer or other mechanical or electronic means.

(2) As defined in paragraph (1), original hardcopy prescriptions which are not handwritten by the prescriber shall bear the date and the handwritten signature or the handwritten initials of the dispensing pharmacist.

(3) In addition to the original hardcopy prescription, the provider shall maintain a daily hardcopy record of filled and refilled prescriptions. The daily hardcopy record shall identify the prescriber who ordered the prescription, the patient for whom the prescription is intended, the strength and dosage of the medication, the number assigned to the prescription and the date of dispensing. The daily hardcopy record shall bear the handwritten signature or the handwritten initials of the pharmacist who filled or refilled the prescription. The data which supports the daily hardcopy record may be maintained by a manual system or by an electronic data processing system which meets the requirements in this paragraph.

(i) The provider shall assure that the system prevents improper access to, and manipulation or alteration of, stored records. The Department may develop provider instructions for the safeguarding of stored records. If the Department does develop provider instructions, they will be distributed to providers as technical assistance to facilitate the provider's compliance with this subparagraph.

(ii) Arrangements shall be made which assure completeness and continuity of prescription records if the relationship between a pharmacy and a supplier of data processing services terminates.

(iii) The system shall provide retrieval of information regarding the original dispensing and the refilling of prescriptions.

(iv) A pharmacist, and a pharmacy intern, if applicable, using a computerized system shall sign or initial the original hardcopy prescription at the time of the first dispensing and the initials of the pharmacist shall be entered into the computer record of the dispensing.

(v) The introduction of prescription refill records into the system shall meet the following criteria:

(A) The initials of the pharmacist who dispensed the refill shall be entered at the time of dispensing.

(B) One of the following:

(I) The system shall be capable of displaying a record of prescriptions refilled each day on a daily hardcopy printout of prescriptions refilled that day and the dated signature of each pharmacist whose initials appear on the printout shall be affixed, on a daily basis, to the daily hardcopy printout to certify that it is a complete and accurate record.

(II) Documentation of the required refill information at the time of dispensing shall be reduced to a hardcopy record of the prescription which contains the information required by this paragraph. The handwritten signature or the handwritten initials of the dispensing pharmacist shall be affixed on a daily basis to the hardcopy record to certify that it is a true, complete and accurate record.

(III) Documentation of the required refill information at the time of dispensing shall be reduced to a pharmacy dispensing log which contains the prescription number which leads directly to the hardcopy record of information under this paragraph in the provider's principal place of business; the signature of the PACE claimant; and the date the prescription was refilled. The handwritten signature or the handwritten initials of the dispensing pharmacist shall be affixed on a daily basis to the pharmacy dispensing log to certify that it is a true, complete and accurate record.

(vi) A pharmacy that employs a computerized system shall have an auxiliary procedure which shall be used for documentation of all new and refilled prescriptions dispensed during system downtime. The auxiliary procedure shall provide for the entry into the computer of data collected during the downtime, and the pharmacist shall insure that the maximum number of refills authorized on the original prescription has not been exceeded.

(vii) Only pharmacists, pharmacy interns or personnel authorized by, and under the direct supervision of, the dispensing pharmacist may enter prescription data into the computerized system. A person authorized to enter data into the computerized system shall be readily identifiable as being accountable for the entering of the specific data which that person entered.

(4) A change of a prescription order shall be documented on the original hardcopy prescription. Changes in the nature of a medication, the brand or manufacturer of a medication, the strength of a medication, or directions for its use are acceptable only if the consent of the prescriber was obtained before dispensing. The written explanation of the pharmacy on the prescription shall state that this was done and give the reasons for the change.

(5) Prescription records of PACE claimants shall be readily available for review, copying or photographing by authorized Commonwealth officials or

their authorized agents. “Readily available” means that the records shall be maintained in a reasonable and retrievable manner at the provider’s principal place of business.

(d) *Maintenance of other records.* Other records necessary to disclose the full nature and extent of prescription drugs, both covered and not covered by the PACE Program, which were dispensed by a provider shall be retained for 4 years and shall be available for review and copying by authorized Commonwealth officials or their authorized agents within 7 business days of a request for the records. These records include purchase orders and invoices, billing records, computer user manuals and computer security information.

(e) *Access to records.* Enrolled providers shall agree to provide reasonable access to records necessary to comply with the provisions for program review set forth in the provider agreement.

(f) *Standards of practice.*

(1) When dispensing prescription drugs to claimants enrolled in the PACE Program, enrolled providers shall conform to the standards of the State Board of Pharmacy, 49 Pa. Code §§ 27.1—27.4 and 27.11—27.18 (relating to general provisions; and standards), and the State Board of Medicine, 49 Pa. Code Chapters 16—18 (relating to State Board of Medicine—general provisions; State Board of Medicine—medical doctors; and State Board of Medicine—practitioners other than medical doctors), the Controlled Substance, Drug, Device, and Cosmetic Act (35 P. S. §§ 780-101—780-144), and other Federal and Commonwealth statutes and regulations applicable to the writing of medical prescriptions and the dispensing of prescription drugs to the general public.

(2) It is contrary to accepted standards of practice for an enrolled provider to differentiate between PACE Program claimants and the general public in levels or quality of service.

(3) Enrolled providers are prohibited from denying services to, or otherwise discriminating against, a claimant on the basis of race, color, sex, age, religious preference, national origin or handicap.

(g) *Verification of claimant identity.*

(1) *Responsibility.* It is the responsibility of enrolled providers of PACE benefits to establish the identity and current eligibility status of claimants which they serve under the PACE Program. Claims for PACE benefits received by persons who are not bona fide PACE claimants will not be considered valid claims.

(2) *Walk-in services.* When providing walk-in prescription services to PACE claimants, enrolled providers shall observe a claimant’s signed PACE identification card on each occasion when a prescription drug is dispensed to a claimant under the PACE Program. Providers are prohibited from retaining the claimant’s PACE identification card after dispensing a prescription drug and shall return the card with the prescription drug to the claimant or the claimant’s

designated representative. Providers may not request PACE claimants to send a PACE identification card through the mail.

(3) *Services by mail.* As a basis for establishing the identity of PACE claimants as program benefits are provided, an enrolled provider of PACE Program benefits by mail, shall have, or secure, and maintain on file a signature reference for each PACE claimant requesting services by mail from that provider. The signature reference shall bear the original signature of the claimant or the claimant's authorized representative and shall form a basis for signature comparisons carried out under § 22.63(d). The Department reserves the right to waive this requirement, and the related requirement of § 22.63(d)(1), for a provider who can present an alternative system of control which offers assurance to the Department that verification of claimant identity and claimant receipt of ordered prescription drugs can and will be effectively accomplished without signature references.

(h) *Designated representatives.*

(1) *Walk-in services.* As required under § 22.52(c) (relating to use of the PACE identification card), walk-in prescription services to PACE claimants may be provided to a designated representative of an incapacitated PACE claimant. Providers shall see the claimant's PACE identification card and obtain the signature and relationship to the claimant of the designated representative. If a provider has reason to believe that a person presenting a PACE claimant's identification card has not been designated by the claimant as the claimant's representative, the provider shall refuse to provide the requested prescription services as a PACE claim.

(2) *Services by mail.* As required under § 22.52(c), a designated representative requesting PACE benefits by mail shall have legal authority to represent an incapacitated claimant as evidenced by power of attorney or other legal document, and shall sign forms requiring the claimant's signature. Providers of prescription services by mail shall require designated representatives to provide documentation of their legal authority to represent the claimant.

(i) *Authenticity of prescriptions.* Prior to the dispensing of prescription drugs, the provider shall take necessary steps to identify prescriptions which may not be authentic. These steps shall include the following:

(1) Prescriptions shall be reviewed by a pharmacist for obvious irregularities, including noncompliance with prescription writing standards, dosage errors, technical errors of drug references and conflicts with claimant medication history.

(2) When an irregularity, as discussed under paragraph (1), is noted, a provider shall contact the prescriber to determine the authenticity of the prescription or, as appropriate, establish errors and make corrections.

(3) Providers shall refuse to fill prescriptions which they suspect are not authentic. If, in the professional judgment of the provider, a prescription does not appear to be authentic, the provider shall contact the indicated prescriber

by telephone to check on its authenticity. Whenever, as a result of a check, the provider is professionally convinced that the prescription is fraudulent, the provider may not return the prescription to the claimant, but shall forward it to the Department accompanied by the name, address and PACE identification card number of the claimant.

(j) *Payments.*

(1) Enrolled providers shall collect the required copayment and, if applicable, the generic differential, from each claimant for each prescription filled under the PACE Program. For the purpose of reimbursement under the program, no provider claim which relates to services for which the full copayment and an applicable generic differential have not been collected may be considered an allowable claim. Failure to comply with this subsection constitutes a false or fraudulent claim under § 22.82 (relating to false or fraudulent claims by providers).

(2) Providers shall consider as full payment for PACE-covered services the claimant copayment, the generic differential whenever applicable and the Department's payment for prescription drugs dispensed. Nothing in this section prevents a provider from appealing an inappropriate reimbursement under §§ 22.101—22.104 (relating to provider hearings and appeals).

(k) *Claimant health and safety.*

(1) *Walk-in services.* Consistent with 49 Pa. Code § 27.18(c) (relating to standards of practice), enrolled providers of walk-in services are authorized to take appropriate steps to prevent the inadvertent misutilization of prescription drugs, with special concern for the potentially dangerous interaction of two or more prescription drugs from different prescribers. Steps may include telephone consultation with prescribing physicians and the maintenance of a medication history on each claimant to whom prescription drugs are dispensed.

(2) *Services by mail.* Enrolled providers offering mail-ordered or mail-dispensed prescription service shall have or establish and maintain a medication history on PACE claimants provided with these services.

(3) *General.* When the Department determines that, in the interest of a claimant's health and safety, a prescription should not be filled, the Department may take steps in accordance with the act and this chapter to prevent the dispensing of the prescribed drug.

Source

The provisions of this § 22.62 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; amended December 13, 1985, effective December 14, 1985, 15 Pa.B. 4427; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (103129) to (103130), (115961) to (115962) and (103133) to (103134).

Cross References

This section cited in 6 Pa. Code § 22.2 (relating to definitions); 6 Pa. Code § 22.11 (relating to general payment principles); and 6 Pa. Code § 22.63 (relating to other provisions for providing services by mail).

§ 22.63. Other provisions for providing services by mail.

(a) *Mail orders for prescription drugs.* Providers shall provide PACE claimants who wish to request PACE Program benefits by mail with order forms and clear instructions for submitting mail orders. As a minimum, order forms submitted shall include the claimant's signature, address, telephone number, where applicable and PACE identification card number. For each initial mail-ordered prescription to be filled, a valid prescription as written by the licensed prescriber shall accompany the order form. When mail-ordered prescription drugs can not be delivered by mail as restricted by the standards of the State Board of Pharmacy, 49 Pa. Code § 27.18 (relating to standards of practice) and other applicable State and Federal statutes, or can not be dispensed for another reason, the provider shall, within 2 working days of the provider's receipt of the mail order, notify the claimant and the prescriber by telephone or mail and return the written prescription to the claimant, except as provided for under § 22.62(g)(3) (relating to conditions of provider participation).

(b) *Telephone prescription orders.* Refill prescription orders may be accepted by telephone. Providers of prescription services by mail may not accept initial prescription orders for PACE Program benefits by telephone except when all of the following control steps have been taken:

- (1) The provider has secured the name, address and telephone number of the licensed prescriber making the telephone order.
- (2) The provider has secured the license number assigned by the appropriate State licensing board to the licensed prescriber making the telephone order.
- (3) The provider has secured the United States Drug Enforcement Administration registration number of the licensed prescriber making the telephone order unless that prescriber has no registration number.
- (4) The provider has verified that the information secured is correct and that the telephone order originated from the licensed prescriber.

(c) *Dispensing prescription drugs by mail.*

(1) Prescription drugs dispensed by mail may not be mailed to an address outside this Commonwealth. Packages used for the dispensing of prescription drugs by mail shall bear the words "DO NOT FORWARD" on the face which bears the claimant's address.

(2) A prescription drug delivered by mail shall be accompanied, as a minimum by the following:

- (i) A Universal Claim Form.
- (ii) Clear instructions to the claimant about the completion, signing and return of the Universal Claim Form accompanied by payments due from the

claimant if full payment has not been received in advance of delivery. These instructions shall advise the claimant that the Universal Claim Form and payments due shall be returned to the provider within 5 days of the claimant's receipt of the prescription drug.

(iii) Information regarding the use and storage of the prescription drug, as appropriate.

(iv) A postage paid, provider self-addressed envelope to facilitate the claimant's response to receipt of the prescription drug.

(d) *Other provisions for control of PACE benefit utilization.*

(1) When a provider authorized to provide prescription services by mail to PACE claimants observes irregularities in prescriptions, dosages, medication history, prescriber utilization, mailing address, claimant name or PACE identification card number or other similar kinds of irregularities, the provider shall make an immediate comparison of signatures in the claimant's file.

(2) The provider shall discontinue prescription services by mail to a claimant who fails to return the Universal Claim Form appropriately completed, fails to submit all due claimant payments, or is suspected of submitting false or fraudulent prescription order or false or fraudulent information on a Universal Claim Form.

(3) Whenever a provider of prescription services by mail discontinues services under paragraph (2), the provider shall notify the Department of the claimant's name and PACE identification card number and the name of the prescriber of prescriptions related to the reasons for the provider's decision to discontinue services.

(e) *Mail order service provider accessibility to claimants.*

(1) Enrolled providers authorized to provide prescription services by mail shall, as required in the provider agreement, arrange for access by claimants and appropriate medical personnel treating a claimant to a registered pharmacist in the event of drug concerns and emergency situations including, but not limited to, the following:

- (i) Disturbing drug side effects and reactions.
- (ii) Drug interactions.
- (iii) Dosage.
- (iv) Drug ingestion or administration and proper storage.
- (v) Drug identification—for example—in the event of lost labels.
- (vi) Emergency medical treatment of a claimant.

(2) Access shall include the acceptance of collect calls from claimants and appropriate medical personnel or a toll-free telephone number, accessible by claimants and appropriate medical personnel on a 9 a.m. to 5 p.m. basis during the days when the pharmacy is normally open for business. The provider shall issue clear instructions to the claimant regarding the access number and its appropriate use.

Source

The provisions of this § 22.63 adopted December 13, 1985, effective December 14, 1985, 15 Pa.B. 4427; corrected December 27, 1985, effective December 14, 1985, 15 Pa.B. 4581.

Cross References

This section cited in 6 Pa. Code § 22.62 (relating to conditions of provider participation).

MISUTILIZATION AND ABUSE OF PROGRAM BENEFITS**§ 22.71. False or fraudulent claims by applicants and claimants.**

Applicants, claimants or other persons submit a false or fraudulent claim subject to administrative action and penalties of § 22.73 (relating to administrative actions and penalties) if they commit one or more of the following acts:

- (1) Make or cause to be made a false statement or representation of a material fact in any application for any benefit.
- (2) Attempt to secure for personal use or the use of another individual an unauthorized benefit by concealing or failing to disclose known information which would result in the rejection of an application for initial or continued eligibility for the benefit.
- (3) Having made application to receive a benefit for personal use or the use of another and having received it, convert the benefit or a part thereof to a use other than that for which it was intended.
- (4) Seek to obtain from providers excessive services or benefits beyond what is reasonably needed, as determined by the Department, for the treatment of a diagnosed condition of the claimant.
- (5) Borrow or use a PACE identification card to which the person is not entitled or otherwise gain or attempt to gain benefits under the PACE Program if the person has not been determined eligible for the program and enrolled in it.

Source

The provisions of this § 22.71 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial page (103137).

Cross References

This section cited in 6 Pa. Code § 22.73 (relating to administrative actions and penalties).

§ 22.72. Prohibited acts and criminal penalties.

(a) It is unlawful for a person to submit a false or fraudulent claim or application under the act; to aid or abet another in the submission of a false or fraudulent claim or application; to receive benefits or reimbursement under a private, State or Federal program for prescription assistance and claim or receive duplicative benefits under this chapter; to solicit, receive, offer or pay a kickback,

bribe or rebate, in cash or in-kind, from or to a person in connection with the furnishing of services under the act; or to otherwise violate the act. A person who commits a prohibited act shall be charged with a criminal offense under 18 Pa.C.S. (relating to the Crimes Code).

(b) A person who is found guilty of a criminal offense under the act is subject to repay three times the value of any material gain received as a result of the offense.

Source

The provisions of this § 22.72 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (103138) and (115963).

Cross References

This section cited in 6 Pa. Code § 22.24 (relating to income provisions).

§ 22.73. Administrative actions and penalties.

(a) A person who is convicted of a violation of § 22.71 (relating to false or fraudulent claims by applicants and claimants) shall, upon notification by the Department, be terminated from the program.

(b) If the Department determines that a claimant misuses or abuses PACE benefits, the Department is authorized to restrict that claimant to a provider of the Department's choice.

(c) If the Department determines that a claimant has violated § 22.71, the Department will have the authority to suspend or terminate the claimant's enrollment in the PACE Program.

(d) If the Department determines that a claimant has violated § 22.71, the Department may request the Attorney General to initiate appropriate proceedings against the claimant.

Source

The provisions of this § 22.73 adopted December 15, 1984, effective December 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial page (115963)

Cross References

This section cited in 6 Pa. Code § 22.71 (relating to prohibited acts by applicants and claimants).

§ 22.74. Claimant right of appeal.

Departmental actions against an applicant or claimant for misutilization and abuse of program benefits are subject to the right of appeal under §§ 22.91—22.95 (relating to claimant hearings and appeals).

Source

The provisions of this § 22.74 adopted December 15, 1984, effective December 16, 1984, 14 Pa.B. 2709.

PROVIDER MISUTILIZATION AND ABUSE**§ 22.81. Utilization control.**

(a) Enrolled providers are required, upon request, to furnish the Department with medical and fiscal records relating to participation in PACE. Providers shall fully cooperate with audits and reviews made by the Department for the purpose of determining the validity of claims and the reasonableness and necessity of benefits provided or for another purpose.

(b) Providers shall furnish to the Department, within 15-calendar days of request, complete information related to PACE-related business transactions.

(c) Under § 22.84 (relating to administrative actions and penalties), failure of a provider to comply with the Department's request for information referred to in this section may result in the termination of a provider's enrollment in the PACE Program.

(d) Enrolled providers shall respond in a complete manner to inquiries by utilization review committees within 7 business days of a committee's request.

Source

The provisions of this § 22.81 adopted December 15, 1984, effective December 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (115963) to (115964).

§ 22.82. False or fraudulent claims by providers.

An enrolled provider submits a false or fraudulent claim if the provider directly or indirectly commits one or more of the following acts:

(1) Submits false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled for dispensing prescription drugs under PACE.

(2) Submits a claim for dispensing only part of a prescription amount which is less than the maximum limit of the program except when the provider can document that insufficient inventory prevented the dispensing of the program limit and that no additional dispensing fee or copayments were charged for dispensing the remainder of the prescription at a later time.

(3) Submits false information to obtain authorization to dispense prescription drugs under PACE.

(4) Solicits, receives, offers or pays remuneration, including a kickback, bribe or rebate, directly or indirectly in cash or in kind, from or to a person in connection with the dispensing of prescription drugs or referral of claimants for prescription drugs.

(5) Submits a duplicate claim for prescription drugs for which the provider has already received or claimed reimbursement from any source.

(6) Submits a claim for prescription drugs which were not dispensed by the provider at the provider's principal place of business or were not dispensed to a claimant.

(7) Submits a claim for prescription drugs dispensed which are not documented in the prescribed manner. See 49 Pa. Code Chapters 16—18 (relating to State Board of Medicine—general provisions; State Board of Medicine—medical doctors; and State Board of Medicine—practitioners other than doctors) and 49 Pa. Code § 27.78 (relating to standards of practice).

(8) Submits a claim, order or prescription, for prescription drugs which are of little or no benefit to the claimant, are below accepted treatment standards or are not medically necessary, in the case of a dispensing physician who is a provider.

(9) Submits a claim which misrepresents the description of the prescription drugs dispensed, the date of service, the identity of the claimant, the identity of the prescriber or the identity of the actual provider.

(10) Submits a claim for a prescription drug dispensed under PACE at a cost that is greater than the provider's usual charge to the general public.

(11) Submits a claim for a prescription drug dispensed for which the provider has not collected from the claimant all due payments, including the required copayment and any applicable generic differential.

(12) Enters into an agreement, combination or conspiracy to obtain or aid another in obtaining from the Department payment to which the provider or other person is not entitled.

(13) Submits a claim for prescription drugs dispensed to a claimant outside this Commonwealth.

Source

The provisions of this § 22.82 adopted December 15, 1984, effective December 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (115964) and (96841).

Notes of Decisions

Violation of Agreement

Pharmacy that participated in the Pharmaceutical Assistance Contract for the Elderly program sought return of moneys Department of Aging recouped from claims it submitted to the Department; pharmacy violated its provider agreement by failing to use the correct National drug code on its claims for reimbursement, which authorized the Department to seek restitution of moneys for which it had reimbursed pharmacy. *Christian St. Pharm. v. Pa. Dept. of Aging*, 946 A.2d 798, 802 (Pa. Cm-wth. 2008).

Cross References

This section cited in 6 Pa. Code § 22.62 (relating to conditions of provider participation); and 6 Pa. Code § 22.84 (relating to administrative actions and penalties).

§ 22.83. Prohibited acts and criminal penalties.

(a) It is unlawful for a person to submit a false or fraudulent claim or application under the act; to aid or abet another in the submission of a false or fraudulent claim or application; to receive benefits or reimbursement under a private, State or Federal program for prescription assistance and claim or receive duplicative benefits under this chapter; to solicit, receive, offer or pay a kickback, bribe or rebate, in case or in-kind, from or to a person in connection with the furnishing of services under the act; or to otherwise violate a provision of the act. A person who commits a prohibited act shall be charged with a criminal offense under 18 Pa.C.S. (relating to the Crimes Code).

(b) A person who is found guilty of a criminal offense under the act is subject to repay three times the value of any material gain received as a result of the offense.

Source

The provisions of this § 22.83 adopted December 15, 1984, effective December 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial page (96841).

Cross References

This section cited in 6 Pa. Code § 22.101 (relating to provider appeals).

§ 22.84. Administrative actions and penalties.

(a) *Grounds for action.* The Department may terminate an enrolled provider's agreement and seek restitution from that provider if it determines that the provider, owner of the provider, an employe of the provider or an agent of the provider has done one of the following:

- (1) Failed to comply with § 22.82 (relating to false or fraudulent claims by providers) or other provisions of the PACE Program.
- (2) Failed to comply with the conditions of participation in the PACE Program.
- (3) Failed to comply with the terms of the provider agreement.
- (4) Been precluded or excluded for cause, either voluntarily or involuntarily, from Medicare or Medical Assistance.
- (5) Been convicted of a Medicare or Medical Assistance related criminal offense as certified by a Federal, State or local court.
- (6) Been convicted of a criminal offense under State or Federal laws relating to the practice of the provider's profession as certified by a court.
- (7) Been subject to license suspension or revocation following disciplinary action entered against the provider by the State licensing or certifying agency.
- (8) Had a controlled drug license withdrawn or failed to report to the Department changes in the provider's Drug Enforcement Agency Number.
- (9) In the case of dispensing physicians who are providers, dispensed prescriptions which the Department has determined to be harmful to the claimant, of inferior quality or medically unnecessary.
- (10) Refused to permit authorized State or Federal officials or their agents to examine the provider's medical, fiscal or other records as necessary to verify claims under the PACE Program.

(b) *Procedures for terminating provider agreements.*

(1) The Department, upon notice, may terminate the agreement of, and suspend payments to, an enrolled provider.

(2) Termination for criminal conviction or administrative action will be as follows:

(i) The Department will terminate an enrolled provider's agreement for a period of up to 5 years if the provider is convicted of a Medicare/Medical Assistance related crime or a criminal offense under State or Federal law relating to the practice of the provider's profession. If the Department has an additional basis for termination which is unrelated to the criminal conviction, it may terminate the provider agreement for a period in excess of 5 years.

(ii) If the additional basis for the termination is a license suspension or revocation following disciplinary action entered against the provider by the State licensing or certifying agency, the period of termination will be the duration of the disciplinary action plus 5 years for the criminal conviction.

(iii) If the Department has a basis for termination which is related to the criminal conviction, with the exception of exclusions from Medicare or Medical Assistance, the minimum period of the termination will be the longer of 5 years or the period related to the other action.

(c) *Effects of termination on providers.*

(1) The Department will not pay providers for prescription drugs dispensed on or after the effective date of the termination of a provider agreement.

(2) An enrolled provider whose agreement has been terminated may not receive payments from the PACE Program during the period of termination.

(3) If a provider appeals the Department's action of terminating the provider agreement, the Department will not pay the provider for prescription drugs dispensed on or after the effective date specified in the notice of termination.

(d) *Notification of termination of a provider agreement.*

(1) The Department will issue a notice of termination to an enrolled provider whose agreement is being terminated for cause or as a result of a criminal conviction.

(2) The notice will state the basis for the action, the effective date, whether the Department will consider re-enrollment and, if so, the date when re-enrollment will be considered.

(e) *Dissemination of information.*

(1) When the Department takes action against a provider, including termination and initiation of a civil suit, it may also notify and give the reason for the termination to the following:

(i) The Medicaid Fraud Control Unit, Office of the Attorney General.

(ii) The Health Care Financing Administration.

(iii) Other State and local agencies involved in providing or paying for the provision of health care.

(iv) The applicable Commonwealth professional licensing board.

(v) The United States Postal Service.

(2) After final adjudication, a copy of the notice of termination and the reasons for termination may be made available to Medicaid agencies of other states, the appropriate professional associations and the news media. Detailed case material and findings will be made available to the agencies specified in paragraph (1) if the agencies are notified.

(f) *Referral of criminal offenders.* In the case of a provider which the Department determines has criminally violated any of the provisions of the PACE Program, the Department may refer the provider to the proper authorities for prosecution under the act or other applicable laws.

(g) *Restitution and repayment.*

(1) If the Department determines that a provider has billed and received payment for prescription drugs for which payment should not have been made, it will review the provider's paid and unpaid invoices and compute the amount of the overpayment or improper payment. The Department may conduct a test audit and base the restitution amount on the findings of that audit or any extrapolations from those findings.

(2) The amount of restitution or repayment shall be equal to the amount of all unauthorized payments which the Department has made to a provider plus interest.

(3) In the case of unauthorized payments made as a result of criminal action on the part of a provider, the provider shall, if found guilty under the act, be subject to repay three times the value of the material gain received.

(4) The provider shall pay the amount of restitution owed to the Department either directly or by offset of valid invoices that have not yet been paid. The method of repayment is determined by the Department.

(5) If the Department determines that a provider has committed a prohibited act or has failed to satisfy any requirement under § 22.82, it may institute a civil action against the provider in addition to terminating the provider's enrollment.

(6) The provider is prohibited from billing a claimant for any amount for which the provider is required to make restitution to the Department.

(h) *Suspension of payments.* If the Department determines that a provider has submitted a claim for payment which violates the PACE Program, the provider may be notified in writing that payment on outstanding invoices will be delayed or suspended for a period not to exceed 120 days pending a review of his billing and service patterns. In this situation, the Department reserves the right to waive the 21 day payment provision of § 22.11 (relating to general payment principles).

Source

The provisions of this § 22.84 adopted December 15, 1984, effective December 16, 1984, 14 Pa.B. 2109; amended December 13, 1985, effective December 14, 1985, 15 Pa.B. 4427; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (96841) to (96842) and (103139) to (103140).

Notes of Decisions*Failure to Keep Pharmacy License Current*

The failure of a PACE provider to have a current license constitutes a material breach of the provider agreement and the recoupment of all claims made by an unlicensed provider is not excessive and constitutes liquidated damages, not a “penalty.” *Calabro v. Department of Aging*, 689 A.2d (Pa. Cmwlth. 1997); appeal denied 698 A.2d 596 (Pa. 1997).

Cross References

This section cited in 6 Pa. Code § 22.62 (relating to conditions of provider participation); 6 Pa. Code § 22.81 (relating to utilization control); and 6 Pa. Code § 22.101 (relating to provider appeals).

§ 22.85. Re-enrollment of providers whose agreements have been terminated.

(a) *Request for re-enrollment.* To request re-enrollment the provider shall send a written request to the Department. For the request to be considered, it should include statements from peer review bodies, probation officers where appropriate or professional associates, giving factual evidence to support their belief that the violation leading to the termination will not be repeated. A statement from the provider setting forth the reasons why he should be re-enrolled should also be included.

(b) *Criteria for provider re-enrollment.* In considering the provider’s request for re-enrollment, the Department will take into account such factors as the severity of the offense, whether there has been licensure action against the provider, whether the provider has been convicted in a State, Federal or local court of Medicaid offenses or similar offenses and whether there are claims or penalties outstanding against the provider. If the Department’s notice of termination or exclusion specifies a date after which the Department will consider re-enrolling the provider, the Department will under no circumstances consider re-enrolling the provider before the specified date. Under § 22.101(b)(3) (relating to provider appeals), the Department rejection of a request for re-enrollment prior to the specified date is not subject to appeal.

(c) *Notification of action on re-enrollment request.* The provider will be notified in writing of the Department’s decision on a request for re-enrollment within 60 days of the date of receipt of the application. The Department’s notification of approval of a re-enrollment request shall contain an effective date of re-enrollment.

Source

The provisions of this § 22.85 adopted December 15, 1984, effective December 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163. Immediately preceding text appears at serial pages (89814) to (89815).

Cross References

This section cited in 6 Pa. Code § 22.61 (relating to conditions of provider eligibility).

§ 22.86. Provider right of appeal.

Departmental actions against a provider for misutilization or abuse of PACE Program provisions are subject to the provider's right of appeal under §§ 22.101—22.104 (relating to provider hearings and appeals).

Source

The provisions of this § 22.86 adopted December 15, 1984, effective December 16, 1984, 14 Pa.B. 2109.

CLAIMANT HEARINGS AND APPEALS**§ 22.91. Applicant or claimant appeals.**

(a) *Appealable actions.* Applicants for, or claimants of, benefits provided under the PACE Program shall have the right to appeal the following adverse actions taken by the Department:

- (1) The rejection of an application for enrollment in the PACE Program except as provided for in subsection (b)(1).
- (2) The suspension or termination of a claimant's enrollment and the benefits of enrollment in the program because of abuse or misuse of the program.
- (3) The disallowance of, and actions to recover, costs related to claimant abuse or misuse of the program benefits.
- (4) Other adverse actions of the Department except those which are indicated in subsection (b).

(b) *Nonappealable actions.* Applicants or claimants do not have the right to appeal the following actions:

- (1) Rejection of an application for enrollment or termination of benefits because the applicant has refused to submit requested documents or other information necessary to establish eligibility for enrollment.
- (2) Rejection of an application for re-enrollment from a claimant whose enrollment has been suspended or terminated prior to the date on which the Department specified that re-enrollment would be considered.
- (3) Disallowances for prescription drugs dispensed during a period of non-enrollment, suspension or termination of claimant benefits, except on the issue of identity.

Source

The provisions of this § 22.91 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (103141) to (103142).

Cross References

This section cited in 6 Pa. Code § 22.37 (relating to right of appeal); 6 Pa. Code § 22.46 (relating to right of appeal); and 6 Pa. Code § 22.74 (relating to claimant right of appeal).

§ 22.92. Notification of adverse action and right to appeal.

(a) The Department will provide written notice of an adverse action it has decided to take against a claimant or applicant directly to the party affected by the decision or to the party's representative.

(b) The notice of adverse action will be given in a timely manner and the notice will not be given more than 30 days after the decision has been made.

(c) The notice will include the reasons for the action and the evidence upon which the action is based.

(d) The notice will advise the person affected by the decision that:

(1) In the case of a proposed action to terminate the benefits of a claimant, the adverse action will be effective no sooner than 30 days after the date of the notice.

(2) The decision may be appealed under this chapter.

(3) If an appeal is to be made, it shall be filed with the Department within 30 days following the date of the notice of adverse action.

Source

The provisions of this § 22.92 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial page (103142).

Cross References

This section cited in 6 Pa. Code § 22.37 (relating to right of appeal); 6 Pa. Code § 22.46 (relating to right of appeal); and 6 Pa. Code § 22.74 (relating to claimant right of appeal).

§ 22.93. Filing of appeals.

(a) Appeals shall be filed within 30 days of the date of a notice of adverse action and shall be submitted to the Department.

(b) In the case of appeals of proposed adverse actions to terminate a claimant's benefits under the PACE Program, filing of the appeal within the 30 days allowed will prevent termination of benefits until the end of the appeal process.

(c) The content of applicant or claimant appeals shall include the appellant's name, address, telephone number, PACE enrollment number and the reasons for the appeal. If the appellant has no PACE enrollment number, the appeal shall include the appellant's Social Security Number, when available.

Source

The provisions of this § 22.93 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; corrected April 12, 1985, effective March 30, 1985, 15 Pa.B. 1353; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (103142) to (103143).

Cross References

This section cited in 6 Pa. Code § 22.37 (relating to right of appeal); 6 Pa. Code § 22.46 (relating to right of appeal); and 6 Pa. Code § 22.74 (relating to claimant right of appeal); and 6 Pa. Code § 22.95 (relating to formal appeals and hearings).

§ 22.94. Informal handling of appeals.

(a) The Department will initially seek to resolve all applicant/claimant appeals through a letter-ruling process which shall consist of the following steps:

(1) The Department will review the adverse action taken, including a review of applicable documentation, to determine any possibility of error.

(2) Within 15 days of the receipt of the appeal, a letter will be sent to the applicant/claimant which sets forth the results of the review. The letter will cite the statutory/regulatory basis for the results, indicate the appropriate action being taken and inform the applicant/claimant of the right to a formal hearing if the applicant/claimant does not accept the results set forth in the letter.

(b) Results and opinions set forth in letter-rulings will have no precedential authority and are subject to withdrawal or change at any time to conform with new or different interpretations of the law.

(c) Appeals or complaints which cannot be resolved informally through the letter-ruling process shall be considered to be formal complaints and will be handled under § 22.95 (relating to formal appeals and hearings).

Source

The provisions of this § 22.94 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163. Immediately preceding text appears at serial page (89817).

Cross References

This section cited in 6 Pa. Code § 22.37 (relating to right of appeal); 6 Pa. Code § 22.46 (relating to right of appeal); and 6 Pa. Code § 22.74 (relating to claimant right of appeal).

§ 22.95. Formal appeals and hearings.

(a) *Right to a formal hearing.* If an applicant/claimant who has filed an appeal under § 22.93 (relating to filing an appeal) disagrees with the Department's letter ruling, the applicant/claimant is entitled to a formal hearing on the complaint.

(b) *Notification of the Department.* If the appellant wishes to pursue an appeal to a formal hearing, the appellant shall notify the Department in writing within 15 calendar days of the date of the letter ruling that the letter ruling is not accepted and a formal hearing is requested.

(c) *Appointment of a hearing examiner.*

(1) When the Department receives a request for a formal hearing as provided for under subsections (a) and (b) the Secretary or the Secretary's designee will appoint a hearing examiner to preside over the formal hearing.

(2) It shall be the responsibility of the appointed hearing examiner to schedule the hearing and conduct it in accordance with this chapter and 1 Pa. Code Part II (relating to general rules of administrative practice and procedure).

(3) Subsection (c)(1) supplements 1 Pa. Code § 35.185 (relating to designation of presiding officers). Subsection (c)(2) supplements 1 Pa. Code § 35.187 (relating to authority delegated to presiding officers).

(d) *Scheduling formal hearings.*

(1) *General provisions.*

(i) The hearing examiner shall notify the appellant and the Department of the date, time and location of the hearing at least 10 days prior to the selected date. This notification shall include clear instructions relative to the appellant's opportunity to have the hearing conducted by way of a telephone conference call, or face to face, as provided for in subsection (e). This subparagraph supersedes 1 Pa. Code § 35.105 (relating to notice of nonrulemaking proceedings).

(ii) A prehearing conference may be held at the discretion of the hearing examiner. This subparagraph is identical to 1 Pa. Code § 35.111 (relating to conferences to adjust, settle or expedite proceedings).

(iii) The hearing examiner shall complete the hearing within 45 days of receipt of the assignment at the time the appointment as hearing examiner is made.

(2) *Continuances.*

(i) Hearings shall commence on the first day scheduled and continuances may not be granted by the hearing examiner except for good cause shown. A hearing examiner may only grant a second continuance in extraordinary circumstances.

(ii) Requests for a continuance shall be made in writing to the hearing examiner and the Department.

(iii) The appellant requesting a continuance shall first consult the Department to seek agreement to the request. The request shall then indicate whether the request is unopposed.

(iv) The Department's objections, if any, to a request for continuance shall be in writing and delivered to the hearing examiner and the appellant or the appellant's representative. Objections shall be made immediately upon receipt of notification of a request for a continuance.

(v) The period of a continuance granted to an appellant may not be counted as part of the 45-day period required in subsection (d)(1)(iii) to complete an assigned hearing.

(vi) Paragraph (2) supersedes 1 Pa. Code § 31.15(6) (relating to extension of time).

(3) *Failure to appear at hearing.*

(i) If the appellant or the appellant's representative fails to appear at the scheduled hearing without good cause, as determined by the hearing examiner, the complaint shall be deemed abandoned and shall be dismissed with prejudice.

(ii) If the Department fails to appear at the hearings without good cause as determined by the hearing examiner, the hearing shall proceed in absentia.

(iii) If neither the appellant nor the Department or their representatives appear at the hearing, the hearing examiner will reschedule the hearing.

(e) *Two hearing procedure options.*

(1) The Department will provide appellants desiring formal hearings with the opportunity of having their hearings conducted by way of a telephone conference call. This opportunity will be provided in writing with the hearing examiner's notification of the date, time and location of a scheduled hearing, and will include clear instructions to the appellant for taking advantage of this opportunity to avoid the time and travel to appear at a special hearing location.

(2) Appellants who do not wish to take advantage of the telephone conference call procedure may elect to have a face-to-face hearing at one of several locations selected by the Department. The hearing examiner's scheduling notification will include instructions for electing a face-to-face hearing.

(3) This subsection supersedes 1 Pa. Code § 35.123 (relating to conduct of hearings).

(f) *Purpose of formal hearings.* The purpose of a hearing includes all of the following:

(1) To give both the appellant and the Department an opportunity to present testimony, witnesses and documentary evidence relevant to the issue in question.

(2) To give both the appellant and the Department an opportunity to cross examine the opposing party's witnesses.

(3) To assure that documents and records presented or referred to during the course of the hearing are made part of the hearing transcript.

(4) To give the appellant an opportunity to review pertinent evidence on which the adverse action was based. This may be done at the prehearing conference, if one is held.

(g) *Hearing authority.*

(1) The hearing authority is the Secretary.

(2) The Secretary will delegate to the hearing examiner the authority necessary to conduct the hearing proceedings and to perform the following functions:

(i) Determine the facts.

(ii) Determine the appropriate regulations that apply.

(iii) Interpret a regulation when the regulation is ambiguous.

(iv) Interpret a directive of the Department when the directive is ambiguous.

- (v) Apply the facts to the law to determine the correct result.
- (vi) Recommend that the Secretary adopt the result.
- (3) The hearing examiner's recommendation shall be submitted to the Secretary or the Secretary's designee within 30 days of the conclusion of the hearing.
- (4) Hearing examiners may not invalidate or modify a Departmental regulation.
- (5) Subsection (g) supplements 1 Pa. Code § 35.187.
- (h) *Decision of the Secretary.*
 - (1) The recommendation of the hearing examiner shall be reviewed by the Secretary or the Secretary's designee.
 - (2) After a recommendation has been proposed by the hearing examiner, appellants will not be afforded an opportunity to submit oral or written statements of their position to the Secretary or the Secretary's designee.
 - (3) Findings of fact made by the hearing examiner are subject to review and reversal by the Secretary. The Secretary or the Secretary's designee may return the case to the hearing examiner for further findings of fact.
 - (4) The Secretary or the Secretary's designee will issue an opinion and order as soon as possible after receiving the final recommendation of the hearing examiner.
 - (5) Paragraph (1) supersedes 1 Pa. Code § 35.201 (relating to certification of record with proposed report). Paragraph (2) supersedes 1 Pa. Code § 35.211 (relating to procedure to except to proposed report). Paragraph (4) supplements 1 Pa. Code § 35.226 (relating to final orders).

Source

The provisions of this § 22.95 adopted March 29, 1985, effective March 30, 1985, 15 Pa.B. 1163; corrected April 12, 1985, effective March 30, 1985, 15 Pa.B. 1363.

Cross References

This section cited in 6 Pa. Code § 22.37 (relating to right of appeal); 6 Pa. Code § 22.46 (relating to right of appeal); 6 Pa. Code § 22.74 (relating to claimant right of appeal); and 6 Pa. Code § 22.94 (relating to informal handling of appeals).

PROVIDER HEARINGS AND APPEALS

§ 22.101. Provider appeals.

- (a) *Appealable actions.* Providers shall have the right to appeal the following adverse actions taken by the Department:
 - (1) The rejection of an application for enrollment in the PACE Program when the provider believes the rejection is based upon incorrect or incomplete information.

(2) The termination of an enrolled provider's agreement under § 22.84 (relating to administrative actions and penalties), except as provided for in subsection (b)(1).

(3) The disallowance of payments to an enrolled provider where the Department has determined the payments are not valid because of provider error, negligence or abuse.

(4) Other adverse actions of the Department except those which are indicated in subsection (b).

(b) *Nonappealable actions.* Providers do not have the right to appeal the following actions:

(1) The termination of a provider agreement because of the provider's termination or suspension from Medicare or Medical Assistance, or because of a conviction of a criminal offense under § 22.83 (relating to prohibited acts and criminal penalties), or because of a conviction of another criminal offense or disciplinary action indicated in § 22.84 except on the issues of identity or misinformation.

(2) Disallowances for prescription drugs dispensed during a period of non-enrollment or termination, except on the issues of identity or misinformation.

(3) Rejection of an application to reenroll a terminated or excluded provider prior to the date the Department specified that it would consider reenrollment.

Source

The provisions of this § 22.101 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109; amended December 14, 1990, effective December 15, 1990, 20 Pa.B. 6143. Immediately preceding text appears at serial pages (96851) to (96852).

Cross References

This section cited in 6 Pa. Code § 22.62 (relating to conditions of provider participation); 6 Pa. Code § 22.85 (relating to re-enrollment of providers whose agreements have been terminated); and 6 Pa. Code § 22.86 (relating to provider right of appeal).

§ 22.102. Notification of adverse action and right to appeal.

(a) The Department will provide written notice of any adverse action it has decided to take against a provider.

(b) The notice of adverse action will be given in a timely manner and in no event will the notice be given more than 30 days after the decision has been made.

(c) The notice will include the reasons for the action and the evidence upon which the action is based.

(d) The notice will advise the provider affected by the decision that:

(1) The decision may be appealed under this chapter.

(2) If an appeal is to be made, it shall be filed with the Department within 30 days following the date of the notice of adverse action.

Source

The provisions of this § 22.102 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

Cross References

This section cited in 6 Pa. Code § 22.62 (relating to conditions of provider participation); and 6 Pa. Code § 22.86 (relating to provider right of appeal).

§ 22.103. Filing of appeals.

(a) Appeals shall be filed within 30 days of the date of a notice of adverse action and shall be submitted to the Department.

(b) The form and content of provider appeals shall be under 1 Pa. Code § 35.10 (relating to form and content of formal complaints).

Source

The provisions of this § 22.103 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

Cross References

This section cited in 6 Pa. Code § 22.62 (relating to conditions of provider participation); and 6 Pa. Code § 22.86 (relating to provider right of appeal).

§ 22.104. The handling of appeals.

Appeals or complaints shall be handled as formal complaints under 1 Pa. Code Part II (relating to general rules of administrative practice and procedure).

Source

The provisions of this § 22.104 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

Cross References

This section cited in 6 Pa. Code § 22.62 (relating to conditions of provider participation); and 6 Pa. Code § 22.86 (relating to provider right of appeal).

OTHER ADMINISTRATIVE PROVISIONS**§ 22.111. Forms, handbooks and other materials.**

The Department may supplement or interpret this chapter by developing and issuing forms, handbooks or other materials necessary to the effective administration of the program.

Source

The provisions of this § 22.111 adopted June 15, 1984, effective June 16, 1984, 14 Pa.B. 2109.

[Next page is 30-1.]