AN ACT PROVIDING STANDARDS AND REQUIREMENTS FOR MEDICAID OVERPAYMENT AUDITS; PROVIDING REQUIREMENTS FOR RECORD REQUESTS AND REVIEWS; PROHIBITING DETERMINATION OF OVERPAYMENTS BY EXTRAPOLATION EXCEPT IN CERTAIN CIRCUMSTANCES; PROVIDING FOR NOTICE OF AUDIT RESULTS; REQUIRING PROVIDER EDUCATION AND AUDITOR EVALUATION; REQUIRING THE PUBLICATION OF AUDIT RESULTS; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTION 53-6-111, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE.

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

Section 1. Definitions. As used in [sections 1 through 10], unless expressly provided otherwise, the following definitions apply:

(1) "Abuse" means conduct by a 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 medical assistance payments to which the provider is not entitled.

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

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

(4) "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. The term includes any documents submitted as part of or in support of the claim.

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

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

(7) "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.

(8) "Followup audit" means a followup overpayment audit of additional claims data or provider records or both for a particular service code reviewed in an initial overpayment audit after an initial audit has demonstrated a significant error rate with respect to the code to determine whether the provider has complied with applicable medicaid rules, regulations, policies, and agreements.

(9) "Fraud" means 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 to which a 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.

(10) "High-risk provider" means a provider who within the previous 6 years and 3 months:

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

(b) has a documented history of a significant error rate that has been sustained over a period of at least 2 years and that multiple documented educational interventions have failed to correct.

(11) "Initial audit" means an initial overpayment audit to examine claims data and provider records or both to determine whether the provider has complied with applicable medicaid rules, regulations, policies, and agreements.

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

(13) (a) "Overpayment audit" means a review or audit by the department or an auditor of claims data, medical claims, or other documents in which a purpose or potential result of the review or audit is an overpayment determination. The term includes an initial audit and a followup audit.

(b) The term does not include a review or audit by the medicaid fraud control unit.

(14) "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.

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

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

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

(16) "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 chapter.

(17) (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 an individual receiving services under the medicaid program;

(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 such records and documents made and maintained by the provider regardless of whether the records are required by medicaid laws, regulations, rules, or policies.

(18) "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 CFR, part 455.

(19) "Significant error rate" means previous billing errors greater than 5% of the total lines reviewed.

Section 2. Overpayment audit procedures -- provider records -- limitations on record requests and reviews -- onsite audits. (1) When conducting an overpayment audit, the department or an auditor shall:

(a) allow the provider at least 30 days to comply with a request to provide records;

(b) include in a request for records adequate information to allow the provider to identify the particular records sought;

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

(d) allow reasonable extensions of the 30-day compliance period for good cause.

(2) If an auditor is conducting an overpayment audit and requires the provider to provide records in a nonelectronic format, the auditor shall reimburse the provider for the cost of providing the records.

(3) (a) For an initial overpayment audit, the department or an auditor may request up to 6 months of records from a provider for claims paid by the medicaid program up to 3 years before the request was made.

(b) If the department or an auditor demonstrates a significant error rate, the department or the auditor with the department's approval may request additional records related to the issue under review for purposes of a followup audit.

(c) The 3-year limitation in subsection (3)(a) does not apply to a record request by the department or auditor for purposes of a followup audit but does apply to such a request by a recovery audit contractor.

(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 by applicable law to retain records for purposes of the medicaid program.

(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 written notice at least 10 days in advance of the onsite audit. The department or auditor shall make a good faith effort to establish a mutually agreed-upon date and time for the onsite audit.

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

(a) in conducting an initial 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 or a followup audit of any 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.

Section 4. Peer review of overpayment findings. (1) (a) A provider's request for an administrative review of an overpayment determination may include a request for peer review of any clinical or professional judgment upon which the overpayment determination relies. A clinical or professional judgment includes but is not limited to any clinical or professional judgment upon which the provider's evaluation, treatment, records, coding, or billing is based.

(b) The provider's peer review request must identify each clinical or professional judgment to be reviewed and include a statement of the provider's opinion regarding the identified clinical or professional judgment.

(2) If a provider requests peer review, the department shall obtain and consider as part of its administrative review a peer review of each clinical or professional judgment upon which the overpayment determination relied. The department shall mail a copy of the peer review to the provider within 10 days of receipt. The department may not issue its administrative review determination or demand or collect repayment of the alleged overpayment until the department has obtained and considered the peer review.

(3) If at any time during an administrative review, appeal, or other legal proceedings regarding an overpayment determination the department relies on a clinical or professional judgment not identified in the initial notice of overpayment determination and for which a peer review was not previously requested, obtained, or considered, the provider may request in writing that peer review be conducted in accordance with this section. The proceedings must be suspended or stayed until the department has obtained, considered, and responded in writing to the peer review.

Section 5. Audit completion -- notice of overpayment determination -- opportunity to resubmit claim. (1) 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 90 days of:

(a) the receipt of all records requested in the department's or the auditor's initial record request;

(b) a determination regarding fraud in cases in which the department investigates a credible allegation of fraud; or

(c) 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 criminal prosecution.

(2) A notice of overpayment determination, including any notice of audit results under subsection (1) that includes a notice of overpayment determination, must include a detailed explanation of the overpayment determination, including at a minimum:

(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 and any clinical and professional judgment upon which the determination is based;

(e) in cases in which an overpayment resulted from incorrect billing rather than a lack of medical necessity or failure to provide the services or items in accordance with applicable requirements, a statement that the provider may submit a new claim or claim adjustment as provided in 53-6-111;

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

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

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

Section 6. Publication of audit results. At least once a year the department shall publish and make accessible on its website the following information regarding all medicaid 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 by provider type;

(4) the number and aggregate dollar amounts of:

(a) overpayments identified;

(b) overpayments collected; and

(c) underpayments identified;

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

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

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

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

Section 7. Audit education and training. In order to carry out the requirements of 53-6-160(6) and to reduce claims errors, the department shall provide:

(1) educational and training programs for providers at least twice a year to discuss a summary of audit results, common issues and problems, mistakes identified through audits, and opportunities for improvement in provider performance related to claims billings and documentation; and

(2) information on the department's website regarding recurring audit issues, including at a minimum a description of each recurring audit issue, the types of providers affected, the review period in which the audit issues occurred, and any applicable department policy or rule related to the issue.

Section 8. 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 10] do not apply to the medicaid fraud control unit provided for in 53-6-156 but 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 9. 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 comments gathered at the auditor evaluation hearings, the department shall adopt rules for:

(1) appropriate and inappropriate conduct and determinations by auditors; and

(2) penalties and sanctions for inappropriate conduct and determinations.

Section 10. Absorption of costs. Any cost incurred by the department of public health and human services in implementing 53-6-111 and [sections 1 through 10] must be absorbed into the department's existing budget.

Section 11. 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) (a) 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.

(b) When submitting a claim for reimbursement, a provider or the provider's agent may reasonably rely on written instructions and advice provided by the department pursuant to 53-6-160 and [section 7].

(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 if the incorrect payment was the result of the provider's error, except as provided in subsection (3), or if the provider's interpretation of the pertinent rule or billing code is not reasonable; and

(ii) the portion of any interim rate payment that exceeds the rate determined retrospectively by the department for the rate period.

(b) If the decision regarding the amount of a payment to which the provider was not entitled depends on an interpretation of a pertinent rule or billing code, the provider has the burden of proving that its interpretation is reasonable and consistent with:

(i) the information given to providers in any applicable Montana medicaid provider rules or manual, including but not limited to the Coding Resources identified in or incorporated by reference in any applicable Montana medicaid provider rule or manual; and

(ii) any written interpretations by the department that were in existence at the time payment was made to the provider.

(c) 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.

(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.

(e) The department may suspend payments to a provider for disputed items pending resolution of a dispute only as allowed under 42 CFR 455.23 as of [the effective date of this act].

(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) In an overpayment determination involving medically necessary services that were provided in accordance with applicable medicaid requirements but were improperly billed, a provider must be allowed to submit a new claim or claim adjustment for the services and the claim or adjustment must be considered to be timely filed if submitted within 60 days of notice of the overpayment determination.

~~(3)~~(4) 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)~~(5) Subject to subsections ~~(5)~~ (6) and ~~(6)~~ (8), the sanctions imposed under rules adopted by the department under subsection ~~(3)~~ (4) 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)~~(6) 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 is investigating a credible allegation that the overpayment was the result of fraud.

(7) (a) If the department or an auditor identifies an underpayment to a provider, the department shall:

(i) notify the provider in writing; and

(ii) within 30 days of identification of the underpayment, pay the provider the additional amount to which the provider is entitled.

(b) If payment depends upon the provider's submission of a new claim or claim adjustment, a new claim or claim adjustment is timely filed if submitted within 60 days of notice of the underpayment.

~~(6)~~(8) 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 12. Codification instruction. [Sections 1 through 10] are intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [sections 1 through 10].

Section 13. Effective date. [This act] is effective July 1, 2017.

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,

SB 0082, originated in the Senate.

President of the Senate

Signed this _____ day

of _____, 2017.

Secretary of the Senate

Speaker of the House

Signed this _____ day

of _____, 2017.

SENATE BILL NO. 82

INTRODUCED BY A. OLSZEWSKI

AN ACT PROVIDING STANDARDS AND REQUIREMENTS FOR MEDICAID OVERPAYMENT AUDITS; PROVIDING REQUIREMENTS FOR RECORD REQUESTS AND REVIEWS; PROHIBITING DETERMINATION OF OVERPAYMENTS BY EXTRAPOLATION EXCEPT IN CERTAIN CIRCUMSTANCES; PROVIDING FOR NOTICE OF AUDIT RESULTS; REQUIRING PROVIDER EDUCATION AND AUDITOR EVALUATION; REQUIRING THE PUBLICATION OF AUDIT RESULTS; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTION 53-6-111, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE.