Regular Session, 2014

HOUSE BILL NO. 1200

BY REPRESENTATIVE STOKES

MEDICAID: Provides relative to Medicaid recovery audit contractors and procedures

AN ACT

To enact Subpart E of Part VI-A of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 46:440.11 through 440.16, relative to the Medicaid recovery audit program; to provide for legislative findings and purposes; to provide definitions; to establish requirements for entities that contract with the Department of Health and Hospitals to recover medical assistance program funds; to provide for a structure of payments by the Department of Health and Hospitals; to provide for appeals by healthcare providers enrolled in the Medicaid program; to provide for contractor oversight and penalties; to provide for promulgation of rules; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Subpart E of Part VI-A of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, comprised of R.S. 46:440.11 through 440.16, is hereby enacted to read as follows:

SUBPART E. RECOVERY AUDIT CONTRACTORS

§440.11. Legislative findings; declaration; purpose

A. The legislature hereby finds all of the following:

(1) States are required to implement provisions of the Patient Protection and Affordable Care Act, comprised of Public Laws 111-148 and 111-152, relative to Medicaid recovery audit contractors.

(2) The recovery audit function is a useful tool for improving Medicaid program integrity and ensuring that public monies are used for appropriate and necessary healthcare services.

(3) Healthcare providers are subject to numerous audits from the state and federal health agencies and reviews by Medicaid managed care companies which result in increased administrative costs that raise costs to all healthcare consumers.

B. The legislature hereby declares that simplifying and standardizing Medicaid recovery audit functions are necessary and in the best interest of this state. Therefore, the purpose of this Subpart is to provide for greater Medicaid program integrity by establishing a standardized recovery audit contractor program.

§440.12. Definitions

As used in this Subpart, the following terms have the meaning ascribed in this Section:

(1) "Adverse determination" means any decision rendered by the recovery audit contractor that results in a payment to a provider for a claim or service being reduced either partially or completely.

(2) "Contractor" and "recovery audit contractor" mean a Medicaid recovery audit contractor selected by the department to perform audits for the purpose of ensuring Medicaid program integrity in accordance with the provisions of 42 CFR 455 et seq.

(3) "Department" means the Department of Health and Hospitals.

(4) "Medicaid" and "medical assistance program" mean the medical assistance program provided for in Title XIX of the Social Security Act.

(5) "Provider" means any healthcare entity enrolled with the department as a provider in the Medicaid program.

§440.13. Recovery audit contractor program established; rulemaking

A. There is hereby established within the department a recovery audit contractor program. The program shall adhere to the requirements provided in this Subpart.

B. The department shall promulgate all rules, in accordance with the Administrative Procedure Act, as are necessary to implement the provisions of this Subpart.

§440.14. Recovery audit contractors; required functions and tasks

A. Notwithstanding any other provision of law to the contrary, the department shall require that its recovery audit contractor perform all of the following functions and tasks:

(1) Review claims within three years of the date of their initial payment.

(2) Send a determination letter concluding an audit within sixty days of receipt of all requested materials from a provider.

(3) Furnish in any records request to a provider adequate information for the provider to identify the patient, including but not limited to claim number, medical record number, patient name, and service dates.

(4) Exclude all of the following from its scope of review:

(a) Claims processed or paid through a Medicaid managed care program.

(b) Medical necessity reviews.

(5) Develop and implement a process to ensure that providers receive or retain the appropriate reimbursement amount for claims in which the contractor determines that services delivered have been improperly billed, but were reasonable and necessary. This process shall include but not be limited to a recoupment reconciliation procedure for claims that were improperly coded or reasonable and necessary in another setting.

(6)(a) Prohibit the recoupment of overpayments by the contractor until all informal and formal appeals processes have been completed.

(b) Nothing in this Paragraph shall apply to claims that the contractor suspects to be fraudulent.

(7) Refer claims it suspects to be fraudulent directly to the department for investigation.

(8) Provide a detailed explanation in writing to a provider for any adverse determination that would result in partial or full recoupment of a payment to the provider. The written notification provided for in this Paragraph shall include, at minimum, all of the following:

(a) The reason for the adverse determination.

(b) The specific medical criteria on which the adverse determination was based.

(c) The qualifications of the individual issuing the adverse determination.

(d) An explanation of the provider's appeal rights.

(e) If applicable, an explanation of the appropriate reimbursement determined in accordance with the provisions of Paragraph (5) of this Subsection.

(9)(a) Limit records requests in a ninety-day period to not more than one percent of the number of claims filed by the provider for the specific service being reviewed in the previous state fiscal year, not to exceed two hundred records.

(b) The contractor shall allow a provider no less than forty-five days to comply with and respond to a record request.

(10) Utilize provider self-audits only if mutually agreed to by the contractor and provider.

(11) Schedule any onsite audits of a low-risk provider with advance notice of not less than ten business days and make a good faith effort to establish a mutually agreed upon date and time.

(12) Publish the process utilized for the approval of new issues for review, and post those issues on its Internet website.

(13) On a semiannual basis, develop, implement, and publish on its Internet website metrics related to its performance. Such metrics shall include but not be limited to the following:

(a) The number and type of issues reviewed.

(b) The number of medical records requested.

(c) The number of overpayments and underpayments identified by the contractor.

(d) The aggregate dollar amounts associated with identified overpayments and underpayments.

(e) The duration of audits from initiation to time of completion.

(f) The number of adverse determinations and the overturn rates of those determinations at each stage of the informal and formal appeal process.

(g) The number of informal and formal appeals filed by providers, broken out by disposition status.

(h) The contractor's compensation structure and dollar amount of compensation.

(14) Post on its Internet website its contract with the department for recovery audit services.

(15)(a) Perform a semiannual review of recovery audit issues and identify any potential opportunities for improvement and correction of medical assistance program policies, procedures, and infrastructure that would result in proactive and efficient minimization of improper payments.

(b) The contractor shall submit the reviews provided for in this Paragraph to the department and publish such reviews on its Internet website.

(16) At least semiannually, perform educational and training programs for providers that encompass all of the following:

(a) A recapitulation of audit results, common issues and problems, and mistakes identified through audits and reviews.

(b) A discussion of opportunities for improvement in provider performance with respect to claims billing and documentation.

(17)(a) Allow providers to submit in electronic format the records requested in association with an audit.

(b) If a provider must reproduce records manually because no electronic format is available, or because the contractor requests a nonelectronic format, the

contractor shall reimburse to the provider the cost of medical records reproduction consistent with the provisions of R.S. 40:1299.96.

B. In any contract between the department and a recovery audit contractor, the payment or fee provided to the contractor for identification of Medicaid provider overpayments shall be equal to that provided for identification of Medicaid provider underpayments.

§440.15. Healthcare provider appeals process

A. A provider shall have a right to the informal and formal appeals processes for determinations made by the recovery audit contractor as provided in this Section.

B. The contractor shall establish an informal appeals process that conforms with all of the following guidelines:

(1) From the date of receipt of the initial findings letter by the contractor, there shall be an informal discussion and consultation period wherein the provider and contractor may communicate regarding any determinations for reasons including but not limited to policies, criteria, and program rules pertinent to the determination.

(2)(a) Within forty-five days of receipt of a notification of an adverse determination from the contractor, a provider shall have the right to request an informal hearing of such findings, or a portion thereof, with the contractor and the Medicaid program integrity division of the department by submitting a request in writing to the contractor.

(b) The informal hearing provided for in this Paragraph shall occur within thirty days of the provider's request.

(c) At the informal hearing, the provider shall have all of the following rights:

(i) The right to present information orally and in writing.

(ii) The right to present documents.

(iii) The right to have the department and the contractor address any inquiry the provider may make concerning the reason for the adverse determination.

(d) A provider may be represented by an attorney or authorized representative at the informal hearing if written notice of representation identifying the attorney or representative is submitted with the request for the informal hearing.

(3) The contractor and medical assistance program integrity division of the department shall issue a final decision related to the informal appeal to the provider within fifteen days of the closure of the appeal.

C. Within thirty days of the issuance of a final decision or determination pursuant to an informal appeal conducted in accordance with Subsection B of this Section, a provider may request an administrative appeal of the final decision by requesting a hearing before the health and hospitals section of the division of administrative law and provide a copy of the appeal to the Medicaid program integrity division of the department.

§440.16. Contractor performance oversight; penalties; protections

A. If more than twenty-five percent of the contractor's adverse determinations are overturned on appeal in any six-month period, then the House Committee on Health and Welfare and the Senate Committee on Health and Welfare, jointly, shall hold an oversight hearing to evaluate the contractor's performance and provide the medical assistance program with direction related to corrective action plans and future reevaluation of performance.

B. The department shall, with input from healthcare providers and in accordance with the Administrative Procedure Act, promulgate rules relative to appropriate and inappropriate determinations by recovery audit contractors, and to establish penalties and sanctions to be associated with inappropriate determinations by those contractors.

C. If the department or the hearing officer in a formal appeal finds that the recovery audit contractor's determination was unreasonable, frivolous, or without merit, then the contractor shall reimburse to the provider the provider's costs associated with the appeals process.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

Stokes HB No. 1200

Abstract: Provides relative to Medicaid recovery audit contractors and procedures.

Proposed law provides a legislative declaration that simplifying and standardizing Medicaid recovery audit functions are necessary and in the best interest of the state. Declares that the purpose of proposed law is to provide for greater Medicaid program integrity by establishing a standardized recovery audit contractor program.

Proposed law defines "contractor" and "recovery audit contractor" as a Medicaid recovery audit contractor selected by the Dept. of Health and Hospitals (DHH) to perform audits for the purpose of ensuring Medicaid program integrity in accordance with the provisions of federal law (42 CFR 455 et seq.).

Proposed law defines "adverse determination" as any decision rendered by the recovery audit contractor that results in a payment to a provider for a claim or service being reduced either partially or completely.

Proposed law requires that DHH promulgate all rules in accordance with the Administrative Procedure Act (APA) as are necessary to implement the recovery audit contractor program provided for in proposed law.

Proposed law provides that DHH shall require its recovery audit contractor to perform all of the following functions and tasks:

(1) Review claims within three years of the date of their initial payment.

(2) Send a determination letter concluding an audit within 60 days of receipt of all requested materials from a provider.

(3) Furnish in any records request to a provider adequate information for the provider to identify the patient, including but not limited to claim number, medical record number, patient name, and service dates.

(4) Exclude all of the following from its scope of review:

(a) Claims processed or paid through a Medicaid managed care program.

(b) Medical necessity reviews.

(5) Develop and implement a process to ensure that providers receive or retain the appropriate reimbursement amount for claims in which the contractor determines that services delivered have been improperly billed, but were reasonable and necessary. Proposed law requires that the process include but not be limited to a recoupment reconciliation procedure for claims that were improperly coded or reasonable and necessary in another setting.

(6) Prohibit the recoupment of overpayments by the contractor until all informal and formal appeals processes have been completed, except in cases of claims that the contractor suspects to be fraudulent.

(7) Refer claims it suspects to be fraudulent directly to DHH for investigation.

(8) Provide a detailed explanation in writing to a provider for any adverse determination that would result in partial or full recoupment of a payment. Proposed law provides that such explanation include at minimum, all of the following:

(a) The reason for the adverse determination.

(b) The specific medical criteria on which the adverse determination was based.

(c) The qualifications of the individual issuing the adverse determination.

(d) An explanation of the provider's appeal rights.

(e) If applicable, an explanation of the appropriate reimbursement determined according to the provisions of proposed law.

(9) Limit records requests in a 90-day period to not more than 1% of the number of claims filed by the provider for the specific service being reviewed in the previous state fiscal year, not to exceed 200 records. Proposed law requires that the contractor allow a provider no less than 45 days to comply with and respond to a record request.

(10) Utilize provider self-audits only if mutually agreed to by the contractor and provider.

(11) Schedule any onsite audits of a low-risk provider with advance notice of not less than 10 business days and make a good faith effort to establish a mutually agreed upon date and time.

(12) Publish the process utilized for the approval of new issues for review, and post those issues on its website.

(13) On a semiannual basis, develop, implement, and publish on its website metrics related to its performance, including but not limited to the following:

(a) The number and type of issues reviewed.

(b) The number of medical records requested.

(c) The number of overpayments and underpayments identified by the contractor.

(d) The aggregate dollar amounts associated with identified overpayments and underpayments.

(e) The duration of audits from initiation to time of completion.

(f) The number of adverse determinations and the overturn rates of those determinations at each stage of the informal and formal appeal process.

(g) The number of informal and formal appeals filed by providers, broken out by disposition status.

(h) The contractor's compensation structure and dollar amount of compensation.

(14) Post on its website its contract with the department for recovery audit services.

(15) Perform a semiannual review of recovery audit issues and identify any potential opportunities for improvement and correction of medical assistance program

policies, procedures, and infrastructure that would result in proactive and efficient minimization of improper payments. Proposed law requires the contractor to submit such reviews to DHH and to publish such reviews on its website.

(16) At least semiannually, perform educational and training programs for providers that encompass all of the following:

(a) A recapitulation of audit results, common issues and problems, and mistakes identified through audits and reviews.

(b) A discussion of opportunities for improvement in provider performance with respect to claims billing and documentation.

(17) Allow providers to submit in electronic format the records requested in association with an audit. Proposed law stipulates that if a provider must reproduce records manually because no electronic format is available, or because the contractor requests a nonelectronic format, the contractor shall reimburse to the provider the cost of records reproduction consistent with present law, R.S. 40:1299.96.

Proposed law requires that any contract between the department and a recovery audit contractor set the payment or fee provided to the contractor for identification of Medicaid provider overpayments equal to that provided for identification of underpayments.

Proposed law establishes that in the event of an adverse determination, a provider shall have the right to informal and formal appeals processes as provided in proposed law. Provides that the informal appeals process conform with the following guidelines:

(1) From the date of receipt of the initial findings letter by the contractor, there shall be an informal discussion and consultation period wherein the provider and contractor may communicate regarding any determinations for reasons including but not limited to policies, criteria, and program rules pertinent to the determination.

(2) Within 45 days of receipt of a notification of an adverse determination from the contractor, a provider shall have the right to request an informal hearing of such findings, or a portion thereof, with the contractor and the Medicaid program integrity division of the department by submitting a request in writing to the contractor. Proposed law provides for the following with respect to the informal hearing:

(a) The informal hearing shall occur within 30 days of the provider's request.

(b) At the informal hearing, the provider shall have all of the following rights:

(i) The right to present information orally and in writing.

(ii) The right to present documents.

(iii) The right to have DHH and the contractor address any inquiry the provider may make concerning the reason for the adverse determination.

(c) A provider may be represented by an attorney or authorized representative at the informal hearing if written notice of representation identifying the attorney or representative is submitted with the request for the hearing.

(3) The contractor and medical assistance program integrity division of DHH shall issue a final decision related to the informal appeal to the provider within 15 days of the closure of the appeal.

Proposed law provides for the following with respect to a formal appeals process: Within 30 days of the issuance of a final decision or determination pursuant to an informal appeal conducted in accordance with proposed law, a provider may request an administrative appeal of the final decision by requesting a hearing before the health and hospitals section of the division of administrative law and provide a copy of the appeal to the Medicaid program integrity division of DHH.

Proposed law provides that if more than 25% of the contractor's determinations are overturned on appeal in any six-month period, then the legislative committees on health and welfare, jointly, shall hold an oversight hearing to evaluate the contractor's performance and provide the medical assistance program with direction related to corrective action plans and future reevaluation of performance.

Proposed law requires DHH, with input from healthcare providers and in accordance with the APA, to promulgate rules relative to appropriate and inappropriate determinations by recovery audit contractors, and to establish penalties and sanctions to be associated with inappropriate determinations by those contractors.

Proposed law provides that if DHH or the hearing officer in a formal appeal finds that the recovery audit contractor's determination was unreasonable, frivolous, or without merit, the contractor shall reimburse to the provider the provider's costs associated with the appeals process.

(Adds R.S. 46:440.11-440.16)