ENROLLED

Regular Session, 2014

ACT No. 568

HOUSE BILL NO. 1200

BY REPRESENTATIVE STOKES

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; to require submittal of Medicaid state plan amendments; to provide for effectiveness; 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 is 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 and shall submit all Medicaid state plan amendments 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 within ninety days of implementation of any Medicaid managed care program.

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

(c) Medical necessity reviews in which the provider has obtained prior authorization for the service.

(5) Develop and implement a process to ensure that providers receive or retain the appropriate reimbursement amount for claims within the lookback period in which the contractor determines that services delivered have been improperly billed, but were reasonable and necessary.

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

(d) 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.

(c) If the contractor can demonstrate a significant provider error rate relative to an audit of records, the contractor may make a request to the department to initiate an additional records request relative to the issue being reviewed for the purposes of further review and validation. The contractor shall not make the request to the department until the time period for the informal appeals process has expired, and the provider shall be given the opportunity to contest to the department the second records 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 on its Internet website department-approved issues for review. Information concerning such issues shall include, at minimum, the name and description of the issue, type of provider, review period, and applicable policy relative to the review.

(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, categorized 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 make reasonable efforts to reimburse to the provider the cost of medical records reproduction consistent with the provisions of R.S. 42 CFR 476.78.

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 providing 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.

Section 2.(A) This Section and Section 1 of this Act shall become effective on August 15, 2014.

(B) Any provision of Section 1 of this Act that requires a Medicaid state plan amendment in order to be implemented shall be null, void, and unenforceable until the date of approval of the state plan amendment necessary for implementation, and shall become enforceable upon the date of federal approval of such state plan amendment.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____