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

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

New 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.

New law requires that DHH promulgate all rules and submit all Medicaid state plan amendments as are necessary to implement the recovery audit contractor program provided for in new law.

New 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 within 90 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) 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. New 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) An explanation of the provider's appeal rights.

(d) If applicable, an explanation of the appropriate reimbursement determined according to the provisions of new 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. New law requires that the contractor allow a provider no less than 45 days to comply with and respond to a record request. Provides that if the contractor can demonstrate a significant provider error rate, the contractor may make a request to DHH to initiate an additional records request relative to the issue being reviewed for the purposes of further review and validation. Provides further that the contractor shall not make the request to DHH until the time period for the informal appeals process has expired, and that the provider shall be given the opportunity to contest 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 10 business days and make a good-faith effort to establish a mutually agreed upon date and time.

(12) Publish on its website information on DHH-approved issues for review, including 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 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, categorized by disposition status.

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

(14) Post on its website its contract with DHH 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. New 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. New 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 make reasonable efforts to reimburse to the provider the cost of records reproduction consistent with federal regulations.

New law requires that any contract between DHH 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.

New 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 new 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 DHH by submitting a request in writing to the contractor. New 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 the Medicaid 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.

New 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 new 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 providing a copy of the appeal to the Medicaid program integrity division of DHH.

New 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.

New law requires DHH, with input from healthcare providers, 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.

New 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.

Effective August 15, 2014; except any provision of new law requiring 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.

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