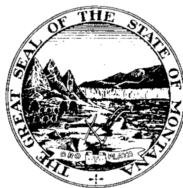

AN ACT PROVIDING STANDARDS AND REQUIREMENTS FOR MEDICAID OVERPAYMENT AUDITS; PROVIDING REQUIREMENTS FOR RECORD REQUESTS AND REVIEWS; PROHIBITING EXTRAPOLATION AND STATISTICAL SAMPLING EXCEPT FOR HIGH-RISK PROVIDERS; PROVIDING FOR NOTICE OF AUDIT RESULTS; PROVIDING DEFINITIONS; REQUIRING THE PUBLICATION OF AUDIT RESULTS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 53-6-111, 53-6-155, AND 53-6-160, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE.

WHEREAS, a strong Medicaid overpayment audit program is essential to ensure that Medicaid funds are paid for appropriate and necessary health care services and to identify and address instances of overpayment and underpayment and cases of provider fraud and abuse; and

WHEREAS, the vast majority of providers deliver appropriate and necessary services to recipients in compliance with Medicaid requirements; and

WHEREAS, despite the diligence and good faith efforts of providers, errors and mistakes may be made by providers or the Medicaid program that result in underpayments or overpayments; and

WHEREAS, underpayment and overpayment errors should be addressed in a reasonable, efficient, and fair manner, providing for adjustment and recovery as appropriate, while continuing to ensure that fraud and abuse are detected and pursued; and

WHEREAS, providers should be encouraged to participate in the Medicaid program to ensure that recipients have adequate and timely access to quality health care services; and

WHEREAS, audit standards that are reasonable and fair will eliminate a disincentive for providers to participate in the Medicaid program; and

WHEREAS, providers are subject to numerous audits from state and federal health agencies, resulting in increased administrative costs that raise the costs for all health care consumers; and

WHEREAS, in addition to other audit and recovery programs, states are required to implement provisions of the Patient Protection and Affordable Care Act, Public Law 111-148 and Public Law 111-152, relating to Medicaid recovery audit contractors.

THEREFORE, the Legislature of the State of Montana finds that providing balance and predictability in the overpayment audit and recovery process by implementing reasonable and consistent standards, rules, and limitations on overpayment audit activities encourages providers to participate in the Medicaid program and is necessary and in the best interest of this state.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Applicability to auditor -- scope. (1) An auditor performing or participating in an overpayment audit, overpayment determination, or related activity is subject to the same laws and regulations that would apply to the department in carrying out the same functions.

(2) [Sections 1 through 7] do not apply to the medicaid fraud control unit provided for in 53-6-156, but shall apply to an overpayment audit, overpayment determination, or related activity by the department or an auditor that is based on or arises out of a medicaid fraud control unit investigation or referral.

Section 2. Provider records -- limitations on record requests and reviews -- onsite audits. (1) In an overpayment audit, the department or an auditor shall:

(a) give the provider at least 45 days to comply with a request to provide records and allow reasonable extensions for good cause;

(b) include in a request for records adequate information, such as the claim number, medical record number, name of the patient, and service dates, to allow the provider to identify the particular records sought; and

(c) allow providers to submit the requested records in an electronic format.

(2) In an overpayment audit conducted by an auditor, if a provider is required to provide records in a nonelectronic manner because an electronic format is not available or because the auditor requested a nonelectronic format, the auditor shall reimburse the provider for the cost of providing the records.

(3) (a) The department or an auditor may request records from the same provider for overpayment audit purposes:

(i) not more than once in any 90-day period; and

(ii) for not more than the greater of:

(A) 1% of the number of claims filed by the provider in the previous state fiscal year for the specific

service being reviewed; or

(B) 200 claims.

(b) If the department or an auditor demonstrates a significant overpayment rate, the department or the auditor with the department's approval may request additional records that are related to the issue under review. The additional records may not be requested until the time period to request an administrative review has expired without the provider requesting administrative review or until an administrative review has been completed regarding the records initially provided, whichever occurs later. In an appeal involving an overpayment determination that is based on additional records that were provided pursuant to this subsection (3)(b), the additional records must be excluded from evidence if the provider demonstrates that the department did not demonstrate a significant overpayment rate necessary to request additional records.

(4) The department or an auditor may not request records or perform an overpayment audit regarding services that were provided outside the period of time for which providers are required to retain records. In addition, a recovery audit contractor may not request records or conduct an overpayment audit regarding services for which a claim was submitted more than 3 years before the request or audit.

(5) Except in cases of suspected fraud or criminal conduct, the department or an auditor may not schedule an onsite overpayment audit without first providing at least 30 days' advance written notice to the provider and making a good faith effort to establish a mutually agreed upon date and time for the onsite audit.

(6) For the purposes of this section, the term "claim" means a claim for a single line item, consisting of a single service, under one procedure rate with one or more units of service, procedure, or item on a claim form for which a provider has received payment.

Section 3. Extrapolation and statistical sampling prohibited -- exceptions. (1) Except as provided in subsection (2):

(a) in an overpayment audit the department or an auditor may not use statistical sampling extrapolation for automated reviews and may not rely on extrapolation to determine or support the amount of an overpayment determination; and

(b) an overpayment determination must be based on and supported by evidence of an overpayment for each claim.

(2) In an overpayment audit of a high-risk provider, the department or an auditor may use statistical

sampling extrapolation for an automated review or may rely on extrapolation to determine or support the amount of an overpayment determination.

(3) The department or an auditor may use data analysis techniques to identify claims that are most likely to contain overpayments for purposes of selecting providers or claims for overpayment audits.

(4) For the purposes of this section, the following definitions apply:

(a) "Automated review" means a claim review made at the system level without a human being reviewing the medical record.

(b) "Extrapolation" means the determination of an unknown value by projecting the results of a review of a sample to the universe from which the sample was drawn.

(c) "High-risk provider" means a provider who within the previous 3 years:

(i) has either admitted to medicaid fraud or abuse in a written agreement with a governmental agency or has been determined by a final order of judgment of a governmental agency or court to have committed medicaid fraud or abuse; or

(ii) has a documented history of a high medicaid claim error rate that has been sustained over a substantial period of time and that documented educational interventions have failed to correct.

(5) The department shall specify by rule the percentage medicaid error rate, the period of time over which the error rate must be sustained, and the nature and frequency of unsuccessful educational interventions provided that will result in the designation of a provider as a high-risk provider within the meaning of subsection (4).

Section 4. Peer review of overpayment findings. Any overpayment finding must be reviewed by a peer before the department or an auditor may issue an overpayment determination.

Section 5. Audit completion -- notice of overpayment determination. (1) Except as provided in subsections (2) and (3), the department or an auditor shall conclude an overpayment audit and notify the provider in writing of the audit results, including any overpayment determination, within 60 days after the receipt of all records requested in the department's or the auditor's initial record request.

(2) An overpayment audit may be extended beyond the 60-day period provided for in subsection (1) if a delay is caused by the provider, in which case the period for completing the audit may be extended no longer

than the period of the provider-caused delay. In an appeal of an overpayment determination, an overpayment determination made after the 60-day period provided for in subsection (1) must be excluded from evidence if the provider demonstrates that the delay was not caused by the provider and was not the result of the circumstances described in subsection (3).

(3) Notice of an overpayment determination must be provided within 60 days of:

(a) a determination regarding fraud in cases in which the department has a reasonable basis to suspect that fraud has occurred; or

(b) the conclusion of an investigation and any related enforcement proceedings, if a government agency or entity other than the department is conducting a civil fraud or criminal investigation of the provider, and the government agency or entity conducting the investigation determines and notifies the department in writing that providing earlier notification would interfere with or jeopardize the investigation, recovery of a fraudulent overpayment, or a criminal prosecution.

(4) Notice of an overpayment determination under this section must include a detailed explanation, including, at a minimum, the following:

(a) a description of the overpayment;

(b) the dollar value of the overpayment;

(c) the specific reason for the overpayment determination;

(d) the specific medical criteria, if any, on which the determination was based;

(e) if the department or auditor determines that a service was reasonable, necessary, and provided in accordance with applicable medicaid requirements but was improperly billed, an explanation of the appropriate reimbursement amount;

(f) the adverse action to be taken by the department;

(g) an explanation of any actions required of the provider; and

(h) an explanation of the provider's right to appeal.

Section 6. Publication of audit results. Twice a year, the department or an auditor shall publish and make accessible on its website the following information regarding overpayment audits:

(1) the number and type of issues reviewed;

(2) the number of medical and other records requested from providers;

(3) the number of audits conducted for each provider type;

(4) the number and aggregate dollar amounts of overpayments identified;

(5) the number and aggregate dollar amounts of overpayments collected;

(6) the number and aggregate dollar amounts of underpayments identified;

(7) the duration of audits from initiation to completion;

(8) the number of overpayment determinations and the reversal rates of those determinations at each stage of the informal and formal appeal process;

(9) the number of informal and formal appeals filed by providers, categorized by disposition status; and

(10) the auditor's compensation structure and total dollar amount of compensation for underpayments and overpayments.

Section 7. Auditor evaluation hearings -- adoption of rules. At least once a year, the department shall conduct auditor evaluation hearings to identify issues, recommend or require corrective actions, and provide for ongoing and future evaluation of auditor performance. With input from providers, including input gathered at the auditor evaluation hearings, the department shall adopt rules addressing appropriate and inappropriate conduct and determinations by auditors and providing penalties and sanctions for inappropriate conduct and determinations by auditors.

Section 8. Section 53-6-111, MCA, is amended to read:

"53-6-111. Department charged with administration and supervision of medical assistance program -- overpayment recovery -- sanctions for fraudulent and abusive activities -- adoption of rules. (1) The department of public health and human services may administer and supervise a vendor payment program of medical assistance under the powers, duties, and functions provided in Title 53, chapter 2, and this chapter and that is in compliance with Title XIX of the Social Security Act.

(2) (a) The department is entitled to collect from a provider, and a provider is liable to the department for:

(i) the amount of a payment under this part to which the provider was not entitled, regardless of whether the incorrect payment was the result of department or provider error or other cause; and

(ii) the portion of any interim rate payment that exceeds the rate determined retrospectively by the

department for the rate period.

(b) In addition to the amount of overpayment recoverable under subsection (2)(a), the department is entitled to interest on the amount of the overpayment at the rate specified in 31-1-106 from the date 30 days after the date of mailing of notice of the overpayment by the department to the provider, except that interest accrues from the date of the incorrect payment when the payment was obtained by fraud or abuse.

(c) In an overpayment determination involving reasonable and necessary services that were provided in accordance with applicable medicaid requirements but that were improperly billed, a provider must be allowed to retain the appropriate amount of reimbursement for the services provided, and the amount may not be considered an overpayment.

~~(c)~~(d) The department may collect any amount described in subsection (2)(a) by:

(i) withholding current payments to offset the amount due;

(ii) applying methods and using a schedule mutually agreeable to the department and the provider; or

(iii) any other legal means.

~~(d)~~(e) ~~The~~ In cases of suspected fraud, the department may suspend payments to a provider for disputed items pending resolution of a dispute.

~~(e)~~(f) The fact that a provider may have ceased providing services or items under the medical assistance program, may no longer be in business, or may no longer operate a facility, practice, or business does not excuse repayment under this subsection (2).

(3) The department shall adopt rules establishing a system of sanctions applicable to providers who engage in fraud and abuse. Subject to the definitions in 53-6-155, the department rules must include but are not limited to specifications regarding the activities and conduct that constitute fraud and abuse.

(4) Subject to subsections (5) and ~~(6)~~ (7), the sanctions imposed under rules adopted by the department under subsection (3) may include but are not limited to:

(a) required courses of education in the rules governing the medicaid program;

(b) suspension of participation in the program for a specified period of time;

(c) permanent termination of participation in the medical assistance program; and

(d) imposition of civil monetary penalties imposed under rules that specify the amount of penalties applicable to a specific activity, act, or omission involving intentional or knowing violation of specified standards.

(5) In all cases in which the department may recover medicaid payments or impose a sanction, a

provider is entitled to a hearing under the provisions of Title 2, chapter 4, part 6. ~~This section does not require that the hearing under Title 2, chapter 4, part 6, be granted prior to recovery of overpayment.~~ The department may not recover an overpayment until all formal hearings and appeals are exhausted, except in cases in which the department has a reasonable basis to suspect that the overpayment was a result of provider fraud.

(6) If the department, a hearings officer, or a court finds that an overpayment determination was frivolous or lacking a reasonable basis, the provider must be reimbursed for costs and attorney fees incurred in disputing the overpayment determination.

~~(6)~~(7) The remedies provided by this section are separate and cumulative to any other administrative, civil, or criminal remedies available under state or federal law, regulation, rule, or policy."

Section 9. Section 53-6-155, MCA, is amended to read:

"53-6-155. Definitions. As used in this part, unless expressly provided otherwise, the following definitions apply:

(1) "Abuse" means conduct by an applicant, recipient, provider, or other person involving disregard of and an unreasonable failure to conform with the statutes, regulations, and rules governing the medical assistance program when the disregard or failure results or may result in an incorrect determination that a person is eligible for medical assistance or payment by a medicaid agency of medical assistance payments to which the provider is not entitled.

(2) "Applicant" means a person:

(a) who has submitted an application for determination of medicaid eligibility to a medicaid agency on the person's own behalf or on behalf of another person; or

(b) on whose behalf an application has been submitted.

(3) "Auditor" means an individual or entity, its agents, subcontractors, and employees that has contracted with the department to perform overpayment audits with respect to the medicaid program. The term includes a recovery audit contractor.

~~(3)~~(4) "Benefit" means the provision of anything of pecuniary value to or on behalf of a recipient under the medicaid program.

~~(4)~~(5) "Claim" means a communication, whether in oral, written, electronic, magnetic, or other form, that is used to claim specific services or items as payable or reimbursable under the medicaid program or that states

income, expense, or other information that is or may be used to determine entitlement to or the rate of payment under the medicaid program. The term includes any documents submitted as part of or in support of the claim.

~~(5)~~(6) "Department" means the department of public health and human services provided for in 2-15-2201.

~~(6)~~(7) "Document" means any application, claim, form, report, record, writing, or correspondence, whether in written, electronic, magnetic, or other form.

~~(7)~~(8) "Fraud" means any conduct or activity prohibited by statute, regulation, or rule involving purposeful or knowing conduct or omission to perform a duty that results in or may result in medicaid payments or benefits to which the applicant, recipient, or provider is not entitled. Fraud includes but is not limited to any conduct or omission under the medicaid program that would constitute a criminal offense under Title 45, chapter 6 or 7.

~~(8)~~(9) "Medicaid" means the Montana medical assistance program established under Title 53, chapter 6.

~~(9)~~(10) "Medicaid agency" means any agency or entity of state, county, or local government that administers any part of the medicaid program, whether under direct statutory authority or under contract with an authorized agency of the state or federal government. The term includes but is not limited to the department, the department of corrections, local offices of public assistance, and other local and state agencies and their agents, contractors, and employees, when acting with respect to medicaid eligibility, claims processing or payment, utilization review, case management, provider certification, investigation, or other administration of the medicaid program.

~~(10)~~(11) "Misappropriation of patient property" means exploitation, deliberate misplacement, or wrongful use or taking of a patient's property, whether temporary or permanent, without authorization by the patient or the patient's designated representative. Misappropriation of patient property includes but is not limited to any conduct with respect to a patient's property that would constitute a criminal offense under Title 45, chapter 6, part 3.

(12) "Overpayment audit" means a review or audit by the department or an auditor of medical claims or other documents in which a purpose or potential result of the review or audit is an overpayment determination. The term does not include a review or audit by the medicaid fraud control unit.

(13) "Overpayment determination" means a determination by the department or an auditor that forms the basis for or results in the department:

(a) partially or completely reducing a medicaid payment to a provider for a claim;

(b) demanding that the provider repay all or a part of a payment for a claim; or

(c) using or applying any other method to recoup, recover, or collect from a provider all or part of a payment for a claim.

~~(11)~~(14) "Patient abuse" means the willful infliction of physical or mental injury of a patient or unreasonable confinement, intimidation, or punishment that results in pain, physical or mental harm, or mental anguish of a patient. Patient abuse includes but is not limited to any conduct with respect to a patient that would constitute a criminal offense under Title 45, chapter 5.

~~(12)~~(15) "Patient neglect" means a failure, through inattentiveness, carelessness, or other omission, to provide to a patient goods and services necessary to avoid physical harm, mental anguish, or mental illness when an omission is not caused by factors beyond the person's control or by good faith errors in judgment. Patient neglect includes but is not limited to any conduct with respect to a patient that would constitute a criminal offense under 45-5-208.

(16) "Peer" means a health care provider employed by or under contract with the department or an auditor:

(a) who has substantially the same education and training, who provides or has provided substantially the same range of health care services, and who has the same license to practice as the provider who is the subject of an overpayment audit; or

(b) who is an expert in the medical, dental, or other health care provider decisionmaking that is at issue in the overpayment audit.

~~(13)~~(17) "Provider" means an individual, company, partnership, corporation, institution, facility, or other entity or business association that has enrolled or applied to enroll as a provider of services or items under the medical assistance program established under this part.

~~(14)~~(18) "Recipient" means a person:

(a) who has been determined by a medicaid agency to be eligible for medicaid benefits, whether or not the person actually has received any benefits; or

(b) who actually receives medicaid benefits, whether or not determined eligible.

~~(15)~~(19) (a) "Records" means medical, professional, business, or financial information and documents, whether in written, electronic, magnetic, microfilm, or other form:

(i) pertaining to the provision of treatment, care, services, or items to a recipient;

(ii) pertaining to the income and expenses of the provider; or

(iii) otherwise relating to or pertaining to a determination of eligibility for or entitlement to payment or reimbursement under the medicaid program.

(b) The term includes all records and documents, regardless of whether the records are required by medicaid laws, regulations, rules, or policies to be made and maintained by the provider.

(20) "Recovery audit contractor" means a medicaid recovery audit contractor selected by the department to perform audits for the purpose of ensuring medicaid program integrity in accordance with 42 C.F.R., part 455."

Section 10. Section 53-6-160, MCA, is amended to read:

"53-6-160. Truthfulness, completeness, and accuracy of submissions to medicaid agencies. (1) A person who submits to a medicaid agency an application, claim, report, document, or other information that is or may be used to determine eligibility for medicaid benefits, eligibility to participate as a provider, or the right to or the amount of payment under the medicaid program is considered to represent to the department, to the best of the person's knowledge and belief, that the item is genuine and that its contents, including all statements, claims, and representations contained in the document, are true, complete, accurate, and not misleading.

(2) (a) A provider has a duty to exercise reasonable care to ensure the truthfulness, completeness, and accuracy of all applications, claims, reports, documents, and other information and of all statements and representations made or submitted, or authorized by the provider to be made or submitted, to the department for purposes related to the medicaid program. The duty applies whether the applications, claims, reports, documents, other information, statements, or representations were made or submitted, or authorized by the provider to be made or submitted, on behalf of the provider or on behalf of an applicant or recipient being served by the provider.

(b) A provider has a duty to exercise reasonable care to ensure that a claim made or submitted to the department or its agents or employees for payment or reimbursement under the medicaid program is one for which the provider is entitled to receive payment and that the service or item is provided and billed according to all applicable medicaid requirements, including but not limited to identification of the appropriate procedure code or level of service and provision of the service by a person, facility, or other provider entitled to receive medicaid payment for the particular service.

(3) A person is considered to have known that a claim, statement, or representation related to the medicaid program was false if the person knew, or by virtue of the person's position, authority, or responsibility

should have known, of the falsity of the claim, statement, or representation.

(4) A person is considered to have made or to have authorized to be made a claim, statement, or representation if the person:

(a) had the authority or responsibility to:

(i) make the claim, statement, or representation;

(ii) supervise another who made the claim, statement, or representation; or

(iii) authorize the making of the claim, statement, or representation, whether by operation of law, business or professional practice, or office policy or procedure; and

(b) exercised or failed to exercise that authority or responsibility and, as a direct or indirect result, the false statement was made, resulting in a claim for a service or item when the person knew or had reason to know that the person was not entitled under applicable statutes, regulations, rules, or policies to medicaid payment or benefits for the service or item or for the amount of payment requested or claimed.

(5) (a) There is an inference that a person who signs or submits a document to a medicaid agency on behalf of or in the name of a provider is authorized by the provider to do so and is acting under the provider's direction.

(b) For purposes of this section, the term "signs" includes but is not limited to the use of facsimile, computer-generated and typed, or block-letter signatures.

(6) The department shall directly or by contract provide a program of instruction and assistance to persons submitting applications, claims, reports, documents, and other information to the department concerning the completion and submission of the application, claim, report, document, or other information in a manner determined necessary by the department. A provider may reasonably rely on the instructions and advice provided by the department. The program must include:

(a) clear directions for the completion of applications, claims, reports, documents, and other information;

(b) examples of properly completed applications, claims, reports, documents, and other information;

(c) a method by which persons submitting applications, claims, reports, documents, and other information may, on a case-by-case basis, receive accurate, complete, specific, and timely advice and directions from the department before the completed applications, claims, reports, documents, and other information must be submitted to the department; and

(d) a method by which persons submitting applications, claims, reports, documents, and other

information may challenge the department's interpretation or application of the manner in which the applications, claims, reports, documents, and other information must be completed.

(7) At least twice a year, the department and any auditor shall provide:

(a) educational and training programs for providers regarding a summary of audit results, common issues and problems, and mistakes identified through audits;

(b) a discussion of opportunities for improvement in provider performance related to claims billings and documentation; and

(c) information on the department's website regarding audit issues, including, at a minimum, the name and description of the audit issue, the type of provider, the review period, and any applicable policy related to the issue.

~~(7)~~(8) This section applies only for the purpose of civil liability under Title 53 and does not apply in a criminal proceeding."

Section 11. Absorption of costs. Any cost incurred by the department of public health and human services in implementing [this act] must be absorbed into the department's existing budget.

Section 12. Codification instruction. [Sections 1 through 7] are intended to be codified as an integral part of Title 53, chapter 6, part 1, and the provisions of Title 53, chapter 6, part 1, apply to [sections 1 through 7].

Section 13. Effective date. [This act] is effective July 1, 2015.

Section 14. Applicability. [This act] applies to overpayment audits, record requests, and overpayment determinations made or commenced on or after [the effective date of this act].

- END -

I hereby certify that the within bill,

HB 0237, originated in the House.

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Chief Clerk of the House

____

Speaker of the House

Signed this______________________________day

of__________________________________, 2015.

____

President of the Senate

Signed this______________________________day

of__________________________________, 2015.

HOUSE BILL NO. 237

INTRODUCED BY A. OLSZEWSKI, F. GARNER, W. MCKAMEY, J. TAYLOR

AN ACT PROVIDING STANDARDS AND REQUIREMENTS FOR MEDICAID OVERPAYMENT AUDITS; PROVIDING REQUIREMENTS FOR RECORD REQUESTS AND REVIEWS; PROHIBITING EXTRAPOLATION AND STATISTICAL SAMPLING EXCEPT FOR HIGH-RISK PROVIDERS; PROVIDING FOR NOTICE OF AUDIT RESULTS; PROVIDING DEFINITIONS; REQUIRING THE PUBLICATION OF AUDIT RESULTS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 53-6-111, 53-6-155, AND 53-6-160, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE.