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S.B. 61

MEDICAID AUDIT AMENDMENTS

2015 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Lyle W. Hillyard

House Sponsor: _____

LONG TITLE

General Description:

This bill establishes Medicaid audit standards for the Office of Internal Audit and Program Integrity within the Department of Health and the Office of Inspector General of Medicaid Services.

Highlighted Provisions:

This bill:

- defines terms;
- requires the Office of Internal Audit and Program Integrity within the Department of Health to adopt administrative rules, in consultation with providers, for audit and investigation procedures;
- establishes certain audit and investigation standards for audits and investigations conducted by the Office of Internal Audit and Program Integrity within the Department of Health and the Office of Inspector General of Medicaid Services; and
- makes technical amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

S.B. 61

AMENDS:

26-18-602, as enacted by Laws of Utah 2011, Chapter 362

26-18-603, as enacted by Laws of Utah 2011, Chapter 362

26-18-604, as last amended by Laws of Utah 2013, Chapter 167

63A-13-102, as renumbered and amended by Laws of Utah 2013, Chapter 12

63A-13-204, as last amended by Laws of Utah 2013, Chapter 359 and renumbered and amended by Laws of Utah 2013, Chapter 12

63A-13-502, as last amended by Laws of Utah 2013, Chapter 359 and renumbered and amended by Laws of Utah 2013, Chapter 12

ENACTS:

26-18-606, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-18-602** is amended to read:

26-18-602. Definitions.

As used in this part:

(1) "Abuse" means:

(a) an action or practice that:

(i) is inconsistent with sound fiscal, business, or medical practices; and

(ii) results, or may result, in unnecessary Medicaid related costs or other medical or hospital assistance costs; or

(b) reckless or negligent upcoding.

(2) "Auditor's Office" means the Office of Internal Audit and Program Integrity, within the department.

(3) "Extrapolation" means a method of using a mathematical formula that takes the audit results from a small sample of Medicaid claims and projects those results over a much larger group of Medicaid claims.

[~~(3)~~] (4) "Fraud" means intentional or knowing:

(a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, claims, reimbursement, or practice; or

(b) deception or misrepresentation in relation to medical or hospital assistance funds,

costs, claims, reimbursement, or practice.

[~~(4)~~] (5) "Medical or hospital assistance" is as defined in Section 26-18-2.

(6) "Office" means the Office of Internal Audit and Program Integrity within the department.

[~~(5)~~] (7) "Upcoding" means assigning an inaccurate billing code for a service that is payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking into account reasonable opinions derived from official published coding definitions, would result in a lower Medicaid payment or reimbursement.

[~~(6)~~] (8) "Waste" means overutilization of resources or inappropriate payment.

Section 2. Section **26-18-603** is amended to read:

26-18-603. Adjudicative proceedings related to Medicaid funds.

(1) If a proceeding of the department, under Title 63G, Chapter 4, Administrative Procedures Act, relates in any way to recovery of Medicaid funds:

(a) the presiding officer shall be designated by the executive director of the department and report directly to the executive director or, in the discretion of the executive director, report directly to the director of the Office of Internal Audit and Program Integrity; and

(b) the decision of the presiding officer is the recommended decision to the executive director of the department or a designee of the executive director who is not in the division.

(2) Subsection (1) does not apply to hearings conducted by the Department of Workforce Services relating to medical assistance eligibility determinations.

(3) If a proceeding of the department, under Title 63G, Chapter 4, Administrative Procedures Act, relates in any way to Medicaid or Medicaid funds, the following may attend and present evidence or testimony at the proceeding:

(a) the director of the Office of Internal Audit and Program Integrity, or the director's designee; and

(b) the inspector general of Medicaid services[~~, if an Office of Inspector General of Medicaid Services is created by statute,~~] or the inspector general's designee.

(4) In relation to a proceeding of the department under Title 63G, Chapter 4, Administrative Procedures Act, a person may not, outside of the actual proceeding, attempt to influence the decision of the presiding officer.

Section 3. Section **26-18-604** is amended to read:

26-18-604. Division duties -- Reporting.

(1) The division shall:

(a) develop and implement procedures relating to Medicaid funds and medical or hospital assistance funds to ensure that providers do not receive:

(i) duplicate payments for the same goods or services;

(ii) payment for goods or services by resubmitting a claim for which:

(A) payment has been disallowed on the grounds that payment would be a violation of federal or state law, administrative rule, or the state plan; and

(B) the decision to disallow the payment has become final;

(iii) payment for goods or services provided after a recipient's death, including payment for pharmaceuticals or long-term care; or

(iv) payment for transporting an unborn infant;

(b) consult with the Centers for Medicaid and Medicare Services, other states, and the Office of Inspector General [~~for~~] of Medicaid Services[~~, if one is created by statute,~~] to determine and implement best practices for discovering and eliminating fraud, waste, and abuse of Medicaid funds and medical or hospital assistance funds;

(c) actively seek repayment from providers for improperly used or paid:

(i) Medicaid funds; and

(ii) medical or hospital assistance funds;

(d) coordinate, track, and keep records of all division efforts to obtain repayment of the funds described in Subsection (1)(c), and the results of those efforts;

(e) keep Medicaid pharmaceutical costs as low as possible by actively seeking to obtain pharmaceuticals at the lowest price possible, including, on a quarterly basis for the pharmaceuticals that represent the highest 45% of state Medicaid expenditures for pharmaceuticals and on an annual basis for the remaining pharmaceuticals:

(i) tracking changes in the price of pharmaceuticals;

(ii) checking the availability and price of generic drugs;

(iii) reviewing and updating the state's maximum allowable cost list; and

(iv) comparing pharmaceutical costs of the state Medicaid program to available pharmacy price lists; and

(f) provide training, on an annual basis, to the employees of the division who make

decisions on billing codes, or who are in the best position to observe and identify upcoding, in order to avoid and detect upcoding.

(2) Each year, the division shall report the following to the Social Services Appropriations Subcommittee:

(a) incidents of improperly used or paid Medicaid funds and medical or hospital assistance funds;

(b) division efforts to obtain repayment from providers of the funds described in Subsection (2)(a);

(c) all repayments made of funds described in Subsection (2)(a), including the total amount recovered; and

(d) the division's compliance with the recommendations made in the December 2010 Performance Audit of Utah Medicaid Provider Cost Control published by the Office of Legislative Auditor General.

Section 4. Section **26-18-606** is enacted to read:

26-18-606. Review of claims -- Audit and investigation procedures.

(1) (a) The office shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in consultation with providers and health care professionals subject to audit and investigation under this chapter, to establish procedures for audits and investigations that are fair and consistent with the duties of the division and office under this chapter.

(b) If the providers and health care professionals do not agree with the rules proposed or adopted by the office under Subsection (1)(a), the providers or health care professionals may:

(i) request a hearing for the proposed administrative rule or seek any other remedies under the provisions of Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) request a review of the rule by the Legislature's Administrative Rules Review Committee created in Section 63G-3-501.

(2) The office shall:

(a) notify and educate providers and health care professionals subject to audit and investigation under this chapter of the providers' and health care professionals' responsibilities and rights under the administrative rules adopted by the office under the provisions of this

section;

(b) ensure that the office, or any entity that contracts with the office to conduct audits, has on staff a medical or dental professional who is experienced in the treatment, billing, and coding procedures used by the type of provider being audited;

(c) ensure that a finding of overpayment or underpayment to a provider is not based on extrapolation, unless:

(i) there is a determination of sustained or high level of payment error involving the provider;

(ii) documented education intervention has failed to correct the level of payment error; Ŝ→ **[~~or~~] and** ←Ŝ

(iii) the value of the claims for the provider, in aggregate, exceeds $200,000 on an annual basis; and

(d) require that any entity with which the office contracts, for the purpose of conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both overpayments and underpayments.

Section 5. Section **63A-13-102** is amended to read:

63A-13-102. Definitions.

As used in this chapter:

(1) "Abuse" means:

(a) an action or practice that:

(i) is inconsistent with sound fiscal, business, or medical practices; and

(ii) results, or may result, in unnecessary Medicaid related costs; or

(b) reckless or negligent upcoding.

(2) "Claimant" means a person that:

(a) provides a service; and

(b) submits a claim for Medicaid reimbursement for the service.

(3) "Department" means the Department of Health, created in Section 26-1-4.

(4) "Division" means the Division of Health Care Financing, created in Section 26-18-2.1.

(5) "Extrapolation" means a method of using a mathematical formula that takes the audit results from a small sample of Medicaid claims and projects those results over a much

larger group of Medicaid claims.

[~~(5)~~] (6) "Fraud" means intentional or knowing:

(a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a claim, reimbursement, or services; or

(b) a violation of a provision of Sections 26-20-3 through 26-20-7.

[~~(6)~~] (7) "Fraud unit" means the Medicaid Fraud Control Unit of the attorney general's office.

[~~(7)~~] (8) "Health care professional" means a person licensed under:

(a) Title 58, Chapter 5a, Podiatric Physician Licensing Act;

(b) Title 58, Chapter 16a, Utah Optometry Practice Act;

(c) Title 58, Chapter 17b, Pharmacy Practice Act;

(d) Title 58, Chapter 24b, Physical Therapy Practice Act;

(e) Title 58, Chapter 31b, Nurse Practice Act;

(f) Title 58, Chapter 40, Recreational Therapy Practice Act;

(g) Title 58, Chapter 41, Speech-Language Pathology and Audiology Licensing Act;

(h) Title 58, Chapter 42a, Occupational Therapy Practice Act;

(i) Title 58, Chapter 44a, Nurse Midwife Practice Act;

(j) Title 58, Chapter 49, Dietitian Certification Act;

(k) Title 58, Chapter 60, Mental Health Professional Practice Act;

(l) Title 58, Chapter 67, Utah Medical Practice Act;

(m) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;

(n) Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act;

(o) Title 58, Chapter 70a, Physician Assistant Act; and

(p) Title 58, Chapter 73, Chiropractic Physician Practice Act.

[~~(8)~~] (9) "Inspector general" means the inspector general of the office, appointed under Section 63A-13-201.

[~~(9)~~] (10) "Office" means the Office of Inspector General of Medicaid Services, created in Section 63A-13-201.

[~~(10)~~] (11) "Provider" means a person that provides:

(a) medical assistance, including supplies or services, in exchange, directly or indirectly, for Medicaid funds; or

(b) billing or recordkeeping services relating to Medicaid funds.

[~~(11)~~] (12) "Upcoding" means assigning an inaccurate billing code for a service that is payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking into account reasonable opinions derived from official published coding definitions, would result in a lower Medicaid payment or reimbursement.

[~~(12)~~] (13) "Waste" means overutilization of resources or inappropriate payment.

Section 6. Section **63A-13-204** is amended to read:

63A-13-204. Selection and review of claims.

(1) (a) The office shall periodically select and review a representative sample of claims submitted for reimbursement under the state Medicaid program to determine whether fraud, waste, or abuse occurred.

(b) The office shall limit its review for waste and abuse under Subsection (1)(a) to 36 months prior to the date of the inception of the investigation or 72 months if there is a credible allegation of fraud. In the event the office or the fraud unit determines that there is fraud as defined in [~~Subsection~~] Section 63A-13-102[~~(5)~~], then the statute of limitations defined in Subsection 26-20-15(1) shall apply.

(2) The office may directly contact the recipient of record for a Medicaid reimbursed service to determine whether the service for which reimbursement was claimed was actually provided to the recipient of record.

(3) The office shall:

(a) generate statistics from the sample described in Subsection (1) to determine the type of fraud, waste, or abuse that is most advantageous to focus on in future audits or investigations[~~.~~];

(b) ensure that the office, or any entity that contracts with the office to conduct audits, has on staff a medical or dental professional who is experienced in the treatment, billing, and coding procedures used by the type of provider being audited;

(c) ensure that a finding of overpayment or underpayment to a provider is not based on extrapolation, unless:

(i) there is a determination of sustained or high level of payment error involving the provider;

(ii) documented education intervention has failed to correct the level of payment error;

Ŝ→ **[~~or~~] and** ←Ŝ

(iii) the value of the claims for the provider, in aggregate, exceeds $200,000 on an annual basis; and

(d) require that any entity with which the office contracts, for the purpose of conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both overpayments and underpayments.

Section 7. Section **63A-13-502** is amended to read:

63A-13-502. Report and recommendations to governor and Executive Appropriations Committee.

(1) The inspector general of Medicaid services shall, on an annual basis, prepare a written report on the activities of the office for the preceding fiscal year.

(2) The report shall include:

(a) non-identifying information, including statistical information, on:

(i) the items described in Subsection 63A-13-202(1)(b) and [~~Section 63A-13-204~~] Subsections 63A-13-204(1) through (3)(a);

(ii) action taken by the office and the result of that action;

(iii) fraud, waste, and abuse in the state Medicaid program;

(iv) the recovery of fraudulent or improper use of state and federal Medicaid funds;

(v) measures taken by the state to discover and reduce fraud, waste, and abuse in the state Medicaid program;

(vi) audits conducted by the office;

(vii) investigations conducted by the office and the results of those investigations; and

(viii) administrative and educational efforts made by the office and the division to improve compliance with Medicaid program policies and requirements;

(b) recommendations on action that should be taken by the Legislature or the governor to:

(i) improve the discovery and reduction of fraud, waste, and abuse in the state Medicaid program;

(ii) improve the recovery of fraudulently or improperly used Medicaid funds; and

(iii) reduce costs and avoid or minimize increased costs in the state Medicaid program;

(c) recommendations relating to rules, policies, or procedures of a state or local

government entity; and

(d) services provided by the state Medicaid program that exceed industry standards.

(3) The report described in Subsection (1) may not include any information that would interfere with or jeopardize an ongoing criminal investigation or other investigation.

(4) On or before October 1 of each year, the inspector general of Medicaid services shall provide the report described in Subsection (1) to the Executive Appropriations Committee of the Legislature and to the governor on or before October 1 of each year.

(5) The inspector general of Medicaid services shall present the report described in Subsection (1) to the Executive Appropriations Committee of the Legislature before November 30 of each year.

Legislative Review Note
as of 1-12-15 12:11 PM

Office of Legislative Research and General Counsel